GROUP WORK WITH SURVIVORS OF SEXUAL ABUSE

A SOLUTION-FOCUSED APPROACH

BY (61)

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A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
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LITERATURE REVIEW

1.1 The Nature of the Problem

Some experiences of trauma are so difficult to tolerate that it becomes difficult to think, to speak, and to write about them. Sexual abuse is one of these experiences. Secrecy regarding the experience and silence about the pain surrounding the abuse along with its long-term impact makes sexual abuse a major social problem. Although both boys and girls are vulnerable to being abused, for the purposes of this paper, discussion will be limited to the effects of sexual abuse on girls and women.

Therapists working with survivors of childhood sexual abuse, and women themselves, are recognizing the profound and complex effects of the abuse on an individual, family, and societal level. The woman, as a child in a family, had power and control taken from her when she was sexually exploited. Being a child, she was dependent on the offender, emotionally, physically, or often both. This dependency entrapped her into secrecy. If she told others about the abuse, she faced the risk of being burdened with breaking up the security and the sanctity of the family unit. Further feelings of abandonment and a sense of powerlessness over her life were and continue to be a persistent reality. The people there to protect and support her ended up exploiting, blaming, rejecting, or victimizing her. Her basic concept of being loved and valuable was deeply wounded. The whole self of her developmental life was traumatized: physically, emotionally, intellectually, psychologically, and spiritually. In order to survive the trauma, she developed a variety to ways to cope. The coping activities at the time provided her with adaptations to deal with her environment. These adaptations frequently continued into adulthood. Some of the adaptations became problems which now, as an adult, bring her into therapy.

On a societal level, elements were present that not only maintained the secrecy of the abuse but also allowed the abuse to occur. Our historical context as human beings has been one of male domination and male privilege with women and children held in submission. Women and children have been viewed as the property of men with little or no power. Now, as in the past, it has been difficult to confront the perpetrator and to hold him accountable. At times the focus has shifted to the aftereffects of the abuse on women or children. Instead of recognizing the source of the problem as the result of male violence and exploitation, the responsibility is put on the victims to heal themselves and to "get on with life". There are laws to protect women and children who are vulnerable but the justice system in its emphasis on providing a fair trial to the accused has been largely impotent in enforcing these laws. And when society has acknowledged abuse at all, it is often the survivor who has disclosed who has become stigmatized again. Little, if any support has been provided to the survivors of abuse in the past. These elements continue to allow sexual abuse to occur today as well as help to suppress an examination of these experiences.

And yet, people can heal and recover. More than one survivor has been able to develop and utilize supports and resources both within herself and from supportive others to deal with the abuse. If a survivor can talk about what she feels is necessary regarding the sexual abuse as well as its impact on her life, and receive the support she needs while doing this, healing can occur. A survivor can learn to recognize and deal with the symptoms stemming from the abuse that disrupt her life. She can rework the thoughts related to the abuse so she can learn to live a satisfying life.

In the past, the role of the mental health professions in working with women who have been sexually abused as children has been one of minimizing, silencing, and exploiting the victims and survivors. As professionals began to understand the trauma of childhood sexual abuse the silence could no longer be contained. Professionals who listened to and were taught by survivors became aware of the complexities of the abuse in

shaping women's lives, identities, and experiences. It has taken time for the helping professions to develop an understanding of the problems presented by women who were victims of of abuse. We are only now in the last two decades becoming aware of some of the discussion that can be helpful in the recovery process of these women and their families.

Initially, therapeutic work with women who had been traumatized centered around validating and reworking the experiences of abuse. It is now recognized, however, that a survivor also comes with many adaptations, strengths and solutions she has already used in her survival. Therapists need to acknowledge these solutions. In walking through the long, slow journey of healing, a survivor will be facilitated in her process by helping professions' recognizing healing that is occurring thereby validating her strengths. Positive changes can continue in therapy with the co-creation of new solutions by therapist and survivor. In order for healing to occur, therapists need to learn to work as the survivor participates in her own recovery.

In order to receive hope or remain hopeful, the survivor needs to be encouraged that many other women have survived and are now living satisfying lives. Group participation is an excellent vehicle for this. Group support allows for a fuller resolution of the issues of secrecy, guilt and shame, isolation, and powerlessness. A survivor can learn that separation from family need not always lead to further loss and victimization. She may learn to value herself and set limits with her family in order to have a relationship based on mutuality rather than domination. In addition, she may recognize that some family and friends in her supportive network may want to continue to support her. She may need some coaching as to how to receive support from them. In her efforts to distance, connect and reconnect, she can learn how to care for herself rather than be exploited. Instead of further erosion in her concept of self in relationships with others, she can become empowered as she sees how other women have used their strengths to survive.

The study and work in this area is a difficult one. Speaking about the horrible experiences of abuse that no one wants to talk about is traumatizing for both therapist and survivor. So are the destructive family and societal messages which maintain the denial, guilt and shame, imbalances of power, distorted communication, isolation, and blurred family boundaries. Unless some intervention occurs, these familiar but destructive messages are allowed to continue. The emotional, behavioral, and cognitive elements that make up the bonds of relationship, whether the bonds be within family or in society at large, need to be examined. As well, the nature of these bonds need to be examined in order for growth to occur. This student believes the use of the group is a powerful context in which to examine a survivor's strengths as well as her maladaptive ways of functioning, since they can be acknowledged in the relationship of a safe community. Growth within each woman and as well as growth within her relationships is the goal of group work. Growth includes pain, confusion, regression as well as excitement, healing, and recovery. Each sign of awakening can be supported in this climate of growth within the group.

It would be helpful to develop more research around how therapists can become more effective in participating in the healing process. Methods of measuring change as well as the effectiveness of the change from the survivor's perspective will be included in this practicum.

1.2 Definition

What makes an experience sexual? What makes a sexual experience abusive? The answers to these questions involve asking: *Who* is involved and *what* is happening? Definitions of sexual abuse vary according to the activity engaged in, the ages of the victim and perpetrator, and the age difference between them. A wide range of behaviors,

alone or in combination, may be expressed. The inability of the victim to give informed consent to the sexual involvement is usually considered.

In a study at the University of Manitoba, (Jehu, 1988) the researchers looked at several features which they used in their definition of sexual abuse: the abuse occurred over a lengthy period; it included bodily penetration; the perpetrator(s) were considerably older; coercion was used; the victims experienced the abuse as negative; and the attempts at disclosure were met with negative reactions.

Ellenson (1986) defines childhood sexual abuse as repeated physical contact of a sexual nature between an adult and a child. The adult is in a position of trust, authority, or a caretaker (regardless of kinship) and is one who has violated their position.

Other authors would add that physical contact need not always be present for the experience to be abusive. Courtois (1988) says that the contact with the child may or may not be genitally focused. What is important is that the major focus of the contact is the erotic gratification of the adult, and the relationship reflects the dynamics of abuse either overtly or covertly. The perpetrator represents someone from whom the child victim should rightfully expect warmth, protection, nurturance, and sexual distance (Courtois, 1988). Instead, the needs of the child victim are ignored. The perpetrator will have a strong desire to keep the sexual activity a secret. The need to maintain the secret may result in further coercion.

The Ontario Association of Professional Social Workers (1983) provides the following definition:

"sexual abuse is the use of a child for the sexual gratification of an adult, or the allowing of such use of a child by a parent, caretaker or legal guardian. It includes any manual, oral, or genital sexual contact, or the use of an object for sexual penetration, or other explicitly sexual behavior that an adult family or caretaker imposes on a child by exploiting the child's vulnerability and powerlessness. It also includes exploitation of a child for pornographic purposes, including posing children for photographs, alone or with

other children or adults, or animals, which are sexual or erotic in content, and /or making them available as child prostitutes." This wider definition includes the behaviors which are exploitive of the child's sexual vulnerability for the perpetrator as well as others who may use the exploitation for their own gratification.

Some research definitions of incestuous sexual abuse requires an age difference between the perpetrator and the victim to be at least five years and that the victim be 14 or 15 years or younger (Briere, 1989). Other definitions believe the age of a child is important. Diana Russell, a sociologist and human rights activist, has conducted the most sophisticated epidemiological survey in the early 1980's, using 900 women (Herman, 1992). Her respondents reported the following concerning their age of onset: 11% were abused for the first time before age five; 19% between the ages of six to nine; 41% between the ages of ten and thirteen; and 29% between fourteen and seventeen (Courtois, 1988). In addition, she states that most perpetrators are considerably older than the five year age difference.

The range of sexually abusive behaviors as outlined by Sgroi (1982), are on a continuum from exhibitionism to intercourse, and can include gestures, comments, and observation as well as actual bodily contact. Courtois (1988) adds that the hierarchy of the behaviors in which either force or penetration were used does not necessarily determine which behaviors are the most disturbing or damaging to the child. All forms of abuse are serious and affect the victim, even though children may react differently at different times (Gil, 1983).

The definition of childhood sexual abuse that this student will use in this practicum will include all behaviors of a sexual nature between an adult who is in a position of trust, authority, or caretaking, and a child, regardless of kinship. The behaviors are exploitive of the child for the gratification of the erotic needs of the adult. The needs of the child for nurture and comfort from the adult will have been either ignored or violated to satisfy the adult in a sexual manner. The definition for childhood sexual abuse will include incest

when the perpetrator was a family member, sexual molestation, sexual assault, and exploitation for the purposes of pornography or prostitution.

This broad definition of childhood sexual abuse is useful for therapeutic purposes. In order for therapists to understand the impact of the abuse on the child who is now an adult, a broad definition is helpful since many exploitive experiences during childhood may have distorted a survivor's identity and relationships. In addition, the child victim may have experienced repeated victimizations throughout her lifetime by several adults and older children. All of the victimization experiences have an profound influence on the child who is now an adult. The meaning of these experiences will be expressed in the symptoms she presents clinically. Fragments of these experiences may surface in her memory and be presented as problems she brings to clinical work prior to the memories of sexual contact with a close relative or trusted adult. As she feels safe to work on the memories and is supported while talking about her secret, she will bring into therapy that what she sees as necessary for her own healing.

1.3 Incidence of Childhood Sexual Abuse

Until the last twenty years, the incidence of sexual abuse was believed to be rare, or indeed rarely spoken about. Olafson, Corwin and Summit (1993) reviewed studies to determine how prevalent it was in the past. They used anecdotal accounts by physicians, government investigators, court records and popular folklore. Their findings indicate that domestic servants, especially children, were frequently vulnerable. Some more specific findings indicated that in the American South, slave girls were subjected to rapes and forced breeding as were Chinese slave girls on the west coast. The Victorians linked sexual abuse to poverty and overcrowding. In contrast, medical science connected insanity and sexual behavior but saw the sexual behavior, not sexual victimization, as the cause of sexual abuse. The children who reported accounts of sexual victimization were

viewed as untruthful, "fantasy-based lies". Womens' stories of accounts of childhood sexual abuse were labeled as "the lies of hysterical women".

The frequency of childhood sexual abuse and its pervasive traumatic psychological effects were described as early as 1896 by Freud in his seduction theory. In his studies to solve the mystery of hysteria he recognized one or more occurrences of premature sexual experiences. He also discovered that the hysterical symptoms could be alleviated when the traumatic memories, as well as the intense feelings which accompanied them were recovered and put into words (Herman, 1992). Social class, power, and gender issues were some of the issues raised by Freud when he validated the accounts he heard. He suggested that incest was more common than suspected, even in respectable families. Due to the radical social implications of his hypothesis, the theory was later repudiated by Freud and he ascribed the accounts as early childhood autoerotic fantasies. The result of this repudiation by Freud was that psychoanalysts were taught to treat the memories of the trauma as sheer fantasy (Herman, 1981; Draucker, 1992; Meiselman, 1990; Olafson, Corwin, and Summit, 1993).

Following that period, victims' accounts continued to be silenced, minimized or blamed. In the latter part of the seventies, feminists, social workers, and rape trauma specialists pioneered work into sexual abuse awareness (Olafson, Corwin and Summit 1993; Butler, 1985; Browne and Finkelhor, 1986; Herman, 1981, 1992). Finkelhor, in a 1985 study for the Los Angeles Times, found that 27 percent of the women and 16 percent of the men disclosed a history of some kind of sexual abuse during their childhood. Russell's large scale study indicated that approximately 20% of all women had at least one incestuous experience before the age of 18 (Courtois, 1988).

Using Canadian statistics, the 1984 Badgley Report in its Committee on Sexual Offences Against Children is often cited as being the most recent and extensive data (National Health and Welfare, 1989). It found that about one in two females and one in three males have been victims of one or more unwanted sexual acts as children (ranging

from exposure to forced intercourse). This report stated that threats were used on 17% of the girls under 18 years, and about 1/3 of both the boys and girls in the sample groups suffered either attempted or actual rape.

A random sample of 1006 women drawn from the national population of Canada completed a questionnaire that was delivered and collected by a member of the survey staff. The response rate in this survey was 94%. Twenty-three percent of the respondents cited an unwanted touching of a sex part of their body prior to 18 years (Jehu, Gazan, and Klassen, 1988).

Croll (1991) reported a survey of 149 adolescent runaways in Toronto which stated that 73% of the females and 38% of the males reported sexual abuse in their histories. She also stated more recently discovered facts about child sexual abuse. Some of these facts state that the rates of sexual abuse do not vary significantly across socio-economic, education or ethnic groups; the median of sexually abused children is 11 years; girls from the ages 10-13 years are the most vulnerable for incest; the average length of time of an incestuous relationship is 3 years; the abuse is rarely a one time event; 85-90% of the offenders are known by the victims; and 86% of sexual assaults occur in the home of the victim or perpetrator (Croll, 1991)

Even though it is difficult to ascertain the exact incidence of child sexual abuse, there is evidence that this is a major problem, as reported by women who were sexually abused as children. Finkel (1987) notes that 25% of women in Canada were sexually abused at least once before the age of 16:

"Given these numbers, it is easy to see that not only is sexual abuse a closely guarded secret of the child and the family, but the maintenance of the secret is inadvertently and even deliberately supported by health care professionals. " (p.245)

From these numbers, one can state with confidence that childhood sexual abuse is, unfortunately, a common event in women's lives. Just how prevalent the problem is depends on the definition of abuse that has been used. In reviewing the data, it is clear

that sexual abuse is a frequently occurring event and that professionals need to pay attention to its effects on the victims.

1.4 Dynamics of Sexual Abuse within Families

In order to understand experiences of women who were sexually abused in childhood, it is helpful to study the pattern of the occurrence of the abuse within the environment of a dysfunctional family system. Sexual abuse in the family contradicts everything that a family represents for a young, immature child, in need of nurturance and protection. The dysfunctional family dynamics that were present as a child usually persist into adulthood. The dynamics do not cause the abuse to occur, but they allow the conditions for the abuse, as well as the secrecy surrounding the abuse to take place. It is therefore necessary to be aware of the family dynamics when working with survivors since they develop adaptations to cope with dysfunctioning within the environment. Survivors, as adults, continue to communicate using these adaptations in therapy. The adaptations may become symptoms which bring women into therapy.

Sexual abuse occurs within many forms of "family" (Croll, 1991). The family may be urban or rural. They may be families who are experiencing socio-economic difficulties such as unemployment, alcohol or drug abuse (Black, 1990), and/or physical violence. Fortune (1983) and Heggen (1993), see parents who belong to a conservative religious group with traditional role beliefs and rigid sexual attitudes as being a predictor for fathers to sexually abuse their children (Heggen, 1993).

Perpetrators of sexual abuse are usually members of the immediate family or are part of the family system or network. Immediate family members may include mother, father, stepfather, brothers, sisters, with the male members being the most frequent offenders (Courtois, 1988). Extended family members may include grandparents, aunts, uncles, cousins who are related to the family. Also included in the list of perpetrators are

people whom parents have trusted. They may be friends of the parents, neighbors and other community members working in daycares, schools, churches, and clubs (Croll, 1991).

Stages of Sexual Abuse

Sexual abuse usually begins gradually and occurs over a period of time. Sgroi, Blick, and Porter (1982), suggest five stages through which the sexual abuse is formulated: (1) the engagement phase; (2) the sexual interaction phase; (3) the secrecy phase; (4) the disclosure phase; and the (5) suppression phase (Courtois, 1988).

The engagement phase provides an opportunity for privacy, vulnerability, and inducement of special favors or attention. It allows for the exploitation and misuse of power by an adult in a position of accepted power and authority over a child who needs love and attention. The authority of the adult implies to the child that the behavior is acceptable. And yet, from the perspective of the child, her place of safety has been violated.

The sexual interaction phase is a progression from less to more intrusive sexual activity such as exposure to actual body contact, including penetration. The perpetrator further transmits confusion about sexual behavior, affection, bodily integrity, arousal, pain, and morality.

During the secrecy phase the perpetrator must pressure or persuade the child to maintain the secret to eliminate accountability and allow for the repetition and continuation of the addicting /compulsive behaviors. In this stage the child may be made to feel responsible to please the perpetrator, to protect family members, or to maintain the pleasure and attention from the relationship. Shame and blame, as well as threats and violence, are also used to keep the secret. Secrecy often seems the only option for the victim since she had no place to go, no one to tell, and no one to listen to her. Ganzarain and Buchele (1987), also suggest that it may be helpful for therapists to look at her

behaviors for secret keeping as meaningful ways of coping to master the traumatic experience.

The disclosure phase includes the stage in which the secret escapes either accidentally or purposefully. Unless the disclosure is planned, this phase may result in a crisis reaction. The response of the family depends on the domination of the offender, on family loyalty, and on outside support. In some cases, rather than being listened to, the victim's statement is viewed with disbelief. Mothers can either protect the child or deny the allegations as a self-protection measure for themselves or their family. It is very difficult for a mother to support her child unless there is immediate intervention to force responsibility on the father/perpetrator (Summit, 1983). A mother frequently has to choose between supporting her child or protecting her marriage (Steed, 1994). If she is economically and emotionally dependent on the husband/perpetrator, she will feel forced to react with disbelief in order to protect her marriage. Disclosures are also made difficult for children because they lack the language to express what is happening. Gold-Steinberg and Buttenheim (1993) recognize the inadequate vocabulary the child victim had developmentally to either conceptualize or name what she was experiencing.

The suppression phase allows for the family's minimization of the severity of the abuse and the child's response to it. Pressure to suppress the reports is most intense when there is a great deal of contact with the victim. She is frequently threatened with dire consequences. As a result, she may recant the allegations or refuse to receive intervention. Her experience is that, instead of compassion, concern, or protection, she is greeted with disbelief and hostility (Courtois, 1988). Many of the threats used to maintain the secrecy come true. As a result the victim admits to lying "to do what is good to preserve the family and to undo the bad that threatens to destroy it" (Courtois, 1988).

A child caught in this environment has very few effective options. Herman (1992) recognizes this experience as a formidable developmental task. The child must find

a way to form and maintain primary attachments to caregivers who are either helpless, dangerous or negligent, or untrustworthy and unsafe. She must find a way to develop a sense of self in relation to others who are uncaring and cruel. She has to find a way to self regulate her body when her body is at the disposal of others' needs. She has to develop the capacity for initiative while surrounded by demands that she must conform to her abuser. In addition she has to develop a capacity for intimacy when all her intimate relationships are corrupt and identify her as a whore and slave.

Existentially, her task is equally formidable (Herman, 1992). She needs to find a way to preserve hope and meaning while being abandoned to a power without mercy. To preserve her faith in the fantasy of loving parents, she must reject the obvious which is that they are terribly impaired. She will go to great lengths to absolve her parents of any responsibility and blame.

Family Dynamics

Courtois (1988) further describes the family process in which sexual abuse occurs. To begin with, the family will have rigid boundaries with regard to outsiders which enable the sexual activity to occur and to remain secretive. The family is frequently isolated from others so that it is difficult to disclose to anyone. Instead of having individual identities, members are enmeshed with each other so that they look to each other for meeting their needs. A child who is sexually abused is given conflictual messages which make it difficult to leave or escape, e.g. "If you leave me, I lose part of me."

The communication system is ineffective regarding healthy sex, feelings, and attitudes. The family has a poor body self image with a shame based, negative view of sex and the body. Physical touching for affection becomes equated with physical and sexual abuse. This is due to the distortion of the erotic potential of individual family members. It is restrained in one area while fostered inappropriately in another (Larson and Maddock,

1986). There is generally a lack of a knowledge about sex, instead there is an emphasis on societal myths, distortions, and stereotypes.

Roles among members become confused so that children take on the parenting roles. There is a lack of respect for gender differentiation with rigid role expectations. Power and control imbalances exist between the marital couple. The abuser believes in and maintains a hierarchical order of his supremacy within an intimate relationship. This allows him to maintain control over other members. Gender relations are deeply embedded not only in family relations, but also reinforced by society. The gender paradox that women can not and should not stand up to men and yet women need to take care of men is modeled not only within family but in all of society (Goldner, et al, 1990). Role contradictions organize family life and lead to internal confusion. Appropriate boundaries are lacking between family members and generations (Courtois, 1988), which can also then set the stage for the multigenerational transmission of sexual abuse.

The family develops messages which Black (1990) calls rules to protect the family. The common ones are that it is not safe to feel, talk, or trust. The survivor is expected to be in control of any outward expressions at all times and not ask for help. It is important to deny what is really happening, to disbelieve her own senses and perceptions. This will help to keep the secret. In order to prevent the perpetrator from taking responsibility, the child victim must accept blame for everything (Courtois, 1988).

The family system in which the sexually abused child grows up is therefore a very powerful context for forming and deforming her identity and her relationships. Her needs are not recognized, her reality is distorted, her experience is denied or minimized, she cannot escape and/or discuss her trauma. This sets the stage for powerful and long lasting aftereffects.

1.5 THE AFTER EFFECTS OF CHILDHOOD SEXUAL ABUSE

The Initial Effects

In determining the extent of trauma to the child as a result of sexual abuse, no single contributing factor seems to be associated with a more unfavorable prognosis. However several factors should be considered in looking at the severity of the aftereffects. One important factor is the status relationship of the child and adult. The more closely related and the greater the distance in ages between the adult and child involved, the greater the potential for trauma (Courtois, 1988; Larson and Maddock, 1986). Another factor is the amount of force or threat that was used to coerce the sexual activity. However, it should be noted that current indications are that incestuous abuse does not usually involve much physical force or coercion (Courtois, 1988; Draucker, 1992). For some survivors, however, the greater the use of force, the greater the negativity of the experience. The longer the time frame during which the incest occurred, along with the younger the age of onset, the greater is the potential for trauma. The degree of social isolation coupled with a lack of normal social development outside the home intensifies the incest experience as negative. The ability of the other parent to nurture and protect from further trauma has a powerful impact on the victim as does the nature of the reaction to any abuse disclosure by parents, siblings, social service and law enforcement agencies (Butler, 1985). The meaning of the experience to the child, which may change over time, needs to be understood as a factor. Direct or indirect sexual contact has an impact in that penetration usually involves more disturbing consequences (Meiselman, 1990). All of these factors influence the impact of the trauma on the child.

The prolonged aspect of the abusive environment forces the development of abnormal aftereffects in the child as she responds to the trauma. The trauma or psychological impact of the abuse on the child can be experienced in the following ways:

traumatic sexualization; powerlessness; loss and betrayal; and stigmatization (Beverly James, 1990; Finkelhor & Browne, 1986).

Traumatic sexualization occurs through the child victim being rewarded with inappropriate sexual behaviors, the meeting of non-sexual needs through sexual behavior, and through sexual activity being conditioned with negative emotions and memories. As a result, feelings of confusion surface with regard to sexual identity and sexual norms. Non-sexual needs become distorted with sex. Negative associations are made about the body and arousal sensations. There may be an aversion to sex and intimacy. On the other hand sexual preoccupations and compulsive sexual behaviors may be apparent (Croll, 1991).

Powerlessness results from the child's lack of control over her own body; her inability to protect herself or stop the abuse; her susceptibility to force or trickery; and her inability to persuade others of the reality of her story. The child is left with feelings of fear, anxiety, shame, inadequacy, and need for control (Croll, 1991). The violence and threats may leave her with an omnipresent fear of death and abandonment. The violence may also force her to adopt a position of complete surrender or constant alertness. She may avoid, placate, or automatically obey the abuser (Herman, 1992). The anxiety and fear may show up in compulsive and ritualized behavior and phobias; sleep, feeding, and elimination disturbances; perceptual distortions; dissociative reactions; mood swings; hypervigilence and hyperactivity (Courtois, 1988). Since children have a high capacity to induce a trance, this form of dissociation becomes a useful way to ignore severe pain. She may hide her memories in complex amnesias or alter their sense of time, place, or person. She may also induce hallucinations or possession states and fragmented personality states (Herman, 1992).

The state of loss and betrayal recognizes the many losses the child has experienced as a result of her victimization, i.e.; her childhood; her self-worth; her trust in self and others; her freedom to develop at her own pace; her availability for love, affection,

nurturing and intimacy; and her life assumptions and dreams. She was betrayed by her vulnerability, by her feelings, by her "specialness", by her own body responding to the abuse, and by her lack of protection from adults. As a result she is left with feelings of grief, despair, and depression. She does not trust her own judgment as well as that of others and she may be extremely dependent. Anger, hostility, shame and guilt may be present.

The stage of stigmatization occurs when she has been blamed by the perpetrator for the abuse. The experience is forced into secrecy, thereby indicating its negativity. The perceptions she forms about her self as a result of the abuse are that she is shameful, that she holds the guilt for the abuse, and that she is different from others. She is left with a low sense of self-worth. Blume (1990) says that she blames her self as an adaptation to control the abuser and her environment. The threats of her abuser feed her guilt in that she chooses sex rather than beatings or abandonment. She fails to see the cruelty and absurdity of holding the child responsible for making such choices. She may take care of the shame she is left with by making herself invisible, by being very good, "perfect", or by acting out her "badness" (Blume, 1990).

The hostile environment of the child victim forces the child to develop extraordinary capacities, aftereffects, which are both creative and destructive (Herman, 1992). These adaptations often become well established and continue into adult life. They have enabled the child to survive and have allowed her to preserve the appearance of normality. They permit her to cling to the hope that when she grows up she will be able to escape and have freedom. However, the personality that was formed in the dangerous, negligent, or untrustworthy environment has some maladaptive problems in adult life. The aftereffects of the trauma continue to emerge in her life with presenting symptoms. These presenting symptoms will be more closely examined in the long-term effects of the trauma.

Long Term Effects

The long term effects often include all of the initial aftereffects. They may be described as chronic manifestations of acute aftereffects or they may develop in a delayed fashion (Courtois, 1988). Defenses which allowed her to survive the abuse now prevent her from living in a climate of freedom and interfere with her daily living. In addition, the secrets from her past may become too burdensome. Often she fears that she is going insane or that she has to die. The long-term effects will be categorized, as suggested by Courtois (1988) in the following groupings: emotional, self perceptions, physical/somatic, sexual, interpersonal, and social. The spiritual will also be added.

Emotional effects frequently bring a survivor into the mental health system. They may persist over time but vary in continuity and intensity. They include the mood disturbances, with chronic depression being common (Dolan, 1991; Meiselman,1990). These feelings, as well as the flashbacks, are often evoked by the traumatic experiences which remind a woman of the terror, grief, and rage. The feelings are on a continuum ranging from unease, through states of anxiety and dysphoria, to extremes of panic, fury and despair. Sleep disturbances are common. The initial protective feeling of detachment and depression is useful, but may become pathological in that she may disconnect from others and disintegrate from her self (Herman, 1992). The survivor's response to this is that she feels numb, detached, or dead inside.

Self-destructive behaviors such as self-mutilation may be a survivor's attempt to terminate her annihilating feelings and flashbacks. This major jolt to her body can be viewed as her way to produce a feeling of calm and relief from the emotional pain. Herman (1992) especially views the self-destructive behavior as a pathological self soothing mechanism and notes that a distinction must be made between repetitive self injury and suicide attempts. Other self-destructive behaviors to regulate a survivor's

emotional state may include chemical dependency, eating disorders, compulsive risk taking and compulsive sexual behavior.

Feelings of helplessness and powerlessness continue in the survivor's life. In addition, a variety of dissociative responses continue in order for her to adapt to these feelings while still retaining an attachment to her parents who were helpless, exploitive, or cruel. If she does feel, her fear may be that her feelings will be so intense that she will hurt others, go crazy, or cause others to further abandon or reject her (Courtois, 1988). Not only is she fearful that her own rage will explode, but having the rage exist within her is also deeply repugnant to herself. A great deal of energy is used to suppress, avoid, and deny these feelings, resulting in feelings of helplessness and powerlessness.

A survivor's feelings of horror and rage may be represented by hallucinations and nightmares (Ellenson, 1989). The hallucinations often suggest an incest experience by their content. Ellenson (1986) has studied these hallucinations and has suggested that they tended to be brief and elementary. Visual hallucinations were similar in the women he studied. The shadowy figures were described as dark featureless silhouettes, nearly always male and evil. The figures were usually seen from the client's bed and at the foot of the bed. Mobile figures were engaged in rapid, darting movements sometimes seen out of the corner of the eye. Common psychosensorial auditory hallucinations he studied included footsteps, breathing, doors and windows opening and closing, thuds, or a name being called. Psychic auditory hallucinations were more elaborate and included persecutory voices with condemnation or threats, directive voices which goaded survivors into physical mistreatment of themselves or others, and inner helper voices which attempted to soothe and defend the survivors. Other hallucinations, such as tactile, kinesthetic, somatic, and olfactory, were reported although they were somewhat less common.

Self perceptions are emotional effects which are predominantly negative for the survivor (Courtois, 1988). The perceptions of the self are marked with a sense of badness and shame, confusion, stigmatization, and a feeling of being different from others. As a child, in order to preserve a faith in her parents, she rejected the conclusion that something was wrong with them. She was left with the belief that the abuse happened because she was "bad", since then her parents could be "good". This sense of badness may have been confirmed by her parents blaming her for whatever happened so she, in turn, became the scapegoat. Participation in the sexual activity confirmed her innate sense of badness and enforced compliance with others. She took the evil of her abusers into herself to preserve her primary attachment to her parents. Her need for attachments kept this contaminated identity strong into adulthood. The shame she recognized in herself was often camouflaged by her attempts to please, be good, perform well. She became a very empathic caretaker, an academic achiever, sacrificing for the togetherness of her family.

These two self representations, a debased and an exalted self, are difficult to integrate. In extreme situations, they split from the self, forming dissociated alter personalities. Also, in order to preserve her faith in her parents, she may direct her anger at one parent, usually the non-offending one, and idealize the other parent. The fragmented self prevents her from integrating knowledge, memory, emotional states, and bodily experiences (Herman, 1992). The fragmentation makes it difficult for her to connect her thinking and feeling.

Physical/ Somatic effects for a survivor appear in ways that seem like the body is fighting itself (Courtois (1988). Physical effects she experiences may be related to the type and locus of the abuse - breasts, thighs, genitals, genitourinary organs and their functioning; nausea, gagging, vomiting, or choking reactions; rectal discomfort, hemorrhoids, constipation and diarrhea. She is prone to stress related diseases such as migraines, headaches, joint pains, gastrointestinal problems, as well as having a weakened

immune system. Because her body put her in jeopardy as a child, she may now, as an adult, feel disconnected from her body. Her self and her body may not feel like the same thing. Touching often feels like violation, rather than affection. Nakedness may feel like defenseless exposure. Bathing activities may be carried out in a protective way. She may overprotect her body or dress it in a sexually inappropriate way. She may manipulate her body size with overeating to become powerful or with purging to become invisible or perfect. The alienation from the body can result in a failure to heed signals to take care of the body.

Sexual effects a survivor experiences are results of the child victim being confused about sexual identity, norms, love, sexual arousal, sexual activity and intimacy. A survivor's sexual emergence in early adulthood can be one of either withdrawal or indiscriminate sexual activity. In order to achieve some mastery over her body she may use men sexually. Prostitution may be also be a means of acting out negative self. Some survivors feel their sexual activities were trouble-free until they entered into a committed intimate relationship. It is at that point that they feel trapped again into meeting sexual demands (Courtois, 1988).

Courtois (1988) states that is unclear whether problems with sexual orientation and preference are related to abuse . Blume (1990) states that, although incest does not create homosexuality it does have an effect on lesbians; i.e., self-doubt, self-hate and confusion. Courtois (1988) recognizes that survivors who are basically heterosexual may choose to have female sexual partners because of their fear of men and their belief that they can only be safe from sexual abuse when experiencing sex with a woman. Some researchers have suggested that some incest survivors have become lesbians in order to work out a personal solution to disturbances associated with incest (Maltz and Holtman, 1987). Herman (1981) reported that the incest experience was a causal factor in the development of a lesbian's sexual preference. Furthermore, she states that the lesbian

identity provided some degree of mastery over the trauma and allowed survivors to achieve a healthier and more satisfying personal life than would have otherwise been possible. Moberly (1983) suggests the unmet developmental needs from the lack of same gender nurturing by an non-protective parent may be connected to the homosexual condition.

Survivors do, however, report problems with sexual arousal, response and satisfaction (Courtois, 1988: Meiselman, 1990; Jehu, Klassen, and Gazan, 1988). Sexual desire may be low or there may be an aversion to sexual activity. This may be due to the negative conditioning from the past as well as the negative emotions such as fear, helplessness, shame and disgust associated with the abuse activities. The ability to become sexually aroused and to perform sexually may be impaired. Orgasmic disorders are common. Pain may be present during coitus as the result of conditioned involuntary phobic response or from actual physical injuries from the abuse. Intrusive flashbacks with reexperiencing symptoms can be triggered by any sexual activity which impair her ability to function sexually. Her response to the flashbacks may be to go numb or to dissociate, to become hyperalert, or be unable to relax. Other responses include insomnia, sexual deviance, chemical abuse, increased vulnerability to revictimization, the tendency to reenact the trauma by victimizing or abusing others, and by mistrusting intimate relationships.

Interpersonal problems for a survivor include isolation, insecurity, stressful and unstable relationships, difficulties in intimacy, and difficulty with authority figures (Jehu, Klassen, and Gazan, 1988 and Meiselman 1990). Her intimate relationships are driven by the hunger for protection she did not receive as a child and by the fear of abandonment or exploitation. It becomes very difficult for her to trust others. She develops a pattern of intense unstable relationships while enacting situations of rescue, injustice, and betrayal.

The abuse dynamics may be replayed in the choice of her partner. She may choose an dominant and/or older man who can take care of her and provide her with protection. On the other hand, she may find an immature partner who desires her caretaking but can give her very little in return. Or she may end up with an abusive or neglectful partner. Her longing for nurturance makes it difficult to establish safe and appropriate boundaries. She is at great risk for repeated victimization. For her, it seems to be the price to pay for being in a relationship. Her dissociative skills lead her to ignore or minimize the social cues that would ordinarily alert her to danger. She has outgrown her fragmented identity and dissociative defenses which were useful to her as a child. These adaptations prevent her from living in freedom and adult responsibility (Herman, 1992).

The relationships a survivor has with her family of origin often continue to be conflicted. These difficulties can be projected onto in-laws and other authority figures. Her conflicts with her mother often continue unresolved long into adult life. Her ungratified need for nurturing often keeps her with a hostile and fearful attachment to her mother.

Parenting her children may or may not be problematic. Due to her having experienced weak parenting, her own parenting skills may be weak but she may be very motivated to provide for her children the nurturance and protection that she did not receive. It is often the desire to nurture her children effectively that brings a survivor into treatment. Other survivors repeat the pattern of relating the same way to their children as their parents did with them.

Social impairment becomes visible by the survivor's either withdrawing or overfunctioning in social situations. The emotional effects she experiences may make it difficult for her to function on the job or in the community. Survivors tend to be isolated from their peers. The hostile and impulsive characteristics, substance abuse, mistrust of others, social withdrawal, and flashbacks may end up leaving her disconnected. Some

survivors isolate themselves because they think that people can tell by looking at them that something terrible and shameful has happened to them.

On the other hand, it needs to noted that many survivors function very well. The survivors skills they learned in childhood may now have enabled them to become outstanding in their community. Concern is sometimes expressed for these women in that their resources become depleted and they are susceptible to stress overload and exhaustion.

Spiritual effects occur for a survivor as a result of a loss of faith in the systems of meaning. In Russell's (1986) study, a high rate of religious defection on the part of incest survivors was noted. Compared to nonabused women, survivors were more likely to have no religious preference. More than half of the survivors had defected from the religion of their upbringing compared to 30% of nonabused women (Russell, 1986). For a survivor, it becomes very destructive, confusing, and complex when the abuse and religious instruction come from the same person or institution. When, as a child, she was abandoned to a power without mercy, now when the power source uses words that describe mercy, she becomes confused. She wants to find a way to preserve hope and meaning. To have none induces despair. Heggen (1993) states that profound damage occurs when the abuser and victim are religious people. In a nonreligious system, she can label the offender and the experience as sinful and evil. If, in a religious system, she called out to God for protection during the time of her abuse, and the abuse continued, she may view God as uncaring, impotent, aloof, and disinterested in the human condition and in her personal well being. Not only does she see her parents abandoning her, but she may see God doing the same. There is bitterness and desperation in feeling forsaken by God. Or, like trying to keep her parents in a good image, she may view that the problem isn't her parents' or God's, but that she is the problem. She again thinks she is bad, flawed, and defective and must be punished for her badness. In order to preserve her faith she must

adopt an identity that makes her acceptable to others by again denying her own truth (Bradshaw, 1992). The fragmented image of her self combined with a distorted image of God makes it difficult for her to feel the unconditional love of God. This makes it difficult for her to have a reverence for all things, to be in awe and praise of someone, something greater than herself.

And yet, many survivors are devout in their spiritual disciplines. They work very hard to use whatever inner resources they can find to find healing and wholeness.

Sylvia Fraser (1987), in her first person narrative of her experience summarizes the aftereffects:

> "Looking at my life from one vantage point, I see nothing but devastation. A blasted childhood, an even worse adolescence, betrayal, divorce, craziness, professional stalemate, financial uncertainty, and always, a secret eating like dry rot at my psyche..... the dark side. Yet, like the moon, my life has another side , one with luminosity." p.251

It also needs to be noted that not all women who have been sexually abused as children suffer the aftereffects in the same manner. Women who have had supportive relationships, who have allowed their secrets to surface, and who recognize that everyone is in some way a prisoner of their past, have recognized and used their survival skills to heal. These women who can resolve their trauma do learn to live satisfying lives.

1.6 Diagnosis

Naming the symptoms described earlier as the result of repeated traumatic experience is important not only to understand the connection between the trauma and the symptoms, but also to find ways to be helpful to provide healing. The diagnosis of post-traumatic stress disorder is not totally useful (Herman, 1992) since it does not recognize the complexity of the prolonged repeated trauma. Herman suggests the language used be

that of complex post traumatic stress disorder. The diagnosis of post-traumatic stress disorder was initially based on "prototypes of combat, disaster and rape" (Herman, 1992, p.119). Although the intention here is not to minimize the painful effects of these experiences, Herman suggests that the the symptom picture is far more complex in survivors of prolonged, repeated trauma. Two of these differences Herman notes will be discussed since they focus more on a victim response to an abusive situation rather than underlying psychopathology.

First of all, the nature of the abusive environment needs to viewed as being in subjection to totalitarian control over a period of time (Herman, 1992) rather than merely an event outside the range of human experience as stated in the DSM-III-R. As stated earlier, the latter is based on prototypes of combat, disaster or rape. They were coined to deal with the experiences of Nazi Holocaust survivors and Southeast Asian refugees. The deformations that occur in childhood sexual abuse as a the result of prolonged exploitation are more complex.

Secondly, a diagnosis needs to include, as does the PSTD of the DSM-R-III, the deformations of the identity and relationships. Herman (1992) suggests it would be more useful, however, to include the responses to the trauma in relation to the after effects. These are the alterations in affect, consciousness, self-perception, perceptions of the perpetrator, alterations in relations with others, and alterations in systems of meanings (Herman, 1992). In applying this diagnosis, the survivors' reactions to the trauma are be normalized and validated while also recognizing their maladaptive reactions.

1.7 INTERVENTION APPROACHES

A number of theories are helpful when looking at intervening with survivors to promote their healing. In this section, a few approaches will be highlighted along with the implications for intervention. A systems approach, a feminist approach, and a solution-focused approach will be briefly discussed. In working with survivors, no one approach can be used alone if a therapist wants to effectively listen to the experiences of women's lives, the complex problems resulting from the abuse, and the women's attempts at survival. Threads from each of the approaches need to be pulled together in understanding each woman and in working with her towards her healing.

Systems Approach

Humanistic psychology promotes personal awareness, self-management, growth, individuality, and empowerment. Each individual, however, does not live in a vacuum. The human system is a complex entity wherein interactions between people are just as important as the interaction between an individual and her experience. The whole is viewed as being greater than the sum of all the parts. This view promotes the theory that living systems become more ordered and complex over time rather than random and disordered. In addition, this view operates on an organismic rather than mechanistic level in that it states that the same end state can be arrived at from many initial conditions. Organic systems develop and change over time, but they possess an internal blueprint for development. The change can be spontaneous, novel and creative, but not necessarily predicted ahead of time. Human systems create systems of meaning using symbolism which becomes central to the way the system regulates itself (Breunlin, et.al, 1992).

Giarretto (1982) and Martens (1988) describe systems-based models using this treatment approach. The traumatized child victim is seen as living or coming out of a system in which the family is a place of danger. These models attempt to treat the

individuals and the family in an effort to resocialize or restructure them to become a place of safety. Structures within society are expected to provide reinforcement to allow this to happen. This approach attempts to address both the social and criminal components of sexual abuse. Offending members are treated using the judicial system as punishment if they do not cooperate in the treatment process. Guided self help groups for parents, offenders, child and adult victims and siblings are an essential part of the program. The strength of this program is found in the supportive programs to the parents themselves and the programs provided for the adult victims (Giarretto, 1982; Kissner, 1989; Orenchuk-Tomiuk, 1990). The self-help groups provide a practical and nurturing component which help individuals and families break out of the shame and isolation they have been experiencing in their dysfunctional families. Families and individuals learn to relate to others who have similar experiences immediately upon entry into the program. The groups are not autonomous, but are connected to the entire treatment program, allowing for feedback among groups, family therapy, individual therapy, and probation workers. The continuous feedback is useful to break through the denial and to monitor future reoffending. Using this model, people are held responsible for their choices and the resulting consequences.

The goal of treatment in the Giarretto model is the resocialization of individuals and family members as well as the reunification of the family. Although this may be a desirable goal, it may not be a realistic one since the trauma is so devastating to many of the family members. One of the problems with this theoretical orientation is that its focus on personal responsibility does not take onto account the power imbalances that exist within families and genders. What is male is seen as being powerful and desirable. Traditional male activity is frequently held up as the norm against which all relationships are measured. In this context, then, the female reality of the victim's experience and pain disappears. In this model, mothers are viewed as being the primary caregivers for nurture so that the mother-daughter relationship becomes the one that is strengthened. The

concern in this is that everyone will return to their respective roles. The result is that mothers and children are expected to be policemen over the offenders. In addition mothers are expected to be the primary sources of nurture and protection for family members. The impact of the offenses on the child victim is not dealt with on the part of the fathers. The fathers, who are usually the perpetrators, do not become aware of, nor do they take responsibility for, the disastrous results that their powerful behavior has had on the rest of the family. This can result in the minimization of the trauma and the premature reunification of families since a father's capacity to nurture his family is not sufficiently assessed. The child victim may see the therapists as colluding with the family in minimizing the impact and consequences of the incest experience. Sagatun and Prince (1988) researched families who had been treated using this model. Their study indicated that the daughters who had been violated did not improve in their perceptions of improved family relations as a result of attending the program, while other family members showed improvement.

The systemic orientation allows us to look outside of the woman victim/survivor to provide us with an understanding of her situation. Its emphasis on growth also allows us to look at the strengths of the ways individuals in the family have been coping. However, using its humanistic underpinings, the model does not give us any understanding of the nature of violence within a system (Bogard, 1992). This orientation uses a humanistic philosophy of treatment with growth language and neutrality with no consideration of blame, responsibility and accountability which are necessary for personal responsibility. Butler (1993), in her assessment of this treatment orientation, states that a woman cannot grow outside of her social context . While personal empowerment is a first step, it is not big enough. The focus must not only be on the woman as an individual who cannot control her life by her self. She needs to stop looking inside of her self only for what is wrong. The competing feelings a survivor has about herself and her family should be incorporated into her past and become integrated rather than living them out or purging

them as the result of her personal awareness. An awareness of her family and social context will allow her to see the reality of her life and then empower her to find and use alternative options to provide her with healing.

Feminist Approach

Feminist intervention deals with gender differences as well as violence and power issues (Goldner et al, 1990; Walters et al, 1988). Although these issues are touched upon in the systems orientation, they are presented as neutral aspects in a relationship. Feminist intervention focuses on the reality of women's lives as experienced by women (Brickman, 1984). It recognizes that the family is the breeding ground for women's sexual exploitation, that men are conditioned into roles of power and domination with regard to females, and that girls are abused based on their gender. Men are violent and abusive because they physically can be, and they get away with it (Bogard, 1992).

Using this approach, the focus of intervention is on a woman's pain and the consequences of abuse. Intervention includes making visible everything that a woman comes with such as her gender, race, class, state of health, family dynamics, level of education, and structural oppression (Butler, 1993). The purpose of therapy is to provide relief and comfort to the victim of abuse by listening to how vulnerable she was, to explore how the abuse has impacted her life and to hold the perpetrator(s) responsible for the dominant and abusive behavior.

Using this orientation, the family is viewed as having potential allies as well as having perpetrators of violence or dominance, (Brickman, 1984). In order to look for potential allies, treatment attempts to reconnect mothers and daughters since the daughters often feel that the mothers had abandoned them. The nurturing, caring strengths of women are valued as powerful as opposed to the competitive, aggressive, hierarchical values of the traditional male dominant culture. Power and authority have

become confusing issues for the victim, so therapy would focus on who was responsible for the abuse. In this way, the power that belongs to the survivor would be restored.

Due to her powerlessness in the family as the result of being a traumatized child, the survivor may have felt she could not speak up. She may have been left with dissociation or numbness. For Butler (1993), therapy does not assume a split between mind, body, and spirit. Symptoms are viewed as appropriate adaptations of an annihilating environment. Butler uses the expression "to tell without telling" in describing the symptoms. In therapy, the overdevelopment of these coping strategies for survival as a victim needs to become recognized when they become maladaptive to her.

Each woman needs to be seen as the expert of her own experience. Using the feminist approach, she is in charge of when she comes and how long she stays. She needs to take charge of the rate and speed at which she works. She needs to be free to talk and to leave behind that which she wants to leave behind.

The process of the survivor's relationship with her healer, the therapist, needs to be observed to see how the survivor has organized the ambiguities of her life . The language of the therapist is important. The meaning of the client-therapist relationship needs to be examined. The survivor has been betrayed in the past and expects the therapist to do the same. She needs to be in a relationship with a therapist who is trustworthy. Boundaries between the survivor and therapist need to be maintained. The therapist may also need to inquire about cultural appropriateness. It is helpful for the survivor to know and express to the therapist what it is that will make her feel safe in therapy.

Listening to the survivor and validating her experience from a victim position as well as a survivor perspective provides a feminist approach for intervention. Her lack of power and how she used herself to survive the trauma is examined. Her connections or lack of nurturing supports become aspects of therapy along with learning how she can recognize and use her personal power.

Solution - focused Approach

This approach utilizes the concept that in order to respectfully and effectively address a survivor's treatment needs, therapy needs to include and emphasize the resources that the survivor has developed, as well as her images of future goals and possibilities (Dolan, 1991). In addition, this approach is built on the notion that all the people are working on a goal to be accomplished or a problem to be solved and they organize their reality around this purpose.

Self-determination is one of the fundamental values of social work. Not only do clients have a right to make their own decisions, they also have a right to participate in their own healing. Wieck and Pope (1988) suggest that each person carries within her the capacity to develop in a uniquely personal way. The body has the ability to know what it needs for its own survival.

There are several assumptions which are basic to a solution-focused approach. Each woman is viewed as the being an expert on herself. This is a non-pathological approach since the skills and resources she has to change become recognized. Since change is occurring all the time, healing from the trauma of abuse is viewed as the body's "tenacious and purposive attempt to repair itself and become whole" (Wieck and Pope, 1988). It is assumed that the survivor is always cooperating. By focusing on the positive, the solution, change is facilitated in the desired direction. Any change that a survivor describes as a solution for herself will affect her future interactions with all involved. Understanding the complexity of the survivor's problem along with its exact nature is not necessary in order to generate solutions. Only minimal changes are necessary to generate changes as a result of the domino effect. Therapy is then directed toward creating choices and providing opportunities and resources to meet these needs by co-constructing a vision of what the future will look like once the problem is resolved. Exceptions to every problem can be looked for and amplified by both therapist and survivor. The

exceptions or problem-free times can be examined to build solutions. In recognizing the choices that a woman will select, attention needs to be drawn to the meaning that she gives to her life events. A change or shift in the perception or meaning that a survivor associates with her problems can lead her to her desired solutions. These are the assumptions which are basic to the solution-focused approach (Walter and Peller, 1992)

Dolan (1991) further states that it is necessary to ensure that the survivor has acquired some physical and emotional stability to feel in control before she begins to focus specifically on the past trauma. Solution oriented techniques are offered to provide some realistic hope and stability for her during her therapy so she can focus on what she needs to feel in control.

In order to feel in control, one of the things a survivor can do for herself is to alter the feelings and thoughts associated with the memories of the trauma. The negative, self destructive expectations need to be replaced with healthy, hopeful and realistic expectations for the future. Solution-focused techniques are borrowed from cognitive therapeutic approaches (Burns, 1980). A survivor will learn to look for exceptions in the way she feels or thinks during the problem free times or during the times when the problem is less intense. Using cognitive therapy to reframe the way she thinks and feels, she may receive some relief.

In addition to borrowing from cognitive therapy, a solution-focused approach also borrows from behavior therapy by using task-oriented behavioral techniques such as the first session formula task, symbol for safety (Dolan, !992). These techniques will be discussed in the next chapter. Using these techniques, a survivor can look for clues in herself and with others which will help her to recognize her healing and to change her focus from trauma to recovery.

Solution-focused therapy borrows from other therapeutic approaches such as cognitive and behavioral, as already stated, but it is also consistent with assumptions of the systems and feminist approaches. The concepts of change and growth occuring all the time

is a tenant of systems theory. The systems approach recognizes that people create systems of meaning which is the way a system regulates itself Any change about how a person describes her goal affects what that person does as well as all future interactions with all others involved (Walter and Peller, 1992). Solution-focused assumptions therefore look for the meaning that a person gives to their problems. Systems theory would recognize that a person and people are resourceful and would allow an appoach used which would focus on the strengths an individual has used in coping with problems.

A solution-focused approach is also consistent with a feminist approach in that the client, the survivor, is viewed an an expert on her own life. The experience of an abused woman's situation is validated, but even more so there is recognition of the goals she has for change or desired behavior. Her connections and supports she has for doing so are also recognized. How she sees the utilization of her supportive others are encouraged. The nurturing strengths of a woman are valued. Her symptoms are viewed as adaptations to her environment but she is given the choice at looking at them to see if she sees them being consistent with her desired goal. Empowerment means that this approach focuses on issues which a survivor wants to work on, that is, to begin where the client is. The feeling of powerlessness and power imbalance which a feminist approach recognizes are reframed in a solution-focused approach for a survivor as that, as a child, she did the best she could to survive, but now, as an adult, she has different choices as to how to use her power.

The problem faced in using the solution-focused approach is that a survivor may know what is best for herself, but the aftereffects of the trauma experience will not allow her to follow this knowledge. The survival skills she has learned to cope with the trauma, i.e., her desire to please others, her self-hatred, her ability to deny and dissociate, hypervigilance to cope with fear of abandonment, may get in the way of learning new skills required for healing. What is useful for her is to then examine what she needs in

order for her to make the necessary choices. Making connections between past and present situations allow her to see differences that can be helpful.

Another drawback with this approach is that the solution focused approach is an outgrowth of brief therapy. In our attempt as therapists to look for the positives, the solutions instead of problems, the trauma experience can be minimized to the extent that the experience of the abuse is minimized and therapy results in devaluing and minimizing the reality of the horror of the experience. The assumption in solution-focused therapy that understanding the exact nature of the problem and its origin is not necessary to generate solutions may tend to overlook the trauma as well as the effects resulting from it. A survivor may experience this as again being silenced and therefore be impeded in her healing process. A balance therefore needs to be maintained between looking at the past as well as looking at the future. The evolution of solution focused approach from brief therapy might also be misleading in that the assumption may be made that this may lead to healing in a shorter time. The reality is that healing from the long term effects of childhood sexual abuse is long and hard and any suggestion that there may be a quick cure would be further damaging.

These treatment approaches provide a context for work with sexual abuse survivors. It is clear that none of the models can be solely used alone since the work involves aspects of each of the models if we want to work with the complex problems presented by each client and find solutions with her in developing her own life.

1.8 TREATMENT MODALITIES

The symptoms which a woman presents when she comes into treatment as the result of the trauma are complex and may require several treatment modalities. In recognizing the various ways in which survivors recover from the trauma of sexual abuse, two modalities will be discussed, namely, individual therapy and group therapy.

Individual Therapy

Courtois (1988) states that the organizing principle of incest therapy is that the trauma of the sexual abuse in childhood is a real experience, not a fantasy occurrence or a wish. Briere (1989) agrees that the philosophy of treatment needs to specifically focus on the original abuse context as one of the key issues in treatment, relating the early trauma experiences to later and current experiences and behavior. Cross-examining the survivor for detailed aspects of her historical account is not helpful when her presenting issue is sexual victimization. In looking at the various aspects that are involved in individual therapy, it is helpful to look at the stages, as outlined by Herman (1992) that emerge when facing the trauma induced symptoms and how a survivor is able to receive healing in these stages. Principles of therapy will be highlighted in this section, but more specific intervention based on the solution-focused treatment approach will be discussed in the next section.

Stages of Therapy:

Following the acceptance of the abuse as a real experience, therapy can be directed toward following the principles of recovery. These principles are based on the reality that the survivor has been disempowered and disconnected from others. Herman (1992) outlines the principles into three stages. The first stage includes the empowerment of the

survivor by restoring control and power to the traumatized woman. In the second stage, the survivor tells her story of the trauma in a way which allows her to retain her control and power. In this stage many emotions surface, including a profound sense of grief which emerges as the survivor remembers and expresses her many losses. In the final stage the survivor uses the principle of reconnection. The reconnection includes an integration with her self as well as realignment with others, especially with significant others in her network.

a. Restoring Control and Providing Safety

In the first stage, therapy is directed toward the development of a therapeutic relationship and providing a safe environment from which the survivor can rework the trauma of the abuse experience (Courtois, 1988; Herman, 1992; Meiselman, 1990). The bond between the therapist and survivor needs to be one of shared work in which both partners commit themselves to the task of healing. Explicit boundaries that both therapist and survivor consider fair and reasonable need to be negotiated at the beginning of the contract and maintained throughout therapy. Meiselman (1990) and Herman (1992) suggest that the avoidance of a dual relationship is especially important since a survivor's history is filled with confused roles. The therapist's caring must never become sexualized. When the therapist communicates with other professional people and family members regarding the client, it must be done with her knowledge and consent. Herman (1992) also states that there may be conflicting requirements for flexibility in the area of boundaries and the therapist can repeatedly feel put on the spot. Distinguishing when to be rigid and when to be pliable is a constant struggle. Since the survivor's fear of abandonment is present in the therapeutic relationship, it is necessary for the therapist to be predictable and reliable.

To effectively use the therapeutic relationship, the therapist also needs to be aware of the power aspects of the relationship. For this reason, it is important that the survivor

takes control of her therapy. Seeing the client as the expert on her own life, the therapist respects her choices and plays the role of her guide rather than authority figure. The therapist also needs to guard against role reversal especially if the survivor has become skilled in the caretaker role. In order to provide safety and control for the survivor, the survivor needs to be allowed her own timing of when to enter therapy, when to leave, and when to return.

The trauma needs to be directly treated, along with its original and compounded effects. The abuse needs to be named. Herman (1992) suggests that if a therapist believes a woman is suffering from a traumatic syndrome, this information should be shared with her since knowledge is power. Dolan (1991) is more cautious in naming the abuse and prefers to use neutral language in referring to the symptoms as the problem that brought a survivor into therapy. For many survivors (Herman, 1992), having a language for their experience is the beginning of their process of mastery in their recovery. Reframing the accepting of help as an act of courage allows her to take control of her recovery. Normalization of her current behavior as an understandable reaction to her childhood experiences is helpful in restoring control.

The survivor has developed useful coping strategies to keep her from feeling the feelings that she especially views as dangerous. These strategies have also been developed to protect her from losing control when she does begin to feel. The surface emotions such as anger and sadness prevent her from feeling revictimized by the deeper emotions such as despair, abandonment, terror and feeling overwhelmed (Briere, 1989). It is useful for her to label and express her emotions by recognizing the differences between feeling the painful affect and doing an activity when she feels like she is "losing it". Catharsis is only useful when structure is provided along with safety and closure.

b. Remembering and Mourning

Several areas need to be addressed in the second stage. First, the survivor may want to relate the facts of the experience. Courtois (1988) recognizes that the recounting of the incest story is highly variable. Frequently, the telling of the story is done in pieces as the repression lifts and the many memories surface. For some survivors, presenting a detailed account is necessary for their healing, but for many others this is not necessary. Dolan (1991) suggests that in discerning this, a therapist may be advised to ask the survivor what she needs to tell that is necessary for her healing and to leave the rest behind. Herman (1992) adds that letting one incident stand for many can create new understanding and meaning. The therapist will encourage her to associate the meaning and feelings with her memory and experience. This association will help the survivor to extinguish the need for dysfunctional defenses. The therapist needs to understand each survivor and how she communicates about herself and her experiences.

Secondly, the survivor's symptoms are understood in the context of having had her trauma experience repeatedly invalidated. Courtois (1988) states that is helpful not to pathologize the symptoms. The needs of the survivor are such that she needs to be viewed as the expert on her own experience. A warm, caring but not overindulgent therapist is required to establish an environment where the survivor can express that which was impossible to express in childhood. The abuse dynamics should not be recreated in exploiting or invalidating her. The usefulness of allowing a survivor to express and explore her symptoms is that she can assess the necessity for them, as well as how her symptoms now can get in the way of her healing. Ellenson (1989) states that the symptoms are often present to defend the survivor from the affects associated with the memory. Rage is one affect that is especially repressed. One useful suggestion from Ellenson is for the survivor is to create a conscious connection between present experiences and the submerged memories that give rise to the present experiences. He suggests that it is helpful to alert her to a probable increase in symptoms. The symptoms

can be reframed as precursors of memories which would indicate that some relief is likely in the wake of each memory. The assumption here is that the ventilation of actual memories and associated affects reduces the collective upward pressure of the affects (Ellenson, 1989). The symptoms as memories also need to be shifted from the symptoms as representations of the affects such as rage or depression. Engaging in the exploration of the meaning of the affects for the survivor may result in some mastery of them instead of reviewing the memory of them.

Thirdly, addressed in this stage is the resolution of responsibility and survival issues (Courtois, 1988). Once a survivor has been able to transfer the responsibility to the perpetrator and other non-protecting family members as well as analyze her family dynamics, she is able to understand her powerlessness. This shift in insight allows her to recognize her coping mechanisms she used for survival. Involved in this shift is a change from her self-concept as being negative, guilty and worthless to one of being positive, healthy, and valued. This is often a very difficult and threatening step since it counters everything she has been previously taught. Yet, it offers her the potential to embrace her self with a greater empathy.

Fourthly, cognitive therapy is helpful in this stage to rework her thoughts, interpretations, memories, and feelings that cause her to feel bad or different from others. It will provide a disentangling of the connection between ideas of having bad things happening to her versus her being bad (Briere, 1989). Consistent support and patience is needed on the part of the therapist. Abuse related beliefs are often slow to change.

The fifth principle of mourning the many losses a survivor has experienced is a necessary yet often very difficult task of this stage of recovery. The loss of her innocence of childhood, her self-development, her bodily integrity, dignity, self-worth, family, and intimate relationships are but a few of the multiple losses. The losses of family and intimate relationships frequently continue as she becomes aware of the impact of the abuse. It is the therapist's role to encourage grieving and then to foster the conditions

which allow the grieving through support and compassion. Courtois (1988) recognizes that a survivor must give up attempts to control that which she cannot control and accept the losses involved.

Herman (1992) further elaborates on the ways in which a survivor may resist the mourning process. One way is to refuse to grieve since she views grieving as a way of giving in to the perpetrator. Magical resolution of the trauma through revenge, forgiveness, or compensation may be viewed as attempts at empowerment but frequently delay the mourning process.

Herman (1992) says that this stage of recovery has a timeless quality that is frightening. The only assurance to the question of how long it will last is that it cannot be bypassed or hurried, but it will not go on forever. A survivor will never forget the trauma but she will come to a point where it will no longer take the central place in her life or control her life. The major work of this stage will be accomplished when the survivor reclaims her own history and feels renewed hope and energy to engage in and rebuild her life.

c. Reconnection

The work done by the pioneers of sexual abuse therapy up until the late eighties included the aspects of listening, validating the abuse, recognizing the commonalties, and reworking the distortions created by the abuse. At the end of the eighties and in the nineties, the work included these aspects but it also incorporated the aspects of empowerment and reconnection to help the survivor by developing a new self and creating a future (Butler, 1993; Dolan, 1991; and Herman, 1992).

The third stage of reconnection focuses on how the survivor would like to feel; how she can practice new ways of thinking and behaving; how to challenge her passivity, helplessness and isolation; how to learn new ways of relating; and how to reconcile with her body and accept her sexuality.

It is during this stage that the survivor will struggle to find meaning in the abuse and will ask many "why" questions. Meiselman (1990) suggests that as a child she already answered this question with the conclusion that she was bad and deserved punishment. Posing these questions in therapy offers an opportunity for her to undermine the assumption of badness and develop a more complex and realistic picture of what occurred.

When a survivor enters into this stage of her recovery she is willing to engage her fears. This engagement would not be a reenactment of the trauma to master the traumatic experience but rather to fight the passivity. Fighting the passivity means that she will not allow the fear to continue to terrorize her. An awareness of her vulnerability would enable her to work in a planned methodical manner by voluntary, direct exposure of her fears. Confronting others and disclosure of the abuse are fears that are included here. The disclosures and confrontations need to be properly timed and well planned and should be undertaken when the survivor feels ready to speak the truth as she knows it. Herman (1992) suggests that the time is ready for her when she does not need confirmation of the abuse from her family members and when she does not fear their consequences.

The task of knowing and owning herself is one to be accomplished during this stage. The survivor's task is one of becoming the person she wants to be (Herman, 1992). She can remember the person she was and wanted to be before the abuse. It is during this time that she sheds her victim identity. She develops a compassion and respect for the traumatized, victim self but she also joins in a celebration of the admiration for the survivor self (Herman, 1992). In this process, intense feelings of grief may emerge. The concept that grief comes in "waves" is a particularly useful one since it provides the perception of a gradual recovery of a loss in spite of the reversions to grieving that inevitably occur (Meiselman, 1990). Sometimes the sadness alternates with periods of anger and denial and permission to allow the feelings to be experienced becomes part of therapy.

Feelings of love are often intertwined with feelings of sadness and anger toward a survivor's parents, especially if the parent is also a perpetrator. In coming to terms with the reality that her parents will never be as she wants or needs them to be without feeling chronically disappointed, a survivor will use a variety of activities. Dolan (1991) suggests a frame for a survivor in which she can view her parents' good qualities as being real without denying the truth of their abusive behavior. It is helpful in therapy for the therapist to acknowledge the good qualities of the parent so the survivor doesn't need to resort to the protection of the parent and thereby further intensify the denial of the abuse again. The giving up of the fantasy parent is a very difficult time and Dolan (1991) suggests it is crucial that the therapist provide hope for the future that the survivor will not always feel this intense pain regarding her family.

There are a variety of ways in which a survivor will bring closure. One area that is troublesome for many survivors is the area of forgiveness toward the perpetrators and also toward themselves. The problem with forgiveness is that it often becomes a cruel torture since it remains out of reach for many individuals. Part of the problem for this lies in the understanding of forgiveness. Complete forgiveness cannot be granted until the perpetrator has sought for and earned it through confession, repentance and restitution. Because this is so rare, it is helpful for the survivor to realize that her healing does not depend on the activities of the perpetrator, but rather on the restorative love in her own life (Herman, 1992). Heitritter and Vought (1989) recognize that part of the difficulty with forgiveness is the notion of "forgive and forget". Forgiveness is not the first issue to be addressed in the recovery process. The abuse needs to be named for what it is along with taking the time to assess the full emotional damage that has occurred, the distorted belief systems that have developed, the maladaptive choices that are being made, and the anger and rage that remain. This assessment follows with an intense grief over the many losses experienced. This process can not be short circuited by denial and minimization which happens when survivors are told to forgive. It is not helpful to be encouraged to

forgive since it makes the survivor feel responsible, shamed, and re-victimized if she continues to experience emotional distress. Forgiveness includes allowing the survivor to be where she is at with her feelings. Simon and Simon (1990) state that forgiveness is a byproduct of an ongoing healing process. It is an internal process and a letting go of the intense emotions attached to incidents from the past. It is an acceptance that nothing can be done to punish the offender that will heal the survivor. It is a freeing up and putting to better use the energy consumed by the rage. Forgiveness is a moving on to a better life.

Moving on to a better life will include the reconnection with others since the survivor has regained some ability to appropriately trust others. She can learn to view alternate ways of relating, while respecting her own boundaries as well as those of others. She is now ready to take more risks, to see vulnerability as a risk instead of only a curse. She has a greater capacity for self appreciation and can tolerate more inner conflict (Herman, 1992). Both Butler (1993) and Herman (1992) view this stage as being similar to adolescence in that the survivor is moving in and out of the social skills that are required for adulthood. It is during this time of reconnection with others that a survivor becomes aware of the pain her partner has experienced along with her during her journey of recovery.

The resolution of this stage is often seen when a survivor develops a mission for meaningful social action (Butler, 1993 and Herman, 1992). Becoming part of a group where she can help others who have been similarly victimized can continue the healing for her. She may want to work together with others to prevent children from being victimized in the future. Once she has committed herself to speak about the unspeakable in public she often finds herself connected to a power that is greater than herself. Her survivor mission for meaningful social action may also take the form of pursuing justice by bringing offenders to court. She becomes concerned not only for her own well-being but also for the larger society.

To the question "When is a survivor healed?" one may return the question, "How high is high?" Healing is never complete. For Dolan (1991), healing would include developing a positive, practical and healthy future orientation that results in non symptomatic patterns More importantly, the survivor would be living what she would consider a "satisfying" life. Herman (1992) puts it this way: "though resolution is never complete, it is often sufficient for the survivor to turn from the tasks of recovery to the tasks of ordinary life. The best indices of resolution are the survivor's capacity to take pleasure in her life and to engage fully in relationships with others" (p.212). Butler (1993) describes healing for a survivor when she can tolerate her symptoms and when she is able to bear her feelings associated with the memory of the trauma. When a survivor has authority over her memory and the memory is a coherent narrative linked with feelings, she knows that she is on her way. This will allow her to restore and develop her self will and to have the capacity for relationships of many sorts. Recognizing who she is will provide her with a reconstructed system of meaning and beliefs about the world. She will also know that she is healing when she can understand that with the trauma comes responsibility. Embracing her responsibility will allow her to know that pain and evil exist in her life and others' lives and she will have an idea what to do with this knowledge.

It is important to recognize that in practice, these three stages outlined here do not follow a linear pattern. The course of recovery is often circular and spiral. Issues are reviewed that have already been addressed many times before in order to deepen and expand the survivor's understanding and integration of her experience.

GROUP THERAPY

When a survivor comes into therapy, she hopes that change is possible, but doesn't know exactly how or what to change. In individual therapy, the focus remains on herself and her interaction with the therapist.. In group therapy, this interaction expands to others who have had similar experiences. Listening to and observing the work of the other group members, a survivor can develop a greater awareness that changes can be made. She can recognize that she has choices. She can see what others do and where they go when looking back becomes too painful. She can see that not all efforts to change create the same results. She can study pattern interaction in a context of a safe group. She can see what happens when others risk to do what they feel is necessary. Group interaction may provide her with new insight into the problem she has brought to therapy which can lead to changing the negative messages and self-limiting beliefs.

Using feminist theory in studying women, survivors are seen not only individually, but also in relationships. The relationships women have with men and children are usually acknowledged since they benefit families and the larger society. What is also needed is to study the benefits of women in relationship with each other. The relationships a survivor has with other supportive women are helpful to acknowledge. One issue for a woman who has survived sexual abuse is that she needs to hear from and receive support from other women who have had similar experiences. Together, they can be heard and respected for their ability to find and use effective strategies for surviving (Brown and Dickey, 1992). Group participation has the potential for alleviating the devastating effects of the incest. It allows provides a powerful tool for a more full resolution of the trauma. Bergart (1986), Butler (1993), Courtois (1988), Dolan (1992), Felton and Berry (1992), Gordy (1983), Herman (1992), and Sprei (1987) are but a few authors who endorse the use of group treatment in addition to individual therapy.

Benefits of group treatment

It needs to be recognized that individual therapy is an essential vehicle of recovery for many survivors. However, within this treatment modality it is often difficult to come to a full resolution of the issues of secrecy, shame, stigma, and isolation. Identification with other women can allow these issues to be more quickly and thoroughly addressed than in individual therapy. Sprei (1987) identifies several benefits of group treatment. First, the recognition of commonalties among members allows a survivor to externalize her problems rather than internalize them as personal defects. Secondly, open acknowledgment of the abuse, helps to open up the secret and give her the courage to talk to other close friends or family members. In the group, she can prepare for and rehearse disclosures to her family and possible outcomes. Thirdly, the group can become a support network for the survivor. It can become a new family where she can discuss conflicts openly without being rejected or abused. Fourthly, it provides a catalyst for identification and exploration of emotions and beliefs which can help break the minimization and denial. It challenges beliefs and childhood messages so she can choose which beliefs she wants to maintain and which beliefs need to be replaced with more positive self-messages. Fifthly, group treatment allows the observation and exploration of a survivor's dynamics in interacting with others, especially in the ways she protects herself and how this then in turn, affects others. It provides a safe environment to practice social skills and therapeutic gains. And lastly, it can also give her hope for healing through mutually rewarding relationships, by observing the improvement of other group members, and through collective empowerment.

Solution-focused therapy is a useful approach to group therapy in providing these benefits. By building on strengths of the survivor and recognizing the strengths all group members have used in their healing up until this point in their lives strengthens each one of them. Explorations as to how to tip the domino, to change the dance of the symptoms in

one member can result in others finding hope and courage to do the same. Looking at exceptions as to times when life is less painful or even enjoyable for any survivor in the group provides hope and collective empowerment. Together as a new family the group can translate and share their goals into meaningful behaviors. They can learn what to do to keep the changes going. They can assess potential challenges and how to overcome them. They can recognize stumbling blocks to avoid especially in the area of behaviors and beliefs. Together and individually they can make connections between past behaviors and present ways of behaving and how to keep what is useful and leave behind what is unnecessary. They can share results of improved communication with spouses, parents, siblings.

By focusing on the behaviors and commonalities among survivors in a group setting, a survivor can find the solution approach helpful to externalize the past rather than view it as an underlying psychopathology on her part. She can utilize the hope she has for change and find measurable ways of defining her desired goal.

Group structure

Although the literature on group treatment for survivors suggests that the groups can be long-term or time-limited, the majority of groups cited are time-limited, varying from 10-12 weeks (Drews and Bradley, 1989; Gordy, 1983; Herman and Schatzow, 1984; Sprei, 1987; and Yamamoto-Nading and Stringer, 1991) to one year in duration (Hazard, Rodgers, and Angert, 1993). The time frame of 12 weeks is most often cited because it allows for the sessions to be more focused and structured. The short-term, time-limited sessions can highlight the strengths of an individual and minimize regression by becoming dependent on another system. The authors suggest that these groups be closed rather than open drop-ins to enhance the development of cohesiveness and trust. Although both Butler (1993) and Herman (1992) work with long-term groups, the majority of these

groups are found in self-help settings such as AMAC (Giarretto, 1983) or the Canadian-based SARA (Kissner, 1989).

Two therapists usually facilitate the weekly groups which can last between 1 1/2 to 2 hours. Sprei (1987) suggests offering pre-group socializing in the meeting room area so the women can socialize and build a support network independent of the therapists.

Most groups begin with each member speaking briefly about her life since the last session and about how she is presently feeling (Briere, 1989). The content of the group may be unstructured as in a psychotherapy process group or it can be more structured with a teaching component of a specific focus, outside readings, homework assignments, and exercises where appropriate. Many authors suggest that it is helpful to focus on one topic at a session since it sends the message that it is okay to put other issues on hold while working through one area of the abuse. The other message that is left by staying with one topic is that the healing work proceeds slowly. The unstructured groups may, however, still have a structure in that the topics for each meeting are determined by the participants and the focus will be on their abuse or its resulting impact. Herman (1992) suggests that these unstructured groups would be trauma- focused groups relating to the second stage of therapy while the third stage would be dealing more with the present and the focus would be on interpersonal issues.

At the end of each group meeting, the group process is recapped by one of the leaders, significant points are reemphasized, a global perspective of this particular group process may be offered, with commonalties of experience stressed. Members may also wish to make a statement about how they are feeling or how the group was for them (Briere, 1989).

Screening for groups

Selection of members is an important aspect of group treatment. Most of the literature suggests that members be screened in a pregroup evaluation interview. This

meeting allows the co-facilitators to assess with the survivor whether this group might be therapeutic for her and whether she could be therapeutic for the other group members. This meeting also allows the survivor the opportunity to meet a familiar face before she comes to the group meeting. The co-facilitators become familiar with each survivors' dynamics, issues, goals and interpersonal skills. It desensitizes the survivor to the idea of discussing the sexual abuse with others. Corey and Corey (1992) believe that screening of potential group members is even more crucial in a long term group when survivors need to be assessed for level of motivation, current coping skills, and emotional stability since the issues of trust, discrimination, and the reworking of the trauma are dealt with on a more intense level.

It is also helpful to note that the groups are useful for those who have some clear memory of some abuse and some understanding of who the perpetrator(s) is. Some authors (Yamomoto-Harding and Stringer, 1991) suggest that the memories need to have been present at least for a year in order for survivors not to become too overwhelmed with the other group members' stories.

Some authors suggest ineligibility factors among the women such as (a) either chronically unstable or currently in crisis, (b) currently abusing drugs or alcohol, (c) psychotic or (d) suicidal (Briere, 1989). Briere suggests that these factors need to be considered since they are problematic to the functioning of a group. The reality is that they frequently are accompanying factors associated with the long-term effects of sexual abuse and become issues to be addressed in group work.

Some factors affecting the effectiveness of group treatment can also be looked at. In a study (Hazzard, Rodgers, and Anger, 1993) to determine the factors affecting group treatment outcome for sexual abuse survivors, the only variable that indicated a causal relationship was previous psychiatric hospitalization. This variable indicated a negative treatment outcome. Group experience is often stressful, even though it is an empowering experience for a survivor. A number of the authors suggest that, in order to deal with the

stress of being in a group, it is useful for the survivor to have well established individual therapy in place if needed at the same time (Herman and Schatzow, 1984 and Sprei, 1987) . Permission would be obtained from perspective members to contact individual therapists should the need arise to coordinate treatment planning.

During the intake interview, it is helpful to ask demographical data at the beginning to allow the survivor to relax and become familiar with the group leaders. This information serves as the basis for a discussion of the client's life situation. The amount of information regarding the trauma experience obtained at the intake varies among authors. Jehu, Gazan and Klassen (1988) follow a lengthy, detailed format. Sprei (1987) directs the therapist to ask more general questions such as who the perpetrator was, how old was the victim when the abuse began and ended, the degree of violence involved, how the woman survived while the abuse was occurring, what were the reactions of other family members, and how does the incest affect her now. The therapist can ask about her goals for participating in a group and if she has any fears about being in the group. Heitritter and Vought (1989) also discuss with her the expressions of love and messages received from parents, previous counseling history, responses to previous disclosures as well as current lifestyle. The literature regarding this interview leaves some gaps about asking about the strengths the survivor comes with into the group, her coping mechanisms, and her supportive relationships whether they be individuals, groups, or clubs.

Group themes, process and stages

Although each group has its own process, survivor groups usually go through three phases (Corey and Corey, 1992; Goodman and Nowak-Scibelli, 1985; Herman and Schatzow, 1984).

The initial stage of the group involves getting to know one another and establishing ground rules. Aspects that are emphasized are the importance of confidentiality, regular attendance, the limitations of time, expressing feelings without

hurting oneself or others in the group, disclosure of information as the survivor sees necessary, and bringing unresolved issues into the group. Authors vary as to the amount of contact among members outside the group. Sprei (1987) encourages contact outside the group provided there is no discussion of group issues involving other members or leaders. Goodman and Nowak-Scibelli (1985) request no contact outside of group meetings while Herman and Schatzow (1984) place no restrictions. Bergart (1986) believes that it is crucial that the therapist be available to members for individual interviews or phone calls between meetings. Others, as stated earlier, suggest this be done by another primary therapist.

Goal definition of a survivor's expectation within the group (Herman and Schatzow, 1984) can be stated in this initial stage. Plans for self-care and mobilizing supportive people are a place to start for a survivor who is at the beginning of her work. It is helpful to focus on her identity, feelings and behaviors. The themes of acknowledging the ownership of her personal choices and being responsible for her own healing can be elaborated on.

Although there is high anxiety in the group, the survivor's compelling interest to meet another survivor allows a bond to develop quickly (Goodman-Nowak-Scibelli, 1985) and allows her to challenge her belief system. Drews and Bradley (1989) use group exercises to encourage desired behavior changes and expect the specific, measurable changes to be reported by each member. The role of the therapists at this stage is encourage members to share information about themselves, to inform others why they wanted to join the group, to facilitate discussion, and to point out common feelings and experiences.

In the middle stage of the group module, the stories of the abuse begin to be told. Authors vary as to the expression of detail of the trauma. Goodman and Nowak-Scibelli (1985) suggest that it is important for the details to be explored so the underlying affect can surface. Sprei (1987) also encourages a focus on the past at the beginning of this

middle stage so the survivors can describe their family patterns, faulty childhood messages, and the abuse itself. However, Sprei says that the survivor should be encouraged to choose only as much as she wants to tell so she can remain in control of all disclosures. Herman (1992) emphasizes this point in that safety and control are the most important aspects in this stage of telling, since group members can easily frighten themselves and each other with the horrors of their past lives and the dangers in their present experience. Although earlier it was stated that regular attendance to the group is useful for the group to be therapeutic, Herman (1992) states that participants should be under no obligation initially to attend regularly or to speak, especially if a survivor is in the early stages of recovery. Once a survivor has her safety and self-care securely established, her symptoms under reasonable control, and reliable social supports in place, she can enter into the process of remembering.

Gold-Steinberg and Buttenheim (1993) offer group therapy for survivors in which they prepare the group members for the telling of the trauma experience. The survivor is extensively questioned not about the trauma itself, but about her previous experience of the telling of the trauma as well as her expectations about telling the present group members. The therapist's goal, Gold-Steinberg and Buttenheim offer, is to posit exploration of the similarity and differences of the telling experience as a means to achieve greater understanding of the self as well as of others. The therapist's responsibility is also to establish connections between the details of what was shared and how it was shared with the salient characteristics of the survivor's interpersonal behavior in the group as well as outside of it. The telling of the story then can become a way to integrate the strong affect a survivor has associated with it.

Following the disclosures, which are usually shared in snippets, the common themes such as secrecy, isolation, shame, and feelings of anger, hurt, grief, helplessness and fear emerge. A bonding and mutual cohesiveness develops. Through the group process, a survivor becomes aware of the faulty belief system she has developed, either

through watching others do their work or by being challenged by other group members. She can learn to create functional positive self statements. The group can also help her to reclaim her inner child as well as to integrate her dissociated part of herself into their current adult definitions of herself (Roberts and Lie, 1989). In working on the area of healing her inner child, a survivor is asked what she would need to help her in recounting her feelings about her inner child and what she would need for comfort should she become distressed or overwhelmed. Bergart (1986) stresses the ambivalence the survivor often displays when she is experiencing her feelings. She cautions against going too fast in revealing disclosures, feelings, and meanings. The therapist needs to listen to the comfort level of the survivor as to the speed of disclosures which the survivor needs to maintain her control.

Trust in interpersonal relationships, both within the group and outside of the group setting, becomes an area to be worked on during the middle stage. A survivor may challenge appropriate boundaries and act out in destructive and impulsive ways with others and herself. Ganzariain and Buchele (1987) view these behaviors as attempts to communicate the confusing feelings resulting from the trauma. These authors view the meaning of the actions as being outside the survivor's conscious awareness in order to avoid full awareness of her emotional problem i.e. "tell without talking". These authors suggest translating acted-out impulses into meaningful interaction within the group, so that these exchanges can then be discussed and acted upon. If possible, the meaning of the behaviors should be put into words. In order to enhance self-understanding, each group member could translate the words into the survivor's own language in order to see how the same behavior appears in different contexts. The survivor may then be able to learn new reflections on her behaviors and bring about new views of herself and others.

This stage of remembering is very difficult but group processes can allow members to help each other bear the terror and confusion of recovering the awful memories that they have lived with. A survivor can also learn by being there for others to bear the pain

of mourning their many losses. Herman (1992) uses the creativity of the group to construct shared mourning rites and rituals that are especially useful when a relationship has terminated. The group can help a woman grieve the things she cherished most about a family that never was and a childhood that was torn away. Sharing grief at a time such as this can be helpful to mourn the many losses.

Termination

The termination becomes the last stage of group therapy. Termination for the groups begin at the initial interview. The number of the remaining weeks is regularly announced at the meetings. The ending is highly formalized. The rituals of farewell are carefully planned. The reason for this is that many relationships a survivor has been part of have not been formally or appropriately terminated. Because it has been difficult and painful for a survivor to invest in a relationship, endings imply an emptiness difficult to handle or to admit (Drews and Bradley, 1989).

Goodman and Nowak-Scibelli (1985) describe further feelings that resurface for a survivor at group termination. These feelings include abandonment and loss, guilt that maybe she should have worked harder to come farther along in healing, as well as anger toward group leaders. To balance these feelings, there needs to be a focus on the changes she has made and that she has seen others make. Remaining areas for future healing can also be identified. People to call on for help and support can be defined.

Focusing on the changes noticed can become an evaluation. Such an evaluation actualizes the group experience in terms of assessment. Items such as journal writings, craft projects that reflect healing, or objects that symbolize a survivor's inner self can help to tell the group of her experience. Drews and Bradley (1989) and Herman (1984) suggest a social event such as a meal be planned to encourage the natural expression of newly acquired skills and behaviors in a social and open environment. Individual termination interviews or written client satisfaction evaluations can be useful.

2.1 Solution-Focused Treatment Approach of the Practicum

Having discussed the nature of the problem of childhood sexual abuse and the effects of the trauma on adult women, this student will now discuss the approach and modality of the intervention used in this practicum. In order to be effective in dealing with many of the effects stemming from, or related to the trauma it was difficult to utilize one approach solely, since many factors affect the resolution of the trauma. However, the treatment approach adhered to in this practicum was the solution-focused approach. This approach was chosen as it allowed for the inclusion of many healthy coping responses as well as the inclusion of different treatment approaches of healing a survivor was using in recovery. The solution-focused approach was used was in a group treatment modality.

Goals for Intervention

In working with survivors in a group setting, there are several goals that need to be attended to. Firstly, it is essential to provide a safe environment where a survivor can deal with the trauma of childhood sexual abuse with her power and control. The goal of restoring power to the survivor facilitates the opportunity to set goals for herself. These goals will reflect a survivor's desire for change as well as how she can see change occurring in her life and environment. The expectation is that the survivor's restored sense of power and control she experiences within the group would then transfer outside of the group setting as well.

Secondly, another goal of intervention is to provide the survivor with stabilization when experiencing the symptoms related to the sexual abuse along with relief from their

occurrences. The stabilization and relief from the symptoms occurs by exploring the survivor's emotions and beliefs about the past, especially when she remembers the traumatic experiences. The goal is that a survivor obtains relief by reworking her emotions and beliefs about herself and in her interpersonal relationships. Techniques are presented and discussed to provide relief and stability for the problematic symptoms. A survivor is assisted to normalize her sexual abuse experiences by becoming aware of the commonalties of the impact of the trauma with other group members. Opportunities are provided to share her secrets and name the abusive experiences should she desire to. A survivor is encouraged to grieve her lost childhood, to grieve the loss of the fantasy of having had good parents, to recognize the changed family relationships, and to nurture the child she was at the time of the abuse.

Thirdly, another goal of intervention is that each member is encouraged to identify with other survivors, to establish an alliance in healing together, and to use the group as a support network to provide a context for hope and healing. During this process, each survivor is facilitated in recognizing and using her strengths for survival and healing.

Assumptions of the Solution-Focused Approach

In keeping with the goal of restoring power and control to the survivor, a solution focused approach is used. In using solution-focused therapy (Walter and Peller, 1992), several assumptions are attended to:

1. Change is occurring all the time. The therapist takes responsibility for empowering the survivor to create and experience unique, meaningful, and effective changes to continue to find solutions for healing.
2. Small change is all that is necessary to continue the process of healing.
3. Therapy becomes a co-creation of solutions by the survivor and her therapist. Both survivor and therapist can look for exceptions as to what happens when the survivor is problem-free or when she is experiencing fewer symptoms.

4. Therapy becomes a recognition of the solutions a survivor has used in her survival process. It is assumed a survivor comes to therapy with resources to construct highly individualized and uniquely effective solutions which have helped her cope with and survive the trauma.
5. Shifting the perception of the problem a survivor is experiencing can lead her to look what the future will be like once the problem is resolved.
6. The survivor is the expert on her life.
7. A therapist doesn't need to know everything about a survivor's life nor does a survivor need to understand everything about her life to begin to solve her problems.
8. A survivor defines her goals as she understands them.

This approach for intervention provides the control and power which needs to be restored to the survivor. It also allows the survivor to alter the negative self-destructive feelings and thoughts associated with intrusive, painful, ever present memories of the trauma. This approach can provide for the survivor a healthy, more realistic view of the future. Respect, pragmatism, and hopefulness are attitudes practiced throughout the stages of the therapy process.

Specific intervention using the solution-focused assumptions will now be discussed using the three stages of therapy as described by Herman, 1992. These stages were earlier described in the literature review.

Stages of Therapy

1. Safety and Control

Of primary concern in choosing a treatment approach, is the restoration of safety and control to the survivor. Since solution-focused therapy is based on the assumption that the survivor is the expert, she is given control in working toward her goal or solution. When she comes, how long she stays and when she leaves are her decision. The control that was taken from her as a child and continues to threaten her as an adult needs to be restored. When she chooses to come to therapy, it will be recognized that she will create a safe environment for herself. This safety needs to be upheld so she can make the major changes to her desired direction. She also needs to feel safe to take risks when faced with difficult choices. When she recognizes that some of the coping mechanisms she has used to keep herself safe are no longer useful, or are even getting in the way of healing, she needs to be made aware of alternative ways of relating, thinking, and behaving. Safety needs to be built into the group by letting each member know ground rules. In the beginning of the group sessions, it is helpful to remain in a cognitive and educational perspective. An exploratory one becomes frightening when a survivor does not feel ready to explore.

Information needs to be shared with the survivor from the beginning of treatment so she can learn the language for her experience. Frequently, a survivor comes into the community mental health system with vague feelings of depression, numbness, self-hatred, lack of autonomy, and chronic perceptions of danger and fear. Relief occurs when a survivor makes the discovery that there is a name for her behaviors, experiences and emotions stemming from the trauma. Hearing another member from the group exchange similar thoughts helps her understand the validity of her own thoughts. Understanding that she is not crazy, but responding in a way that is normal for many who have gone before her, can provide hope. Naming the commonalties of the experience gives her a

mastery of the process of recovery. This provides a change in self-perception as well as a change of meaning of the abuse experience. The change helps provide a solution to the problems she is bringing into therapy.

Establishing safety is a concern the therapist needs to be aware of throughout the healing process. The therapist becomes aware that the present living environment for the survivor may not always be a protective one. In fact, some parts of her life may continue to be hostile. The potential for violence is explored if she is in an abusive relationship. A survivor's goals for herself as well as for the present relationship are assessed. Ways to help her recognize her desire for the relationship to continue or to end are looked at. In addition, her denial and minimization of the ongoing danger are addressed. The meaning she gives to her present living experience is what she brings into therapy, and it influences the degree of safety and protection she gives herself.

Therapy needs to become a safe experience. The assumption in solution-focused therapy is that the survivor has the skills and resources to know whether she feels safe. These skills are highlighted and utilized in therapy. Because she has been exploited in the past by people who represented caring for her, the survivor sometimes views the therapist as a person who may not be trustworthy. A survivor's assessment of the healing process is carefully heard so she can continue to provide safety for herself. When a survivor questions a therapist's honesty and trustworthiness or the treatment process, careful attention is given until the survivor is satisfied she will be safe and not further violated. This is done with the assumption that a client is always cooperating. She is doing this to show the therapist how she is thinking and acting in order to provide safety. Any fears she has about being with the group is shared in the pregroup meeting.

In order for healing to occur a survivor also needs to have control of her emotional state and her body. She needs to have control of her basic health needs, of her sleeping, eating, and exercise patterns, her intrusive post-traumatic symptoms, and her self-destructive behaviors (Herman, 1992). In addition, the symptoms of hyperarousal and

intrusive flashbacks and dissociation need to be dealt with. In desiring a satisfying sexual relationship with her partner, she may find her body betraying her. In working in these areas of control, the assumption is that small changes in one area can lead to larger changes in other areas. The group can become a safe place to teach a survivor to work at this.

Socially, a survivor's relationships tend to oscillate between extremes as she attempts to establish some degree of safety for herself (Herman, 1992). It is important to construct with her a vision of what relationships with others will look like once she feels safe and in control of her responses to other people. Family members, partners, and friends can be of help but they can also be a source of danger. Helping her sort out the areas of support and non-support in relationships will assist her in utilizing the strengths of her relationships. Other people from whom she feels support can be taught how to become helpful in her healing. Some degree of coercive control may however still be present between the perpetrator, her family, and herself. Attempting to deal with this can be difficult since control is easily taken away from her again. For her own future protection, the decision to separate or distance from her family or reconnect with them again must be her own. Criminal reporting must be left as her choice. If indeed she has laid charges, the justice system may continue to undermine her sense of control and safety.

In solution-focused therapy, there are several tools that provide safety and control while the survivor is working through the trauma. These tools are based on several assumptions. One of the important aspects of solution-focused therapy is that the survivor comes with many strengths that she has used to help her cope with the trauma. Another assumption is to look for the exceptions to the problem a survivor is bringing into therapy. Since exceptions to the problem are not usually thought of by the survivor, she may be surprised when asked about when the problem doesn't occur. Using whatever opportunities she brings into therapy, the therapist can ask the survivor to think about any time when the problem doesn't occur and what is different about the time(s) when it

doesn't happen. To find out what the survivor does when there is an exception, the therapist can ask the survivor what she does differently at those times and what has to happen to do it that way more often. Examples of the questions that can be asked are listed under the heading of "constructive individual and systemic questions".

Some of the tools suggested by Dolan (1991) to recognize a survivor's strengths are: pretreatment changes, the Solution-Focused Recovery Scale, the miracle question, the first session formula task, the "older, wiser self", and constructive individual and systemic questions. To ensure that a survivor feels safe and in the present, a tool for finding a tangible symbol of safety is suggested.

Pretreatment Changes:

The solution-focused approach suggests it is helpful for the survivor to identify any changes in her healing that she is noticing before coming for treatment. She can be asked what changes she has noticed in herself since she scheduled the appointment. If she is aware of any changes, she can be asked which she would like to continue. This approach utilizes her natural and already present ability to experience change in helpful ways. The questions also lead into the following solution-focused recovery scale.

The Solution-Focused Recovery Scale

The copy of the solution-focused recovery scale is found in Appendix 8.
Dolan (1991) devised this scale to help a survivor identify and talk about ways healing is already occurring. Recognizing these ways can help convince her in the future that she is still healing. This scale helps provide a context of hope and shifts the focus from trauma to healing. Noticing signs of healing as well as identifying the effects of trauma lays the groundwork to move beyond identity as a victim of sexual abuse. Once a survivor has identified a healing sign, she can be assigned to notice when it happens as well as notice

other signs of healing. It is suggested that the smallest signs of healing be identified first to make the tasks more achievable and manageable.

Dolan (1991) suggests that the scale can be used by having the therapist read each item aloud to the survivor with her responding verbally. However, the scale can also be used by having the survivor fill it out individually or in a group. Using the item of "other signs of healing" recognizes other ways healing is occurring, along with any pretreatment changes she can identify.

If a survivor has difficulty in identifying any healing signs as a result of being severely traumatized or demoralized, Dolan (1991) suggests asking a systemic constructive question such as "What do you think your (significant other) would say that your first small healing sign would be?" Both the survivor and her supportive relationships can look for small and gradual healing signs as therapy progresses. This outlook can provide a very hopeful, positive orientation.

The Miracle Question

The miracle question is useful for a therapist to ask. It empowers a survivor to imagine a solved version of her problem. Dolan (1991) states it this way:

> If a miracle happened in the middle of the night and you had overcome the effects of your childhood sexual abuse to the extent that you no longer needed therapy and felt quite satisfied with your daily life, what would be different? p.34.

A survivor can then identify various useful perceptions and behaviors of recovery. The therapist could ask if any of these changes are already occurring. The healthy perceptions and behaviors can be reinforced by asking the survivor to notice the times she carries out these healthy behaviors and thinks the healthy thoughts. Noticing the times these

perceptions and behaviors are occurring can help her realize she already has some control of her life.

The First Session Formula Task

Dolan (1991) suggests for the survivor to make a list of those areas of her life right now that she would like to have continue. This strengthens the survivor's awareness of resources that she wants to hang onto as well as to have continue during therapy. A survivor may want to include her job, relationships, hobbies, or any aspect about herself that she values. The list serves as a reminder of her safety, comfort, and support available to her in the present. These reminders are especially important in the early stages of therapy when the intrusive flashbacks can become overwhelming.

The "Older, Wiser, Self"

This technique uses a futuristic approach, assuming that the survivor will grow older, wiser, and presumably progress further along in her healing process. The therapist can suggest the survivor imagine herself as a healthy, wise, older woman, looking back on her life. The therapist asks the survivor to ask this older woman "Self" for advice as to what would help her get through the current phase of life. What would she ask her to remember? What would be most helpful to have in order to heal from the past? What could she hear that would comfort her? Would she have any advice about how therapy could be most helpful? The survivor could also imagine receiving a letter from a supportive but deceased older person, or having the survivor write the letter she would want to receive. The survivor can also write a letter to the "older, wiser self" telling her of her struggle. In response, she can then write herself a letter offering support, comfort, and advice.

Constructive Individual and Systemic Questions

The solution-focused questions help a survivor recognize what she is already doing that is helpful in her healing, The questions are imagined solutions or ideas about how to make desired changes happen. The questions framed relate only to behaviors that the survivor is able to influence. Dolan (1991) offers that looking at a survivor's responses to these questions provides a highly personalized map for therapy which fits into her life's situation and uses her resources. Examples of questions that Dolan (1991) uses to help the therapist and the survivor identify what is needed for the survivor overcome the trauma and its impact are :

> "What will be the first (smallest) sign that things are getting better, that this is having less of an impact on your life?"
> "What will you be doing differently when this (sexual abuse trauma) is less of a current problem in your life?"
> "What will you be doing differently with your time?"
> "What useful things will you be in the habit of saying to yourself?"
> "What will you be thinking about (doing) *instead* of thinking about the past?"
> Are there times when the above is already happening to some (even a small) extent?"
> What differences will the above healing changes make when they have been present in your life over extended time (days, weeks, months, years)?" p. 37.

Examples of constructive systemic questions include:

> "What do you think your that your (significant other) would say would be the first sign that things are getting better? What do you think your (significant other) will notice first?"
> "What do you think your (friends, boss, significant other etc.) will notice about you as you heal even more?"
> "What positive differences will these healing changes you've identified make over time in your relationship with (significant other)?"
> "What differences will these healing changes you've identified make in future generations of your family?" p.38.

Symbol for Safety in the Present

When a survivor comes into therapy, it is helpful for her to identify something in the room that can be used to remind her of the present situation. This is useful since she may feel that once she begins to talk, she may become overwhelmed with her material to the point where she feels unsafe and out of control. Once she has identified something external in the room, it can become a conscious break from the material she is recounting. This reduces its emotional impact. The symbol can be a reminder that she is not the child experiencing the abuse but is now an adult, safe and having choices. The item can be any object she came with such as her purse or watch. It could be something in the therapist's office, outside the window, or an object she chooses to bring from home that reminds her she is safe and in the present.

Restoring control and ensuring safety are initial aspects of intervention, but they do not end at the beginning stage of therapy. These principles need to be maintained throughout the entire intervention process. The type of work done in therapy may change, but the restoring of control to the survivor and ensuring her safety will continue even when the strategies and tools of intervention change. Herman (1992) states that the single most common error of this stage of therapy is avoidance of the traumatic material while at the same time the other side of the coin of error is premature engagement in exploratory work. In order for the survivor to be ready to deal with memories associated with the trauma, she needs to feel safe enough and in control to establish a therapeutic alliance. Only then, can she choose to deal with the issues and memories that brought her into therapy.

The group helps define the problems each member is experiencing. The group can look at ways a survivor is using the tools to provide her with relief and stability to deal with symptoms. Listening to ways another survivor is healing can bring relief and hope.

The principles of providing safety and empowerment in intervention continue when the survivor begins to deal with the memories and intrusive flashbacks. The therapist continues to assist the survivor in providing stability and relief from symptoms related to the traumatic, often unspeakable past. The intervention includes altering feelings associated with memories of the trauma so that the memories can be understood and controlled instead of being so painfully intrusive and therefore avoided.

As the survivor begins to relate the events concerning her trauma, it is necessary to balance what she needs to leave behind with what she needs to remember. It is her choice to uncover that which is bearable. It is her choice to bring into therapy what is needed to heal the problem that brought her into therapy, and to leave the rest behind.

Remembering the trauma and its impact on the survivor's life begins with a review of her life before the actual events of the abuse took place. It is helpful to allow her to look at her ideals, values, dreams, hopes, and struggles prior to the events of the abuse. This will allow her to focus on what was rightfully hers and what was taken from her. It will allow her to place her life and the events of the abuse within the total context of her life. This can free her to realize the reality of the destruction of the trauma and to place the responsibility for the abuse where it belongs, on the abuser.

Some survivors come into therapy with a great deal of doubt that their memory is indeed real. Dolan (1991) recognizes this doubt as being necessary for some survivors so they can ease into the realization that the abuse is real. It is helpful to encourage a survivor to hang on to her doubt as long as it is necessary for her to come to terms with the truth of her experience. When she is ready, she will work with the reality of it. During this process, Dolan (1991) advises survivors to be cautious with others and not verbally attack other peers or family members who remember the trauma or who are further along in the remembering process.

The telling of her story is a often a very intense period for a survivor. When a survivor is telling the story of how life was as a child, it can be helpful for her to take a deep breath, have her feet firmly planted on the floor, and keep her eyes open. It is also helpful to remind her of an object of safety to keep her in the present and to use her associational cue for safety (which will be described later, along with other relaxation techniques). In recounting her memories, a survivor again experiences the same feelings of pain she has defended herself against. As a result, dissociation, denial, and lack of affect may protect her from experiencing the fear, pain, rage, shame, guilt and sadness as overwhelming. If the therapist can respond with empathy about the difficulty dealing with intrusive memories and flashbacks, the survivor can be directed to the dissociative abilities she used to protect herself when nothing else was available. The strengths and the inner resources she has used for coping need to be respected and worked with. Admiration can be expressed for having a healthy ability to help herself unconsciously. At the same time a survivor needs to be encouraged to take responsibility for what she needs to remember in order to heal. What she presents when recounting her life will be fragments of the story. In order to maintain her control and integrity, these bits of narration may include visual, olfactory, and auditory aspects, cognitions, sensations, and affects. The goal of telling her story is to put her words of facts, feelings, and meaning together so they can be integrated. Then the survivor can recognize her past is real and her present perceptions are valid.

The result of the telling and the validating of the story is threefold: firstly, she can have relief from the problem that brought her into therapy; secondly, she can put the responsibility for the abuse where it belongs; and thirdly, she can continue to use her energy to heal. During this process of discovering meaning to her past and present life, she can be asked what she needs to maintain stability and safety. She needs to be affirmed for having the resources to achieve relief and stability.

Following the telling of her story in the group, it may be helpful for the survivor to reflect on the experience of the telling. Any new connections she can make as a result of

the telling may help illuminate her present relationships. Any previous telling experiences could be compared to the present telling. This process allows her to integrate new ways of seeing herself and others. Reflection can provide valuable feedback to others in their attempt to tell what they believe is necessary for their healing. A member who chooses not to tell her story may, by hearing another member's reflections, integrate some aspects of the other member's story for herself.

It is helpful for a survivor in therapy to look at the events of the trauma in the context of her life. One way to do this is to draw a time line and write on it the significant and developmental events of her life. This process may bring her to the difficult and lengthy process of mourning. As she recognizes and accepts the losses she encountered as a child and as an adult, she will come to a place where she realizes how different her life is now as a result of the abuse. This process will include grief and anger. Various techniques can be used to express this. Writing feelings, reading them and then burning the paper can be healing for some survivors. If this is difficult, the feelings can be spoken into a tape recorder and the tape can be kept safe or discarded. The mourning process will help her adjust to recognizing her present environment with a profound loss of fantasy attachments. She may have some ideas on how some of the losses can be recaptured.

It is also helpful to discuss with a survivor the meaning she gives by not wanting to look at the losses and grieve (Herman, 1992). This can be viewed as beginning steps of the mourning process instesd of "resistance" and it can take several shapes. Firstly, it can take the shape of revenge as a way of getting even with the perpetrator. Secondly, it can take the form of premature forgiveness as a survivor's way of transcending her rage against the perpetrator. Blaming or premature forgiveness may relieve the pain briefly but it does not lead to empowerment or to taking responsibility for one's life. Or thirdly, a survivor can ask for compensation from the perpetrator as a way of avoiding her grief. These resistances can be traps for a survivor to avoid the grieving process because the

reality is that as a survivor grieves, she becomes more aware of her pain. However, in allowing herself to mourn, a survivor can honor the child she was when she was violated.

In addition to allowing and encouraging the survivor to grieve her losses, it is helpful to work with her in getting to know the child she was. Staying distant from the needs of the inner child locks out her present feelings toward her child within. In order to connect with her basic needs, she may want to connect with the child she was at the time of the trauma. In understanding the distorted feelings and thoughts of the child who was hurt, she may gain some understanding about the feelings and thoughts she now experiences as an adult. This connection may allow her to recognize needs she has as an adult. In group therapy, she is encouraged to do whatever she feels comfortable with, in group or alone, to get in touch with the child she was. She can use stories, drawings, paintings, journalling, music, metaphors, photography, bodywork, guided imagery, or role plays. The feelings of rejection, abandonment, self-hatred, and negative specialness are accessed. She is encouraged to take whatever steps she needs to keep safe and whatever is necessary for her healing. Hopefully she will recognize many strengths, skills as well as needs and vulnerabilities she had as a child.

This is often a time when the boundaries between the survivor and therapist are tested. It is imperative that the therapist maintain the physical and sexual boundaries of the relationship so the survivor is kept safe from a reenactment of the original abuse. Nurturing the child within who never received the affection and nurture she deserved can be comforting to a survivor, and can bring as sense of lightness into her present life. Asking her to identify and carry out meaningful activities that she wasn't able to do as a child is appropriate. Connecting the strengths and needs from the child to the adult may help her make some meaning for her present feelings, thoughts, and behaviors. The therapist can ask what difference it makes to make the connection between the past and present. Recognizing which needs were not met in the past or in the present may help her look for ways she could meet her needs now and in the future. She could be asked how

she would effectively communicate her needs. A survivor could also be asked how her life would be different if her needs would be met.

Techniques that allow a survivor to remember and to mourn recognize resources and inner strengths that are being used. There are times when therapy will include silence as well as words. Drawing, painting and music may be useful to tell the unspeakable, but care needs to be taken not to encourage her to express more than she can control. She needs to be encouraged to leave behind whatever is not necessary for her healing. Gesalt techniques such as the empty chair can be used to explore and identify disowned feelings she may want to express, but only when she is ready to do so. She can then take a step back to see the validity of those feelings in the present. She can ask herself if she sees the necessity of looking and thinking about them differently. It is useful to remember that not all memories need to be recalled. One episode can stand for many.

A survivor may find herself in a double bind. She may still care a great deal about the perpetrator or about a parent who refuses to protect her. Dolan (1991) suggests a helpful method to deal with this problem by recognizing the seemingly paradoxical truths present. She suggests the survivor express her dichotomous feelings. These feelings may include the love she has for the perpetrator(s) as well as the hurt she experienced as a result of the hurtful or exploitive behavior toward her. She may also recognize the perpetrator is not only denying the truth of what happened to her in the past but is also denying his present harmful treatment toward her whenever she tries to resolve the past. The fear is that these dichotomous feelings will not allow her to continue to love her perpetrator. Intervention would help her recognize feelings of love toward the perpetrator(s) as well as the inability to reconcile with him at present because of the past abusive behavior. Recognizing the coexistance of these feelings may be helpful to solve inner conflict and integrate her feelings. Although this may be too much of a neutral stance for some survivors to be comfortable with, it does allow some survivors to be true to their own perceptions and to have them validated.

If a survivor wants to confront a perpetrator, Dolan (1991) suggests that time in therapy be used to review any past attempts. The results of past attempts and the emotional impact it had on her can be explored. Possible consequences from family members can be predicted by their past reactions. A survivor needs to be asked what she needs to maintain her self support and safety during the disclosure. Having a symbol of the truth written on paper and carried in her pocket or shoe can be strengthening.

Writing three healing letters before the disclosure can help prepare her for hopes, disappointments, and fears of a confrontation. The first is a letter of disclosure but it may not be mailed. The next is a realistic but imaginary response she might receive from the first letter. It should reflect any fears she may have about the response. The third could be an imaginary letter she would like to receive from the perpetrator with the response she would desire to receive. She then could imagine the worst possible outcome as a result of confronting her perpetrator and arrange for personal protection if she fears physical violence or further sexual assault. The confrontation should include a description of the abuse, the impact it had, and what she expects from the perpetrator such as an apology, payment for therapy, or lost time. It is helpful for the survivor to recognize that healing can continue regardless of the outcome of the confrontation, even though she may be very disappointed, angry or numb. Breaking the pattern of the secrecy will have empowered her to perform one very fearful task. It will have helped her to relinquish a victim identity and to recognize her strength and autonomy.

The nature of relationships following a confrontation or disclosure usually change. Interventions to deal with the loss of family of origin are difficult. It is helpful for the survivor to evaluate and remember the pleasant memories she had about her relationships in addition to remembering the pain inflicted on her. A survivor will usually grieve the end of a fantasy family that had not been there when she needed them. Each survivor will form a different frame for doing this. Permission needs to be given to hold on to whatever was good in the relationship. If she wants to have a ritual or ceremony when the

relationship has ended, she can be asked what she expects to happen as a result. The people and objects she wishes to be present for the ceremony of ending the fantasy family will reveal her meaning for the experience.

Using cognitive therapy, the therapist works with the assumption that the survivor is fundamentally responsible for changing her thoughts and behaviors. The survivor becomes aware that she has choices about the ways she can respond. Essentially, she learns how to manage her behaviors and thoughts. The denial and minimization of the abuse, her dissociation, her feelings of fear and anxiety, shame and guilt, anger and frustration, as well as sadness are reframed, normalized, and legitimized. Triggers for her thoughts and feelings are identified. Her behaviors are analyzed to determine whether she is responding as a child-like part or as an adult. She is encouraged to listen to her self-talk, to talk back to the negative self-statements, and counter them with self affirming ones. Group members are often very helpful in counteracting self-blame, providing reassurances, putting responsibility for abuse where it belongs, and recognizing vulnerabilities. Therapists can highlight similarities as well as discrepancies in group members' experiences. The meanings and connections each survivor brings to the group becomes therapeutic.

Stress reduction techniques are useful only if they allow the survivor to relax so she can remember with control that which she needs to remember and talk about. The techniques can help her identify and express memories and feelings with some sense of stability, resulting in some mastery over the crisis she may find herself in. This mastery will also help her make a connection with the past stresses and her current situation. If she can initiate new ways of thinking, perceiving and feeling, she can develop more helpful ways of coping.

Dolan (1991) views relaxation techniques as ways to help a survivor find control and stability so she can obtain relief from the symptoms that brought her into therapy. Examples Dolan suggests are the 54321 Self Relaxation Technique, the Associational Cue

for Comfort and Safety, and the Four Step Approach for Dealing with Flashbacks. These are found in Appendix 6. They will allow her to deal with the memories and mourn her losses. In addition Dolan offers the techniques of the Rainy Day Letter or Tape, the Movie Screen, and Non-Dominant Handwriting to reinforce a survivor's strengths. These techniques are found in Appendix 9.

Using the techniques from solution-focused therapy, it is helpful to ask a survivor about any positive changes she is noticing. She may recognize she can be part of the solution for her healing. If she set back in her journey of healing, she can be asked if she has learned anything about herself during the setback. She can be asked if anything has been better as a result of the setback or what has helped her manage or get through this difficult time. If she can notice any positive changes, ask her for details about when they happened, who else noticed, what was going on that helped, where it happened, and how she did it. Reinforcing changes by asking more questions helps her notice and value herself for the changes she is making. Any information she can learn about herself can provide symptom relief and rework the effects of the trauma.

3. Reconnection

As with the previous two stages, the stage of reconnection can occur at any time along a survivor's journey of healing. This stage can be recognized by observing and hearing the survivor's desire to reconnect in two areas: a) with herself and b) with others. She becomes aware of how she would like to feel rather than how she is feeling. She becomes aware of the possibility of new ways of relating. She focuses less on being a passive victim. In fact, she can refocus on engaging in a fight to own herself and her body, and to establish meaningful relationships.

During this stage, a survivor will challenge her passivity by recognizing where her fears and her chronic perceptions of danger have come from. She can learn how she is

allowing them to dominate her life. In learning she has the ability to engage these fears, their impact becomes minimized. Intervention would help her recognize situations where she has challenged her fears successfully. This recognition empowers her to move into other areas she still feels controlled by the fears.

A survivor will also begin to ask questions regarding assumptions about herself. Therapy becomes a place where these questions are encouraged. She can find meanings why the abuse occurred, how the violence was condoned, how her compliance was exploited, and how her voice was continually silenced. The dynamics of her family interactions will be questioned so they can be understood. Gender relations within the larger society may become more obvious as she questions family interactions. She will begin to examine beliefs regarding her sense of shame, guilt and badness. She will begin to understand ingrained self-hatred and her need to please others in order to feel better. It is hoped the understanding will help her become open to view herself and her behaviors with compassion and understanding rather than with negativity and blame. As a result, she can reconnect with the meaning of living she has, about her spirituality, beyond the aftereffects of sexual abuse.

A survivor will also become aware of the meaning of dissociation. Some survivors need to understand memory and process its meaning and their feelings one at a time, before they can put it in its place. Others, find there are so many painful memories that they allow their unconscious to put each memory in " storage" as in a computer. Later, when a pattern emerges which a survivor can make sense of, she can process the entire pattern of memories. Using the computer metaphor is one way to help her understand dissociation as a resource. She can make sense of all the information she may not have been able to deal with earlier.

In learning to reconnect with her body as an alternative to self-destructive behaviors, she can become aware of a variety of ways of valuing her body. One way is by pattern interruption. This can be a different activity or an activity she normally engages in.

It should be a different experience as she focuses on reconnecting with her body. Using the safety in the present symbols as well as associational cues (see Appendix 9), she can use the tools she is comfortable with to own her body. She can be asked what she needs to comfort herself. If she is recognizing different parts of herself, she can be asked what each part needs to feel safe. She can be asked what difference it makes when she feels safe. Using this language, her dissociation can be redirected as a resource instead of something to be feared. The therapist and other group members observe her learn to integrate or work co-operatively with her parts.

Some survivors may want to deal with the facts of the memories and the feelings they have associated separately in order to feel safe. The facts may include visual, olfactory, auditory, tactile, kinesthetic taste, or breathing sensations. When ready and able, she may add feelings to the experience to the degree that is necessary to heal. Giving reminders to leave behind whatever she needs to is always a necessary component of therapy. In therapy, she can also add the meaning for the facts and feelings she wants to remember. When she recognizes what she needed as a child at the time of the abuse, or as an adult if she experiences revictimization, she can be asked what was missing for her. She can be asked to imagine receiving what she needed during that or any other negative experience and notice what difference it makes. This information can help her put into place what she needs in order to remain in the present.

Listening in a group how other survivors use body work to enjoy and reconnect with their bodies can be helpful. These can be activities such as comfortable body massage, aerobic activity, walking, running, dancing, or self-nurturing rituals such as bathing with bubble bath. Homework assignments to provide self-nurturing could be discussed. These experiences can be used in the group to help a survivor identify when she does have positive experiences connecting with her body. Using the solution focused assumption of looking for exceptions to the problem of disconnection, the survivor can look for times she does have positive feelings about herself and her body. This awareness

allows her to notice other positive feelings. One task that can allow her access good body feelings is to work through the difference between sensual and sexual feelings (Drews and Bradley, 1989). She is encouraged to take an imaginary journey into sensory experiences by recalling whatever pleasant feelings she feels safe to recall. These may be feelings associated with activities like seeing a beautiful sunset, smelling hot buttered popcorn, or drinking something cool and refreshing on a hot day. It may be difficult for a survivor to use sensual imagery because it may remind her of suppressed sexual feelings that were disgusting. Helping her sort out the difference between pleasant sensual feelings which provide a sense of well-being and the fears with anticipating unwanted sexual feelings may not only help understand her sexuality, but also make her aware of a whole range of feelings beyond the sexual.

Reconnecting with others is a powerful aspect of group therapy which is necessary for a survivor's healing. One of the most pervasive aspects of being sexually abused is the feeling of being different, the negative specialness, the need to remain isolated, and the need to keep the secret. The group experience allows feelings of universality and the connection with others to neutralize the negative stigma. It is often easy for a survivor to recognize powerlessness in relationships, since her life may reflect many relationships where power was taken as a result of manipulation and exploitation. Yet, a survivor will have developed strengths which she can define as powerful, such as the ability to take care of others. These strengths often go unnoticed. Her use of power or her lack of it is often used in an either/or perspective. She feels either no control or that she must take control in relationships. This dichotomy results in the difficulty of trusting others and forming relationships which not only have a sense of autonomy but also a sense of mutuality. Individual therapy encourages her to examine and form healthy, satisfying relationships. Group therapy provides a context to examine and put into practice behaviors which allow her to find and develop intimacy with family and friends.

A sense of belonging develops among members as a result of the common themes expressed A survivor's perception changes about herself and others. By identifying with other survivors and hearing their stories, it is as though a survivor is able to grant others absolution and thereby lessen their sense of badness, shame, and guilt. This allows her to feel safe to verbally express her hostility instead of acting it out in self-destructive ways. She begins to see other survivors as valuable and worthy of respect. She honors other survivors' ways of coping and surviving the trauma. She discovers other members' responses to the trauma as normal, instead of evidence of insanity. She sees herself and other survivors as persons with many interesting experiences, beyond that of being a survivor of sexual abuse.

During this period, a survivor may be ambivalent about her feelings, thoughts, and behavior, much like an adolescent. She may give the group information about herself at an adult level, only to retract it later. The emotion she demonstrates in the group will vacillate between that of a child and adult. She may act out behaviors toward other group members instead of thinking, talking or reflecting about her feelings and thoughts. It may be that she is trying to communicate her pain without being able to do so in words. Ganzarain and Buchele (1987) suggest there are three areas which survivors act out in the group instead of talking about them. The three areas of acting out are: firstly, sexual fantasies in the styles of dress, flirtatious mannerisms, and postures; secondly, power and sadism to keep secrets, negative specialness, intimidation, and identifying with the aggressor to get her way; and thirdly, self-destruction stemming from the dichotomous feelings of love and hate toward her abuser which can result in self-reproach and punishment to herself. Intervention focuses on translating the acting out behavior into a language which can be discussed and reflected upon in the group. This translation is a process in which a survivor can identify and think about what she feels rather than act on her feelings. This process can help test her perceptions and make them valid. The meaning of the behavior can be put into words that make the actions understandable. In a

group, each member can put the behavior into her own words to learn how the same behavior could appear in different contexts. Making these connections can be helpful in learning new ways of thinking about the behaviors, herself, her view of others, as well as how her behavior impacts others. The connections provide a survivor with alternate ways of thinking, feeling, and acting. These alternate ways can then be practiced in the safety of the group. More awareness of new ways of relating is not enoughto produce the desired changes. She needs repeated practice so that the new ways of relating can be sustained over a period of time. If she experiences the group as a safe place, she can practice these in the group and get affirmation.

The group is also a place where a survivor can learn to set appropriate limits. She can learn which areas in her life she is responsible for and in which areas others need to take their own responsibility. She will understand from others' experiences how she has been made to feel false guilt in her family of origin as well as in other relationships. New insight may provide meanings which have propelled her to take on the role of a caretaker and protector as the consequence of unrealistic guilt. Or, she will gain insight as to how difficult it has been to become an adult in a relationship where she is expected to remain a child. As she works on setting boundaries, enjoying intimacy, letting go of guilt, becoming assertive, she will learn how others in the group deal with feelings of abandonment or being controlled by others. A further discussion as to the commonalties of these experiences for other group members can help her notice healing changes she is making in maintaining appropriate roles as a result of this connection.

The group provides each survivor with the courage to expose the distorted thoughts, the misplaced loyalties, the uncomfortable emotions which keep the survivor stuck and unable to change. Each member affords her the opportunity to observe modeling of how change takes place and how change can happen for her. The experience of change can become refreshing and soothing for a survivor instead of anxiety producing.

The areas which survivors become stuck when trying to change can also be addressed in this context.

Each survivor's uniqueness and her own experience needs to be upheld as similarities among group members are noted. It is not helpful for survivors to compare the severity of their traumatic experiences. Meanings that each survivor has for her experiences as well as for the other members' experiences will be different and it is important to acknowledge the differences. This not only reinforces the uniqueness of each group member but allows her to tolerate the differences and dichotomous thinking that can co-exist within herself and within the group. Commonalties are stressed, but not sameness. The impact of each person's past on her present needs to be expressed by her own perceptions in the group. These perceptions need to be validated by therapists and other members. The memories a survivor brings to the group can be shared for the purpose of how they impact her present life and to determine what she can now do to make the memories less intrusive or painful. Remembering this purpose in sharing memories is crucial to help a survivor remember only her experiences. This will prevent the comparison of the severity of the traumatic experiences. Reminders to remember only what is necessary for her healing and to leave the rest behind reinforces the uniqueness of her situation. Bringing details of memories to the group is unnecessary and need not be encouraged. Leaving the details provides safety and control and also avoids frightening the other members.

Whenever a group member feels safe, she is invited to bring issues of relationships she is working on. She may choose to bring work from her individual therapy or from her relationship with her partner, family of origin, place of employment, or friends. This is to encourage her to establish a flow of similarities in the way she relates and to recognize process issues in relationships. A long-term group is usually needed for an appropriate trust level to develop where members can offer empathy as well as challenge each other. Intervention will allow individuals to explore and challenge each other's understandings

not only of their past abusive experiences but in all of their life. It is not uncommon to find a survivor leaving an unsupportive relationship to find and make a new family with people who truly care about and for her in mutually satisfying ways. One of the ways a survivor is able to make this happen is to translate past pain into social action by being helpful to others who have been victimized. It is her way of transcending and transforming her pain to make an alliance and share in helping others. In this way she is able to resolve her past and live an ordinary satisfying life.

Setting

The student of this practicum was looking for a setting in her geographic area where she could carry out the intervention with survivors of childhood sexual abuse. It was important to provide the intervention in a setting where control and power would be restored to the survivor while working through the impact of the trauma. It was hoped that during this process the strengths the survivor had could be recognized and utilized. It was also hoped that the intervention could provide a survivor with supportive relationships, other than professionals.

The setting available was the Eden Mental Health Centre. The Centre is a non-profit facility which provides in-patient and community based mental health treatment in the southern Manitoba region. It is funded jointly by the Manitoba government and supporting churches, primarily Mennonite. The Centre offers a variety of individual, family and group therapy. Social Work, Psychology, Nursing, Medicine, Clergy, Occupational Therapy, and Music Therapy disciplines are represented on the professional staff. Clients come to the Centre through self-referral or through referral by family physicians, school teachers, community mental health workers, child protection workers, women's shelter workers, or the clergy.

The population the Eden Mental Health Centre serves is largely Anglo-Saxon, along with various Mennonite groups. There are pockets of French-speaking groups with smaller clusters of Dutch, Flemish and Eastern European residents. Traditionally, much of the economy was agriculturally based. Presently, the region is becoming more diversified, with the lower income population growing. Religion in the area has a strong cultural component with Protestant, Catholic, and Mennonite the main churches represented.

The agency is working with survivors of childhood sexual abuse in individual, couple and group therapy. Centre staff were willing to work with a student in time-limited group therapy. Kathy Genoway, a psychiatric nurse and community services worker became the co-facilitator. She had several years of experience in this area and provided a great deal of assistance and direction in the preparation as well as follow-up of each group session. Kurt Guenther, M.S.W., a long-time community services worker, provided the necessary and insightful on-site supervision and encouragement. The university advisor for the entire project was Dr. Elizabeth Adkins.

Time limited group therapy for survivors was compatible with the goals of this practicum. It allowed survivors the opportunity to interact and share with others who had similar experiences. The group work also discouraged dependency on a therapist. Authority was shared within the group, allowing members to control what they said and listen to the effects of their common experiences on each other. Members modeled how healing could take place. Time-limited group interaction encouraged survivors to develop goal-oriented work. It allowed survivors and student to make a short term commitment to work on issues related to the trauma and healing of the effects of sexual abuse.

The physical arrangement of the room was conducive to group work. The room was large with adequate light from the southern exposure. The outdoor light was warming on afternoons when the weather was gloomy. Blinds could be used if the sun shone in too brightly. Tables were available for the exchange of books, articles, videos, tapes brought by facilitators and survivors. A table was also available for self-anchored scale marking and for coffee, tea, and hot chocolate. The beverages were available to members at their leisure. All chairs were soft, padded, upright with padded arms. The chairs were arranged in a circle for the exact number of people expected in the session. Facilitators attempted to sit opposite each other instead of side by side to counter-balance any perceived power. In the center of the circle was a small round table with a box of tissues. A large white board was available on a side wall. Unfortunately, the room was

also used to store some larger equipment, so the corners sometimes looked like a storage area. The walls were painted a light color. Pictures and other artwork on the walls would have made the room more attractive.

Research Design

The primary purpose of this practicum, as previously outlined, was to provide intervention in a group setting to promote healing and well-being of survivors from the effects of the trauma of childhood sexual abuse. The secondary purpose was to measure the effectiveness of this intervention. To apply single system research design, an A B design was used with pre and post-test measures and checklists to evaluate the effectiveness of group therapy with survivors. The A B design is seen as the foundation of single system designs because of the distinction between the baseline observation period, A, and an intervention period, B. Intervention would not be undertaken until baseline observations were made using a self-anchored scale of client goals, (Appendix 4). Observation of the treatment effects during the intervention period would be monitored continuously using the same self-anchored scale. Although threats to internal validity such as history or maturation could be eliminated by using a control group, it was not suitable to establish a control group as in classic experimental designs. The therapist can therefore not be certain that other explanations for the causal effect other than the treatment could account for test results. However pre and post-test measures and checklists compared the extent to which the problem occurred after the intervention against that pattern of problematic thoughts, feelings and behaviors existing prior to it. These measures and checklists were used to strengthen the research design. Measures used included the Hudson Self-Esteem Scale, (Appendix 6) to measure a survivor's thoughts relating to self-esteem and the Brief Beck Depression Inventory (Appendix 5) to measure her feelings. Checklists used were the Support Network Form (Appendix 7), to assess the social

support of a survivor, and the Solution-Focused Recovery Scale (Appendix 8) which help a survivor recognize her signs of healing. These will be described in the chapter dealing with evaluation. Testing was completed at the conclusion of the initial interview using the above measures and scales. Continuous measurement was done at the beginning of each group session, using the self-anchored scale. At the last group session, each survivor was provided with a client self satisfaction questionnaire to be completed and returned anonymously to the agency receptionist prior to the post-test interview. This was to allow for an unbiased evaluation of the survivor's group experience. Post-testing, using all the same measures, was completed one month following the last group session. In the post-test interview, the measures, scales, and checklists were administered at the beginning of the interview to deal with external validity of reactive testing.

In keeping with the goals of restoring the survivor's power and control, the testing was optional. Intervention was not withheld if a survivor chose to omit any or all the measures at the pretesting, continuous testing, or post-testing. This self-deterministic approach allows a survivor greater control and participation in evaluating the effectiveness of treatment.

There are several limitations to this design. Although clinical evaluation techniques are strengthened through the use of a randomly assigned group, an uncontrolled case study was used in this design. Threats to internal validity cannot be as effectively ruled out as they can be with classic experimental designs (Rubin and Babbie, 1989). A practitioner cannot rule out explanations for the causal effects other than the treatment. Secondly, a practitioner is unsure what effect (if any) previous testing experiences may have on test scores. Thirdly, natural maturation and learning may account for some changes and this would not be detected in this design. However, the continuous testing throughout the course of treatment establishes more credibility for internal validity to the design (Rubin and Babbie, 1989).

Also, this A B design does not provide as strong an argument against threats to external validity as those using a control group (Kazdin, 1982). It becomes more difficult to generalize uncontrolled case studies or extend the findings beyond the conditions of the intervention. The practitioner cannot know: firstly, the extent to which the group facilitator, the setting, the clients, the measurement devices may have influenced the results; secondly, the extent to which one or more possible combinations of interventions involved in the group therapy process effected change; thirdly, the extent to which pretesting may have sensitized individuals toward issues addressed on the instruments of measure, and therefore affected scores on the post-test; and fourthly, the extent to which the test scores are limited to the short period of time before the sessions and post-testing period.

Selection of Group Members

Survivors who come to this agency for group intervention usually do so as upon referral from staff. It was expected that survivors who would become part of the group would have had at least a few sessions of individual therapy. Women who chose to come to the group for this practicum did so as the result of the suggestion by their primary therapist at the Eden Mental Health Centre, or their family physician, or their community mental health worker. It was hoped the survivors could continue their individual therapy or have access to their therapist as needed throughout the group sessions. The women who chose to come were initially informed that the group would have co-therapists, with one of the therapists a staff member who had led several groups at the agency over the previous years, and the other therapist a master's student at the University of Manitoba. Also of note, five of the seven women who joined the group had been together in a survivor's support group at the same agency, a few months earlier.

Even though five of the seven members had been in previous group therapy, all prospective members were interviewed individually prior to the group sessions. The individual pre-group interview was held to determine her appropriateness for the upcoming group experience and to meet the therapists. This interview provided the opportunity for each survivor to set her goals for the group experience.

At the individual interview, expectations therapists and survivors had about the group experience were exchanged. The therapists assumed a survivor could talk in the group about anything. Details of the past trauma were not encouraged, however. A group member had the option to be silent at any time. One way to give a survivor a sense of control to avoid telling more than she wished, was to contract a time for talking. If she needed more time, she could ask for this. A member was encouraged to tell her story, but work on current issues would also be stressed in group sessions. Any fears a survivor had about hearing other members' accounts and effects of abuse was shared in the initial interview. This allowed the therapist to assess her readiness to function in a survivor's group. The common tendency for a survivor to flee therapy when hearing about or working on difficult, painful material, was framed as being a normal aspect of healing. A survivor was encouraged to take time out if her pain became too intense. She could leave the session and return when she was able to during the same session. It was expected another group member would follow the survivor who left the room, to reassure her if she would want her to. If a survivor decided to leave the group permanently she would be asked to come for one more session and discuss her difficulties if she was able to. This return to the group for one more session was to clear up misunderstandings or to bring closure for herself and the others.

Other expectations for work in the group were stated. She was encouraged to attend all sessions. She was expected to be on time to receive the maximum benefits and to promote continuity for the others. Confidentiality of group members' identity and identifying circumstances was expected to be maintained. Respect for herself, other group

members, and property was expected while attending the group sessions. This meant she would not be actively suicidal, nor come intoxicated with alcohol or drugs, have a life threatening eating disorder, or behave in an aggressive manner toward others. Each member was encouraged to stay healthy, alive and in the present.

The group work was done with adult women who lived outside the home where the childhood sexual abuse occurred. It was expected a survivor would be at a place in her life where she would be able to tolerate the painful feelings that would come up within herself as well as from the others in the group. The painful feelings could be aroused from the focus on the trauma as well as on relationships. For this reason, it was expected she would have enough interpersonal skills to function with the others in the group. Issues of intimacy, trusting, controlling, caretaking, and sexualization could be discussed. It was expected that, if a group member dissociated, she could use her dissociation to function so she could help herself and others move toward healing.

In the initial interview, a letter of introduction (Appendix 1) and a consent form (Appendix 2) was given each prospective group member to help her understand the purposes of the group and the reason for having a student in the group. Many aspects of a survivor's past, present, and future was discussed with her. A survivor's reasons for interest in group therapy at this time was noted. It is common for survivors who are reworking their trauma to be dealing with many difficult issues at the same time. The added stress of being in a group of this nature was discussed. Discussion of her lifestyle with its day to day routine helped reveal coping styles, current stressors, current strengths, supportive relationships, as well as any major crisis she had faced in the past year. Any use of drugs, including prescription drugs, or alcohol, and/or treatment for these, was noted. Asking how long she had been clean and sober was helpful since group treatment might be sabotaged if she was abusing chemicals. Questions were raised about eating disorders or treatment for other medical conditions. Asking about her last physical exam

was helpful to rule out physical problems she might not be aware of. A history of psychiatric treatment was discussed along with any suicide attempts. Because the facility for the group experience for this practicum was a mental health facility, it was expected a diagnosis be given each client who received treatment. All seven survivors who chose to be part of the group therapy were diagnosed with post-traumatic stress disorder. Two had also been given the diagnosis of an affective disorder of depression.

A discussion of a survivor's previous counseling history may reveal her past learning experiences, her expectations of the group experience, and of therapists. It was helpful to know if the past sexual trauma was one of the issues which originally brought her into counseling and whether it was the focus in previous treatment. Her plan in continuing other counseling provided information on her supports outside of the group experience.

A brief sexual abuse history was helpful to note if a survivor had conscious and recent memories of abuse experiences. It was important for the therapist to use neutral language when asking about "the problem which brought her to group therapy". Neutral language provided the survivor the opportunity to speak of her past with her own control. Aspects for the therapist to note were the age of onset of the abuse, the duration, the perpetrator(s), and related significant issues for the survivor at the time. Any disclosure of the abuse experience the survivor made as a child was significant, for example: to whom did she disclose, what was the response, the outcome? She was asked whether she had made any disclosures as an adult and what the responses were. Had she had any other sexual revictimizations? How long ago were these? Was the survivor or anyone in her family involved in any criminal or civil justice action regarding the childhood victimization? All seven members in the group had memories of being abused by either a father, grandfather, uncle, older brother, and/or older teenage boys. Some survivors had a history of being abused by multiple offenders in their family of origin. One survivor also had memories of an aunt being involved. Some survivors knew they had more body

memories or feelings of having been abused than their conscious memories were able to hold at the time of the initial interview. One survivor spoke of her memories being fragmented. Although, for most of the survivors, disclosures as a child had been met with disbelief, all seven had their stories corroborated by at least one other adult in their family network when they disclosed their abuse as adults. One survivor, however, had her sole corroboration for the occurrence of sexual abuse in her family of origin retract just prior to attendance in the group, although the allegations of physical abuse were still corroborated.

In order to become more understanding of the survivor, the therapist also noted information about her family history. Heitritter and Vought (1989) provided some interesting questions for this part of the interview. The present interaction the survivor had with the offender was noted. Had she engaged in any confrontation with the offender(s)? If so, what was the outcome? Her present relationship with her family of origin was assessed to determine her supportive relationships. She was asked to use a word to describe her mother, father, sister, or brother. How did her mother and father express anger, fear, or sadness? What messages did she get from her mother and father? How did she think mother and father felt about her? How did her parents express their love and care to each other? Using solution-focused therapy, how might she have wished her parents to express their feelings to her? What difference might this have made to her?

The survivor's current living situation was discussed, along with the relationship with each member of her household. She might want to share how she expresses her feelings and thoughts. How does she express love to her spouse, her children, and to others? Does she have some feelings acceptable to discuss and some which are not? It may be helpful for the survivor to share secrets in the initial interview, but caution needs to be exercised since the survivor can be encouraged to share this with the group. For the group to be effective, secrets of the past need to be shared to take away their power as well as the denials of the abuse and trauma accompanying it.

From the onset of work with a survivor, the affirmation needs to be built in that she has many strengths which have helped her survive the trauma. When working in a group, it is helpful for her to notice and use these strengths. Look at what she wants to have continue in her life to give her reminders of safety, support, and comfort available to her throughout the group experience. She can also look at what she is doing that is giving her signs of healing. She can be encouraged to notice the times, perceptions, and behaviors which indicate healing. Asking her the solution focused "miracle question" helps her recognize what would have to happen for her to know when her problem was solved. What difference would this make in her healing?

The information to look for in the initial interview is very lengthy, but useful. It is not possible, nor realistic, to look at all the information presented during the two hour screening interview. The information from the pre-test measures, checklists, and self-anchored scale provides a guide for the initial interview.

Sessions, Process, Themes

The format for the group therapy sessions continued as established within the agency. This involved presenting the basic structure of a group meeting for the members' approval. The content of the issues presented was determined by the group members. It was expected members would bring their goals and day to day issues they were working on. Themes were drawn from the work they presented. Survivors were involved in deciding the themes. This was consistent with the objective of providing power and control to the survivors.

Survivors were responsible for recording the progress they saw themselves making in regard to the goals they had decided upon for this group module. This was done using the self-anchored scale for goal attainment devised with each survivor at the pregroup interview.

Sessions are briefly described in the following pages. Snapshots of the issues are described but the areas covered do not necessarily reflect those more important than others. A few major themes discussed in each session are presented to provide an understanding of the work done by a few courageous women in their process of healing from the trauma of childhood sexual abuse. These areas of concern are common to many survivors. Names and circumstances are altered to provide confidentiality to each group member.

Session 1

The group facilitators decided to provide structure for the first group meeting. To provide a sense of control for each survivor, the format was presented ahead of time so each member would know what to expect. Guidelines (Group Guidelines, Appendix 3) for the group were handed out, read together and explained. The format for each of the following group sessions was then presented.

At each group session it was decided to have a check-in time for each member present. This was done as a barometer, thermometer, or number check for a survivor to let the group know how she was feeling and/or how her week had been. This activity was designed for members to physically and mentally orient themselves to each other and to the group. This was also useful to have members give themselves a reality check of their present state.

The check-in was followed by a time where each survivor could set an agenda for work she would like to address during the group session. This meant the members would decide the content of each session. The agenda building time was kept brief so each member could state her work. The facilitators did not expect all members would set an agenda at each meeting nor would there necessarily be time for each member's agenda in the session. Should work be unfinished, it was brought as an agenda item to the next session. Sometimes, during the check-in time, a survivor spent time talking about an important problem. One way of helping her be brief was to simply ask if the issue was something she wanted as an agenda item. It was expected each member could speak at any time when presenting her agenda, rather than going in a circle.

Following the agenda building time, work began on issues identified. It was expected each survivor would stick to her agenda and remain focused on her work, unless she deliberately stated she wanted to bring in other material. Reactions by one survivor to another's agenda was expected since common themes emerged. Following the working

section of group time, the session wrapped up with each survivor stating how she felt about the work generated at that session, how she felt leaving the session, and any homework she wanted to do in the coming week.

Although it would have provided a more structured format, this student chose to do little didactic teaching as part of the intervention. It was thought group members would provide sufficient opportunities for teaching, not only by the facilitators but also by each other. Spontaneous learning could take place more readily if each member was allowed to use her own timing.

It was expected there would be high anxiety for the group members, especially for those new to the group. This was addressed in the first session, to make it more comfortable for each member to talk. In addition, the anxiety and fear was normalized. Each member could expect to experience increased stress in the form of flashbacks and memories.

More compelling than anxiety however was each survivor's need to meet another survivor of childhood sexual abuse. This need to connect with others became apparent when each survivor was asked to introduce herself. The facilitators stated introductions could be made by sharing current circumstances, for example: which community she lived in, the people she lived with, or her job. The facilitators also introduced themselves using the same data.

In their introductions, members stated something about themselves and their goals. Facilitators recognized from the introductions that group members had varied understandings of where they were on their journey of healing. Some expressed hope for moving beyond the victim and survivor stages. One survivor wanted to hear how other women were impacted by childhood abuse as she shared present stressors. Another survivor wanted to learn how childhood abuse experiences influenced her past and present choices. She recognized her present partner reflected past abusive experiences. Her hopes were to become more assertive and be a good parent. The group member who

called herself an incest survivor during the introductions stated her hope was to get beyond the survivor identity. She recognized some difficulty becoming more assertive as this was impacting the relationship with her partner. Another member wanted the freedom to be assertive regarding her decisions. Remaining connected to other women was important for her. At the same time she wanted to discover a healthy balance in becoming an adult while nurturing the lost girl within her. Another member, new to the group, wanted to connect with women who had experiences similar to hers and to hear their stories. She expressed feelings of not having choices with some important relationships. She did not like the modeling from the adults presently in her life. One survivor stated she had a dislike of herself. A part of her continued to believe she was stupid and ugly, but her hopes were to learn to like herself.

In order to allow for the expression of commonalties of each member's experiences of abuse, an exercise was planned using the whiteboard. Four questions were directed to the group. The first question asked the women to throw out buzz words that spontaneously came when they thought of sexual abuse. Immediately all women became involved. The words were then written on the white board. Some words were: dirty, shame, stupid, ugly, crazy, no sleep, disbelief, denial, secret, guilty, father, uncle. It was not uncommon for a member to respond emphatically to the previous member's response. The next question was directed to messages they received that helped them keep the abuse a secret. Messages shared were: "That's what girls are good for"; "That's what you can expect in large families"; "I love you"; "What happens here stays here"; "A father would never do that"; "I'm doing this to teach you"; "This is all your fault"; "No one will believe you if you tell"; "It didn't really happen"; "You were too young to remember anything"; "It will break up the family"; "You were always bad"; and "You asked for it". Responses to the question of how abuse impacted how they saw themselves included: they couldn't sleep, they couldn't carry out the responsibilities of a job, they felt revictimized in relationships as being raped all over again, they felt they didn't count, they experienced

eating disorders, they had difficulty making decisions, they felt crazy, they became perfectionistic, and they used comedy to prevent themselves from expressing painful feelings.

The last question in this exercise was more solution focused. It was to help the survivors open themselves up to the possibility of having a positive, hopeful future. The question was framed by asking them how they wanted to see themselves. Replies included being free, being a healthy adult, being assertive, making decisions, taking care of their inner child, and recognizing they are survivors and have survived a terrible past. All members were involved throughout this exercise. The time taken to complete this discussion was approximately 40 minutes. These questions could be answered in the third person, which helped survivors keep painful feelings under control early in group work. Themes which recurred during the discussion centered on relationships, parenting, assertiveness, the child within, and how to achieve a healthy adult-child balance in oneself. The commonalty of these themes was framed in that any other group of survivors in this country who had a session today would have ended up with very similar responses due to the nature of the effects of childhood trauma.

Homework was assigned at the end of the session. The task was to find something to do which would provide each survivor with self-nurturance. Each member was encouraged to be good to herself or find something which could nurture the child-part of herself. All present found it easy to think of something nurturing to do. Two poems about healing from Martha Jensen's Secret Shame were read at the closing. A rose was given to each member from the flower arrangement on the beverage table to highlight her value as a woman.

Members were encouraged to go to the group room upon arrival instead of waiting in the waiting area. This allowed members to browse at the book table, sign out a book, and check off their self-anchored scale. In addition, it provided members the opportunity to meet and talk before the therapists arrived. It also provided the

opportunity to socialize on issues not relating to the group work. They could then experience themselves as more than women who had been abused. The building of mutual support could be enhanced in this way.

Since this was the first session, no videotaping was requested by this student. The group members were informed that they would be asked for permission at the next session.

Session 2

The facilitators made time available for the members to report back on the ways they had been able to nurture themselves. It was hoped each member could share how she could use this group module to help grow in recovery. The facilitators also wanted to encourage members, when sharing their story, to tell only the piece which would be helpful for their healing. In order to feel comfortable and safe while telling their story, it was suggested the members use the solution-focused tool called "a safety in the present object". They were encouraged to use whatever reminder they needed to feel comfortable that they were in the present: for example, keep their feet firmly planted on the floor while telling their story, or take a few slow deep breaths. Survivors were encouraged to recognize whatever it was they were already doing to help themselves feel comfortable and to share this with other members. As facilitators, we allowed time at the beginning to ask what each member's particular agenda was for this session. Each member's agenda was summarized by a facilitator. If a survivor listed several items, the facilitator asked which one of the issues she wanted to address today.

Individual issues survivors brought to the pregroup or from the previous session were kept in mind. Some of the issues in this session included: dealing with boundaries in a survivor's parental and child relationships; helping a survivor recognize choices; watching how a survivor builds up self-esteem or gives up self-hatred; and assisting each

survivor to see herself as an active group participant. The latter was important since there was more cohesiveness amongst some members, due to their previous group history. The facilitators wanted the group to nurture each survivor and affirm each member's strengths.

Permission for videotaping was requested by the student. Each member gave her permission. At the end of the session the student again asked if all members were comfortable with the material from the session to be kept on videotape for the student. Permission was given. All seven members were present.

Since the group had decided to take the first ten minutes of each session to engage in pregroup conversation without the facilitators present, this was done. When the facilitators returned, a check-in time was taken to gauge the feeling level of each survivor. Some of the activities members used in the week to nurture themselves included listening to classical music, running in the leaves as a child, or going out with friends. All members clearly declared their goals which had been stated in the pregroup interview (see Appendix 3). Four members declared an agenda for this session.

The work began in this session with one of the members being in crisis. She had learned there was a possibility her child was molested by other children in the neighborhood. The group assisted her to get in touch with her feelings, in order to help herself and be helpful to her child. As a result of the group's intervention in helping her make connections, she identified herself as the girl being molested. The information about her child's situation shifted her perception of the problem to similarities of her victimization experience as a child. She chose to share a part of her painful past. Memories were stirred up which were very painful and confusing and she expressed these memories with appropriate affect. She expressed a desire for her pain to go away. In all of this she became aware of her strong desire to be helpful to her child, as well as how she could do this. From her previous positive group experience, she felt this support group was the only source of relief and stability today. Other survivors normalized her feelings and reactions as a mother and validated her anger. Group members and facilitators

continued to help her in the process of problem solving. She was reminded of her strengths. During the conversation, she recognized how she could help her child avoid becoming a victim. She stated she was able to shift from her own pain and saw how she could use her experience to help her child. As a result, she became clear in planning and focused on her goal to be a trustworthy, approachable mother. Group members normalized the difficulties they or their children had in discussing traumatic sexual abuse. One member recognized the difficulty she had in discussing her sexual abuse with her mother, even now, as an adult. Another member stated her daughter, as a child, had been unable to discuss her abuse with her, because as a mother, she had been in denial. Members commented it was common for children to want to protect their mothers and would only disclose sexual abuse when they thought their mothers could handle the information. The group affirmed the member in crisis for the parenting she had already done in this situation. This member also recognized her need to do more memory work of her childhood trauma. At closure, she stated that processing her feelings took away some of their intensity. Following group, she asked for a hug from the person next to her. This was freely given. This survivor was visibly in pain as she heard of the possibility of the child's molestation. Later, she able to verbally identify with some of the fears others had experienced.

Another theme in this session was recent dreams and flashbacks members were experiencing. One survivor had fears as some of her abuse occurred as a preverbal child. She only had fragments of memory. As she related some of these fragments of memory, she concluded there was a link between some of her somatic pain and her childhood sexual experiences. She was asked what this connection meant to her. She stated in a very surprised tone that her physical pain had greatly diminished in intensity following her disclosure of the partial memory. She also found having another recent memory was a freeing up or validation of her abuse. She found it difficult to put words to her emotions but was aware of her physical sensations. Her present goal was to receive more meaning

and cognitive awareness of her dreams. Facilitators asked her what she needed to do and use to feel safe, to allow herself to understand. The student wondered whether an associational cue for safety would be helpful to keep her in the present. The group validated her for talking about her experience and feelings.

Group members provided some disclosures of their own as they were working on each others' agenda. The pain from the member sharing her present fear of her child's molestation and the association it had with her own trauma as a child was evident in the room. At times some were shaken, while at other times they became quiet as they needed to for their comfort and safety. All remained in the room during the entire session.

Session 3

This session allowed more time for each group member to become involved as only five members were present. Facilitators were aware that not all the agendas had been attended to in the previous session, and were attentive to seeing that these might be addressed.

Several group members expressed pain in the go-around check. The member in crisis thanked the group for the assistance received last week. She reported back that some positive effects with her child had occurred during the week.

Pain in the form of loneliness was a theme in this session. One survivor verbalized what loneliness meant for her. She felt it was exacerbated by emotional neglect she was experiencing from her partner. She connected the present neglect to previous physical abuse from other partners, but this neglect was producing greater pain. Her partner's minimization of her pain made it difficult for her to trust other adults. She remembered the frequent betrayals by other adults from whom she had expected nurturing. The present experiences reminded her of her vulnerability as a child. Messages from her childhood family of origin were being replayed which made her feel "dirty and ugly and

stuck". The group highlighted her choices. In discussing whether her partner needed coaching as to what her expectations of him were, she stated he simply refused to listen to her pain. Discussion focused on her needing to give up something in the way of her healing and then needing to replace it with something that would help support the choices she wanted to make. Other group members validated her feelings and shared similar experiences. The member experiencing the loneliness affirmed herself for techniques she had used to help her cope, such as journalling or going out. The group offered other suggestions for coping, such as writing herself a rainy day letter or tape. She stated that these were not helpful. She was looking for affirmation from other caring individuals during the times she felt depleted. Another member offered her phone number to call when she needed someone to talk to. Another stated she had experienced times when she had been able to look only within herself for the kind of support she needed. At closure, the member who was lonely stated she had felt comfortable in sharing her feelings with the group.

Another member expressed fears for herself and her sister's suicidal ideation. She wanted to be helpful to protect her her sister from suicide but feared discussing their past childhood. This sister was part of the victimization and a discussion of the past would trigger flashbacks that she wanted to be protected from. The result for this member was confusion and physical pain. The group focused on how to be helpful to a family member while still validating one's need for self care. Other group members shared family experiences of sibling suicide. The need to use this opportunity to recognize and address the present pain in a family as well as oneself became evident during the group's intervention. The member's strengths in dealing with the abuse in her family in the past year were highlighted by other members.

Another issue raised in this session was that fears which survivors experienced were invalidated. The minimization of pain had not only been expressed to survivors, but this message had also been accepted by the survivors. This invalidation resulted in painful

sensations in different parts of the body. The group provided understanding that fears were legitimate. One survivor recognized how negative family messages still triggered and invalidated her fears. She taught the group how she drew on the strength of friends to provide an object of safety in the present as well as an associational cue for safety. She demonstrated how she used her physical pain as feedback. Her plan had been to write a letter of confrontation to one of her perpetrators this week but she had been unable to do so. She viewed her inability as a form of self care. At the end of the session she laughingly illustrated her skills of dissociation by referring to herself as presently sitting in the chair, while having been out of it during part of the session.

The issue of setting boundaries was discussed. Members found this difficult to implement and as a result, some were left feeling no sense of self. One survivor articulated these feelings using the metaphor of feeling like a tree trunk with no roots. She was tossed to and fro by the winds and whims of family members. Using the solution-focused technique of looking for exceptions, the group assisted her to discover one area where she was exercising choice. By altering her distorted thinking, she was helped to validate some sense of self.

Session 4

At this session, the check-in time became intertwined with the agenda setting. As a result, both took a little longer. Five members were present. One of the members who had missed last week was again absent. All the members stated an agenda and four were addressed in the session.

One member disclosed in the pregroup her experience with her family. A family meeting resulted in positive feelings since her experiences of emotional and sexual childhood abuse by several family members had been corroborated. She felt a renewed, closer connection to family members who supported her. This connection was tempered

by the concerns of suicide. As she processed her feelings with the group, she recognized she had taken appropriate action and put responsibility where it belonged. She recognized feelings of grief she was experiencing at the possible abandonment by some family members after just having reconnected with them. Adding to her confusion was a conflictual relationship with one of her perpetrators, who continued the emotional abuse. As the session progressed into intervention with other member's agendas, she became quiet. At the end of the session she stated her intention for the coming week. It indicated the useful problem solving she had done after she had processed thoughts with the group.

Other present stressors were shared. One stated her partner's behavior caused her to realize she needed to separate from him. She now understood how messages from her family of origin as well as from her partner caused her to choose, and stay in an abusive marital relationship. Her anger at her partner over the years now erupted. Using the group's intervention, she realized her anger frightened her. Members processed how she had used anger to propel herself into positive activity. She used trustworthy, supportive relationships to provide stability during the week. She stated her surprise at feeling so calm. She had always feared the breakup of her family. This had now happened, and she realized for the first time that she could "hold it together". She valued herself for who she was and what she had done. The group listened to her and she thanked them for listening. Some members affirmed her for being assertive.

The conversation on being assertive triggered a response from one member who enjoyed her new-found strength. She also found it confusing as her partner had challenged this. The group reframed how a partner's reactions could provide a survivor with a new opportunity to deal with conflict. The member stated in the past she had backed off her ideas when challenged. Her hopes were to continue to value her ideas and to be more integral in family decision-making. Others validated this. The group discussed the difference between "caregiving" which implies choice, i.e., giving something to a person one cares about, versus "caretaking" i.e., having no choice or autonomy.

One survivor shared her present recognition that her family of origin had not met her emotional needs as a child and would never be able to. The grieving of the loss of a fantasy good family was becoming apparent to her. She modeled for the group how she had provided a grieving ritual for herself.

By this time it was apparent to this student that much of the work the survivors did was the result of their dedicated efforts to find many avenues which provided healing. Several members used the book table extensively and brought information be used by others in the group.

Session 5

The check-in time for all seven members present was brief. During agenda setting, the group was reminded that the module was one-third complete. Members acknowledged ways they saw healing occurring. One member stated she was sleeping better following the completion of a flashback. The facilitators acknowledged one member whose agenda had not been attended to in the last two sessions. This member began by recognizing healing changes she was noticing within herself in some relationships that had been tension producing for her in the past. She recognized her strengths and choices. She shared her frustration with the social welfare system which sabotaged healthy decision-making. This led to a lively discussion on the social injustices women experience for not being believed or supported. Connections were made as to how their present feelings were different from or similar to the original abuse experiences they had as children. Recognizing the strengths they had used to survive helped several group members see how they were now different. One member stated her voice was stronger. Having a stronger voice however, meant that forces in a patriarchal society would want to see her voice weaker again. The positive work some members had done to bring about changes were shared. The price society pays for keeping women quiet was highlighted.

One member shared how she had worked hard to fight back to survive when she felt abandoned by her family. Another stated she was gaining insight as to how she was socialized to lean on a man. She realized how her partner was not dependable. She projected wishes to have a different relationship with her daughter, where she would not expect her daughter to" fix" her marriage. When asked what needed to happen for her to parent her daughter she stated she did not know how. One member shared how she was learning to relate to her children as a parent, rather than as a child who needed to be cared for.

Although the discussion about gender equality involved everyone, it became apparent that being vulnerable was viewed very negatively. One member drew attention to this when she shared a recent episode where she desired to lean on a man. The universal need to belong, to share with, to care for and be cared about was normalized at this time. This member used the concept of seeing herself as "an older, wiser self" in reflecting on her life at this time. Her sense of having a mission to help other younger survivors in their healing was a meaningful goal for her.

Session 6

In this session, again with all members present, it was evident the group was more cohesive. Group interaction was more of a member-to-member style rather than a leader-to-member style.

Ways of dealing with flashbacks of childhood trauma were discussed. One member stated the fear, stress, and pressure of another flashback coming was resulting in severe headaches for her. She recognized this fear as a trigger to numb herself chemically, which she did not want to do. The group provided several ways for her to deal with flashbacks. Some of the ways suggested included pattern interruption, body work, relaxation techniques, nurturing and getting in touch with the child she was at the time of

the abuse. Looking for exceptions from previous destructive behaviors as to some of the ways she was positively dealing with the flashbacks were amplified. One of the group reframed the surfacing of the memory as a healing sign, by stating she must now feel safe and strong enough to allow the memory to surface. When the member was asked how the telling of a piece of the traumatic story had been for her in the group, she said it had been comforting. She knew she would be understood since they had similar experiences. At closure, she planned a few ways to take care of herself as homework for the coming week.

Self doubts about the abuse experience when other trusted adults alluded to the trauma as "false memories" was a matter of concern for a member during this session. She recognized that some of her traumatic childhood experiences were similar to her difficult adult life experiences. She recognized doubt as a child and as an adult. Now, as an adult, she felt the experiences as extreme physical pain. She recognized she felt the bodily pain when emotional pain became too intense. This link between physical and emotional pain helped her frame self doubt as a protective mechanism when emotional pain became unbearable. She was able to understand the value of listening to her pain and her doubts. Feeling pain when she was having doubts meant listening to the pain and doubting was a necessary place for her to stay at without doing exploratory memory work. This solution-focused connection to listen to her body was very revitalizing. She recognized herself as the expert on her experience and, when and if, was ready she could do more memory work.

Continuing messages from the family of origin made some survivors feel guilty, dirty, angry, and grieving. In addition to validating her feelings, one member listened to the group reframe her feelings as a strength. She felt free to put responsibility for childhood role reversals back on her parents. It was stressed that unlearning distorted thinking and putting new learning into practice takes time. Looking for small changes they were making was highlighted using solution-focused intervention. Looking to other trusted adults for nurturance was discussed.

The conflict of feeling abandonment from significant family members versus needing nurturance from them was exemplified by the problems one member wanted to discuss. The need for a survivor for approval and material help from others when making decisions was apparent. Abandonment was an issue in relation to partners and family members of origin. The group helped this survivor recognize her choices and strengths. It was difficult for some survivors to see themselves other than as a victim with no choices. Suicidality had been one method of coping with this conflict so members discussed their personal safety plans. Avoiding role reversals between parents and children was discussed, along with protecting children from an abusive situation.

Some members found their pain so great during the session that it was difficult to focus on other members' issues. Other members wanted to look at the impact that the difficult work had on them during the session as their homework.

One survivor shared the positive results of teaching her partner how to listen to her instead of him trying to fix her.

At closure, the group was reminded that the module was half over. The members were encouraged to look at areas they saw themselves healing and areas they wanted healing to continue.

Session 7

The members continued to share the work they had been doing on their own and with each other. Some members said they were calling each other during the week when they needed someone to talk to or when they sensed another member needed nurturing.

This session focused on recognizing the various experiences survivors had grown up with which set the stage for sexual abuse to occur, for example, severe physical abuse in the name of "punishment". For some survivors, the result was that, as small children, their voices were silenced. Now, as adults, their voices needed to be heard. The group

discussed ways they were nurturing the child they had been at the time of abuse so their frozen voices could now be heard.

In doing this, some survivors saw their children voicing pain that they wanted to be in a family where parents could live together. This tension was addressed by realizing that parenting could continue even when they were living apart. A danger expressed by one member was that when some parents lived together they presented the illusion of a family when they were not functioning as one. The effects this had on them plus ways they were changing to stop revictimization in their lives and families was affirmed. Members also recognized that mothers often became the targeted parent for anger when there was family tension. The group discussed ways of dealing with this.

One member walked out near the beginning of the session after stating suicidal thoughts but returned and talked about her self-hatred, anger, guilt and shame. The need to direct the anger toward the perpetrators rather than toward people with whom survivors are in a relationship, was identified as the result of connections made during the discussion. The theme of misdirected anger allowed members to discuss changing negative messages, finding places of safety, the need to apologize, forgiveness, and the letting go of unsupportive relationships using solution focused intervention.

Session 8

In preparation for this session, the facilitators were aware of several concerns. One was the recognition that sometimes a group member needed to say something the rest of the group would differ with. This could be problematic and could result in a member feeling isolated. It was, however, an opportunity for a survivor to recognize the dichotomous attitudes present in the group as well as in themselves. A second concern was that some members had not stated an agenda for several weeks. The facilitators decided to approach this concern by acknowledging it. They asked members if they were

getting from the group what they had hoped for. Members were encouraged to use the group to share whatever parts of their life they wished. Another concern for facilitators was that some members were sharing parts of their story and getting in touch with the child they were at the time of the abuse. But, sometimes a member would share she had a part of the memory and knew more would be coming. Facilitators were concerned that members should retrieve the memory as their own agenda as well as share if they wanted to, without feeling compelled by the group. Reminders were given for survivors to do what they felt was necessary for their healing, and to leave areas they were not ready to discuss, consistent with solution-focused therapy.

In this session, members dealt with more memories, intrusive flashbacks, various traps in the cycle of violence, doubting one's own choices, abandonment, grieving a life of losses, and relationships with partners. One member became aware of her way of coping with painful feelings as numbing out and dissociating. This made it difficult to recognize when she was in a dangerous place. Another connection made was that she had feelings she did not know how to manage while with her children. She agreed to use role-play in the next session to discuss this further.

Session 9

The interaction among some members was apparent. Some had been out for lunch together. They were interacting on issues other than abuse during their pre-group.. Their pleasure in each other's company was evident.

Preparing for holiday celebrations with a changed family structure was confusing for some members. Fears of having some family of origin members present at a family celebration were expressed. For some, the presence of perpetrators at a holiday celebration table would represent a denial of the reality of the abuse. Discussion focused on how to celebrate with people one truly cared about. During the upcoming holiday

some members wanted to be cut off from family members who were abusive in the past. Others wondered how to have a relationship with family of origin who had been abusive at times while at other times supportive. In this way differences in relationships were highlighted.

Ambivalence in the area of body image was also expressed during this group session. Conflicting values society places on body size were discussed. Different ways members used their body to deny their sexuality were expressed, for example: thinness, obesity. Meanings these body images held for survivors were provided. Some of the meanings were invisibility, protection, decreased self-esteem, the power of being sexually attractive, the vulnerability of being powerless to abusers, and the need to party and abuse alcohol. In this discussion, members heard some of the old destructive messages and values that denigrated their self worth. This was followed by positive cognitions that some survivors wanted to replace the negative ones with, such as "I can care for myself", "I can be thin as well as strong". The members thought of ways to nurture themselves that were not self-sabotaging.

Reactions to being called a "woman" in this group, by other members and facilitators, brought some surprise. One survivor stated she was beginning to enjoy being called a woman. Another wondered about the ambivalent feelings she was experiencing and recognized that some words of endearment left her with feelings of physical pain. Others recognized they were beginning to enjoy some body sensations as pleasurable whereas previously any body sensations had been perceived as painful.

Experiences of confrontation were shared. Some were finding their healing and growth as survivors was destabilizing the marriage relationship. Experiences of effectively teaching partners what expectations they would like, were shared. Another member read a letter of confrontation to her parents. In it she stated the facts of the abusive past, who was responsible for the abuse, and the impact it had on her then and now. She also described the impact on her present family and wrote of her expectations of them. She

was able to validate her strengths and hopes for the future. Her hopes in writing the letter were to let go of her past and obtain some relief. Group members marveled at her clarity.

Session 10

All six members present brought painful work into the session. A seventh member had telephoned a facilitator saying she was in crisis. When the facilitator asked, she stated she was safe and would contact her primary therapist if she felt unsafe.

In addition to dealing with their issues, the members heard each other and formed a healing alliance at various times during the session. All were impacted and responded to one member who shared a violent traumatic experience. This member used triggers she experienced while doing some creative work. Now as an adult, she remembered an abusive incident which represented the loss of her voice as a small child. Her innocence as a child and her need to be nurtured had not been attended to. The group validated her, now as an adult, for giving the child a voice. The member felt her anger but shared her difficulty in expressing it safely. The group shared suggestions on how she could allow this to happen.

The need for children to expect affection and nurturance from parents was affirmed by the group. One member shared her present fears in relating to her father, since she now received inconsistent attention from him. At times he offered affection, while at other times she experienced revictimization. She felt empowered to speak out against child abuse since society was recognizing its existence through activities like White Ribbon Week. Yet, fears of losing the relationship with father, held her back from writing a letter of confrontation. She experienced the fear as bodily pain. One member suggested she listen to her body rather than her head, since her body was telling her she was not yet ready to write a letter of confrontation.

Listening to one's inner self was validated by several members during the session. One member struggled with her desire for group affirmation to have a relationship with an abuser while he needed help. She clearly asked the group to listen to her needs. Tension was evident in the group. Body language, tone of voice, questions that were asked and affect, were ways in which the tension was apparent.

One member stated charges she had laid against her perpetrator had been stayed due to insufficient evidence. Feelings of numbness and anger were expressed by members against the criminal justice system. As the member processed her feelings and behaviors throughout the day, she discerned she was acting in different ways from her past self-destructive behaviors. In replacing the negative messages, she saw exceptions in her behavior and thinking. Intervention focused on amplifying the exceptions. This connection also encouraged her to react differently to her emotionally abusive parent.

Session 11

Relationship issues with partners and parents were the focus of the session. The upcoming holiday season was triggering a great deal of tension. Pressure to be together with abusive parents and ex-partners was triggering feelings of being stuck and having no options. Survivors expressed this as being victimized all over again. In addition, feelings of abandonment vacillating with feelings of anger caused one member to recognize that she dissociated under stress. The group discussed ways to exercise choices when feeling as the survivor did. One survivor used humor during the session and went to the bathroom to relieve stress. She also asked about another support group to help her when this module was over.

One of the ways the group found it helpful to listen to their tension was to recognize that the cut-off relationships needed to be replaced. The group brainstormed ways this could happen. One survivor stated her hope was to have a relationship with her

mother but not this holiday season. Her nuclear family was a safe family. This was affirmed by her children and this energized her. Another member recognized anger against mother and was unsure where control was in the conflictual relationship. Her concern was to protect herself.

One member found it useful to use the whiteboard to write out her feelings of tension and their meaning for her. Using the solution-focused technique of non-dominant handwriting, she wrote out the needs she had as a child. It was suggested to keep the needs as a child present as a reminder that her needs were valid. She realized how difficult it was to express her needs but wanted to learn to use supports to do so. The amount of disbelief in her network made this problematic. At closure, she felt tension leaving and felt sleepy. This difference in her experience was viewed as a healing sign.

At closure, members were reminded the next session would be the last one. The format for the last session was explained. Termination would include a sharing of feelings and thoughts about the time spent in the module. They were encouraged to share a statement each member had given them. It could be a wish for another member, something they had learned from another member, a healing sign they had noticed, or something they would like to ask a member. Members were also encouraged to bring something that would help symbolize their learning experience in the group. The members decided to have a potluck lunch in the meeting room prior to the last session. The absent member would be notified of the activities planned.

Session 12

The session was a potpourri of expressions that each woman brought. It reflected individual creativity and how each survivor understood change. It provided a time for celebrating positive aspects in themselves and each other. There was a great deal of laughter and joviality during the delicious meal. Symbols were brought and gifts were

exchanged by some members. A number of the gifts had been made by the women. A plant was given as a gift to both facilitators by the group. A small plant was also given each survivor by the facilitators to symbolize growth. One member commented on the plant's significance. It reminded her of her deceased grandmother who had provided the nurturing she had been looking for.

Feelings of sadness for the ending of this group module were shared. Some members reflected on the positive experiences of the last module termination session.

The format allowed for each group member to be a "star". A survivor's reflections of the group experience was shared, followed by positive affirmations from members, which were followed by an observation and encouragement from a facilitator. The first member to be the "star" used the symbol of a popular song to recognize the strength she had inside. She came prepared with a piece of her writing. She gave permission for it to be put into the practicum report.

" I have a lot of mixed feelings about this last day. You all have given me so much - more than I ever imagined. This is directed to all of you. I have had the honor to be with women who could really identify with me, my feelings, my struggles, my courage and hope. I have been empowered by each one of you in a very special way, by your strength, peace, determination, honesty, and voice as well as by your grief, anger, truth, tears and laughter. Thank-you for your guidance, compassion, warmth and understanding. Thank-you for providing a safe place for me to talk, to feel, to think, and to heal. Thank-you for accepting and loving me as I am. As I am writing this I realized you will always be a part of me in my thoughts: giving me the positive messages I need to hear; giving me the warmth, compassion and love I need to feel; and in my memory showing me what I needed to see - that I am a determined, beautiful, strong, growing, healing woman.

"In my journey, just the last year alone, it feels like I have walked a million miles. I thank God that I haven't had to walk alone. In fact, it feels a lot easier since you, my friends have come into my life to walk alongside with me. Despite the pain, the hurt, the

sorrow, and the hard work that healing requires, I am glad that I chose to heal because my life now makes sense. There is a reason for my behavior, my emotions, and my physical pains. My questions have been answered. Now I know the "whys" and the "how comes". I feel more whole, complete, in control of my life now that I can speak and know the truth of what happened to me as a child. For the first time in my life all the desires of my heart can and are being fulfilled. Now I have a voice and I am being heard. I wish you all joy, peace, hope and love through the holiday season and in the years to come."

Affirmation by the group was spontaneous. Members highlighted how her gentleness and strength fit together to provide healing. Her ability to teach her supportive others was useful for others to model. When asked, she stated she enjoyed the feedback but felt a little shocked to receive it. She had recognized her gifts but hadn't known what to call them before. She shared some of her creative work as a gift the group. The facilitator affirmed her strengths as the ability to validate her own as well as other members' work in recovery. She was involved in the work of others as well as discerning what was useful for herself.

In addition to providing positive feedback for work members had done in the group, the facilitators also provided encouragement to continue to focus on areas which could help in healing. For example, one member was encouraged to assess her readiness for moving into another area of healing until she felt ready. The ability she had to listen to herself would be a valuable skill to hang on to.

The second member to share had been involved in several survivor groups. She stated that working with this group had helped her move from being at the end of the world to feeling she was a very important part of this world. The group helped her feel she was not "crazy" or alone. She now enjoyed the new feeling of being a friend with women. She had an unfinished symbol for group closure. She recognized her area of growth in her parenting. Members thanked her for her understanding, compassion, warmth, and validation of others' healing. The facilitator encouraged her to continue to

find supportive others in her recovery. She was encouraged to continue grieving the loss of childhood as she moved beyond survivorship.

The third member expressed sadness at the ending of the group module and with it recognized many losses experienced in her recent past. She saw herself moving into recovery, and for the first time, enjoyed being called a woman. Group feedback recognized she had allowed her defenses to come down and they, as members, could now appreciate her gentleness. They noticed her frequent encouragement. Facilitators pointed out she had a keen understanding and was now more aware of the connections between feelings and body sensations. Listening to herself, as well as using her strength and understanding were useful skills. It was hoped she could find and teach supportive others what she needed, even though some in her network continued to replay the abuse.

A fourth member thanked group members more than once during the session. She stated the group helped her do more in the last twelve weeks than she had been able to do since she was a little girl. The group had taken away her sense of isolation and feeling of being "crazy". She felt stronger and able to like herself more in the last twelve weeks "and that is more than money can buy". Members recognized her strengths, identified with her and called her a friend and sister. Her response to the feedback was: "When is the next group starting?". The feedback by the facilitator recognized her taking risks. She showed the group her pain and recognized her sense of worth by caring about herself in difficult situations. She was encouraged to continue to use choices in relationships, to listen to herself with others, and to allow vulnerability to become her strength.

Another member shared her group experience with an expression of creative work. She stated the group had taught her to set boundaries with relationships instead of being swallowed up by them. The group had been a safe place to recognize and use her voice. Other members admired her strength and validated her for sharing even when it was difficult. The facilitator used her metaphor from a previous session to describe her

healing, and encouraged her to continue to set boundaries. The roadblocks in her journey became apparent, and she was rerouting them so they could work for her.

The last member to share also gave each member a piece of creative work. She pointed out her growth dealing with family members in the past few weeks, as well as in dealing with flashbacks. She saw herself having a long way to go in healing and vacillated between liking and hating herself. She thought she had stopped blaming herself for the abuse. Feedback from the group reflected ways she had discovered to nurture, rather than harm herself for the past trauma. The facilitator affirmed her for working from the position of an adult woman rather than a child. Her courage in looking at potential areas of great pain to help heal herself and her siblings was recognized. Hopes for this survivor were to continue to recognize her choices. Changing her body image to value it as a gift was one way to make a choice along with the continued sorting out of the emotional abuse.

This group session was a great source of information on the effectiveness of group therapy. In addition, a client satisfaction questionnaire was given each member to be returned to agency receptionist prior to the post-test interview.

This group session was a highlight for all in the group. It amplified areas of positive change in a survivor's life. A renewed sense of power and connectedness was apparent. The goal of the group to provide a safe context for hope and healing had been realized. Survivors recognized a greater potential in their own strengths and choices. These were affirmed by other group members. Some relief seemed to have been provided from the symptoms stemming from the abuse. Feelings and thoughts associated with past trauma were recognized, and some were altered so they were no longer as intrusive, nor did they lead to self-destructive behaviors.

One of the purposes of this practicum was to measure the effectiveness of the intervention when the treatment approach of solution-focused group therapy was applied. As stated in the practicum methodology, the research design allowed for both qualitative and quantitative evaluation to be carried out by the survivors and facilitators. The final session of the group provide a great deal of descriptive information as to the results of the intervention as perceived by the survivors. Subjective dimensions of change survivors see in themselves can remain constant or may shift. Due to shifts that might occur, the post intervention testing was done a month following the last group session. The post-test interview was done at the agency with each survivor. In an ideal setting, another evaluation six months after the group therapy module would have been useful as well.

The results of the evaluation are discussed using subjective and objective measures.

3:1 Client Self Satisfaction Questionnaire

A consumer satisfaction rating is a common component of a single study research design. It is essential to look at the subjective therapeutic gains seen by a survivor. Although it is recognized that satisfaction with the work accomplished in a group is difficult to define, several specific questions were included. Therapist desirability was one factor used to determine an effective match between survivor and facilitator. This was included to assess a survivor's level of safety and comfort. In addition, a subjective understanding of a survivor's goal attainment in this stage of healing was accessed. The questionnaire was taken from another practicum with women survivors of childhood sexual abuse (Flaherty, 1992). Six of the seven evaluation forms were completed and returned. The completed forms came to the agency receptionist to decrease a positive

response bias with the therapist. The following are examples of the comments from returns.

1. Were you satisfied with the number of sessions you had in this group module?

The women's responses were equally divided. Three stated they were satisfied with the number of sessions and three wished for more sessions. One who wished to have more sessions stated she would like to see them go on indefinitely. Another stated she had not been able to attend all the sessions, so she felt there were too few.

The women who were satisfied with the number of sessions felt it:
"was enough time to get to know each other and establish a safe place and trust. Was also long enough to deal with a number of problems whether they were new ones for you or old ones."
" Satisfied as long as there are more sessions in the near future. It is not possible to resolve all the issues that come up in one group of sessions."
" I felt this module was instrumental in moving me forward but not too fast."

2. How comfortable were you with the physical setup of the room?

Two women were satisfied with the room, but one of them would have appreciated pictures/posters on the walls. She also did not like some of the Centre residents trying the door during the session, though she knew the door was locked. Another said she felt very comfortable only after the first session.

The four women who felt very comfortable wrote:
"I find the view to the east very soothing. I was pleased in that when someone was missing in the group, the extra chair was removed."
"Sitting in the circle allowed everyone to see each other."
"Private windows, airy and pleasing to the eyes. Refreshments provided."

3. How helpful did you find the group sessions?

All the women responded that the group was very helpful.

"The sessions helped me understand my abuse a lot clearer. It was helpful getting ideas on how to deal with specific things."

"It was more helpful than I ever imagined. I dealt with common individual and personal problems."

"My healing has been processed and is moving me in many directions but mostly ahead and that is due to the sharing with other survivors and other people who, like me, are not alone anymore."

"With input from so many others, I have learned much more about myself than is possible from a one-to-one."

"I'm very pleased with the help and understanding in group."

"I find the group sessions even more helpful than individual counseling. We seem to be able to do a lot more stuff in a lot less time."

4. How close did you come to reaching the goals you had set for yourself?

The group was divided in half in answering this question. Those who said they had reached many of their goals did so as the result of new learning about themselves. The other three were unsure.

" I may not have reached all my goals, although I did learn I do have the strength with continuing group therapy to reach the goals I am aiming for."

" I reached them with a few downward slides so I did show improvement. I've found when dealing with these complex emotions and feelings you are bound to go up and down when reaching goals. Just setting goals (stating them) makes me aware what goals I want to reach, therefore I want to try to achieve them."

" There is still a lot of confusion where I stand with my goal, but did show some improvement compared to where I started."

5. What did you like most about the time in the group?

"I was able to share ideas and receive feedback as well."

"The feeling of fitting in, that there are other people who have survived, and I drew from their coping skills and strengths."

" The good friendships that grew out of meeting new people with our common problems. Was wonderful to find people that know how you feel and can express compassion and understanding."

"Learning from others to better understand myself."

"The sharing each person gave."

"I can't isolate any one thing. For me, it has been an overall positive experience."

6. What did you like least about the time in the group?

"I know that time (or lack of it) is always a difficulty but that is my only complaint. Those two hours move so fast."

"Sessions too short at times."

"The pre-group. I'm still not sure what it is for and what purpose it serves."

"Nothing about the group in particular. I don't like the time, money, and tremendous effort and pain that it takes to heal from sexual abuse in general. I'm sure nobody does."

7. What did you find the most helpful as a result of being in the group?

"Everyone's input to our situation in our situations. I learn a little or a lot from each person. Also, using the charts, etc. Visual input seems to help me. I really recommend using the lending library again. Being from a small community, I would not go to the local library for such books since I would feel that everyone in town would know what I was reading. "

"The most helpful is you know you're not alone when dealing with complex emotions and feelings. Together we are a source of greater power. From shared experiences, you can see the healing taking place in others and yourself. This is very important to me because it gives me the strength and courage to go on knowing you don't know what you will remember next or the challenges that lie ahead."

"Being more sure about myself. Seeing the improvement in my self-esteem."

"Listening to others and to have them there to listen and to believe in me."

"The friends I have discovered - in general, connecting with other women who have been where I have been and who can validate my experience."

"At the beginning of each session, the facilitators asked for a number to describe what level of feelings we were at and what our focus of subject we wanted or were able to share. I found this helpful in keeping on track and most times it established a set time for ourselves to speak, i.e., only as much or as little as we liked."

8. What did you find the least helpful?

"Can't think of anything, as all was helpful."

"A group member dropping out without explanation."

"The ten minutes sharing as a group without the facilitators present."

9. Is there anything that you would have preferred to have been done differently in any particular session or in your overall group experience?

"I always felt some initial discomfort with the camera, but I could ignore it after the first few minutes."

"Continue for more than twelve sessions."

"I found it uncomfortable when people missed sessions and then came back. It made it hard to get to know that person and where they were at emotionally."

10. How easy did you find the group leaders to understand you and the group?

All women stated they felt very understood.

"They were a model for me of the kind of listening that I never experienced and need to learn."

"There is something to say about being understood by people who have experienced the same situations. The group leaders were well trained and devoted to helping survivors. The leaders, although not abused, sure did their research."

"The leaders were not pushy, but helped me to say what I needed to say without making me feel ashamed of what had happened to me."

"Kathy and Ingrid understood my feelings so well and were instrumental in making or helping me to dig deeper."

"Ingrid and Kathy did a superb job of understanding, reassuring, and heading me in the right direction when I couldn't see past the end of my nose."

11. How safe did you feel with the group leaders?

Five of the responses indicated the women had felt very safe. One stated she felt safe, but unsure at times, because in some sessions it was hard being around all the women.

"I felt very comfortable and safe in this group. I knew I was among friends, not just group leaders. Kathy and Ingrid eased my feelings of anxiety and fear and I felt protected."

"Very compassionate, understanding and listened very well. They stayed in control and had good techniques to help us get in touch with feelings and/or explaining why we have them or act the way we do. The leaders seemed to know when to step in to ask questions so we could answer questions for ourselves. Very encouraging, positive attitudes. They were committed to their jobs and what they were doing was more than a job."

The use of a self-anchored scale to evaluate the effectiveness of the intervention was consistent with the outcome objective of restoring power and control. The use of the scale was also consistent with the assumptions of solution-focused therapy since therapy begins where the client, the survivor in this practicum, is at. The scale became a subjective measure for a survivor to track her progress. Bloom and Fischer (1982) state that self recording can be a useful tool for clients to be aware of their behavior. The increasing awareness becomes a motivating factor in change and control. Describing the scope of a problem a survivor wants to work on is helpful to decrease the exaggeration or minimization of the information as it is perceived. The accurate recording of change as it related to her problem was helpful. This accentuated a survivor's strengths and gave her a more positive outlook. An empowering aspect of this scale was its usefulness in providing feedback on her progress during the group module.

In the intake interview, each survivor chose a goal for any action, thought or feeling she wanted to work on during the module (see Appendix 4). With the therapist, each survivor developed a scale with zero (0) being the lowest number possible associated with goal attainment and nine (9) being the highest. Once the goal was chosen, the survivor was asked what number she would like to achieve by the end of the module. She was then asked what would have to happen to indicate that she had attained that number. This was followed by asking her to rank herself (Week 0 on the graph). Since goal attainment and healing is not accomplished in a short period of time, she was asked what number would she need to be at the end of the module which would indicate that healing had taken place.

A reconstructed baseline was established to enhance the measurement of change. This was done by approximating the naturally occurring level of the problem using the survivor's memory. The phone call for the intake interview was a week before the

interview. She was asked at what number she saw herself in regard to the problem at the time of the phone call. This was Week minus one *(-1)* on the graph. Also, she was asked at what number she saw herself two weeks ago. This was Week minus two *(-2)* on the graph. These numbers, in addition to the number used at the intake interview, Week zero *(0)* on the graph, provided the baseline for the assessment of the extent to which the target behavior, thought or feeling occured before the intervention began. This reconstructed baseline also had utility in that the First Session Formula Task, the solution-focused technique could be implemented here. There was a slight problem in using this as a baseline measurement. The pre-session changes since the time of the phone call could also have been used as a measurement of intervention rather than as a baseline.

At the beginning of each of the twelve group sessions which are noted as Weeks one to twelve *(1 to 12)* on the graph, the survivor was asked to rate her goal attainment on a weekly basis. The principle of self-determination continued as it was acceptable if a survivor decided on any week not to mark her graph. The number she put on her graph was used to state her feeling level at check-in time.

At the post-test interview one month following the module, each survivor again evaluated her goal attainment. This was noted as *(post)* on the graph. The data was graphed for her visual inspection.

The self-anchored scale has a high face validity since the internal thoughts and feelings of a survivor were measured as the result of being in each group session. Social desirability bias could be a threat to internal validity since the survivor could have a cognitive belief to please the therapists. There is a high potential for the client to distort or change the rating as a result of being monitored so that testing reactivity is another threat to internal validity.

The results of the group members' goal attainment graphs are shown on the following pages. Each member's goal is also stated.

One of the goals of group therapy was to provide stability and relief from symptoms related to the abuse. Mood disturbances such as chronic depression is one of the symptoms. To assess whether a survivor was experiencing relief from depressive feelings and thoughts as a result of therapy, the Brief Beck Depression Inventory (BDI) (Beck and Beck, 1972), (Appendix 5) was used. The BDI is a widely used, 13-item instrument designed to assess the intensity of depression of a normal population. Its utility is that it is easily answered, easily applied, rapidly scored and accurate. It has good to excellent reliability and validity. Split half reliabilities ranging from .78 to .93 indicate good to excellent internal consistency. Test-retest reliabilities have been good to very good, ranging from .48 for psychotic persons to .74 for undergraduate students.

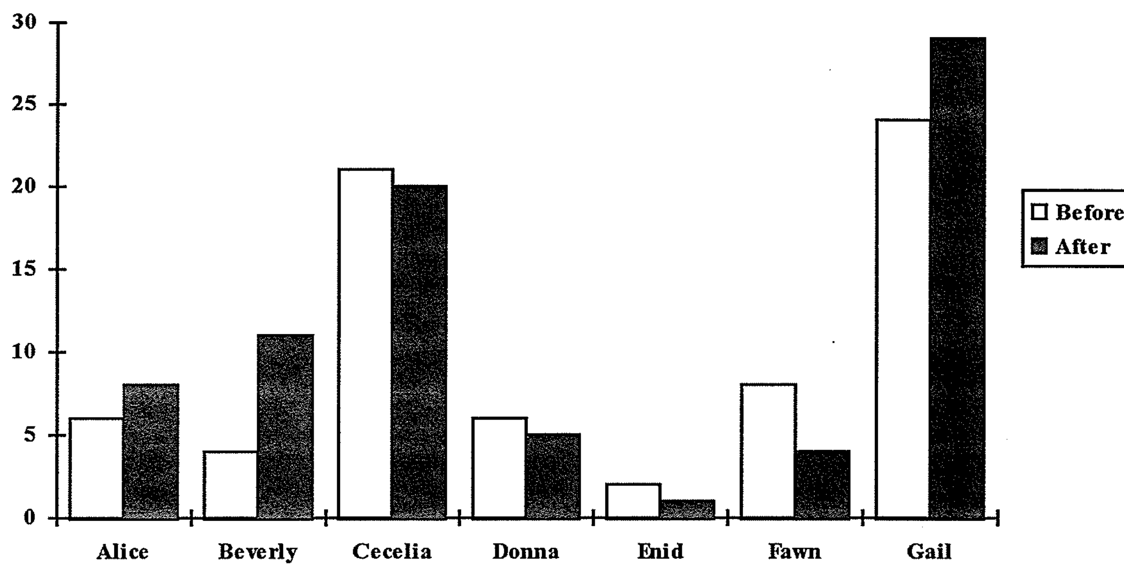
One of the limitations in using this measure with survivors of sexual abuse is that, as they feel more in control, they may become more aware of the impact of the abuse on their lives. The remembering and mourning process may indeed cause them to experience more feelings of depression. It is not unusual for scores to go up negatively as survivors become more aware of their feelings and go through the process of healing. Though the increased awareness may be viewed by a survivor as a sign of healing, the score using this measure may be negative and needs to be interpreted with this in mind. As a result, the information that negative scores may indeed reflect positive change, depending on a survivor's goal, was shared with survivors when doing pre-testing.

It needs to be noted that one member's pre-test scores was adjusted due to some missed questions.

Estimated Degree of Depression according to BDI

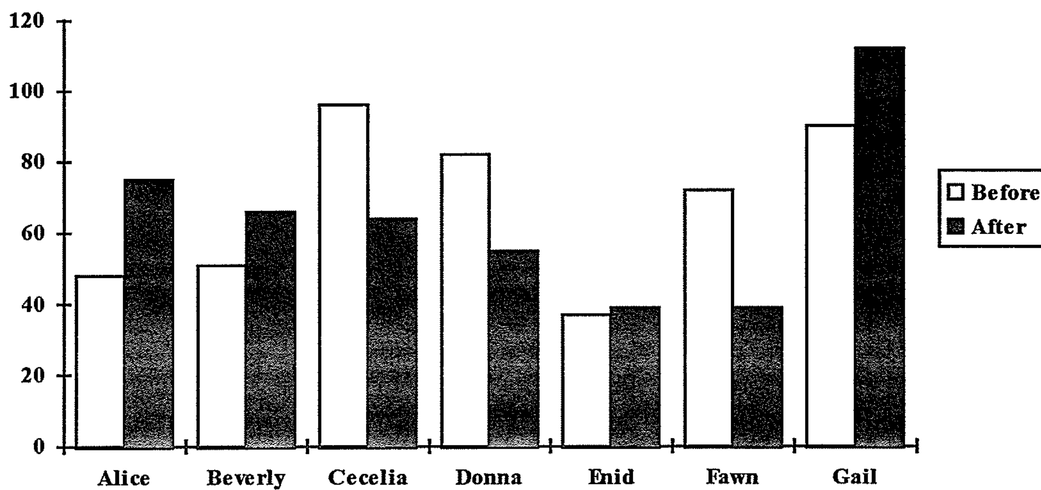
Range of Scores	Degree of Depression
0 - 4	None or minimal
5 - 7	Mild
8 - 15	Moderate
16+	Severe

Results of the Brief Beck Depression Inventory



Another after effect of childhood sexual trauma is that in adulthood, self-perceptions of a survivor continue to be predominantly negative. The goal of group therapy is to alter these thoughts and feelings a survivor has about herself and her body. To measure increased self-esteem as the result of managing the symptoms related to sexual abuse and developing a more positive future, the Hudson Self Esteem Scale (Appendix 6) was used. In discussing standardized measures, Bloom and Fischer state this scale "measures the degree or magnitude of a problem the client has with her self-esteem" (Bloom and Fischer, 1982, p.148). The 25-item scale is short, easy to administer, interpret, and score. It has been designed specifically for single system research. It has high internal consistency reliabilities and test-retest reliabilities of .90 or better. It has high face, concurrent, and construct validity. The total score used in this practicum could potentially range from 0 to upwards over 100, with the higher range indicating more of a problem. Scores of 30 or higher indicate a potential problem with self-esteem.

Results:



3:5 Support Network Checklist

The social support network checklist modeled after Hirsch (1980), McCannell Saulnier (1984), and Oritt, Paul and Behrman (1985), (Appendix 7) was used to assess the exchange of resources provided for a survivor by family, friends, and professionals. The checklist measures several types of perceived primary support from formal and informal sources. The types of supports the checklist measures include emotional support, cognitive support, and material support. Emotional support includes relationships which provide caring, security, belonging, and feeling loved. Cognitive support includes relationships which provide information, knowledge, and advice. Materials support refers to the provision of goods and services to solve practical problems. The reason for using the checklist was twofold: a) to recognize the social isolation of women survivors and b) to observe changes the survivor makes in finding or using supportive relationships as the result of group therapy. The resources provided for the survivor were expected to be supportive. Changes in relationships with weaker or stronger ties would be noted.

When evaluating the results of using this checklist, a general explanation of the findings will be given to maintain confidentiality. The results varied among the group members. One member now saw herself using her network for more support. She had strengthened her ties with her husband as well as with supportive family members. Some ties with friends and professionals were also stronger. Ties with group members were either added or strengthened.

Concern had been raised among survivors about not using their children as caretakers, so some survivors left children off the list at the post-test. For some survivors, ties with the formal (professionals) sources had been deleted or weakened. With other survivors, they remained the same. Some survivors added or deleted friends if they saw them supporting or blocking change. One woman said, "I wouldn't put anyone on this list if they didn't support me".

For other members, the ties with the network had become weaker, especially for those who became more aware of the extent of their victimization. Two survivors who had become more aware of their abuse during the group module chose to cut off or distance themselves from some family ties they previously felt were occasionally supportive. Some family members on the pre-test checklist were left off in the post-test. Another survivor had been cut off by some family members. For the survivors who felt isolated on the post-test, the survivor group did not appear on the checklist, even though interactions with some members had occurred between the last session and the post-group interview. Others stated they knew they could call on group members if they needed to, although they had not done so. Most of the members expressed concern that another group would soon form so they could continue the supportive relating.

3:6 Solution-Focused Recovery Scale For Survivors

This scale (Appendix 8), is a 37-item subjective measure devised by Dolan (1991). It is rated on a 4-point scale ranging from "not at all" to "very much". The scale is unique in its focus on healing from the after effects of the trauma and providing survivors a context of hope. Helping survivors identify and describe healing signs shifts the orientation from trauma to healing. It allows survivors to talk about ways they are using their strengths. Identifying ways healing already is occurring provides a hopeful, optimistic future. Using the scale, survivors can identify the healing signs and are also encouraged to notice when it happens. Supportive others can also notice when healing signs occur. In noticing healing signs, survivors and supportive others can develop solutions for healing changes to continue.

The scale has usefulness beyond the scope of the group therapy session. Survivors can look for signs of healing when the group sessions and the post-testing have been

completed. With this in mind, a copy of the scale was given each survivor following the post-test for her to assess her future healing signs.

In looking at the results of the recovery scale, items either remained similar or shifted positively one point on the Likert scale for all seven survivors. The shifts usually reflected some attainment of goals the group members. Changes included needing less medication to sleep; having more awareness of the abuse; feeling less anger; needing friends in a more positive way; enjoying being alone; developing one's own interests instead of total concern with others; becoming more discerning about who is a supportive friend; and reinforcing measures for personal safety.

The research measures used provided the survivors with control and power throughout the entire group process. All the measures were optional. Participation in the group was not dependent on participation or completion in the research project. All participants were encouraged to be part of the entire evaluation process. Each survivor who participated in the group courageously participated in the entire project. All seven participated in all the pre and post-test measures. They were committed to their healing. They also allowed the information gleaned from this project to be shared in this written report so others could benefit. Each survivor's courageous commitment is gratefully acknowledged.

Results need to be interpreted with caution. There are always factors with unknown validity. This is especially so in working with a survivor. Her life can frequently be in a state of crisis and it is often then that she will seek the services of a community or mental health professional. Maturation and history influence the outcome of test results taken during a certain few months of a survivor's life, and so it was with this practicum.

Findings from the Brief Beck Depression Inventory indicated levels of depression changed significantly in both directions for three of the participants. Two women showed an increase in levels of depression following group intervention whereas one woman showed a significant reduction in depression. The woman who scored lower as less depressed and showed improvement felt it was due to the group participation. The women who scored higher depression levels felt it was due to further revictimization in their networks.

The magnitude of improvement showed more variance using the Hudson Self-Esteem Scale. Three of the participants showed increased scores indicating a greater problem with self-esteem. Two of these were the same two who showed higher depression levels due to revictimization in their networks. The other participant who had a higher score felt it was due to other circumstances. One of the participants showed no significant change in scores. Three showed a drop in scores indicating improved levels of self-esteem. One of the participants who showed a marked drop was the same who showed a marked reduction in depression level.

The positive finding between goal attainment and completion of group therapy was interesting to note. Perceived goal attainment was strong by those who attended most of the group sessions. Solution-focused therapy believes changes in perception follow changes in behavior. The fact that a survivor felt she was meeting a stated goal would result in further attainment in meeting her goals and a positive increased awareness of self.

Results indicated that increased awareness in meeting goals had occurred for six of the seven group members. More can be said however about working with clients to state a goal. This student felt goal setting on her part could have been defined more clearly and with more fine-tuning for each survivor. Attempts were made to describe a goal in action or behavioral terms. It would have been useful to have broken this into smaller, more measurable terms. Questions that could be asked to have this happen could include, "How would you notice this happening?", or "What would you be doing instead?" or "What will be the first sign will let you know you are on the track that you want to be?". Some of the goals chosen were large and more difficult to measure. It would be helpful to focus on what the survivor will be doing differently rather than what others in the network will be doing differently. Helping a survivor choose a goal that will help her to achieve the desired changes is a very important part of therapy.

Some of the survivors became more aware of their abuse during the intervention. They saw how abuse had impacted their relationships and choice of partners. As a result, some chose to change or leave unsupportive relationships. For some, this resulted in further isolation. Their perception of connecting with others, a goal of intervention, seemed to be strengthened in the group setting. It did not, however, seem to have a carry over effect once the group module was over since ties among some group members did not seem to be strengthened. This was interesting since some survivors said they had interacted on a social basis during the month between the last group session and the post-test interview. The Support Network Support Checklist was useful to highlight this.

The perception that the sense of connection was not continuous even when members interacted socially bears some discussion. It might have been useful to separate more clearly the types of support survivors chose from their relationships, whether from the group, or from others in their network. The types of support or aspects of network dimensionality the relationships could provide included emotional, cognitive or material support. These could have been evaluated separately to see which ties could still be

useful. The emotional support a survivor received would include a sense of belonging and security, being cared for, and being loved.

In evaluating the social support network checklist one could also ask the question "what are the harmful effects of supportive exchanges?" More distinctions could be made among interactions intentionally harmful, and those that seemed harmful but still provided benefits. In looking at the people have with each other, Shumaker (1984), states that perceptions of exchanges are not synonymous with the effects of exchanges. Incongruity develops when providers (network) and recipients (survivors) have different goals. In looking at the checklist and at what survivors were saying about relationships that were at times supportive, being vulnerable or dependent was viewed as being negative. The potential for being exploited meant being revictimized. It was difficult for survivors to provide information to their network about their needs and the type of assistance necessary as the aftereffects of the childhood trauma included diminished interpersonal skills and dichotomous thinking. It is often difficult for people in a survivor's network to be supportive. For this reason. it may be assumed that strangers, such as members of a survivor group, may temporarily provide the needed resources. And yet, the decision to maintain a tie, whether with a new group or with someone else in the network, must always remain with the survivor.

The fact that some survivors were in crisis with abandonment issues could reflect on the difficulty some survivors had to connect with the group. Jacobson (1986), states that a new object (i.e., new group for support) offered before the old one has been relinquished (i.e., letting go of a fantasy family or accepting the loss of a partner) will not be accepted or experienced as support. The timing of offering a new support needs to be considered.

In addition to looking at the timing of acceptance of new supports, the loss of old, perceived, or fantasy supports need to be mourned. It was difficult to allow expression of all the grief and loss the members were experiencing. Grief work takes longer than 12

week to process. A number of the survivors were dealing with multiple losses. This posed many incompatible tasks and demands on them.

The solution-focused recovery scale was the last measure used in the post-test. It was useful in encouraging each survivor to look at her healing and focus discussion on what she needed to keep the changes going.

One of the useful techniques Dolan (1992) suggests is scaling. The self-anchored scale was an example of this. The group also used scaling on a weekly basis during check-in time. This student wondered how it could have been used more effectively. The scaling technique was used to assess where each survivor was at her feeling state. She could have been asked what it was she needed to get where she would like to be at a particular point in time, e.g., the end of the session or the end of the day.

In addition to the measures used, the feminist alternative paradigm was useful. It provided a framework from session 12 and the questionnaire to see and hear survivors' evaluations of short term change and healing. Expressions of being cared for, understood, and demonstrating concern for others were circulated. Reassurances of worth, approval and praise were meaningful to those to who received them. Feedback was given to deal with difficult and ambiguous situations. Healthy behaviors were modeled. Having opportunity to speak and be heard promoted disclosure which felt like healing and growth to those who found their voice. Other survivor's experiences and perceptions were heard and validated. The symbols and creative objects brought to session 12 were indicative of the power of healing and were useful in evaluating the outcome of group intervention.

3: 8 Conclusions

Group therapy was a useful therapeutic modality for providing survivors of sexual abuse an opportunity to strengthen the healing process. It provided survivors a way to establish a healing alliance and decreased feelings of isolation and stigma associated with

trauma. It helped them put responsibility for the abuse where it belonged. Using solution-focused intervention, the group helped provide choices for survivors so they could grieve for what had been taken from them. Survivors could look at solutions they were using or at solutions others were using to develop a hopeful future orientation and live a more satisfying life.

More use could have been made of the solution-focused technique of using exceptions. For example, on one occasion this student could have asked what difference would it have made if the member's negative cognitions regarding body image were replaced with positive ones. In another session, the student could have asked what difference would it have made if the member were to safely express her anger?

Other questions could be raised because of the agency setting. Women who come to the Centre for healing are often viewed through the prism of pathology. The therapeutic approach used in solution-focused therapy is not always compatible with a disease or illness orientation. The focus becomes more on "wellness", as survivors flower and grow. The solution-focused approach allows her to stay tuned to behaviors and tendencies that are useful and to discard those that are not. Listening, recognizing, and strengthening her useful behaviors, thoughts, and tendencies is what therapy becomes. This aspect could have been strengthened during this group module by helping a survivor sort out what and who was useful among her relationships.

The gender of the therapist was also an issue discussed by the survivors. Those who had been in previous group therapy stated a male co-leader was not a factor in being beneficial to a survivor. Modeling sensitivity and non-exploitation had been adequately done by the previous male leader.

One participant was able to attend only half the sessions. She had been previously psychiatrically hospitalized. This wais consistent with findings of another research project regarding difficulty in treatment completion (Hazard, Rodgers, and Angert, 1993). This needs to be qualified, however, as her circumstances were powerful during the time of

group therapy. Courtois (1988) cautions against forming groups with "isolates". Was this perhaps a factor why this participant felt different from the others? Group-member similarity may have been an issue.

Two members were new to the group. They appeared to make great therapeutic gains. They came to recognize they had the capacity to control their lives. They made attempts at moving ahead in situations that had previously felt hopeless, and they shared this.

Herman (1992) and Butler (1993) both felt groups for survivors would be more helpful if they were clustered by the three stages of therapy, i.e., restoring power and control, remembering and mourning, and reconnecting. Not only is it difficult in any caseload to find survivors at the same stage, but it is also difficult for a survivor to remain in one stage since the work is circular and spiral. The women were constantly learning from each other even when they had been at a particular stage.

Using the solution-focused therapy approach provided several benefits. Firstly, it was helpful since it encouraged looking at a survivor as a woman who had developed and used many solutions in her survival process. This facilitated viewing her through the prism of health and solutions instead of persistent pathology and problems. Secondly, encouraging a woman to define goals provided her and the therapist a direction for work. It reinforced the assumption that clients are experts on their life. The self-anchored scale was a very useful tool to make this practical. An agenda for work during each session defined by survivors who wanted to participate, was another avenue for goal-setting. Therapy became a co-creation of solutions by the survivor, therapist, and other group members. Thirdly, recognizing that change was always occurring prevented therapy from getting bogged down. One only needed to look for small indicators of healing to continue the process. It also freed the therapist from feeling she had to know everything about a client's life to be helpful. Fourthly, looking for the exceptions in a survivor's life when she

becomes symptom free was touched on, but could have been emphasized more during this group module. Along with this, the relaxation techniques as outlined by Dolan, 1991 could have been used more.

In closing, when helping professionals think of healing for a survivor, we recognize "healing" when she thinks of the abuse as an adjunct to her life, not a central, dominating part causing fear and destruction. She may not be sure what healing is, but she knows what her goal is: a healthy, satisfying and fulfilling life, which is what she deserves. Pain and trauma don't always have to be a fixation in her life. She can address how she feels about life and pain and what she can learn about her pain that is necessary for living alone, and in community. She can identify her hopes and dreams and the routes needed to take to get there. This is this student's wish for each woman in the group as her life continues to unfold and flower.

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APPENDIX 1: LETTER OF INTRODUCTION

Welcome to the Eden Mental Health Centre. My name is Ingrid Friesen. I graduated in 1970 with my Bachelor of Nursing and worked for several years as a public health nurse. Since then I have held several short term jobs including some counselling. For the past several years, I have been driving to Winnipeg, studying further counselling through the faculty of social work. I have presently completed the course work towards a masters degree in social work. During this time, I also spent my field work placement at the Eden Mental Health Centre. The final piece towards the completion of the degree is a choice on my part to spend some more time working with women who have survived the trauma of childhood sexual abuse and who want to work towards healing from the effects of this trauma on their lives in a supportive group setting with other women who have had similar experiences. I have worked in this area before and will receive supervision and support from the staff at this Centre as well as two university instructors. These instructors will consult with me relating to issues in counselling and will keep your identity confidential.

As with any counselling at Eden, a file is kept under your name within the building. By Eden policy, this information is kept confidential.

I will also be keeping my own set of notes which will not bear your name, or any identifying information, but will allow me to be more helpful to you in your process of healing. It will allow the team to examine and write about the process of counselling. At the end of the counselling period, I will then write a report about this process. There will be no identifying information about you in this report, and it will be available for your perusal.

Before beginning these sessions, you will be asked to sign a consent form, indicating that you understand and agree to this process. Please feel free to ask any and all questions that you may have.

(Flaherty, 1992)

APPENDIX 2 CONSENT FORM

In undergoing group counselling , I will also be participating in an educational study of Ingrid Friesen, a student of the Faculty of Social Work of the University of Manitoba. As a client , I understand:

1) That the intended time frame of the group counselling sessions are once weekly for approximately two hours for a period of between one to twelve sessions. Prior to the beginning of, and at the end of the group sessions, I will meet with one or both of the group leaders to assess goals and evaluate the effectiveness of the group sessions for a total of 2-3 additional individual meetings.

2) That, as with any other counselling activity at Eden Mental Health Centre, a confidential file regarding my sessions will be kept on the premises. All information, both verbal and written will be kept under strict conditions of professional confidentiality.

3) That information from this file will not be released outside the agency except: a) with signed consent by myself; b) if there is concern that I may be a danger to myself or others; c) as necessary if subpoenaed for court; d) if a child may be at risk and a report to Child and Family Services is deemed necessary.

4) That information may be shared within the agency only as such information is required by individuals who have an identified need to know the information for the purpose of helping you , the client.

5) That in addition to my file kept on the Eden Mental Health Centre premises, I understand additional non-identifying notes will be kept by Ingrid Friesen regarding the process of counselling. These notes shall in part make up a practicum report to be compiled at a later date. These notes will also be the basis for off site supervision by a member of the University of Manitoba Faculty of Social Work.

6) That observation and /or audiotaping or videotaping of a therapy session may be requested but shall not be done so without immediate prior consent. I will also be able to revoke my consent if I have a change of mind.

Name of client:
Signature of client: Date:

(Flaherty, 1992)

APPENDIX 3

GROUP GUIDELINES

1. There will be 12 sessions for this group module. We will begin on September 29 and we will conclude on December 15, 1993.

2. Group sessions will be held on Wednesday afternoons from 1:00 - 3:00 P.M. The 3:00 P.M. closing time will be adhered to.

3. We strongly encourage members to attend regularly and to show up on time in order to receive maximum benefits and to promote continuity. If you are not able to attend any particular session, please phone Kathy or Ingrid at 325-4325.

4. If a group member would decide to discontinue attending, we suggest that she would come back for one more session to discuss her reasons for leaving, to uncover any miscommunication, to share reactions, and to bring closure to her experience.

5. The group therapists will maintain contact with group members' individual therapists.

6. In order for the group to be a safe place, confidentiality is extremely important. The identity and all identifying circumstances of the group members will remain confidential. We expect that you respect each other's personal integrity as you want yours to be respected.

7. We encourage members to be personal and share meaningful aspects of themselves that they are willing to discuss. This includes the expression of any or all feelings in a constructive manner. For the group to be a healing experience, conflicts within the group can be expressed and explored with a commitment toward maintaining the value and dignity of each group member. Respect for self, others and property is expected.

8. We encourage members to be supportive of each other in their individual work of healing as well as in the work done in the group. This will include giving feedback to one another to recognize each members' activity in their healing process.

9. We encourage each member to stay healthy, alive, and in the present.

APPENDIX 4

Name ----------------------------------

SELF ANCHORED SCALE OF CLIENT GOALS

9 -

8 -

7 -

6 -

5 -

4 -

3 -

2 -

1 -

0 -

Goal for an action, thought, feeling, or behavior --

At what number would you like to be at the end of the group sessions?

What would indicate to you that you would have attained the number you have chosen?

At what number do you see yourself today?

Last week?

Two weeks ago?

At what number would you like to be that would indicate to you that some healing had taken place for you at the end of the group sessions?

APPENDIX 5:

Beck Depression Inventory, Short Form

Instructions: This is a questionnaire. On the questionnaire are groups of statements. Please read the entire group of statements in each category. Then pick out the one statement in that group which best describes the way you feel today, that is, right now! Circle the number beside the statement you have chosen. If several statements in the group seem to apply equally well, circle each one.

Be sure to read all the statements in each group before making your choice.

A. (Sadness)

3 I am so sad or unhappy that I can't stand it.

2 I am blue or sad all the time and I can't snap out of it.

1 I feel sad or blue.

0 I do not feel sad.

B. (Pessimism)

3 I feel that the future is hopeless and that things cannot improve.

2 I feel I have nothing to look forward to.

1 I feel discouraged about the future.

0 I am not particularly pessimistic or discouraged about the future.

C. (Sense of Failure)

3 I feel I am a complete failure as a person (parent, husband, wife).

2 As I look back on my life all I can see is a lot of failures.

1 I feel I have failed more than the average person.

0 I do not feel like a failure.

D. (Dissatisfaction)

3 I am dissatisfied with everything.

2 I don't get satisfaction out of anything anymore.

1 I don't enjoy things the way I used to.

0 I am not particularly dissatisfied.

E. (Guilt)

3 I feel as though I am very bad or worthless.

2 I feel quite guilty.

1 I feel bad or unworthy a good part of the time.

0 I don't feel particularly guilty.

F. (Self Dislike)

3 I hate myself.

2 I am disgusted with myself.

1 I am disappointed in myself.

0 I don't feel disappointed in myself.

G. (Self-harm)

3 I would kill myself if I had the chance.

2 I have definite plans about committing suicide.

1 I feel I would be better off dead.

0 I don't have any thoughts of harming myself.

H. (Social Withdrawal)

3 I have lost all of my interest in other people and don't care about them at all.

2 I have lost most of my interest in other people and have little feeling for them.

1 I am less interested in other people than I used to be.

0 I have not lost interest in other people.

I. (Indecisiveness)

3 I can't make any decisions at all anymore.

2 I have great difficulty in making decisions.

1 I try to put off making decisions.

0 I make decisions about as well as ever.

J. (Self-image change)

3 I feel that I am ugly or repulsive-looking.

2 I feel that there are permanent changes in my appearance and they make me look unattractive.

1 I am worried that I am looking old or unattractive.

0 I don't feel that I look any worse than I used to.

K. (Work difficulty)

3 I can't do any work at all.

2 I have to push myself very hard to do anything.

1 It takes extra effort to get started at doing something.

0 I can work about as well as before.

L. (Fatigability)

3 I get too tired to do anything.

2 I get tired from doing anything.

1 I get tired more easily than I used to.

0 I don't get any more tired than usual.

M. (Anorexia)

3 I have no appetite at all anymore.

2 My appetite is much worse now.

1 My appetite is not as good as it used to be.

0 My appetite is no worse than usual.

Appendix 6

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

NAME: ____________________

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

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

Please begin.

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

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

FIGURE 6.3.

APPENDIX 7i

SUPPORT NETWORK

Instructions for Use:

1. Using the attached form, the client is to identify family, friends and professionals from whom they can get help. Each name is to be written beside the appropriate category and questions 1-5 are to be answered about each person listed.

2. For questions 6-7, the client is to identify the various ways those person(s) assist them by placing an "X" across from their name under the appropriate headings.

3. Under the heading "Family", list family members by name and identify their relationship to the client in the appropriate column below. (ie., spouse, uncle, etc.)

4. Omit the "Friends" column.

5. Under the heading "Professionals", list the professional affiliation of those in the client's support group. (ie., physician, priest, etc.)

6. Identify whether network member is male/female and record in the "sex" column.

7. "How often are you in contact" - list frequency. (ie., daily, weekly, twice a month, etc.)

8. "How long have you known this person?" - list in years or "since birth".

9. Under the column "Near/Far", the client is to place a + if that person lives within 10 minutes from their home or a - if they are more than 10 minutes drive from their home.

10. Aspects of Network Dimensionality: eg: chore/task, social activities, etc. Place a checkmark beside each dimension the client feels they would receive from each person identified in the network listing. Leave as blank those dimensions not received. Remember to place an * beside those people with whom the client has a <u>close</u> emotional relationship. (ie., a confidant). Remember to place a ** beside the name of each person in the network listing with whom the client has discussed the child sexual abuse situation.

Appendix 7ii

SUPPORT NETWORK

sing the attached form, identify family, frineds and professionals from whom ou can get help. Write each name beside the appropriate category and answer ne next five questions about each person listed.

nder the column Near/Far, put a + if they live within 10 minutes from your ome or a - if they are more than 10 minutes drive from your home.

or each of the remaining questions, identify the various way those person(s) ssist you by placing an "X" across from their name under the appropriate eadings.

.. Who has helped with tasks (i.e., cleaning, babysitting, shopping)?

2. With whom do you engage in social activities (go to a movies, invite home for dinner, go for a ride, talk, play)?

3. With whom do you talk about personal worres or daily stresses?

4. Whose advice do you consider in making important decisions?

5. From whom would you get needed emergency food, clothing or housing?

6. Who can get information, locate resources, introduce you to new friends or professionals?

7. Who keeps you from changing (makes you feel uncomfortable, influences you negatively, keeps you stuck)?

*Indicate those people with whom you have a close emotional relationship by placing an * by their name.

Appendix 7iii

Professionals						Friends							Family							
																				Names
																				Relationship
																				Sex
																				How Often are you in contact?
																				How long have you known
																				Near/Far
																				Tasks
																				Social Activities
																				Worries
																				Decisions
																				Emergency
																				Information
																				Blocks Change

APPENDIX 8

	Not at all	Just a little	Pretty Much	Very Much
1. Able to think/talk about trauma				
2. Able to think/talk about things other than trauma				
3. Sleeps OK				
4. Feels part of the family				
5. Stands up for self				
6. Maintains physical appearance				
7. Goes to work				
8. Engages in social activities outside home				
9. Able to leave the house				
10. Cares for child, loved ones				
11. Cares for pets, plants				
12. Goes out for dinner				
13. Shows healthy appetite				
14. Adapts to new situations				
15. Telephones friends and loved ones				
16. Laughs at something funny				
17. Able to look loved ones, friends in the eye				
18. Able to look strangers in the eye				
19. Able to shake hands				
20. Holds hands with loved one				
21. Kisses loved one on the cheek				
22. Kisses on the mouth				
23. Enjoys love making				
24. Initiates lovemaking				
25. Bathes normally				
26. Interested in the future				
27. Pursues leisure activity				
28. Engages in new recreational activity/interest				
29. Takes protective measures inside and outside the house				
30. Able to discriminate between supportive and unsupportive relationships				
31. Chooses supportive relationships				
32. Initiates conversation with family, friends, coworkers				
33. Able to initiate conversations with acquaintances and strangers				
34. Able to relax without drugs or alcohol				
35. Tolerates criticism well				
36. Accepts praise well				
37. Other signs of recovery				

Comments:

APPENDIX 9 - Techniques

5 4 3 2 1 Self Relaxation Technique

This technique is useful when a survivor wants to get to sleep, to relax in stressful situations, or reconnect to the present when she is feeling symptoms of post-traumatic stress.

The survivor is invited to find a pleasant position for her body and a pleasant place to focus her eyes. She is encouraged to make any adjustments at any time to be comfortable and at ease. She can keep her eyes open if she wishes, but she should choose to close them when she feels a pleasant urge to do so. She can reorient herself any time she wishes by moving around a little or by counting from one to five telling herself she will be more alert and refreshed with each number.

The survivor is then invited to name aloud five sights, five sounds, five body sensations, then proceed to four sights, sounds, sensations, moving down until she lists one of each category. At this point she can either stop and enjoy the level of relaxation she has created for herself or she can repeat the procedure to deepen her relaxed state.

Losing track of the number or category or yawning is a good sign she is becoming more relaxed. She can again either stop and enjoy the present state or continue. The procedure can be done aloud or silently. Hearing her voice may be self-soothing. As well, it cues the therapist about where a survivor is in her state of relaxation. The therapist can also remind her of her associational cue for comfort and safety. This will make that cue more powerful and effective (Dolan, 1992, pp. 117-119).

Associational Cue For Comfort and Safety

This technique can provide comfort and security to the survivor when she is experiencing times of stress, such as when facing difficult memories or flashbacks and nightmares. It can help her reconnect with her inner strengths. In using the associational cue, an experience of well-being is being recalled to provide her with a calm pleasant state. If she

cannot recall a calm or secure time or place she can be asked what she likes to do when she is not thinking about the problem that brought her into therapy. Another question that can be asked is what does she least dislike doing. Once she has identified an experience of relative comfort and safety, she can be directed to notice and describe all the details of the experience along with the sights, sounds and sensations. She is then encouraged to take some time to enjoy the experience. After a moment or two of enjoying this, she is invited to make any adjustments to the details of the experience that would make it feel even more comfortable and secure. When the experience is just right, she is encouraged to enjoy it one more time and then select any symbol to recall this experience in the future. She is then asked to re-orient to the present, identify the symbol, and re-access the state of comfort and security. This symbol she has chosen can be used to provide a state of comfort and security whenever she needs it to become relaxed, refreshed and alert (Dolan, 1992, pp. 100-103).

Rainy Day Letter or Tape

In a letter or on a tape the survivor identifies, as a reminder to herself, the strengths she has, the reasons to keep living, the progress she has made, her accomplishments, and her hopes for the future. This activity would be completed on a day when she is feeling strong. She would use the tape or letter in a time of future stress (Dolan, 1992, p. 131)

The Movie Screen

The tool is helpful for survivors who want to get in touch with dissociated material but who want to view it at a distance. Using this idea, a survivor would be asked to view the information she wants to heal from by keeping it at a comfortable distance i.e., by imagining it to be on a television or video screen. In her hand she would have the controls for the volume, the color, as well as the power to turn the screen on. She could view the screen from the compassionate vantage of an adult without feeling the emotions of the

characters. She can tell the therapist what she is learning and she can change what ever she needs. This allows her to tell her story at a comfortable pace. It may take several sessions to do so but she would have the control (Dolan, 1992, pp. 151-152).

Four Step Approach For Dealing With Flashbacks

These four steps will help a survivor to understand and control her flashbacks both in and outside the therapy setting.

1. Ask her to describe what she is experiencing. When has she felt like this before? What situation was she in the last time she felt this way?
2. Ask her in what ways the current situation and the previous situation are similar.
3. Ask her in what ways the two situations are different. This could include the sights, sounds, sensations present, the setting, her current life circumstances, personal resources, or the people involved.
4. Ask her what action she would like to take to feel better in the present. Does she need something to make herself safe? Does the reactivating of the previous memory require a message of assurance and comfort to counteract old traumatic memories? A reminder of an associational cue for safety may be helpful (Dolan, 1992, pp. 106-107).

Nondominant Handwriting

This tool would not be included in the category of stress relaxation, but it would give a survivor a way to control a negative learned response such as overeating or self-mutilation. She sometimes needs to develop a way to stop the negative behavior by interrupting the pattern of self-destruction and redirecting to a state where her other resources can be accessed. One way to redirect herself is to write messages to the self with her less dominant hand. Some survivors use the less dominant hand to tell the child within what she needs at the current time. This can strengthen the healing message she needs to hear (Dolan, 1992. pp. 99 -100)

KATHY'S STORY
Session 12

Once upon a time there was a plant. She didn't know what kind of plant she was, as no one had ever taken the time to tell her. She did know, however, that she was a plant. She had a hard time remembering herself as a young seedling. There was an overwhelming feeling that when she was young there was much darkness and that she had often been alone. The plant had no sense of belonging anywhere. Her short roots hung on tenuously, but they always felt like they could let go at any time and she would blow away in the wind.

In her seedlinghood her roots had been hurt by neglect or an over-abundance of heat and water. She had no way of knowing how or where to put down strong roots. She was afraid to let them branch out in any direction for fear they would be hurt again.

One day the plant decided it was time to set out on a journey to find a place to put down roots. On her journey she stopped at various places where other plants appeared to have established themselves. These places were familiar in that they provided too much heat or alternately too much water. The other plants gave her advice on what to do. In her attempts to establish herself, her roots would become entwined and enmeshed with the other or likewise her roots would shrivel up to escape the heat.

The plant became so weary from her journey. She was about to give up her quest to find a life for herself, when she saw a greenhouse in the distance. "Perhaps the gardeners in that greenhouse could help me," thought the plant. She slowly approached the greenhouse with much fear and dread. Would the doors be locked? Would the gardeners scorn her for not knowing how to establish her roots? Would they laugh if they found out she didn't remember her seedlinghood? Worst of all, "would they say she was crazy if they found out that she didn't even know what kind of plant she was?"

She knocked on the door and to her surprise she was invited in by two gardeners. The gardeners recognized her fear and offered her a spot on a windowsill until she felt safe. She agreed to perch on the shelf because nothing could be worse than the places she had already been. As the gardener gently placed her on the sill she squeezed her eyes tightly.

KATHY'S STORY

Slowly she opened her eyes. To her surprise she found herself and six other plants in a circle on the windowsill. They all seemed to be as afraid as she was. Sitting on the windowsill provided sunshine and protection from the elements. The gardeners hovered about checking on the seven plants regularly. As time passed some of the fear began to subside and the plants began to chat.

The plant discovered she had a lot in common with the others. They understood her fear and her desire to find a way to put down roots. They didn't laugh at her lack of memories, or call her crazy for not knowing what kind of plant she was. In fact, they applauded her courage for sharing her fear. The gardeners nodded their heads and smiled. They seemed to believe that what she was doing was good.

Carefully the plant put down a root. She saw the others attempting to do the same thing. She smiled at their efforts and they in turn encouraged her. Occasionally, the gardeners reminded her that she needed to provide nourishment to her new root. Day by day she learned new ways of taking care of herself and began to experiment putting down other roots.

Periodically she exposed herself to too much water or heat, but the others were quick to remind her when she was doing so. She was beginning to understand that she could make her own choices about the balance of sunshine or shade. At times she was overwhelmed by all the new learning and would want to give up. The other plants would remind her of the growth they were seeing in her and that she was worth taking care of. It was OK to ask for support when she felt her old fears coming back.

For the first time in her life the plant felt warm and accepted, not only by the others, but from somewhere within herself. What was this new feeling? Could it be? Yes!!! She had sprouted a bloom!!

She still didn't know exactly what kind of plant she was. However, when she examined the bloom, she found it was beautiful, and best of all - - - she liked it. THE END.

Ingrid's Song - Session 12

We light a thousand Christmas lights
Around the world today
The beams from our group will shine across
Making darkness go away.

You bring the light of a loving heart
Changing messages to those that are sound.
You've nurtured your child, discovering her art,
Your voice which was lost, now is found.

You share the light of wisdom and truth
With disbelief, you've found a safe place.
You can trust your way, and your choices too
For your children, and yourself.

You use the light of your gut feelings
Determined to build self esteem.
You channelled your anger to the offenders
Finding peace at home and within.

You took the light of healing power
Letting go of your pain from the past.
You see so many candles that shine
Finding freedom that can last.

In all our hearts, once cold and dark,
Lord, send your warmth sublime,
With peace when we're alone and in relationships
This blessed Christmastime.