TIME-LIMITED GROUP TREATMENT WITH WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

BY

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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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FACULTY OF GRADUATE STUDIES

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Abstract

Childhood sexual abuse is a life experience that has both long and short term consequences for the survivor. For most women, the experience of having been sexually victimized as children has resulted in chronic feelings of helplessness and powerlessness.

The purpose of this practicum was to implement a time-limited group treatment approach to help the adult women improve their ways of coping through the reduction of feelings of guilt, shame, pain, grief and low self-esteem which are common after-effects of the incest experience. The group was conducted over 12 consecutive weeks in twelve, two hour sessions with the participation of seven women survivors of childhood sexual abuse.

Acknowledgments

Several years ago a wonderful and wise woman, my mother, encouraged me to become a professional. My father wanted me to be a physician as he was. He was quite disappointed when I told him that I wanted to be a social worker. However, when I graduated he was very proud of my success. To both of my parents all my gratitude for all their effort and full support to fulfill my dream.

Grateful acknowledgment is extended to the members of my practicum committee: To Sid Frankel who patiently encouraged and guided me until the end. To Marlene Richert for her cooperation and understanding. To Ruth Rachlis who listened to me and waited patiently.

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Finally, my love and thanks to my brother and sister, my husband, my children and grandchildren, who were my inspiration and made my life worthwhile during my ups and downs.

"Come to me, all of you who are tired from carrying heavy loads, and I will give you rest. Take my yoke and put in on you, and learn from me, because I am gentle and humble in spirit; and you will find rest. For the yoke I will give you is easy, and the load I will put on you is light"

Matthew 11: 28-30.

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Chapter I

Introduction

As the sexual abuse of children is more widely discussed, clinicians have become increasingly aware of the forgotten groups of clients, the adult victims of childhood sexual abuse. A review of current reports on childhood sexual abuse (c. s. a) written for the helping professions indicates that substantial numbers of victims exhibit various difficulties of adjustment in adulthood (Goodman & Nowak, 1985). The immediate reaction of the victim is usually a negative one involving such responses as depression, anxiety, acting-out behavior and serious personality disorders (Meiselman, 1979). Additional problems include shame, guilt, negative self-image, depression and difficulties in interpersonal relationships (Tsai & Wagner, 1978). Perhaps, more importantly, there is evidence that sexual abuse also has long-term effects (Butler, 1978).

These multiple effects have led the therapeutic professionals to face the issue of intervening and counseling those individuals affected by sexual abuse. Social workers have focused their efforts on emerging family concerns (Thomas, 1977). However, there appears to be a lack of appropriate techniques to help the survivors of childhood sexual abuse. There is a tendency to employ some of the traditional techniques such as family therapy and marital counseling, rather than using a different approach that would help the victim to explore the thoughts, memories and feelings surrounding the sexual abuse (Thomas, 1977).

This report of practice with women survivors of childhood sexual abuse will attempt to discuss the time-limited group treatment approach (Sprei, 1987) to helping adult women deal with the long-term negative effects of childhood sexual abuse, including the trauma that affects the development of the victim.

1.1 Objectives of the Practicum

Her interest in increased knowledge about child sexual abuse and how to intervene with childhood victims/survivors led the student to develop a practicum in a centre at which survivors of childhood sexual abuse are helped to break the silence, talk about their

abuse, and obtain group support to help them to heal with the pain they have carried throughout their lives.

1.2 Learning Goals

The student's personal learning goals for this practicum were:

1. To review the existing literature in the area of child sexual abuse (particularly regarding women survivors of childhood sexual abuse), and to identify the dynamics and issues related to child sexual abuse.
2. To acquire knowledge of intervention with childhood sexual abuse with an emphasis on group therapy.
3. To increase knowledge and improve practice of clinical social work with regard to mainstream approaches for working with women survivors of childhood sexual abuse.
4. To increase knowledge in the area of childhood sexual abuse group therapy that in the future would contribute to the treatment of immigrant women who had experienced childhood sexual abuse.

Chapter II

Literature Review

2.1 Dimension of the Problem

Solin (1986) emphasizes that all forms of child sexual abuse (c. s. a), including incest, have in recent years received unprecedented societal acknowledgment. Women who were sexually abused as children have begun to discuss their abuse experience, breaking the silence with which it has been surrounded. Disclosure has been spurred by the women's movement with its interest in all aspects of women's lives and its encouragement of "speaking out" about the previously unspeakable, first about rape and then about all forms of family violence, including incest (Baird & McGillivray, 1982). A simultaneous development has been the discovery of child sexual abuse by researchers studying other types of family violence (Finkelhor & Browne, 1985). As a result, sexual abuse has been acknowledged as a reality in the lives of many children.

Empirical studies have indicated negative reactions in at least some portion of the survivor population (Herman, 1987). Because incest occurs during the course of the victim's childhood, it inevitably influences maturation and development. For many survivors the incest experience, along with its after-effects and coping mechanisms, has influenced and become integrated into their personalities. Herman (1987: 11) described the personalities of some survivors as "walking post-traumatic stress reactions".

Furthermore, these empirical studies establish that many of the victims of childhood sexual abuse manifest identifiable sequelae of psychological symptoms and patterns of social dysfunction (Lindberg & Distad, 1985; Pattern, Gatz, Jones & Thomas, 1989).

Presently, the growing interest in child sexual abuse has led to an increase in the number of cases coming to public attention which involve children who have been sexually abused (Finkelhor, 1986). This increase in public attention has resulted in an increased need to understand the victim/survivor and the many aspects surrounding childhood sexual abuse by practitioners and therapists.

This literature review on sexual abuse of female children consists of two sections: (1) the definition, prevalence, and distribution of this problem; (2) long-term effects of sexual abuse on the victims/survivors.

The sexual abuse of children is a serious problem which must be addressed by both researchers and clinicians working in the area of abuse. Child sexual abuse is so perplexing, so disturbing and so difficult to resolve. The field is too new and the body of accumulated knowledge and skills is too small.

2.2 Definition, Prevalence and Distribution

Until fairly recently, incest was believed to be exceedingly rare. Estimates indicated that it occurred at the rate of one or two cases per year per million population (Weinberg, 1955). Revised estimates based on a variety of data collection systems and studies conducted in the late 1970's and early 1980's have established that sexual victimization of some sort in childhood is anything but rare (Finkelhor & Browne, 1985).

While estimates vary by study because of the sample surveyed, the definition used, the sensitivity and nature of the questions asked and the methodology for collecting data, the prevalence rate for child sexual abuse in the United States is believed to be in the range of 10% to 30% of all girls and 2% to 9% of all boys (Finkelhor, 1984). The best statistics currently available about incestuous abuse indicate that approximately 20% of all women have had at least one incestuous experience before the age of 18 (Rusell, 1986; Wyatt, 1985). According to Rusell's analysis it appears that incestuous abuse has increased, in large measure, due to the following factors: child pornography and the sexualization of children, the sexual revolution, the backlash against sexual equality, untreated child sexual abuse, and the increase in cohabitation, divorce and remarriage, with its resultant increase in blended families.

The Canadian study recently conducted by the Badgley Commission has shown that one out of two females, and one in three males report experiences of improper sexual contact. In this sample, 80% reported these experiences as occurring during childhood and that the offender was known to the child in 85% of the assaults (Badgley, 1984; Vargo, Cole & Walton, 1988).

One commonality among forms of abuse lies in the power dynamics of these situations. Abuse tends to gravitate toward the relationships of greatest power differential. This principle is clearest in childhood sexual abuse. The most widespread form of reported sexual abuse consists of abusers who are both male and in authority positions within the family victimizing girls in subordinate positions (Finkelhor, 1982). This is a case of abuse across the axes of both unequal sexual power (males victimizing females) and unequal generational power (the older victimizing the younger).

Finkelhor (1982) describes five dimensions of sexual abuse:

1. Intercourse, including simulated or attempted intercourse.
2. Any instance of genital fondling.
3. Any instance of exhibitionistic display of genitals by an older person.
4. Any instance of kissing, hugging or fondling in a sexual manner.
5. Overt and frightening sexual overtures to young children.

2.3 Characteristics and Patterns of Abuse

Child abuse research has benefited from the passage of laws which instituted the official reporting of child abuse and the collection of nationwide data about prevalence, at least in the United States (American Humane Association, 1978). Since then, research efforts to learn more about the characteristics and patterns have yielded some starling findings. Among some of the most striking are the following:

- A very substantial percentage of the female population possibly as high as 20%, has had an experience of incestuous abuse at some time in their lives, 12% before the age of 14, 16% before the age of 18. Possibly 5% of all women have been abused by their fathers, 15% by close family friends or close blood relatives such as brothers, uncles, grandparents or cousins (Rusell, 1986).
- Boys are also sexually victimized within the family, but in smaller numbers (Finkelhor, 1986).
- The bulk of child sexual abuse is perpetrated by either a family member or by someone known to the child. Females are more likely to be abused within the family and males outside (Herman, 1987).

- The usual pattern of incestuous abuse is of repeated and progressive sexual activity, beginning when the girl is prepubertal, usually between the ages of seven and twelve; but not uncommonly occurring in early childhood (Rusell, 1986).
- Most child sexual abuse does not involve violence. However, it does involve some sort of coercion and a misrepresentation of the relationship and the activity. The child is coerced by the perpetrator's strong desire to keep the activity a secret, which has the purpose of minimizing intervention and allowing repetition (Finkelhor, 1986).
- Victimized children, especially those for whom early intervention is not available, are at risk for developing a range of negative after-effects both immediately and in subsequent life stages (Rusell, 1986).
- At least one fifth to two fifths of sexually abused children manifest pathological disturbances in the immediate aftermath of abuse (Browne & Finkelhor, 1986).
- Most cases of sexual abuse are not reported outside the family, resulting in no intervention for the exploited child (Herman, 1987).
- Intervention efforts are improving as programs are being developed and expanded; but the vast majority of children either have no access to intervention or experience intervention that is ineffective or, worse yet, that retraumatizes them (Finkelhor, 1986).

2.4 Long Term Effects

Despite the claims of Henderson (1983: 34), who states that "research is inconclusive as to the psychological harmfulness of incestuous behavior", the vast majority of published studies in this area indicate that sexual abuse produces deleterious effects which often persist over long periods of time. These may include low self esteem, depression, destructive behavior such as suicide attempts, alcoholism and drug abuse (Forward & Buck, 1978). Gagnon (1965), in his reanalysis of the Kinsey data, found that 84% of women who reported sexual victimization in childhood rated the experience as negative and 80% experienced difficulties in later life.

Substantial numbers of victims of childhood sexual abuse report surprisingly similar long-term effects: depression, suicidal feelings, self-contempt, and an inability to trust and to develop intimate relationships in later life (Finkelhor, 1982). Finkelhor (1979), in his study of college women, found that 58% of those sexually abused in childhood experienced fear and 26% felt shock at the time of the incident. Clinical studies typically report that victims of sexual abuse experience depression, guilt, poor self-esteem, and feelings of inferiority in their later life (Tsai & Wagner, 1978; Herman, 1981; Courtois, 1979; Meiselman, 1978). These individuals may also present with severe interpersonal difficulties, including isolation, alienation and distrust (Courtois, 1979), or negative relationships (Tsai, Feldman-Summers & Edgar, 1979; Tsai & Wagner, 1978; Meiselman, 1978; Herman, 1981), repeat victimization (Miller, Moeller, Kaufman, Divasto, Pathak & Christy, 1978), promiscuity (Herman, 1981; Courtois, 1979), and sexual dysfunction (Jehu & Gazan, 1983: Fritz, Stoll & Wagner, 1981). Women who were sexually abused as children are also reportedly to be more likely to become dependent on alcohol or drugs (Butler, 1978; Benward & Densen-Gerber, 1975; Spencer, 1978), and to be more likely to engage in prostitution (Rush, 1980).

A number of these studies point to a variety of psychological symptoms which occur more frequently in clients with a history of sexual victimization than in clients with no history of abuse. Loosely referred to as "Post-sexual Abuse Syndrome (P.S.A.S)" (Millon, 1981), this behavior pattern includes alcoholism and/or drug addiction, repeat victimization (battering), suicidality, multiple dissociative symptoms (derealization, "spaciness", out of body experiences), restless sleep and nightmares, feelings of isolation, anxiety attacks, chronic muscle tension, problems with anger, decreased sex drive and sexual dysfunction, the desire to physically hurt oneself, fear of women, and fear of men. Women who were sexually abused as children present with a relatively specific pattern of symptomatology, characterized by multiple dissociative experiences, anger, self-mutilation and self-destructiveness, substance abuse, and alterations in sexual functioning.

The most common problems, which are usually what causes the adult survivor to seek treatment, (Gelinas, 1983) include chronic and atypical depression, eating disorders,

anxiety, dissociative disorders, somatization disorders, and specific personality disorders associated with hysteric, borderline, narcissistic, avoidant or dependent personalities.

The kinds of abuse that appear to be most damaging, according to the empirical studies, are experiences involving father figures, genital contact, and force (Finkelhor, 1989). The controversy over the impact of child sexual abuse is still being discussed and recommendations for future research efforts are needed in order to obtain a more comprehensive understanding of the many aspects surrounding childhood sexual abuse.

Abuse within the family has particular characteristics which have been associated with the most severe reactions: longer duration and frequency, a closer relationship and greater age difference between perpetrator and victim, the use of force, and the greater intrusiveness of sexual activity (Finkelhor, 1989).

2.5 Overview of Group Treatment

The after-effects of childhood sexual abuse are often ignored or discounted, and the incest experience is rarely addressed in therapy (Rusell, 1981). However, research has graphically documented the potential of the after-effects for destructive and pervasive consequences in many areas of the incest victim's life. A survey of the British general population conducted by Baker and Duncan (1985) is one of the most informative sources to date. Among 119 female victims in their study, 13% of them considered the sexual abuse to have been permanently damaging. Rusell (1986) has reported on 187 experiences of intrafamilial sexual abuse that were described by 152 victims drawn from her random sample of the population in San Francisco that 25% of the experiences in her study were described as having had great long-term effects. To ameliorate these destructive effects, treatment approaches specifically addressing the incest experience and its after effects have been developed (Benward & Densen-Gerber, 1975). The intervention applied in this practicum is based upon the model of time-limited retrospective group treatment of adult women incest survivors developed for adult female survivors of childhood sexual abuse (Sprei, 1987).

Specific descriptions of incest survivors' groups are sparse in the professional literature (Cole, 1985; Gorday, 1983; Herman & Schatzow, 1984; Tsai & Wagner, 1978),

although there is general agreement that group treatment is a particularly effective modality for childhood sexual abuse survivors. In particular, the issues of shame, isolation, negative self-concept, anger, and guilt can be more quickly and thoroughly addressed in group rather than individual therapy (Sprei, 1987). Providing an environment that is supportive and non-shaming enough to allow the survivors to drop their defenses rather than blasting away at them is a much more helpful technique (Evans & Shaefer, 1980). It is helpful to educate the survivors about the steps out of a shame spiral: interpersonal relationships, recognition, stopping the inner abuse and affirming the self. The benefits of group treatment with this population, including the group structure and process, the topics and themes discussed in group sessions, and the role of the therapist help the survivors to re-work the after-effects of incest, and to alleviate the most insidious characteristics and effects of incest (Gorday, 1983). The sharing and empathy derived from common experiences and reactions, as well as the analysis of the interactions among members, are of great therapeutic value. The intervention applied in the practicum was useful in helping the group members to build an environment of safety and consistency within which to explore the effects which incest has had on their lives. This is an environment in which they were able to help each other undo the damage caused by the abuse by developing trust and by practicing new skills and behaviors.

For the group member, the time limited group treatment is:

1. a source of immediate support where the knowledge that the meeting will take place every week provides a safety net in itself;
2. a place to recognize shared experiences and the value to be derived from these;
3. a way of breaking down isolation and loneliness;
4. the source of a different perspective on personal problems;
5. a place to experience power over personal situations with the capacity to change and have an effect on these;
6. a source of friendship. (Sprei, 1987).

Through the nurturing, supporting stance of the therapist combined with exercises, focused discussion, and homework assignments, the group members begin the process of growth and healing. In a brief period of time, the therapist shares with the group members

the pain of recalling the abuse, the strength of surviving and the joy of growing and connecting with other women (Courtois, 1988).

In Sprei's (1987) experience, the group helps members to:

1. break down the isolation and enable women to share their experiences, by facilitating friendships between women through relaxation, discussion and activity;
2. build self-confidence and self-esteem by offering women structures that they can take hold of, to develop their own potential;
3. increase self-awareness and help women to understand and appreciate their bodies; and provide practical strategies and solutions to alleviate stress and its physical manifestations;
4. support women through any transition period from one stage in a therapeutic relationship to the next.

2.6 Role of the Therapist

The therapist function in a variety of different roles in a group: as process facilitator, participant observer, educator, female and parental role model, and limit-setter. Their major task is to be a group facilitator, and to create a safe enough environment for group members to explore relationships among themselves and with the therapist (Courtois, 1988).

The therapists are available as supportive persons who help the members to explore their experience, to express what was impossible to express in childhood and is impossible to express alone now (Miller, 1984). The therapists assist the survivors in identifying and reclaiming their personal power, as well as those parts of themselves which were undeveloped or distorted because of the trauma.

The intensity of the group process and emotional content places great demands on the therapist. A co-therapist allows for mutual therapist support and shared observation and processing of group interaction patterns and issues. It has the potential for limiting the intensity of transference, particularly the idealization of the therapist. Additionally, formal supervision and/or the support of a co-therapist is advisable to assist leaders in

analyzing and maintaining control of group process and in identifying and ventilating their own emotions.

Finally, the therapists serve as role models and educators. Not only must they be models of understanding, patience, emotional sensitivity, and of fair, unbiased authority; but they must also be models for performance of parenting and other social roles (Leehan & Wilson, 1985).

2.7 Treatment Principles

Most papers and texts on the treatment of childhood trauma emphasize the need for adequate emotional discharge, whether the trauma be war experiences (Williams, 1980) or abuse (Burgess & Holmstrom, 1979). It is now recognized that, although trauma often brings with it a tendency to avoid any feelings or events that might remind the survivor of her experience (Horowitz, 1976), release of emotion is nevertheless a necessary condition for full recovery. Because repressed emotions are often quite powerful, and given that the survivor equates feeling with (in some sense) no survival, the former abuse victim may actually believe that emotional release is dangerous. The therapists must obviously approach the necessary task of feeling with care. One must convey and believe that all emotions are good in that emotional expression is understood as a positive thing. This holds for what Blake-White and Kline (1985) refer to as "surface emotions" (anger and sadness) and the stronger emotions of terror, despair, abandonment, fear of pain and the fear of being totally alone and overwhelmed and rage as described by Anderson (1986).

As described before, group therapy has certain advantages over individual therapy (Johnson, 1985). Most research (Sprei & Courtois, 1987) in this area specifically stresses the benefits of decreased isolation and stigmatization, reduced shame, the development of interpersonal trust, and identification with a supportive network of other similar survivors of childhood sexual abuse. Additionally, participation in such groups offers the survivor the opportunity to help as well as to be helped - a process that supports self-esteem and lessens the sense of being a deviant and passive recipient of treatment. It provides its members with the experience of a safe, supportive, and consistent environment in which to

develop trust in others. Many survivors come to view the group as a new family in which they are reparented and help to reparent others (Courtois & Watts, 1982).

Quite commonly, survivors have sealed off their emotions and trained themselves to operate strictly on a rational basis (Herman, 1987). The therapy challenges this split. With consistent encouragement and support for the exploration of both conscious and unconscious material, the survivor learns to recognize and label her feelings. Survivors of abuse, like children from other types of dysfunctional families, grow up with misinformation or a lack of information about various life tasks and skills (Finkelhor, 1986). They have missed the normal learning experiences of healthy family life. The therapist may need to function as an educator in teaching such basic life skills and information as communication, decision-making, conflict resolution, friendship, intimacy, sexuality, parenting, and boundary-setting (Miller, 1984). In particular, this applies to education about incest and any other major family problem, such as alcoholism. Group therapy allows the members to explore issues of interest to them; as well as the opportunity to learn and to explore common feelings and experiences.

As the therapy progresses by stages to the discussion of the abuse, the survivor begins to explore warded-off unconscious material about her childhood sexual abuse, material that she had to repress to survive (Courtois & Watts, 1982). This exploration allows access to the constructs she developed about herself, her ability to direct and control her life, and her relations with others. Gradually, the survivor determines who she is apart from her family and her abuse experience, and makes changes in her behavior as conditioned by fear, anxiety, and guilt to those determined by what she wants and feels. She is more free to reclaim those lost or undeveloped parts of herself. She works to resolve conditioned fear and phobias, challenges her learned helplessness, learns new roles and new ways of relating, and develops an acceptance of her body and sexuality. This process includes the ability to practice new ways of relating and behaving, including being able to experiment with adult behaviors rather than relying on past parent/child interactions, dependency and manipulation (Wooly & Vigilanti, 1984).

Chapter III

Intervention

3.1 Overview

The consequences of incest are compounded by its occurrence within the family, sometimes in the context or under the guise of love and affection. A pattern of secrecy, rivalry, guilt, and power is maintained by family members and because the disclosure of the incest is so disruptive to family functioning, the victim is under intense pressure to remain silent (Finkelhor, 1986). Moreover, "because the betrayal of sexual misuse is often embedded within the broad context of a caring relationship, the victim may be left with both tender and negative feelings towards the perpetrator and with guilt and self-doubt" (Courtois, 1984). The long-term effects of incest exacerbated by the denial, secrecy and shame surrounding its occurrence, are pervasive (Sprei & Courtois, 1987). Peters (1976) compares the after effects to "psychological time bombs" that, with acute stress responses precipitated by other types of intense trauma, may be set off without warning.

Meiselman (1978) notes that the personal and professional experiences of therapists working with survivors of childhood sexual abuse have shown that women brought together can offer each other support, validation and strength, a growing sense of personal awareness, and mutual learning to take power for themselves and use their energy positively. Despite the range of women's negative self-perceptions, there is an expressed wish for change in self, in life style, and in the circumstances surrounding this. Women taking power means that time is often spent in deliberating about the old order and engaging in the excitement, but also the apprehension, of the new (Courtois, 1979). Sprei (1987) believes that group treatment has many benefits that give the victim a sense of identification. In the group, members come to realize that they share similar problems regarding self-esteem, guilt, self-destructive behavioral patterns, control, intimacy, and sexual functioning. The members are able to internalize and recognize the abuse as the cause of those problems. The diversity among women is a positive asset, enriching and challenging to such an extent that horizons are widened and women's relations with each other become a force for change.

The group provides scope for re-evaluation, with change emerging out of collective and individual action. During the group sessions the clients were helped to understand the nature of abuse against children and the personal and emotional impact upon women. They will be enabled to understand, emotionally, their own needs and to explore the neglected emotional aspects of themselves due to the childhood sexual abuse. They were allowed to focus on their own victimization and mourning experiences as survivors (Sprei & Courtois, 1987).

The group will encourage the women to express their pain, fear, ambivalence and isolation as well as to be able to understand their emotional reactions, and to gain a sense of mastery about what to do and how to have control over their own vulnerabilities (Courtois & Watts, 1982).

3.2 Goals

Goals for the short-term group include acknowledging the abuse, reattributing responsibility for the abuse, recognizing, labeling, and expressing such emotions as guilt, shame, anger, fear, and grief, gaining knowledge about incest and family dynamics, breaking feelings of isolation, gaining insight, making behavioral changes, and deciding on a future course of action.

Another goal for the short-term group was that by re-working her emotions the survivor will decrease the level of her depression, increase her social skills and restore the sense of power that will allow her to make changes in her life and environment.

3.3 Time Limited Retrospective Model

Most survivors have developed hypersensitivity to their environments and the people in them (Brown & Finkelhor, 1986). For many, the experience of their abuse has been like a menacing hand reaching for them out of nowhere. Consequently, their guard is up. The purpose of establishing a structured format in the weekly meeting is to provide enough consistency and predictability that members may be able to lower their guard, and thus derive full benefit from their activities (Sprei & Courtois, 1987).

Sprei (1987) suggests that a group meeting should begin with an opening round or check in, in which each member takes a minute or two to describe how she is feeling and to relate major events that occurred during the week.

Immediately following the opening round, the therapist asks whether there is any left-over business from previous sessions. This gives members an opportunity to clear up any misunderstandings, hurt or angry feelings, fears, or concerns that may have arisen from the previous session. It also provides a safe environment to practice good communication skills.

Problem solving or education comes next. Education, or exploring common themes is accomplished through either a mini-lecture, group discussion or exercises.

The next stage of the group work involves expressing appreciation to other group members.

The session ends with a closing round, with each member making a simple statement of how she feels.

Obviously, if a member is in severe distress, the group might readily agree to continue for another 15 minutes, or the member might speak with the therapist immediately after the group session ends.

3.4 Group Program

Following is a detailed outline of each of the 12 groups.

Week	Theme	Objectives	Activities
1	Group Purposed Expectations	To introduce members To develop group rules	Introduction Clarification of group purpose Introduce concepts: trust, talk and feel
2	Boundaries	To increase knowledge of c. s. a, the concept of boundary, and the process of healing	Handout: Ways to Reduce Anxiety Self-care

Week	Theme	Objectives	Activities
3	Why C.S.A	To reduce guilt & self-blame To raise awareness of c. s. a as a "social problem"	Introduce concept: feeling/ thinking Ways child understands & rationalizes abuse Handout: Myths
4	Survival Skills	To describe adaptive behavior as survival skills To discuss concept of chemical dependency To alleviate guilt by redefining coping mechanisms as survival skills To discuss cost/benefits of their adaptive behaviors	Ways you've survived Examination of costs & benefits (writing assignments) Discussion & sharing
5	Speaking Out	To provide an opportunity to begin to share the experience of abuse To lessen isolation To enable provision of support To lessen feelings of shame, guilt & self-blame	Exercise: write a letter to someone who has hurt you Sharing/discuss Homework handout: The Little Girl Within
6	"The Little Girl Within"	To facilitate resolution of personal trauma To promote personal growth through getting in touch with the "child within"	Exercise to focus on c. s. a: Write about a significant event in your life Sharing of writing and discussion Homework handout: Shame & Guilt
7	Shame/Guilt	To identify and connect with feelings of guilt and shame To enable the resolution of personal trauma To begin to process shame feelings	Introduce concepts shame/ guilt Handout: Shame and signal that shame exists Draw feelings - exercise Sharing and discussion of drawing

Week	Theme	Objectives	Activities
8	Anger	To identify what they have learned about anger To explore societal context of difficulties women experience with anger To identify connections between anger, shame and fear	What we have learned about anger from our families and society (discussion) Introduction of anger - lecture Exercise: anger script Sharing and discussion
9	Grief	To identify and understand feelings of grief To provide information about process of grief and its connection to addiction and c. s. a. To connect with feelings of loss	Introduce concept of grief Review stages of grief Connect grief to process of recovery from addiction and c. s. a. Exercise: Write a letter about the loss Sharing and discussion
10	Self-Awareness	To focus on self-awareness To identify the "masks" they wear To promote sharing of self with other members of group To make choices about the self they present to others To begin to define self To identify components of "self" To promote sharing of self with other group members	Concept of self-awareness: Who am I? Costs/benefits of masks Read handout on masks Exercise: Introduction/ definition of "self" Collage exercise to represent aspects of self Sharing/feedback Homework: Who Am I?
11	Relationships	To explore relationships with regards to women's role To identify familial influences in relationship patterns To explore ways to change current relationships To address the termination	Abusive relationships in adulthood Exercise: Complete relationship history Healthy relationships Discussion/sharing Group to decide the activity for termination

Week	Theme	Objectives	Activities
12	Saying Good-bye	To offer a formal closure to the members To provide recognition to the group for its commitment	Wrap-up about the sessions Group activity

3.5 Group Structure & Organization

The time limited group for adult incest survivors met for 12 two-hour sessions for 12 consecutive weeks. It was a closed rather than a drop-in group to enhance the development of cohesiveness and trust. The group started with nine women.

Two female co-leaders conducted the sessions. The format of the group was for the most part structured, and outside readings, homework, assignments, and exercises were used where appropriate. Upon termination members were invited to attend or join a local chapter of a self-support network organized by participants in previous groups.

This group proceeded according to a predetermined plan, where each session had a specific focus, and in some cases specific exercises. Early sessions focused on introductions, description of ground rules, didactic information on sexual abuse (both orally presented and in the form of reading lists or handouts) disclosure of molestation, and the development of group cohesion and identity. Middle sessions were devoted to extensive discussions of individual group members' childhood sexual abuse experiences, with support and feedback from other members and the group leaders, and final sessions worked to develop a sense of closure of the experience, including the work of termination.

Although open groups have several positive attributes, some survivors are unsettled by the shifting membership of such groups (Goodman & Nowak, 1985). Nevertheless, they are less subject to structure regarding the appropriate content of any given session. The topics of each meeting are more typically determined by the participants, given the overriding assumption that the general context will still be members' survival experiences.

3.6 Clients and Selection Criteria

The recruitment of group members was through referral of clients by the host agency. The selection criteria for group members required women who were survivors of childhood sexual abuse, had had treatment for addiction, were at least 18 years old, and were or had participated in individual therapy related to the sequelae of abuse.

All referrals were screened as possible candidates for the group using the following criteria: members should not be a) either chronically unstable or currently in crisis; b) currently abusing drugs or alcohol; c) psychotic or; d) suicidal. Briere (1989) suggests that these factors need to be considered since they are problematic to the functioning of a group. The purpose for this criteria for group entry was to provide guidelines for suitability to the group and to achieve some sort of appropriate homogeneity.

It was hoped that the members could continue their individual therapy or have access to their therapists as needed throughout the sessions. The women were initially informed that the group would have two facilitators, with one of them a staff member who had led several groups at the agency, and the other a Master's student at the University of Manitoba. All the members were interviewed individually prior to the group sessions to determine their appropriateness for the upcoming group experience. Expectations for work in the group were stated and all members were encouraged to attend all the sessions. A consent form for recording sessions was given to each member. It was requested that members maintain confidentiality of other group members' identity and issues disclosed by members.

Client #1

This client is 39 years old. She is married and she does not have children. She was sexually abused between the ages of three and eight by her two older brothers. During that time she was emotionally and physically neglected by her parents. She has worked for 20 years in the same company. She drank heavily for over 20 years but; she has been sober for over two years.

Client #2

This client is 41 years old. She is married, has two children and works. During her 15 years of marriage, she has been separated twice; but after marriage counseling their

relationship improved and her husband is very supportive. She was sexually abused by her father from the time she was four-years-old and also by her oldest brother between the ages of 12 to 18 years. She was raped by a classmate at the age of 16 when she was in high school. She also was sexually abused by a doctor who was her specialist.

Client #3

This client is 23 years old, single and has no children. Her abuse history began at age 11 when she was sexually abused by her brother who was one year older than she was, and she also was sexually assaulted by her uncle who was three years older than she. At that time her mother lost her common law husband from cancer. She did not want to tell her about the abuse so as not to cause her more problems. She remembers being abandoned and neglected.

Client #4

This client is single and presently working. She was sexually abused from age 9 to age 16 by her step-father. Her mother was working everyday, and he was taking care of her. This client has been sober for about three years.

Client #5

This client is 31 years old. She has been in a common-in-law relationship for a period of two years. She is a survivor of child sexual abuse and satanic ritual abuse. Her father was an active Satanist, and he abused her sexually since she was a baby. Starting around age 14 she was involved in drugs, namely heroine and cocaine. She was raped numerous times before she was 16 years old. She became a prostitute in order to support her drug addiction. She has been involved for three years in special treatment at St. Boniface General Hospital because of her addiction to methadone.

Client #6

This client is 35 years old. She is single and she attends college. Her abuse history began when she was sexually assaulted by her older brother. Later abuse included repeated sexual assault by her uncles. She was involved in drugs, mainly hashish. She attempted suicide a couple of times between the ages of 15 and 16. She is attending Alcoholics Anonymous twice per week, and she has been sober for three months.

Client #7

This client is 40 years old. She is divorced and has a seven-year-old child. She was sexually abused by her father at age five. She attempted suicide once. She was an alcoholic for many years; but she has been sober for five years.

Client #8

This client is 40 years old. She is married and she does not have children. She was abused by her brothers. She attempted suicide three years ago. She has been involved with A. A. and has been sober for three years.

Client #9

This client is 26 years old, single and has no children. This client did not want to talk about her abuse when she was screened. This is the only information that she provided.

3.8 Setting

The service was provided at Women's Post Treatment Centre, which has offered direct service to survivors of childhood sexual abuse since 1985. It had a permanent staff of a part-time Executive Director, 3 1/4 professional counseling positions and an administrative assistant. The agency is an independent voluntary sector organization governed by a board of directors.

The funding for the Women's Post Treatment Centre came from a variety of sources. Approximately 26% came from the Manitoba Department of Family Services, 29% from the Manitoba Department of Health through the Addiction Foundation of Manitoba. As well, the United Way contributed 15% of the core funding. The remaining was raised from donations and one-timed grants.

The agency is working with survivors of childhood sexual abuse in individual, couple and group therapy. Centre staff were willing to support the student to work in a time-limited group therapy. Marlene Richert, a social worker and therapist became the co-facilitator. She has several years of experience in this area and provided a great deal of assistance and direction in each group session. The physical arrangement of the room was

very comfortable for group work. The large room had adequate lighting and soft, comfortable cushions on the floor arranged in a circle around the room.

3.9 Demographic Characteristics

A total of nine women who had experienced childhood sexual abuse were involved in the group. The demographic data included:

- the age range was from twenty-three to forty-one years.
- the median was thirty-two years.
- the mean was thirty-three years.
- the standard deviation was 6.86 years.
- all the women had at least a high school diploma.
- only two women had children.
- one woman was Aboriginal, and the others were Caucasian.

3.10 Descriptions of Group Sessions

Session 1: Group Purpose and Expectations

The purposes of the session were as follows:

- To offer the members and the facilitators the opportunity to get to know each other.
- To introduce the purpose, content and process of the group.
- To provide to the group members a safe and supportive environment.
- To set the group rules.

Activities

The main activities of the session were:

- Introduction of the members and facilitators.
- Presentation of the format, guidelines and group structure.
- Brainstorming with regard to group rules.
- Discussion about member's feelings, and expectations.

Summary

This first session was attended by all nine group members. The purpose of this session was for the members to get to know each other and the facilitators. The group was divided into pairs, and each person had to introduce herself to each other providing some personal information (where they live, family composition, kind of work, hobbies). Some expressed the need to meet other survivors and learn from them how they coped with the abuse. One member wanted to know how to set boundaries and to become more assertive. Another member stated her hope to go beyond her negative memories and feelings towards her family. In general, the group wanted to connect with women who had similar experiences to theirs and hear their stories. The facilitators provided the members with information about the group structure (time, number of sessions, outline of themes and purpose). Some members raised an issue about coming a little bit late because they work. The facilitators accepted this situation. The facilitators described the purpose of the group as providing the opportunity for support, education, exploration and disclosure of feelings related to the abusive experience. They emphasized the importance of establishing rules for the safety and well-being of the group members. They led the discussion; but the members created their own rules, e.g. open-mindedness, respect for others, not being judgmental, informing the facilitators about their absenteeism, not being forced to talk, sharing time equally, no drugs or alcohol during the interventions, being allowed to cry. This was designed to enhance mutual support among the members and to give them a sense of belonging and safety. The members were reminded that the facilitators were there to share information and answer questions; but it was also expected that they share with each other. In this session one of the members was encouraged by the student to share with the members of the group her disability. She has a hearing loss. She explained to the members that she does not wear hearing aids when she gets anxious because they block off. She informed the members that she can read lips. Special arrangements were made by the facilitators and members of the group for her to sit in a strategic place where she could face everyone in the room. The facilitators felt that it helped her to have a sense of empowerment and self-confidence. The facilitators explained that there could be high anxiety levels and stress expressed in the form of

flashbacks and memories, since sensitive and unexpected issues could emerge. This was addressed in this session to make it more comfortable for each member to talk. It was explained by the student that she will do some teaching as part of the intervention. The facilitators told the members that they would be provided with sufficient time for spontaneous sharing. In spite of the fact that it was the first session, some group members were highly involved and engaged in a good deal of personal disclosure that gave them the opportunity to feel emotionally connected. The session wrapped up with each member stating how she felt about the work done. In general, at closure, all members appeared to have enjoyed the group.

Session 2: Boundaries

The purposes of the second session were as follows:

- To encourage the development of group trust and cohesion.
- To redefine abuse as "boundary violation".
- To help the members to cope with their own experiences of being abused.

Activities

The main activities of the session were:

- Boundary exercise.
- Discussion of feelings about the experience of boundary violation.
- Homework assignment: to do something good for themselves.

Summary

Client 9 was absent, and she did not call to notify that she was not coming. The facilitators began the group with a check-in time to give each member the opportunity to express how she was feeling and/or how her week had been. The session for the day was introduced by the facilitators and the exercise about boundaries was explained. The exercise consisted of dividing the group into pairs. The women faced each other and were seated on the floor. One person was A, and the other was B. Instructions were given for each to draw, using chalk, a circle around themselves. This circle represented each person's personal boundary. The facilitator asked the B's to cross A's boundary, putting

both circles together. Afterwards, they were asked to separate again, but the B's had to cross A's boundaries, either by putting their hands or feet inside A's circle. A's and B's were then asked to erase their circles (no boundaries), and at the end both of them were asked to draw their circles again. Afterwards, A had to do the same to B. Moments of silence were given for reflection at each step of the exercise. The members were asked: How does it feel to have your own boundaries? How does it feel to be invaded? These questions led to a discussion about their feelings. The members had a difficult time when their boundaries were erased and crossed. They felt invaded, damaged and violated. As soon as their boundary was crossed they felt different, angry, fearful, and sick. Their feelings varied when their own boundary was maintained. They felt protected and in control. The person who crossed the other's boundary felt powerful. The facilitators then provided the group with information about boundaries. The presentation focused on the idea that boundaries help us to be able to differentiate between our needs and the needs of others, to know where our rights end and someone else's begin, to communicate effectively and to negotiate effectively by relating with others, asking questions, expressing our emotions, recognizing our feelings, understanding others, and developing positive relationships.

Facilitators explained how abused children lose a sense of themselves as distinct, separate people. They feel invaded and they are invaded. Therefore, they lose the means to know themselves. Some members expressed their powerlessness about stopping or not having disclosed their abuse. The facilitators comforted and validated the members' feelings, and stressed that the sexual abuse happened because the offender invaded their boundaries from a position of power over them. This exercise helped the members to begin to be more verbal about their abuse and their healing as part of the process of the sessions, as well as to minimize the blame they felt about their sexual abuse.

Client 6 did not want to work in pairs. The facilitators emphasized that working as a team was part of the therapeutic process, and gently they encouraged her to participate. The facilitators reframed the issue of setting boundaries and validated the member's feelings by re-stating how difficult it is to implement boundaries and to trust others after our boundaries have been violated. Client 8 appeared withdrawn and preoccupied. The

facilitators spoke with her after the session. She recognized feelings of confusion and loneliness that she was experiencing, possibly because of her participation in the group. The facilitators encouraged her to see her therapist to provide some stability during the week. One of the facilitators planned to discuss this situation with this member's therapist.

The exercise used in this session appeared to increase the level of cohesion and identity among group members.

Session 3: Child Sexual Abuse - Why It Happens

The purposes of the session were as follows:

- To assist the members to develop an understanding of child sexual abuse.
- To reduce the feelings of guilt and self-blame.
- To provide the opportunity to explore and release feelings.

Activities

The main activities of the session were:

- Brainstorming with regard to the definition of child sexual abuse.
- Explanation of myths and family dynamics related to sexual abuse.
- Exploration of the distortion of reality and the stereotyping of women in the media.
- Passing out of pictures from magazines to explore the distortion of gender by the media.

Summary

Eight of nine members attended this session. The facilitators were informed by her therapist client 8, who had been withdrawn last session found her emotions very difficult to handle and chose to withdraw. She has been drinking heavily and has had suicidal thoughts.

Looking at this member's decision to withdraw, the student felt that it was possible that she may have experienced some tension in the group; and that her traumatic childhood experiences surfaced, creating in her emotional discomfort, pain and suicidal ideation. The members were reminded about the possibility of having flashbacks, stress

and maybe fear as a result of the discussions. Ways of dealing with flashbacks were suggested. Some of these ways were relaxation techniques, nurturing themselves, exercising, and directing their feelings towards the perpetrator(s).

The facilitators began the group with the check-in. Client 9 reported that she was attending another group, and that she was learning the same and possibly better things in that group. She even stated that the facilitators were more knowledgeable. The facilitators gave her the option to decide which group she would like to attend. They were supported by some members who questioned her about her role in their group. There had been some tension in the group caused by client 6's interventions and constant interruptions with discussions irrelevant to the agenda. The facilitators felt that it was a situation of power struggle, confrontation and attention seeking. The facilitators noted some discomfort among group members and recognized the need to place more effort into building the level of safety and comfort within the group by reviewing with the members the group structure, the issue of boundaries, and the rules of the group, especially those about equal time for sharing.

The facilitators initiated the presentation by brainstorming with the group about sexual abuse and why it happens. In discussing the issue, the members suggested a number of reasons: poor communication within the family, lack of identification of what was happening as abuse, use of alcohol in the family, parental neglect, lack of support. The facilitators provided five definitions of sexual abuse (Finkelhor, 1982):

- intercourse - simulated or attempted.
- any genital fondling.
- exhibitionist displays of genitals by an older person.
- any instance of kissing or hugging in a sexual manner.
- overt and frightening overtures to young children.

Some members were surprised with this definition because they thought that sexual abuse only happened if intercourse was involved. The facilitators explored with the members the male and female role models to which they were exposed. It was explained to them that according to research studies (Finkelhor, 1986), abuse is a behavior of the strong against the weak and the abusers are usually males in authority positions who direct

the abuse against powerless children. The members came to the conclusion that the abuser used power to control and manipulate the survivor's perceptions of reality, making them believe that they (survivors) had provoked the abuse or that they deserved it.

Through the pictures from the magazines, the facilitators explained how women are victimized, abused and exploited with regard to masculine ideals in our society, and how the media promote the male role as one of power and control. In addition to this, some members pointed out that the media promote the sexualization of women and children. Some of the similarities in the portrayal of gender in the media and in the forms of abuse in the family of origin were discussed. These included the fact that family abuse is the abuse of power exercised against women who are dominated and oppressed by men, the relationship being based on fear, control and the devaluation of the women because of their gender. It was also important to comment that sexual abuse is a social problem because of the intense suffering and sometimes destructive long-term effects that result from it.

Some members disclosed their sexual abuse experiences. Client 5 mentioned her experiences of intra-familial satanic ritual abuse. Although most of them struggled with disclosure around some details surrounding their abuse, the members tried to focus and address many aspects of their victimization and the impact it had on themselves and their families. The members had a difficult time recognizing that they were not responsible for the abuse, but the facilitators helped them to recognize and understand the family dynamics and family dysfunction implicated.

During this session the members recognized that their childhood experiences were extremely painful. Client 4 expressed that telling her story helped her to relate her abuse with the abuse experienced by other survivors. Some members found that it was difficult for them to listen to the impact of the abuse in the lives of others; but they also agreed that it was a valuable opportunity to learn that they have had similar experiences.

It was apparent to the student that in this session the information brought to the members helped them to understand the family dynamics related to sexual abuse; as well as to reduce the feelings of self-blame.

Session 4: Survival Skills

The purpose of the session was to identify adaptive behaviors and coping mechanisms as survival skills.

Activities

The main activities of the session were:

- Brainstorming of coping mechanisms to survive.
- Examining the costs and the benefits of various coping mechanisms.
- Handing out information about coping mechanisms, abuse and addictions.

Summary

Client 9 did not come to this session, and her therapist informed the facilitators that she was attending another group. The group was informed about this. They did not show any concern, and neither did the facilitators because in previous sessions she had mentioned this. The facilitators opened the session with a discussion about coping mechanisms that members had used to deal with the pain of their abuse. A list of coping mechanisms or ways to survive was solicited from the members and was written on the flip-chart. Some of these mechanisms were: drinking, utilizing drugs, creating other personalities, isolation, hurting others, attempting to be the best, attempting to control everything, and compulsively eating.

Each member gave an example of her own coping mechanisms. Throughout the presentation there was the understanding of how certain coping mechanisms are less effective than others, and how some of them can lead to socially inappropriate behavior, permanent withdrawal or self-deception. At this point, client 5 disclosed that for a couple of years she used a great deal of intravenous drugs, such as heroine and cocaine, that she has been under the methadone program for about three-and-a-half years, and that she had tried to overdose a couple of times. She expressed that now for the first time she is having a positive relationship with a man who has given her comfort and support. Client 2 mentioned that she also was an alcoholic, that she has been sober for two years and that she is active in Alcoholics Anonymous, which she considers essential to her sobriety. Client 6 stated that she was involved in dangerous relationships and how she became

addicted to sex and alcohol. Self-mutilation was one of the ways that client 5 used as a way to deal with the emotional pain.

Other healthy ways and coping behaviors were mentioned such as: taking long walks, working, going to school, and talking about their feelings. The facilitators reassured the members that all the behaviors that they mentioned were ways of coping to survive the trauma of being sexually abused. Other coping mechanisms were explained to the members, including: minimizing, denying, forgetting, splitting, addiction and isolation. The levels of disclosure from the participants were quite detailed. Some of them struggled with disclosures around the coping mechanisms, and they felt overwhelmed with the experiences.

The facilitators acknowledged the members and honored the ways they had used as part of their survival. They also congratulated them for their strength and satisfactory changes in their lives. However, they were reminded again about the healthy and destructive aspects of coping and how important it is to differentiate the healthy ones in order to heal. At closure, the facilitators gave advice to the members to reduce the impact of stress, e.g. to change their environments, to change their lives by getting involved in positive activities, and to find more positive ways for coping.

Session 5: Speaking Out

The purpose of the session was to provide to the members the opportunity to explore, share and release their feelings about their childhood sexual abuse.

Activities

The main activities of the session were:

- To utilize an exercise: Writing a letter expressing how the abuser has hurt you.
- To provide a letter as an example.
- To circulate homework: The Little Girl Within - adult-self/child-self.

Summary

This session was intended to encourage the members of the group to explore their own experiences of childhood sexual abuse. After giving the instructions for the exercise

(writing a letter to the abuser), the facilitators left the room to allow the members to have some privacy. The time given to complete the exercise was approximately 15 minutes. In the exercise they had to include what happened, how they felt, how that experience has affected them, and what they would have liked to have done; but were unable to do. In this session some members identified and discussed problems related to their present situation and the abuse. The facilitators made time available for the members to read and share what they could in order to feel comfortable. The facilitators assisted them to get in touch with their feelings by providing and reading a letter as an example. Clients 4 and 5 chose to share their letters. They expressed that although it was very painful for them to bring forward their past, the exercise helped them to have some relief and let the pain go away. Even though the other members could not share their letters because of the interference of painful feelings, they began to disclose some emotions linked with their past and present situations.

Client 7 stated that she did not do the exercise because she did not want to bring back the emotional pain from the past. She also informed the group that she is trying to settle the custody of her son. She wants to get him back. She reported that she never had received any support from her family. She stated that before she thought suicide was the only solution for her problems. Her husband used this against her to obtain the custody of her son. Since her son left three years ago, she feels she has been living in total isolation. Her family supported by affidavit that her husband should have her son. She feels that her family abused her in the past and continues this in the present.

Client 2 indicated that she was sexually and emotionally abused by her father and brother. The family always rejected her and considered her incapable of doing anything right. She commented on how much she hated her father and her brother, and how much pain they had caused to her, especially when she got very sick and was taken to the hospital. Later she knew that she was pregnant from one of them, and that she had had a miscarriage.

Client 1 stated that she was physically, emotionally and sexually abused by her two brothers. Her parents had a "mentally retarded" child. This placed them in a stressful emotional state. They were always fighting. She always felt unsafe. When she became

aware of the sexual abuse she started drinking. It helped her to "numb-out" the pain and the effects of what happened.

Client 3 revealed that her abuse started when she was between eleven and twelve years old. It happened after her mother had lost her common law spouse from cancer. She (the mother) had a lot of troubles herself. This member felt that she could not be around her family. She is going to another province, to move away from them because she cannot handle it anymore.

Client 4 described the role of her mother as a caregiver. She did not have time for her. She never showed affection, talked to her or gave her any advice. It is very hard for her as a survivor to understand and concentrate on what happened.

Client 6 interrupted many times. She provided information about a book that she had read, and the things that she had learned. She appears to be continuously trying to take over the leadership, shifting from one topic to another. This appears to be a coping mechanism in that survivors sometimes may attempt maintain control over others by creating chaos and forcing people around them to respond to their problems. In this way they obtain attention, even though it can be negative (Bass & Davis, 1988). The student kindly got her attention and reminded her about the topic for the session. At break time client 2 approached the facilitators to express her concerns and frustration towards the disruptive member. The facilitators reassured her that they were going to meet with that member to talk to her about the concerns.

The members expressed how difficult and painful the exercise of writing the letter to the perpetrator had been for them. In general they agreed that it was a good opportunity. It helped them to write in some detail how their abuse made them feel. However, client 7 presented as uneasy and anxious. She closed her eyes and later asked for a break. She was allowed to leave the room. The facilitators were very sensitive towards the feelings expressed by the members. They also reassured them of the importance of disclosure and pointed out that the members themselves were not the responsible ones for their sexual abuse. The facilitators comforted the members, explaining that the offenders have to take the responsibility for the sexual abuse.

At the end the members acknowledged that the letter brought back a lot of bad memories; but they felt good to know that they had many commonalties through sharing the same anger, shame and guilt. They were overwhelmed with the disclosure. The group was very positive. The members offered support, care and empathy for each other. The facilitators met with client 6 and tactfully informed her about the feelings expressed by client 2. The facilitators made her aware of her interruptions and sometimes inappropriate comments not relevant to the theme of discussion in the group. The member apologized and expressed that she believed it was important for her to share with the group what she had learned through books and personal experiences. The facilitators validated the member because of her interest in sharing. However, they reminded her about the group rules, to focus on the agenda and to limit the time she utilizes, to be able to accommodate equal participation by other members. The member expressed her understanding and her willingness to cooperate.

Session 6: The Inner Child

The purpose of this session was to enable the resolution of personal trauma, fear and confusion by getting in touch with the inner child or real self.

Activities

The activities utilized in the session included:

- Writing a letter to the inner child.
- Sharing, discussion and exploration of feelings
- Handout homework: shame and guilt for members to read prior to the next session.

Summary

Client 6 with whom the facilitators met last week was absent at this session. The facilitators considered the possibility of her being disappointed because of their intervention. The facilitators addressed the attention of the group to her absence. They informed the members about the concerns regarding the absentee member's interference and interruptions in the sessions. This was to explore their feelings and concerns about this member's participation in the group; as well as to reduce the risk of interference with the group process and safety. For the first time the members revealed their feelings

towards her. The members expressed that her attitude had affected the group process and the group's ability to focus on the purpose of the session. Client 7 expressed her sense of hopelessness and powerlessness with the role that the absentee member has created in the group. This discussion helped client 2 who complained, to feel better because she acknowledged that she was not the only one who had expressed those feelings towards this particular member. She commented to the group that they helped her to decrease her feeling of guilt, thinking that she had betrayed one of the rules of the group (no criticizing each other).

It was a general agreement that client 6 had taken away from many of the members the opportunity to receive a lot more of what they had received, regarding time for more information, sharing and participation. The members communicated in a direct and open way their concerns, feelings and personal opinions. The facilitators gave their appreciation to the members for their openness and verbalization of the problem. It was reassuring to members that this criticism could be used creatively to regain trust and for the safety of the group. The facilitators informed the members that they already had talked to the member about her attitude, and that she was reminded about the rules, the time frame and the focus of the sessions. The group recognized that the facilitators had tried their best in dealing with this situation; but still felt that the member in question does not understand or does not want to change her attitude. The facilitators felt that they had provided the members the opportunity to debrief and address any issues regarding the prior sessions. After the identification of these issues, the group had a great time of self-disclosure and personal sharing of the letters they wrote to the offenders. Some members identified some reasons why they did not share. One of them was that they did not feel comfortable sharing in the presence of client 6 who was absent because she always tried to pretend that she was very knowledgeable. This indicated to the facilitators that some members did not trust her and felt threatened with her presence.

The facilitators complimented the members for their input. The members appreciated being asked for their opinions. The objective for this session was not accomplished. The members unanimously agreed that this session should be postponed for next week. In order to accommodate this decision there will be only one session about

anger, instead of two. The facilitators had agreed to bring all the readings regarding the second session about anger. Although the members had time to write the letter to the child within, they did not have time for sharing. The members will bring these letters for the next session where time will be allowed for sharing.

Perhaps the greatest success of this session was to see the sense of relief of the member who complained when she was supported by other members. It was evident that by sharing their feelings the group was more cohesive. As a result the facilitators felt the need to give to the members more responsibility for their group to help them to have a more effective relationship.

Session 7: Shame and Guilt

The purposes of the session was to enable the members to discuss, identify, differentiate and connect with feelings of shame and guilt that they experience.

Activities

The activities included were:

- Completion of the discussion about the letters written during the last session.
- Introduction of the concepts of shame and guilt.
- Review of definitions and brainstorming regarding signals that shame exists.
- Homework: Assignment of positive messages about yourself to let shame go away.
- Utilization of exercise using crayons to draw the feelings of shame and guilt.

Summary

The facilitators informed the group that client 4 could not attend because she had had an accident in her workplace and was wearing a cast. It was very difficult for her to come because of transportation. Client 2 very kindly offered to pick her up next time. The members showed their concern and their sensitivity towards the absent member. The facilitators were very impressed with the group's participation and interaction. It showed that the members were feeling safer, trusting and comforted. Nevertheless, the members seemed to be disappointed with client 3's announcement that she would be leaving the group to move to another province. Although the theme of the session was shame and

guilt, time was allowed to do a short review about the definition of the inner child or real self. How to get in touch with and nurture the inner child was discussed. Inner child refers to the part of us that is ultimately alive, energetic and creative. The members were given the opportunity to share the letters they wrote in the last session. During the sharing the members expressed that they had not realized that there was the possibility of having an inner child. The student shared with them that it was a new concept even for her. This allowed the student to have a collaborative relationship with the members and to facilitate an open discussion. Client 2 shared that not until she wrote the letter did she understand how hard she had worked to help her inner child to survive. Client 1 described the fear, the stress and the physical and emotional pain she had when she was able to understand how much that child had suffered. Some members felt frustrated and angry to know that they could not do anything to protect the inner child when their abuse occurred. To validate the feelings of the members the facilitators identified their strengths and encouraged them to speak out against child abuse; as well as to take care of the inner child they had discovered.

After this discussion the theme for the session was presented. The members were able to recognize the different feelings associated with shame and guilt. Their responses or survival skills to counteract shame and guilt were discussed among them: anxiety, rage and disassociation. Blushing, perspiring and sweating were identified by the members as signals that shame exists. The members drew a picture depicting with drawings the feeling of guilt and shame. Through coloring they represented these feelings in red and black. In accordance with the members, red represented shame and anger, and black represented pain and guilt.

They expressed how much they appreciated the opportunity they had to identify, to label and to be aware of these feelings. They concluded that knowing about shame and guilt would help them to:

- voice their opinions without fear.
- look and accept them as positive feelings.
- look at people's eyes without any embarrassment.
- help themselves to grow and to feel confident about themselves.

Client 6 was concerned about establishing a good relationship, and she wondered if she could find the right person in her life. At this point the facilitators asked the members if they could give her any advice. The members suggested to her to be patient, to be careful, to wait for the right person and overall to keep away from unhealthy and negative relationships.

Client 7 shared her experience about getting involved in a friendly relationship that she thought was what she needed; but after a while she was disappointed. This intervention from the members appeared to facilitate the breaking down of the barrier that has existed between client 6, who had created many interruptions, and the other members of the group. The members appeared to be interested, empathic and supportive even though before they did not give any attention to her interruptions. The facilitators discussed the need for sexual safety, protection to prevent sexual abuse, and very briefly they reinforced the need for appropriate boundaries and real affection. Client 6, in particular, demonstrated her gratitude to the members for being supportive. This attitude from the members helped her to get the affection and reassurance that she has been constantly seeking from them. The facilitators observed that the members felt good, safe and confident about their role in the group.

The exercise allowed the members to have fun while they were drawing. There was a lot of laughter, and it helped the members to connect and socialize with each other. Some members shared that in order to cover up their shame they used to drink, compulsively bathe to feel clean inside, and to take drugs. The facilitators used this opportunity to reinforce and clarify to the members that the responsibility for the sexual abuse belongs to the offenders and not to the survivors. Therefore, the offenders are the ones to be blamed and to feel ashamed of their actions.

Session 8: Anger

The purposes of the session were as follows:

- To assist the members to connect childhood experiences to adult difficulties dealing with anger.

- To identify connections between anger, shame and fear.

Activities

The activities for the session were:

- Discussion about healthy and negative responses to the violation of our rights.
- Brainstorming about messages women get about anger.

Summary

During the check-in the facilitators allowed time for client 4 to comment about the accident she had at her place of work.. The other members expressed their concern about the incident and very kindly helped her to catch up with the session she had missed.

Client 5 shared her situation and her concerns about her health. She disclosed that she has been sick for almost three months. Her skin was infected, almost out of control. She had been referred to a dermatologist. This situation affected her emotionally, physically and psychologically. She expressed that she had had a lot of problems with her emotions. She told the facilitators that she was pleased to be in the group today because she felt the need to be with the members and especially because of the topic about anger for her own interest. She said that she got overly angry and sometimes she blew matters out of proportion. She even shared that, in the past, she slapped a person in the face and, on another occasion, she hit a person with a telephone. The facilitators and group members listened attentively to her state of distress, frustration and anger.

Client 6 spoke of not being able to make three months of sobriety. The facilitators asked her if she had started drinking again. She expressed that she was too overwhelmed by all the emotions. The facilitators then asked the group members how they felt about this member's concerns. All members empathized with her and gave her some suggestions to stop drinking. They expressed the need for her to attempt to talk to somebody helpful., to pick up the telephone for help, to find a female sponsor, and to avoid going to places that can affect her negatively. The facilitators talked to her at the end of the session, suggested that she should meet with her therapist and reminded her about the group rules. Later, with the permission of the member, one of the facilitators raised this issue with her therapist. Client 6 also disclosed that her sister had been involved in prostitution and how much this embarrassed her. She also commented on how she beat her sister when she was

seventeen years old. The members appeared to be agitated and upset, possibly because they felt that this member was going to take too much of their time again. The facilitators validated the member's feelings; but they asked her to relax and to concentrate on the topic of the session. Client 4 said that she was very confused about her mother's attitudes towards her. After the accident happened her mother was very helpful in taking care of her. The member expressed that her mother was very possessive, and she always embarrassed her in front of other people. In the past the member was also self defensive; but now she had become a very tolerant person who did not get angry easily. Client 7 added that recognizing feelings helped us to take appropriate action and to solve our problems. In the past she used to be quiet when anybody challenged her; but now she has become assertive. She stated feeling the need to express her feelings. She also presented her frustration. She felt that her anger at her ex-husband had escalated, since he insisted on obtaining the custody of their child. She heard that he was laid off, and she felt sorry for him. She is so confused, and does not know if she would like to stop her battle for custody. She recognized that she had tried to remain calm. The other members acknowledged her sadness and discussed the lack of support women can experience from the justice system.

The work that some members have done to transform anger into positive effects was shared. They mentioned going to school, working, speaking out, and exercising. The facilitators used these disclosures to focus on the reality of survivors of childhood sexual abuse turning the anger against themselves, and they reviewed again the healthy ways of coping. The facilitators helped the members to recognize the violation of their physical and psychological integrity. The members understood that anger is a natural response to abuse. Current reactions toward others, misdirecting anger and other feelings associated with it were explored. The group members' participation in discussing their own experience dealing with anger reflected that the members had increased their level of comfort. The facilitators assisted the members to understand some of their past and present behaviors as a reaction to expressing their feelings related to their sexual abuse experiences. The facilitators also encouraged the group members to take care of

themselves and to convert the negative energy of anger into positive actions, such as walking, reading, and swimming.

Session 9: Grief

The purposes of this session were as follows:

- To explore, review and discuss the process of grieving.
- To promote the sharing of unresolved grief and the expression of feelings of loss.

Activities

The activities of this session were:

- Brainstorming about the concept of grieving.
- Reviewing the four stages of grieving outlined by Bowlby, (1980).
- Completing the exercise by writing a letter to someone caring about the loss.
- Providing the handout: "The Original Pain as Grief Work".
- Developing plans for the final session.

Summary

The facilitators explained the stages of grieving. It helped to promote a great deal of discussion and sharing. Client 6 brought up the incident of her friend being killed by a train just three days ago. She was having a hard time sleeping. She felt guilty and sad for the way he died. She was very worried because she could not concentrate on her studies. The facilitators handled this situation by asking the members about suggestions for her. The members were very supportive and encouraged her to make an effort to finish, to keep going on and not to give up.

The exercise aided the members to explore and write about what was destroyed, what was lost and things for which they needed to grieve. The following are the issues and feelings expressed by the members about their personal grieving:

- Resentment towards losing their childhood, their innocence and the destruction of their self-image.
- Remorse and pain because a part of them had died a long time ago.
- A lot of anger for everything that happened.

Some of the members discussed the loss of their parents, and with the help of the facilitators they identified the stages of their grieving. Client 5 expressed that she was getting worse with the skin infection and that her doctor did not want to prescribe for her any other medication since he knew that she was taking Methadone. She shared with sadness to the group members that her father committed suicide when she was twelve years old. She was mourning for years and she still has a lot of anger. Client 1 commented that she liked to come to the group. It helped her to feel good. Client 4, who had the accident, shared that she was invited to attend two A. A. meetings, and she found that there were some people who had a lot of sympathy about her accident. She manifested her feelings of something holding her back. She had not read the handouts and was getting furious over little things. She felt that the group has helped her to "air out" her personal grievances and pain. Client 7 member expressed her feelings of pain, emptiness and sadness when her mother died. Client 2 mentioned that her mother died when she was seventeen. There was a discussion about different kinds of loss and grieving in other cultures. The accident of one of the members was given as an example of loss: the loss of mobility, freedom and a job.

The exercise helped the group members to release their feelings and enhanced their ability to share the grief in a safe atmosphere. The members were encouraged to discuss and start planning for the final celebration.

Session 10: Self-awareness

The purposes of this session were as follows:

- To assist the members to explore the "Real Self" (who we really are) and the "Co-dependent Self" (learned behaviors to cope).
- To identify the "masks" that they have created to cover the Co-dependent Self.
- To facilitate the process for termination.

Activities

The following activities were included in the session:

- Discussion about self-awareness and feelings about the real self.

- Reading of handout about masks, and brainstorming.
- Participating in the exercise: drawing our masks.
- Initiating the homework reading, "Who Am I?"

Summary

Five members attended the group today. Client 5 informed the group members that she had attended two meetings at A. A. She was invited by client 4 of the group. She also provided information about a conference, and also about a support group at the Salvation Army Church. The members of the group expressed their appreciation for the information provided and the encouragement to continue to focus on their healing.

The connection between clients 4 and 5 reflected that the group had helped them to decrease their sense of isolation. It also showed that they had recognized their sense of worth and caring about themselves and others. This definitely was a good indicator that they had dedicated their efforts to finding other resources for healing.

Client 7 talked about her father who is terminally ill with brain cancer. This is a difficult time for her. She has been having confrontations with her sister who, like the other members of the family, is always telling her what to say or what to do. She feels invaded and controlled by her sister.

The article, "The Mask" was read in a loud voice with the participation of each member of the group. The article describes the masks that survivors wear to hide their feelings of confusion, fears and weaknesses. In order to allow for the expression of each member's experiences of feelings about their abuse, an exercise was planned. Each member had to draw her own mask, the one she thought helped her to hide the real self that was destroyed by the sexual abuse. Group members were left alone to do the exercise. The facilitators felt the need to provide them with the opportunity to share their thoughts and feelings openly among themselves. The building of mutual support could be enhanced this way. It was noted by the facilitators that the members were having a good interaction; joking and laughing. This showed that the group has turned to the point of a growing level of trust among the members themselves and among the members and the facilitators. The facilitators then encouraged the group to share the drawings of the masks. Through the exercise they became aware of the masks they wore. They

recognized that the masks helped them to pretend that they were strong and invulnerable. They also acknowledged that the masks never allowed the people to know who they really were. Client 1 stated that it is very important to allow people to look through the masks so they can help them. She was complimented by the group members for her beautiful and meaningful drawing. She represented the mask as a person in control; but also as a sexy, gorgeous, glamorous woman. She expressed that alcohol had taken away from her the skill to draw; but lately she has been regaining it. The exercise helped them to analyze the real self and the false self that covers up real feelings.

The session ended with the group making decisions for the celebration. One member offered her house and everybody was happy and showed their appreciation to her.

Session 11: Relationships

The purposes of this session were as follows:

- To explore feelings regarding women's roles and society's expectations.
- To identify healthy, positive, relationships.

Activities

The activities in the session included:

- Introduction of a concept of relationships and family influence.
- Brainstorming about family of origin and healthy relationships.
- Development of the plans for termination.

Summary

The facilitators informed the members that client 6 was absent again, and that she would not return to the group because she was not feeling well emotionally. This information was provided by her individual therapist. At the exploration of feelings about her departure, with the exception of two members, the members felt that she was very disruptive and always off topic. In general, they agreed that she was not ready for this group. They expressed feelings of hope for her future and sympathy for her present situation. The other two members manifested their understanding towards her and expressed their appreciation about her participation in the group and the effort she made

to integrate. The facilitators' assessment was that either she was not ready for the group or she may have felt isolated or rejected by the group. At the end of the session the facilitators met to debrief because they felt overwhelmed about this situation.

This session allowed the members to understand family dynamics and how they influence the way we relate to others. Issues of trust, intimacy, and controlling or being controlled in relationships were explored. Vulnerability to re-victimization in adult relationships was discussed. The emphasis in this session was about healthy and unhealthy relationships. The members described some of their relationship issues with partners, parents and family members. They recognized that there were some relationships that they had to cut off. Client 1 recognized that her relationship with her mother was very stressful and sometimes she experienced revicitimization. In this session, members dealt with feelings of abandonment and grieving a life of losses caused by friends and relatives that they had trusted.

The members were sorry that the absent member was not present due to the fact that relationships have been a major concern for her. Alternatives were given to the group to engage in other support groups, and some suggestions were given by the facilitators. The facilitators engaged other members in discussing their own experiences with men. The members of the group who were married expressed that they have supportive husbands. The facilitators addressed the importance of all women living in healthy and safe relationships. Characteristics of abusive relationships were discussed. There was a general degree of comfort that indicates the level of cohesion of the group. At closure, members were reminded that the next session would be the last. Termination would include a sharing of feelings about the time spent in the group. The members decided to have a potluck, and words of appreciation were given to the member who offered her house for the final day.

Session 12: Saying Good-bye!

The purposes of the final session were:

- To offer a formal closure to the group.

- To provide recognition to the group members for their effort, courage and accomplishments.
- To encourage the members to still work towards their healing.

Activities

The activities of the final session included:

- Having a potluck dinner at one of the member's house.
- Wrapping up all the sessions.
- Discussion and good-byes.

Summary

The group that started with nine members was now down to a total of five members. From the nine members two only attended the first sessions, another one left the province and one did not attend the last sessions. The members evaluated the progress they had made. Three members suggested that they would continue to be in contact with each other. The facilitators helped them to identify different kinds of supports. They encouraged the members to seek help and to join another support group.

The closure gave to the group members a sense of cohesion, but also a sense of loss and grieving for the termination and separation. The facilitators provided the members with positive feedback for their accomplishments and commitment. In general, the members stated that they felt much better for having attended the sessions. The members expressed their criticism towards the member who had taken too much of their time. Client 4 said that she learned in the group that sharing is transforming and knowing to learn the truth versus denial. She indicated that the group helped her to know the truth of the issues regarding childhood sexual abuse.

All the members appeared to be relaxed and comfortable in the celebration. They provided positive feedback for the work that the facilitators and members had done. Client 7 stated that although she was frustrated at times, she felt that the group helped her to gain a lot of insight, understanding and acceptance for what had happened to her. Client 2 said that the group taught her the right to express her feelings. Client 5 expressed that the group helped her to feel better about herself, and stated that the sessions were very informative.

This final session was a good opportunity to see the sense of group connection and camaraderie among the members. Feelings and thoughts about continuing to be involved in future groups were expressed by some members who felt that their journey had not ended. The facilitators encouraged them to continue working toward healing.

Chapter IV

Evaluation of the Practicum

4.1 Introduction

One of the purposes of this practicum was to measure the effectiveness of the intervention when the treatment approach of time-limited group therapy was applied, and to assess the degree to which the student attained her learning goals. The research design allowed for both qualitative and quantitative evaluation to be carried out, and both subjective and objective measures were utilized.

The evaluation of program outcomes focused upon quantitative measurement of knowledge and depression; and a qualitative description of self-reported satisfaction by clients. The evaluation of student learning was done through written descriptions kept by the student on the group work recording form and audio tapes related to the group sessions that were discussed with the supervisor.

4.2 Quantitative Research Design

The quantitative evaluation of the group treatment combines two research designs, the one group pretest-post test design for the knowledge scale and a series of seven single system A-B designs for each group member (Bloom & Fischer, 1982) utilized with the Generalized Contentment Scale (Hudson, 1974), a measure of non-psychotic depression.

a) One Group Pretest-Post test Design

The one group pretest-post test design (Cook & Campbell, 1979) was used to evaluate data collected from the knowledge scale. A comparison of the scores of each group member taken at assessment and at termination of the intervention indicated the amount of change, and in which direction this change occurred.

The limitations of the one group pretest-post test design is that it does not control for threats to internal validity such as history, maturation and reactivity.

The threat of history was reduced by observation and recording for the duration of the group sessions. In general, threats to validity can be reduced by replication of the treatment program over time.

b) Single System A-B Design

The Generalized Contentment Scale was evaluated for each group member individually, utilizing an A-B single system design. Baseline data were collected during the week between the first and second session, while the B phase consisted of scores measured between the second and twelfth sessions. Three data points were collected for the A phase of the A-B single design and ten data points were collected during the intervention (Bloom and Fischer, 1982). It was hypothesized that scores on this measure would show a reduction in depression, not taking into consideration the effects of the first session.

Threats to internal validity are similar to those for the one group pretest-post test design. However, some control over threats to internal validity can be achieved since A-B designs with two or more subjects, as in the case of this group, constitute a natural replication across multiple baselines (Bloom & Fischer, 1982).

Bloom and Fischer (1982) identify several strengths of the A-B design. First, it allows for ongoing monitoring of changes in target events, and thus lets the practitioner know whether to continue with the planned intervention or to make some modifications. Second, it is a good accounting device providing information not only to practitioners and clients; but to agencies and society at large. Third, information can be helpful in seeking and understanding of the presenting problem and planning the intervention strategy. Finally, any differences found between baseline and events after intervention act as a tentative indication of causal factors and suggest areas for further, more rigorously designed research.

4.3 Data Collection

Two measures were used for two targeted cognitive and affective outcomes, namely knowledge and depression.

The depression inventory was completed by the clients at home, three days per week (Monday, Wednesday and Friday) in the evenings (between 7 p.m. and 9 p.m.). The contentment inventory was collected from each client at the beginning of each respective session and twice more during the five day intervals between sessions.

The knowledge scale was completed at the first session, and at the last session.

4.4 Measurement

a) Knowledge Scale

Since an increase in understanding of childhood sexual abuse was one of the desired outcomes, the student developed a measure. It was to measure as to the extent to which survivors of abuse had the information available to describe and understand the issues and dynamics surrounding sexual abuse. The student constructed a thirty-three item questionnaire where the client had to indicate the numbered response that most clearly reflected their opinion. Response to the categories were on a five point Likert scale range from 1 (strongly agree) to 5 (strongly disagree). This measure was easy to develop and easy for clients to understand and complete. A limitation of this constructed measure is that reliability data (internal consistency) cannot be obtained in such a small sample.

b) Generalized Contentment Scale (G. C. S)

The G. C. S is a 25-item scale that was developed by Hudson (1982) and is designed to measure the degree, severity or magnitude of non-psychotic depression. The G. C. S is one of the few instruments that has been designed to be used as a repeated measure expressly for single system research (Bloom & Fischer, 1982). Responses are on a five point Likert scale ranging from 1 (rarely or none of the time) to 5 (most or all of the time). A particular advantage of G. C. S is a cutting score of 30 indicating the individual has no such problem.

Bloom and Fischer (1982) state that the scale has an internal consistency reliability of .92 and also has excellent stability with a test-retest correlation of .94. It has good concurrent and construct validity. Its main limitation centers upon potential reactivity which should be minimized by its high reliability.

4.5 Data Analysis

The data obtained from the Generalized Contentment Scale was displayed by way of line graphs included in appendix 3 (Bloom & Fischer, 1982). The charting of data allows change to become immediately apparent through visual inspection (Jehu, 1985). Generally, a distinction is made between the baseline and intervention phases when data is graphed (Bloom & Fischer, 1982). The General Contentment Scale was also analyzed with the celeration line approach joining points one and three in baseline data drawn to project into the intervention period. If a certain number of the data points collected during intervention are on the "desired" side of the celeration line - that is, on whatever side indicates desired behavior - then this provides a quick and tentative estimate of the statistical significance (Bloom & Fischer, 1982).

The one group pretest-post test design involving the knowledge scale was analyzed with the Wilcoxon Matched Pairs Signed Rank Test. The Wilcoxon Matched Pairs Signed-Rank Test is sometimes used instead of T to test differences between two paired samples. A common use of the Wilcoxon Signed-Rank test is to replace T if there is doubt that the data are indeed interval (as in the case of the knowledge scale). The Wilcoxon test can determine both magnitude and direction of difference.

4.6 Findings: Evaluation of the Effectiveness of the Intervention

a) Knowledge Scale

The reasons for using the knowledge scale were twofold: a) to assess whether a survivor was aware of the dynamics involved in c. s. a and; b) to observe the changes the survivor makes, possibly as a result of the information provided in the group sessions. When evaluating the results of using the knowledge scale the following general findings were obtained.

The scores of the post-test represented an average increase of 15% in knowledge compared with the pre-test median score value of 65% and the post-test median of 80%. It indicates that all the members of the group had a positive change in the level of knowledge.

The post test score was, statistically significantly higher (T=0, n=7, p=.01 one tailed). When evaluating the results with the standard deviation it indicated a 22% reduction of dispersed score from the mean. Therefore, in general the group became homogeneous in the level of knowledge. The discussions were considered to be relevant to members. The scoring indicates that the group did address group goals, possibly because the members became familiarized with the information and topics discussed in the sessions.

b) Generalized Contentment Scale

The higher the score on this scale, the greater the magnitude of the problem. The clinical cutting score is 30. The baseline median of medians for group members was 38. Over the intervention sessions the median of medians was 36. That represents a decrease of 5% in the score which indicates that according with the clinical cutting score of this scale the group did not have the impact expected in the decreasing of negative feelings in all the members. The Wilcoxon Matched Pairs Signed Rank Test shows that the difference in the median of the baseline and the median of the intervention was not statistically significant (T=5, n=7, p<.05 one tailed). Analysis of median scores at each data point indicates that lower than expected depression from celeration line occurred for the group at .05 level.

However, of the seven members, only three of them (clients 1, 2, and 3) had a score below the clinical cutting score at the end of the intervention. This may indicate that the group intervention had some impact in the increasing of positive feelings according to the G. C. S criterion, but with the celeration line approach significantly lower than expected depression occurred at level .05 for clients 1, 2, 4, 6 and 7. Among the group members, four clients (clients 4, 5, 6 and 7) had scores above the clinical cutting score at the end of the intervention. It seems to represent certain degrees of clinical depression.

According to the visual inspection, client 4's graph shows a peak that corresponds to some stressful events in her life. These events were an accident she had and the announcement of the termination of the group. In the case of client 5 the visual inspection of the graph shows that she maintained a stable pattern in her level of depression.

However, the high peaks reflect that during the intervention she was dealing with health issues that affected her emotionally. The graphic of client 6 shows that her level of depression increased. It appears that this was caused by the sudden death of a friend of hers. In the case of client 7 who was dealing with the custody of her child, the graph shows two peaks that represent an increase in her depression level which may be related to these circumstances.

4.7 Group Evaluation

Group evaluations were developed by the student. The questions were distributed to the group prior to the last session, and five were returned at the final session. This questionnaire provides the members, subjective evaluations of themselves and of the group. Most of the answers were returned in a very informal form. A general overview of the evaluation is presented.

According to the responses to the questions it seems to be that, in general, the members were satisfied with the sessions, and met their main objectives of being involved in the group. Most of the members stated that the group helped them to obtain their objectives, such as to meet other survivors, to learn from them, to communicate, and to share with them their personal grievances, pain and experiences as survivors. Some of the members said that sometimes they felt there was an imbalance in the group for sharing because of a member "having long and boring interventions" that took too much of their time that could have been used to interact and receive more information about the themes. All women responded that the group was very helpful to them, especially the subjects covered and the material provided. Some members stated that the group gave them the opportunity to understand the issues about childhood sexual abuse, and feel much better about themselves.

They found that the role of the facilitators was very important. They considered the facilitators to be very supportive, open, caring, competent and knowledgeable. More important than anything, they felt that the facilitators validated the pain of each individual and helped them to trust in themselves.

4.8 Observations of the Student

Although the facilitators were able to identify the emotional needs of the members and provided the atmosphere to help them have a sense of belonging and security, the group goals were partially met for some members. Issues related to a particular member made it difficult for some survivors to provide more information about their experiences and their needs. This lack of safety hindered the fulfillment of the original group goals, such as breaking down the feelings of loneliness, and developing the capacity to experience power and to change any situation affecting them by developing and practicing new skills and behaviors.

As a result some sessions had to be altered. For example, a session about anger was canceled in order to allow the members to speak more about their emotions, feelings and personal issues related to the exercises of speaking out and the inner child. The lack of safety felt by the members was reflected in the lack of connectedness among a few of the members. Because of these disruptive situations, the student suggests that the members should be encouraged to involve themselves in at least one more group to get more benefit to counteract the long-term effects of their child sexual abuse.

However, there were positive findings related to the goals upon the completion of the group. The fact that the members were committed in their attendance represented a positive attitude, interest and increased awareness about themselves and their desire to change. Most of the members became more aware of their abuse during the intervention. They acknowledged how abuse had impacted their lives, relationships, attitudes and behavior. The group helped the members to explore the dynamics in their relationships with their families of origin, their mothers and their fathers. These helped them to change their own perception about the sexual abuse, allowing them to recognize and label their feelings of anger, disappointment, resentment and sadness toward their abuser(s), as well as their mothers for the lack of protection. Through their participation, sharing of feelings and personal experiences the members recognized and strengthened their positive behaviors, thoughts and actions.

4.9 Progress Toward Student Learning Goals

This practicum has broadened the student's knowledge and understanding of women survivors of childhood sexual abuse and the dynamics of power that consist of both unequal sexual power (males victimizing females) and unequal generational power (the older victimizing the younger) (Finkelhor, 1982). It also has increased the student's expertise in assessment and group treatment. Moreover, the practicum helped the student to obtain her primary goal. This was to gain experience in group work with women survivors of childhood sexual abuse. Through her participation in attending staff meetings, the student had the opportunity to learn about the Women's Post-treatment Centre approach to supporting women survivors of childhood sexual abuse. Working with the other facilitator helped her to develop a better understanding of the mainstream cultural approach of dealing with clients. Her time at Women's Post Treatment Centre was very valuable as she could observe, discuss and learn about the experience of childhood sexual abuse, its impact and long-term effects on survivors.

In doing this practicum the student learned how to assess the reality of child abuse based on the experiences of the women as children and the facts of their lives. It also gave the student the skill to recognize when a member is not prepared to join the group and how the intensity and structure of the group can affect her. The student realized that therapy can have a positive or negative effect because of the intense emotional reaction it can cause in the clients. After this practicum experience the student still has to learn more techniques and to develop better ways of relating with the clients, to help them to identify feelings and behaviors.

The hardest part for the facilitators was to keep members on topic. There was a constant effort to direct; and in the role of facilitator the power struggle was evident mainly with one individual, who tended to alienate others through irrelevant intellectual discussions. Challenge to the leadership role occurred repeatedly in the first sessions. More than once this client attempted to exhibit that her leadership skills were far above those of the facilitators and other members of the group.

Feeling insecure and having her own limitations in this area, the student acknowledged the need for learning and developing more skill to help the members of any

group as well as herself to be assertive, to talk about any obstacles in the group and to explore how to confront and address any issue arising in the group. The student considers that it is very important that the individual's therapists do a better pre-screening before referring any client to the group as to whether the group treatment modality is inappropriate for that particular client. This could minimize interpersonal conflicts among group members and lessen feelings of isolation.

This practicum helped the student to develop her skills with a better understanding of the information obtained through the literature review, and helped her to obtain both the information and the empathy to lead the members of the group through the various stages of readjustment.

Chapter V

Conclusions

Throughout the literature review and within the actual practice three major themes have emerged as being of primary importance in working with women survivors of childhood sexual abuse. This practicum report has integrated these three themes: the family dynamics of child sexual abuse, the effects of the sexual abuse and group work with the survivors. The focus of the clinical program was on the use of a time-limited group treatment with women survivors of childhood sexual abuse. The group was a useful therapeutic modality for providing to the survivors the opportunity to expose the common patterns of guilt and isolation, to understand the impact of the events and to share with other survivors the successful and unsuccessful experiences in their lives.

Most survivors of childhood sexual abuse develop a sense of responsibility and belief that sexual abuse was their fault. They enter adulthood feeling guilty, responsible and worthless. Many of them channel their energy into coping with the negative effects of the abuse by getting involved with addictions to substances such as drugs and alcohol.

Most of the members of the group had had treatment for addictions. They came with the understanding that they were the ones to be blamed for not having stopped the sexual abuse. Some members had a narrow definition of abuse, believing that it only happens if sexual intercourse is involved.

The time-limited group treatment involves several benefits. It was potentially helpful since it encouraged the women to deal with the long-term negative effects of sexual abuse. The group offered an atmosphere of acceptance to share and explore painful feelings, although this was limited by some aspects of interaction in the group. Through the lectures, exercises, and exploration of issues the survivors were able to put the blame and the responsibility on the abuser(s), to define the appropriate behaviors and identify their boundaries.

Although some members perceived another member as a difficulty, it is the student's impression that the group was of significant value. The members grew closer to each other in their expressions of feelings, addictions, losses and gains. They also shared a

significant amount of their knowledge and personal experiences. As a result of the group, the members learned ways of interpreting themselves, their concerns and the surroundings in their lives, and to adjust the experiences of the past into positive experiences in their present lives.

Generally speaking, the objectives of this practicum were achieved. The student greatly enhanced her knowledge of the application of the theory about childhood sexual abuse and its dynamics. She also acquired knowledge of intervention with childhood sexual abuse. Overall, through the intervention the members of the group were assisted to identify their strength and potential in help-seeking and help giving.

APPENDIX 1

CONSENT FOR RECORDING SESSIONS

I _____, give permission to _____ of Women's Post Treatment Centre to audio/video tape therapy sessions.

I understand that I may request any part of a session or whole session be erased or that I may withdraw permission at any point.

The tapes may be used for the following purposes. Please put a check mark by uses which are approved.

_____Counsellor's use to evaluate therapy process and then erased.

_____Supervisors evaluation of counsellors work and then erased.

_____ Client's use

_____ Use for learning and consultation with other theapists at Women's Post Treatment Centre then erased.

DATE _____

CLIENT _____

THERAPIST_____

Group Work Recording Form

Session # :

Date :

Time : From:_____ To:_____

Activities :

Observations :

Analysis :

Overall assessment of sessions:

Suggestions:

A-2: Protecting The Little Girl Within

Step 1: As a survivor of abuse, you had a little girl that was unprotected. This may even have been the case if you were an adult rape victim. Each woman has a little girl within and if she is not cared for (by her mother, father, institution, peers, culture) she can be exposed to sexual abuse. In this exercise the point is to teach the little girl that you intend to do all you can to protect her from this behavior.

Step 2: You need to explain what boundaries you are setting with your body. This is important for a little girl whose boundaries were violated. Writing a letter about this can be very effective. You again may not choose to show this letter to anyone. This letter is for the safety of your little girl within. If the sexual abuse was done by a parent, let him or her know that you cannot accept their inappropriate parenting. Explain to them that a parent has no right to use such power over their children. Tell the parent that there is no excuse that allows them the opportunity to abuse a child in that way. Alcohol and drugs are not an excuse. Loneliness is not an excuse. Attraction is not an excuse. Their own feelings of abandonment are not an excuse. That they could not get sex from an adult is not an excuse. That they were "over-sexed" is not an excuse. That you were their favorite daughter is not an excuse. That you were assumed to be "seductive" is not an excuse. There is no excuse that could allow sexual abuse to be acceptable.

Step 3: If the perpetrator was a stranger or another family member, you can write the same type of letter that is in step 2. The important aspect is letting your little girl know there are limits and that you are going to set them for her.

Loulan, J., 1984

1

THE CHALLENGE OF ANGER

Anger is a signal, and one worth listening to. Our anger may be a message that we are being hurt, that our rights are being violated, that our needs or wants are not being adequately met, or simply that something is not right. Our anger may tell us that we are not addressing an important emotional issue in our lives, or that too much of our self—our beliefs, values, desires, or ambitions—is being compromised in a relationship. Our anger may be a signal that we are doing more and giving more than we can comfortably do or give. Or our anger may warn us that others are doing too much for us, at the expense of our own competence and growth. Just as physical pain tells us to take our hand off the hot stove, the pain of our anger preserves the very integrity of our self. Our anger can motivate us to say "no" to the ways in which we are defined by others and "yes" to the dictates of our inner self.

Bass, E. & Davis, L. (1988)

ANGER

The most logical and appropriate response to abuse is anger. Sexual abuse is a wholly unacceptable and heinous crime. It deserves your full-blown rage. You were the victim of an atrocity. You have the right to get angry and to stay angry as long as you want.

This concept of anger as a positive, healing force contradicts most societal beliefs. Many of us (particularly women) have been taught that anger is unnecessary or counterproductive. We've been urged by family members to hurry up and get through our anger so we can get to the forgiveness part. Many forms of religion and spirituality tell us to turn the other cheek. Even well-intentioned (but misinformed) therapists have been scared by our anger and urged us to contain it.

In *The Courage to Heal* we called anger "the backbone of healing," because it can keep you going through the ups and downs of the healing process. Anger motivates you to say "I'm going to heal, no matter what. I won't give up. I won't let my abuser win." Anger is the most effective antidote to hopelessness and depression. It can inspire you to make deep and lasting changes in your life.

To be effective, anger must be directed clearly at the abuser and at the people who failed to protect you. Yet this is often very difficult for survivors, who frequently turn their anger in on themselves, lost control and lash out at others, or have no awareness of anger at all. When anger is turned inward, the results are depression, illness, addictions, self-destructive behaviors, and self-hatred. When it's misdirected toward other people, anger becomes a destructive force, one that creates barriers to intimacy and leads to further abuse. When you're unaware of anger, you can't begin to focus it or use it as a healing tool. To work for you, anger must be turned clearly and squarely at its source—the people who hurt and abused you.

The exercises in this chapter will help you assess your current experience of anger. A pair of writing exercises will help you get in touch with your anger and give you a chance to express it. You'll be asked to consider the ways anger can motivate you into action. And finally, you'll learn about the role of forgiveness in the healing process.

Bass, E. & Davis, L. (1988)

ORIGINAL PAIN WORK

> Neurosis is always a substitute for legitimate suffering.
>
> --C. G. JUNG

> Problems cannot be solved with words, but only through experience, not merely corrective experience but through a reliving of early fear (sadness, anger).
>
> --ALICE MILLER

We believe that if the theory behind original pain work were better understood, it would revolutionize the treatment of neuroses in general and compulsive/addictive behaviors in particular. So often patients who desperately need to do their feeling work are drugged with tranquilizers. In our Life Plus treatment center in Los Angeles we have run into obstacles from some mental-health professionals who cannot understand why we don't want to medicate our patients. We believe that the only way to cure compulsive/addictive disorders is through the feeling work.

We specialize in treating co-dependence, which is rooted in toxic shame--the internalized feeling of being flawed and defective as a human being. In the internalization process, shame, which should be a healthy signal of limits, becomes an overwhelming state of being, an identity if you will. Once toxically shamed, a person loses contact with his authentic self. What follows is a chronic mourning for the adult self. The clinical description of this state of affairs is dysthymia or v-grade chronic depression. In my book *Bradshaw On: Healing the Shame That Binds You*, I showed how toxic shame was the master emotion. It binds all our feelings in shame so that whenever we feel anger, distress, fear, or even joy, we also feel shame. Likewise with our needs and drives. The parents in dysfunctional families are adult children themselves; their own wounded inner child is needy. Whenever their children feel needy, he feels shamed. For a large part of my adult life I felt ashamed whenever I needed help. Finally, no matter how appropriate the context, the shame-based person feels shame when he is sexual.

Once one's feelings are bound in shame, one numbs out. This numbing out is the precondition for all addictions, because the addiction is the only way the person is able to feel. For example, a chronically depressed man who becomes a superachieving executive through his work addiction can feel only when he is working. An alcoholic or drug addict feels high with mood-altering drugs. A food addict feels a sense of fullness and well-being when his stomach is full. Each addiction allows the person to feel good feelings or to avoid painful ones. The addiction mood alters the hurt and pain of the spiritually wounded child. The spiritual wound inflicted by toxic shame is a rapture of the self with the self. One becomes painfully diminished in *one's own eyes;* he becomes an object of contempt to himself.

When a person believes that he cannot *be* himself, he is no longer at-one with himself. The ecstatic mood alteration of an addiction gives him a sense of well-being, of being one with self. Whenever a shame-based person feels his real feelings, he feels ashamed. So, to avoid that pain he numbs out.

Numbing our pain is achieved through various ego defenses we use when reality becomes intolerable. Some of the most common defenses are: denial ("it's not really happening"); projection ("it's happening to you, not me"); and minimizing ("it happened, but it's no big deal").

Basically, our ego defenses are ways to distract us form the pain we are feeling.

Bradshaw, John (1990).

WHO AM I?

OBJECTIVES

— To identify how I feel about myself.

— To help determine what levels of self-disclosure are appropriate for me.

PROCEDURE

— On 10 small pieces of paper write Who I Am, one thought per piece. It can be a single word, phrase; it can be adjective, characteristic, role, quality, source of confusion: — most important, BE SPONTANEOUS! (approx. 10 mins.)

— Put items (ie. pieces of paper) in order of priority.

— Use as a basis for sharing with one other person. Share only what you wish to share, remembering also that sharing (self-disclosure) builds trust.
As you are listening to the other person, use active listening skills. (approx. 15 mins.)

— Find another couple. Introduce your partner by what (s)he has shared with you.
NB First check with your partner what (s)he does not wish shared in the group of four. (approx. 15 mins.)

QUESTIONS FOR REFLECTION AND/OR DISCUSSION

— What did you discover about yourself?
— What do your items tell you about your self-concept?
— What types of statements make up self-concept? To what extent do you see yourself in reference to your feelings(happy, upset)? Your attitudes (optimistic, insecure)? Your physical attributes (tall, short)? Your intellectual attributes (capable, slow)? Your occupation (student, salesperson)? Your role relationships with others (brother, mother, son, boss, friend)?
— As you think back, how has your self-concept changed over time?
— WHich items were you willing to share with one other person but not with three?
— Which items were you willing to share with 3 other people but not with the class?
— What factors enter into different levels of appropriate self-disclosure?

VARIATIONS see Gamble and Gamble, Contacts p.39-40
Lukasko-Emmert, Instructor's Manual:Interpersonal Communication p.34-5.

Maureen McIntosh
September, 1985

BOTH TYPES OF SHAME LEAD TO

1. A lack of a strong sense of ourselves as worthy people with boundaries and limits and a right to these.
2. A lack of strong sense of others as worthy people with boundaries and limits and a right to these.
3. Violating others rights.
4. Letting people violate our rights.

SHAME BASED PERSON

1. Assumes rejection when someone is angry or confronts us. We can't hear anger or confrontation very well.
2. Part of ourselves is missing:
   a) Self nurturing part
   b) Self protection part
   c) Self worth
3. Problems with intimacy because getting close feels like we're losing ourselves and getting violated again.
4. Afraid of being alone, is too painful we don't like being with ourselves.
5. We give off a double message "I desperately need you" and "don't get close."
6. We tend to use people to fill up the parts of ourselves that are missing but we rarely truly love another.
7. Our "zipper" to ourselves is on the outside. People can open us up and hurt us whenever they want - we think we don't have any control.

RECOVERY PROCESS

Therapy - Strengthening of boundaries by changing shaming self talk to self accepting and self nurturing self talk. Taking control over our "zipper" so we can control who enters and who doesn't (controlling self talk). As we change our self talk to more positive and nurturing messages, our boundaries become stronger and clearer and we feel stronger and better inside.

Stronger boundaries feel more in control of selves - less need to control others.

STEPS TO RECOVERY

1. Stop behaviour that undermines dignity or perpetuates shame (violence, drug abuse, alcohol aubse, etc.). This helps us get in touch with feelings that underlie these behaviours such as fear, hurt, loss, insecurities, sadness, shame, and anger. It also helps us start to focus on ourselves, our self talk, and our problems.
2. Face the shame, accept it as part of ourselves and stop running from it.
3. Move from shame to guilt by changing our self talk "our actions and behaviours need to change but our selves are good."

MASKS

Don't be fooled by me. Don't be fooled by the face I wear, for I wear a mask. I wear a thousand masks, masks that I'm afraid to take off, and none of them are me. Pretending is an art that's second nature with me, but don't be fooled. For God's sake, don't be fooled.

I give you the impression that I'm secure, that all is sunny and unruffled with me, and that I need no one, but don't believe me. Please don't believe me. My surface may seem smooth, but beneath lies no smugness, no complacency. Beneath dwells the real me in confusion, in fear, in aloneness. But I hide this. I don't want anybody to know it.

I panic at the thought of my weakness and fear being exposed. That's why I frantically create a mask to hide behind, a non-chalant, sophisticated façade to help me pretend, to shield me from the glance that knows. But such a glance is precisely my salvation, my only salvation, and I know it. That is, if it's followed by acceptance, if it's followed by love. It's the only thing that will assure me of what I can't assure myself, that I'm really worth something. But I don't tell you this, I don't dare, I'm afraid to.

I'm afraid your glance will be followed by acceptance and love. I'm afraid you'll think less of me, that you'll laugh, and your laugh would kill me. I'm afraid that deep-down I'm nothing, that I'm just no good, and that you will see this and reject me. So I play my game, my desperate pretending game, with a facade of assurance without, and a trembling child within. And so begins the parade of masks, and my life becomes a front.

I dislike the superficial game I'm playing, the superficial, phony game. I'd really like to be genuine and spontaneous and me, but you've got to help me. Each time you're kind and gentle and encouraging, each time you try to understand because you really care, my heart begins to grow wings, very small wings, very feeble wings, but wings. With your sensitivity and sympathy, and your power of understanding, you can breathe life into me. I want you to know that. I want you to know how important you are to me, how you can be a creator of the person that is me if you choose to.

So don't pass me by. Please don't pass me by. It will not be easy for you. A long conviction of worthlessness builds strong walls. I fight against the very thing that I cry out for. But I am told that love is stronger than strong walls, and in this lies my hope, my only hope.

- Anonymous -

— Addictions - Coping Mechanisms —

When looking at women, abuse and addictions we also need not to attend to women's behaviour (ie. addiction) as a pathological behaviour. We need rather to understand the meaning behind the behaviour. We need to attend to the systems as a masked language rather than a pathological or temporary behaviour that can be circumvented. Addictive behaviour is a functional adaption to unlivable emotional experiences that have allowed women to survive pain and struggle in our lives. Therefore we have to begin by honoring and celebrating these behaviours. If these coping mechanisms or survival techniques were not available to a woman, she might not have been able to survive her life. So Thank God they are there!

Such coping behaviours may be getting in the way now. If so, we need to look at that and work on it and get rid of those things that are no longer functional. But we need not be judgmental or beat ourselves up for that behavior being there in the first place.

We need to look at what the behaviour means - what is the language behind the behaviour. Women tend to experience pain by taking it in, ie internalize it through self-abuse. One of the common patterns we see is addictive behaviour. The most common addictions are drug and alcohol use. It makes sense - I prefer to call it self-medication. The only way we can live with painful experiences and memories is not remembering. It is too hard, too painful to always be aware of the fact that someone who was supposed to love and protect you is hurting you. We need to black it out - not think of it, not feel it.

There are other addictions, other coping mechanisms we women use. Sugar is a way of feeding, nurturing, nourishing ourselves. T.V. is a socially acceptable way of buzzing out for a while - of not thinking, not feeling, not being present. Striving for perfection is a way of trying to avoid feeling like a failure. We are never good enough as we are. We have to do more, do better - we believe. These coping mechanisms are not different from anyone else's, just heightened.

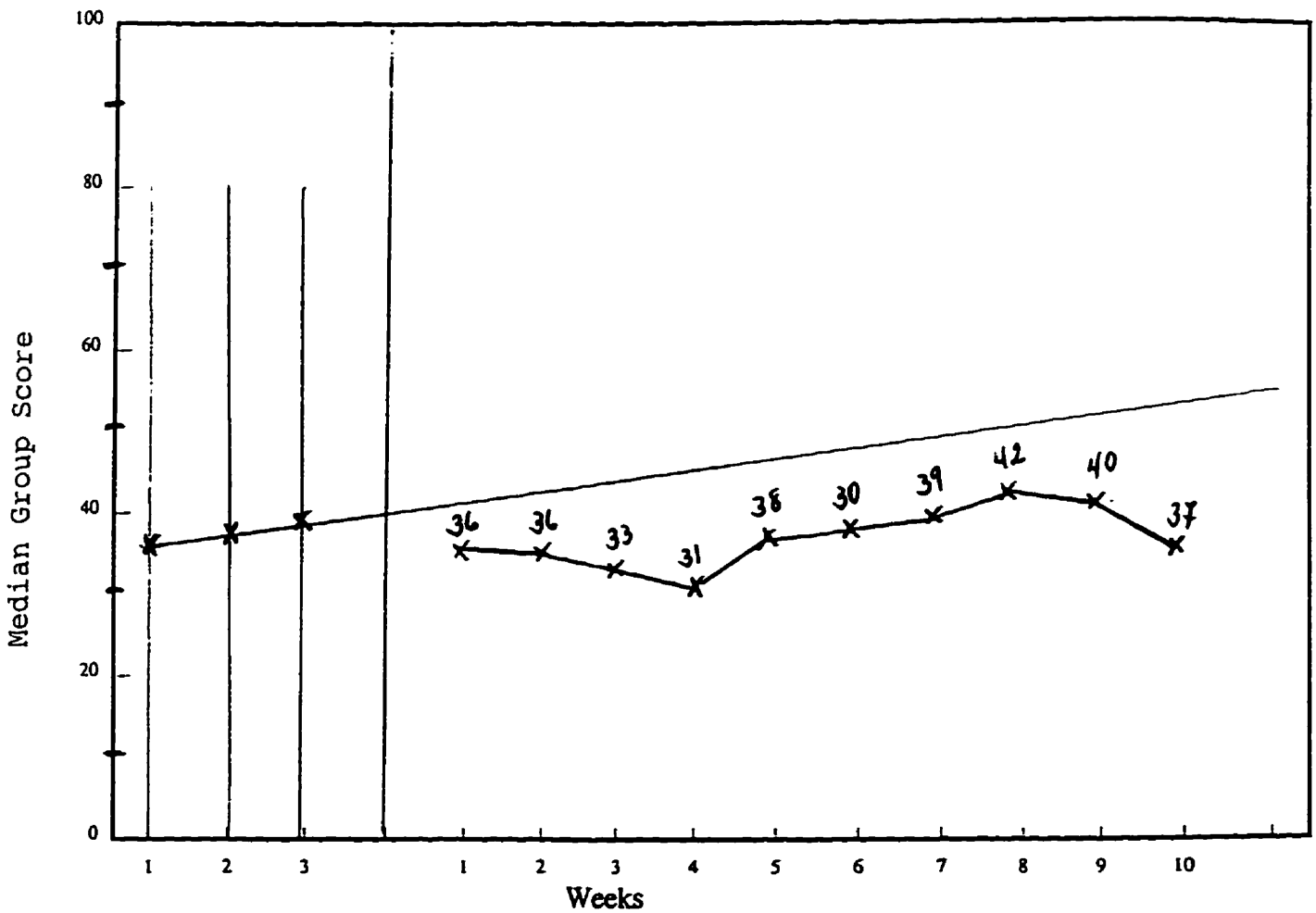
We all have different ways of dealing with pain in our lives, and giving ourselves some feeling or measure of control over the pain.

Defense Mechanisms

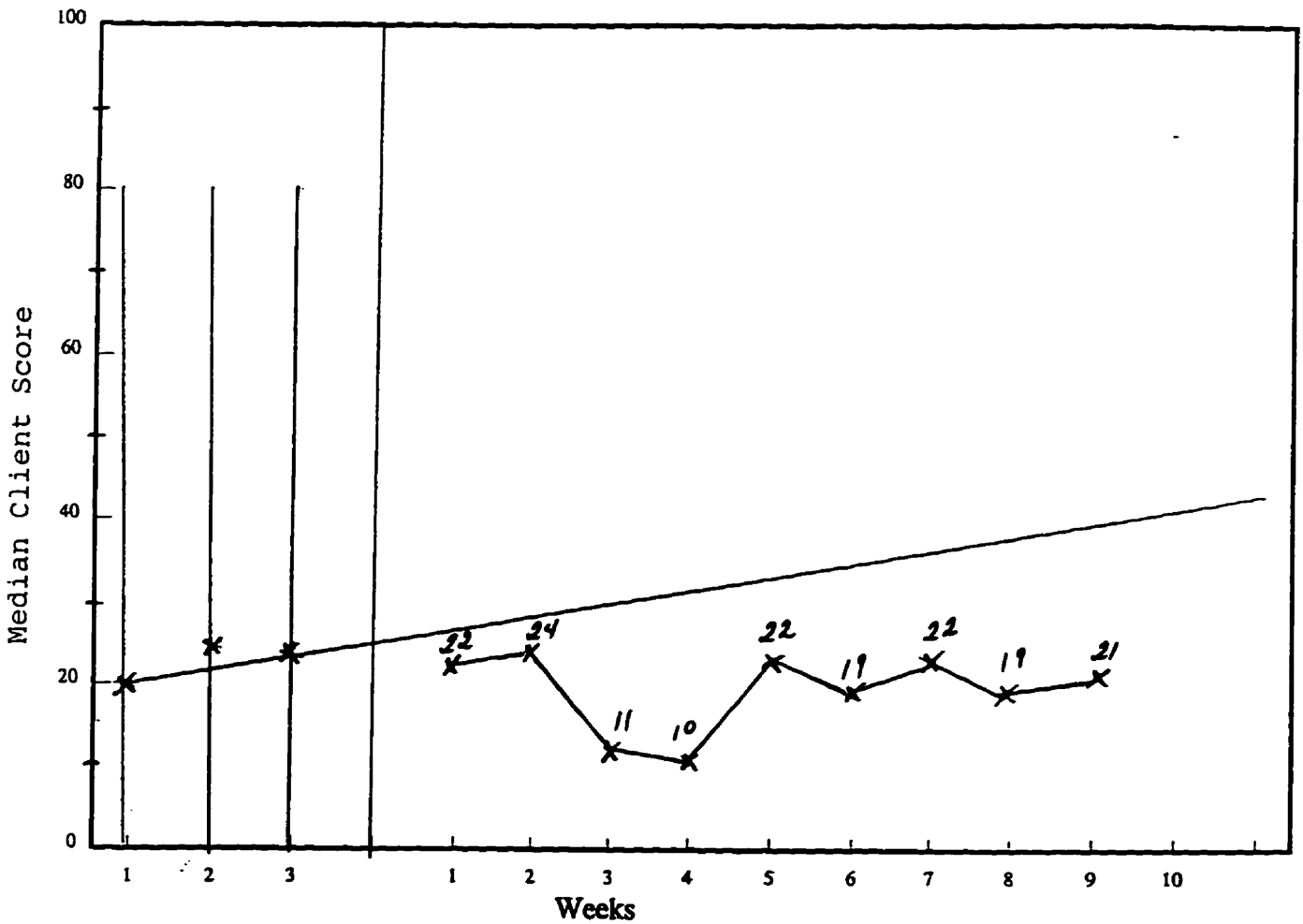
Understanding one's self involves, among other things, an awareness of the mechanisms we use to preserve the self. It is worth remembering that defense mechanisms are learned adjustive behaviors, that they function on relatively unconscious levels, and that they involve a certain amount of reality distortion and self-deception. Defense mechanisms serve the aims of adjustment by reducing conflict and frustration, and particularly because they stand in guard of the self, they function as a bulwark against more serious disturbances. Consequently they can be considered quite normal and desirable, except when they are used to an excessive degree and operate at the expense of a person's ultimate adaptive efficiency and continued personal progress toward greater maturity.

APPENDIX 2

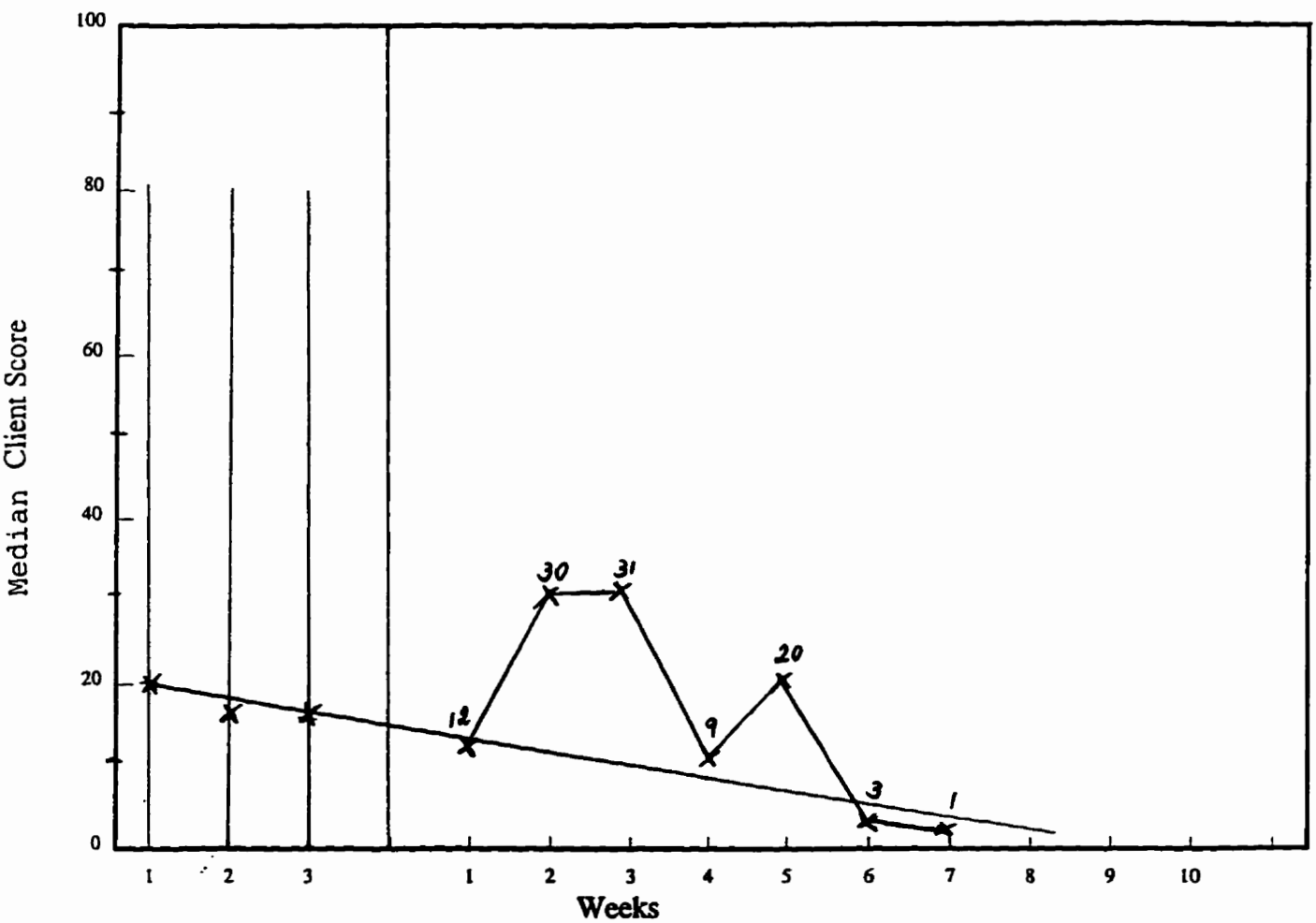
Median Group Score on Generalized Contentment Scale



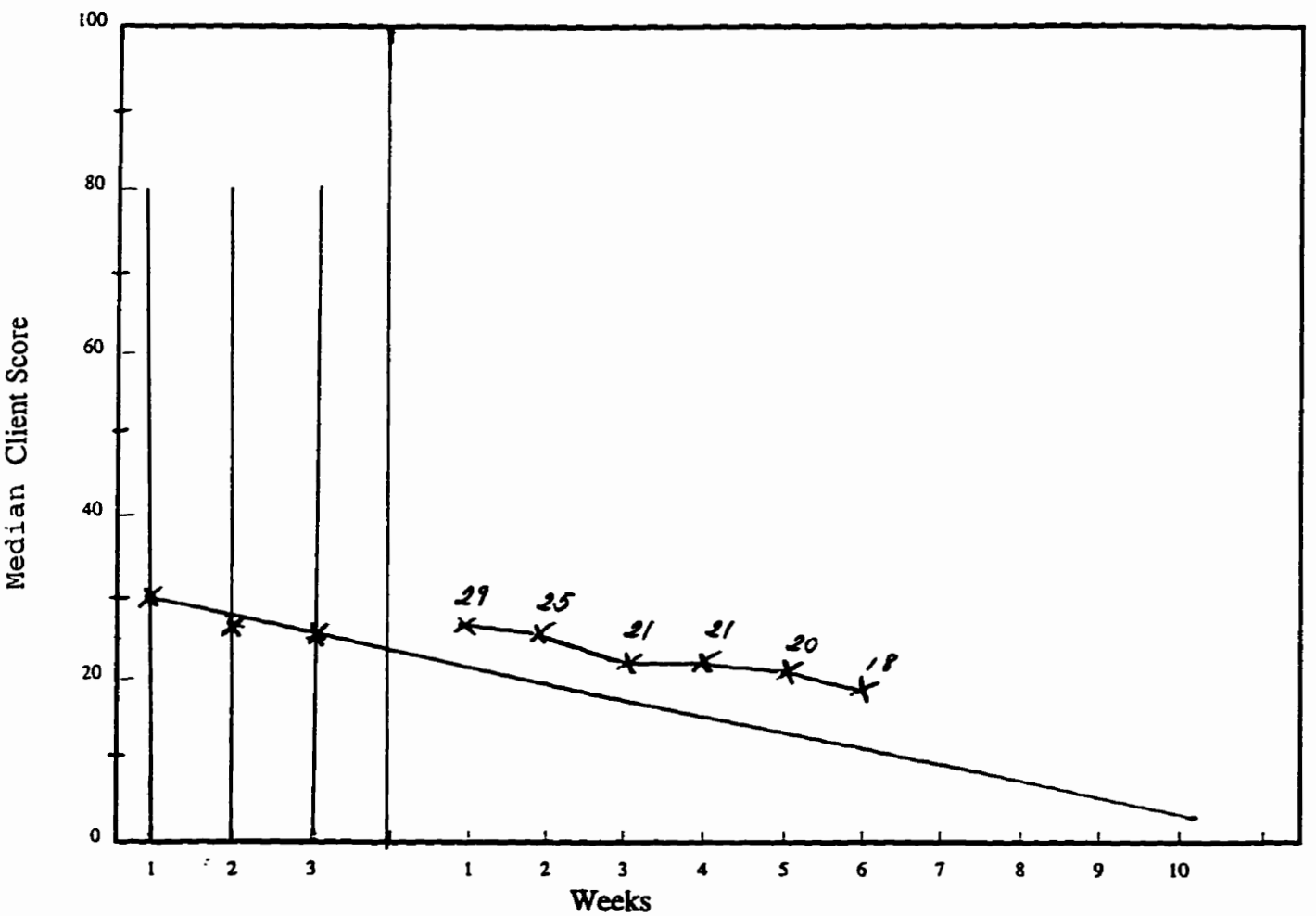
Client No. 1 Score on Generalized Contentment Scale



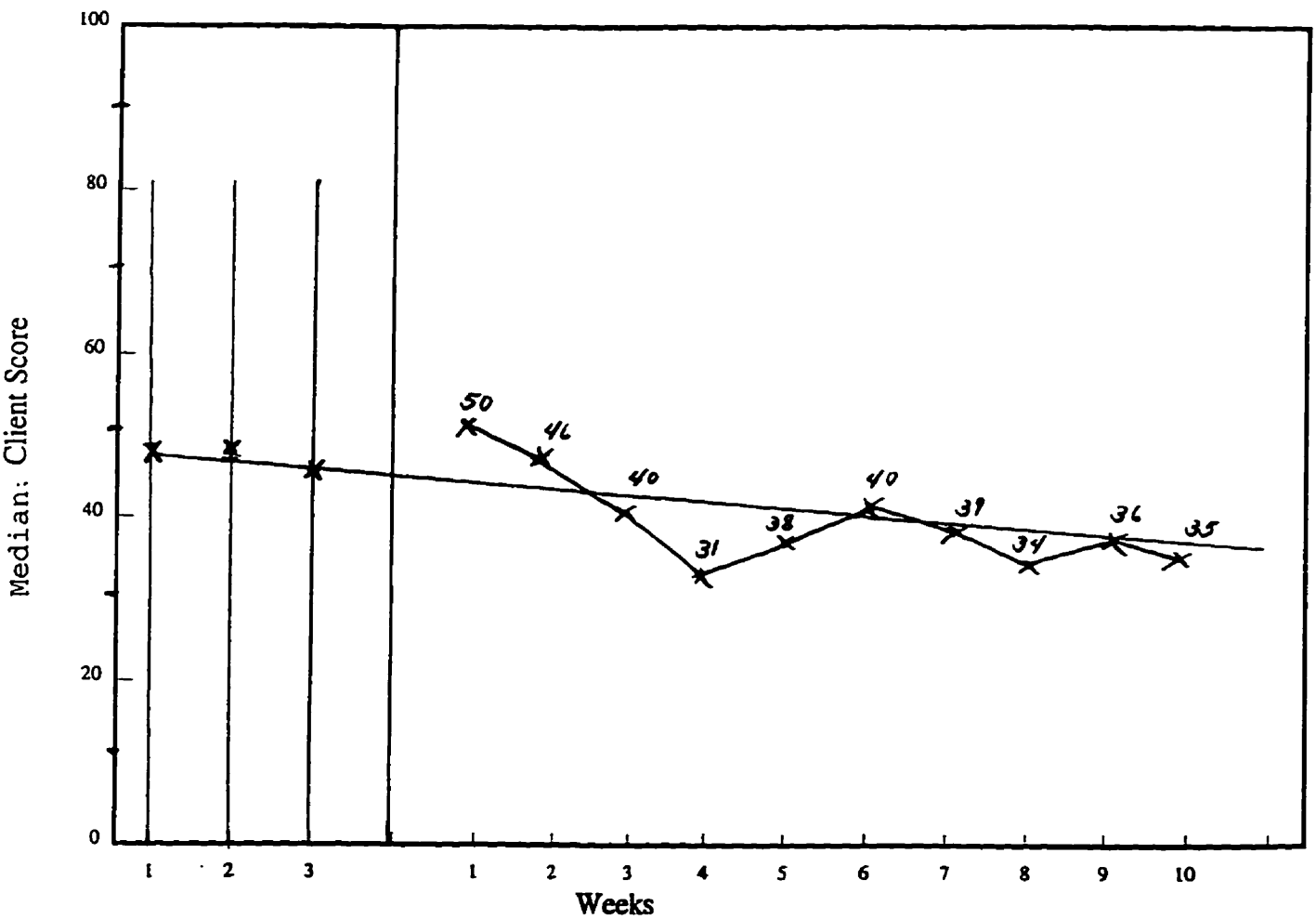
Client No. 2 Score on Generalized Contentment Scale



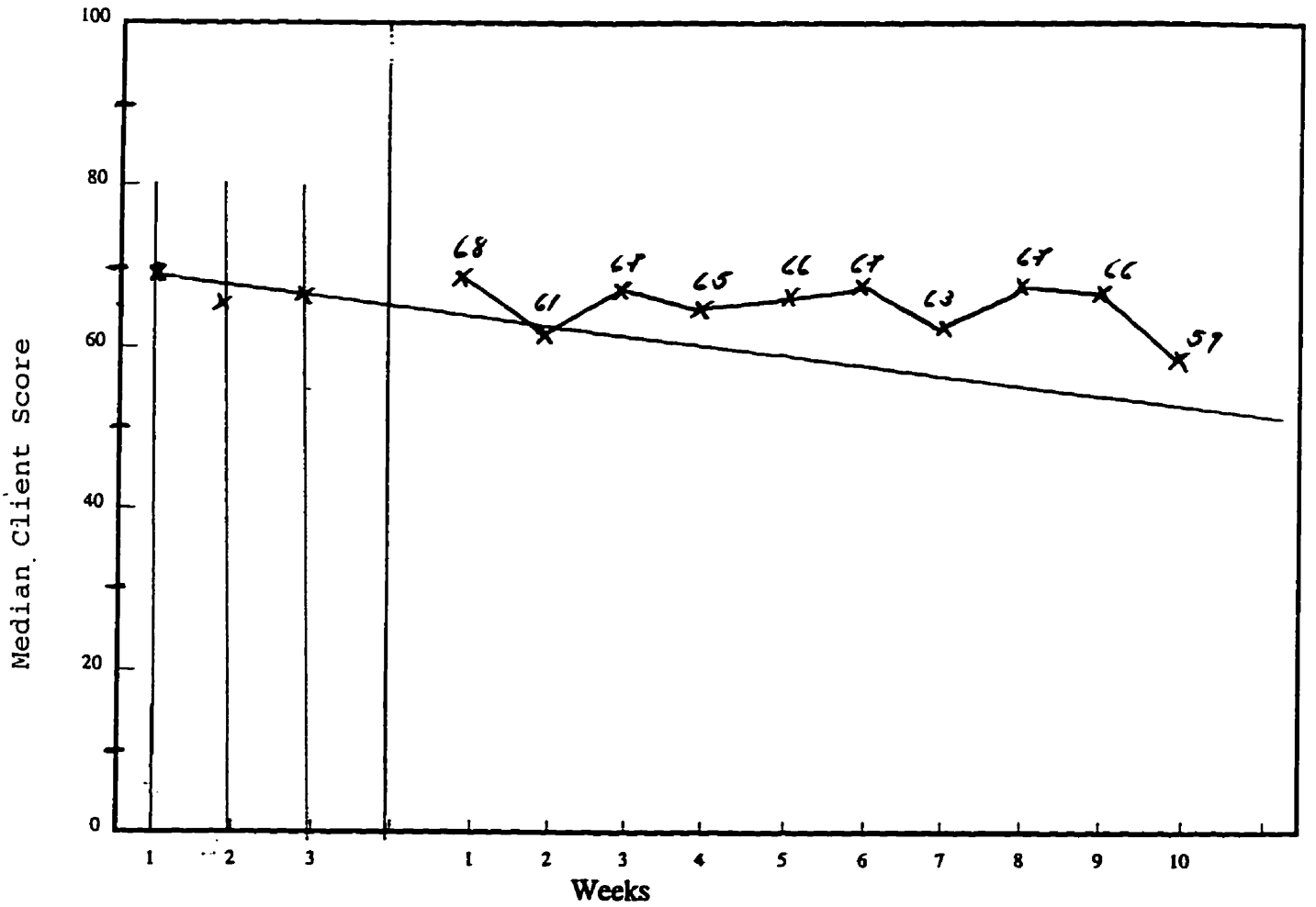
Client No. 3 Score on Generalized Contentment Scale



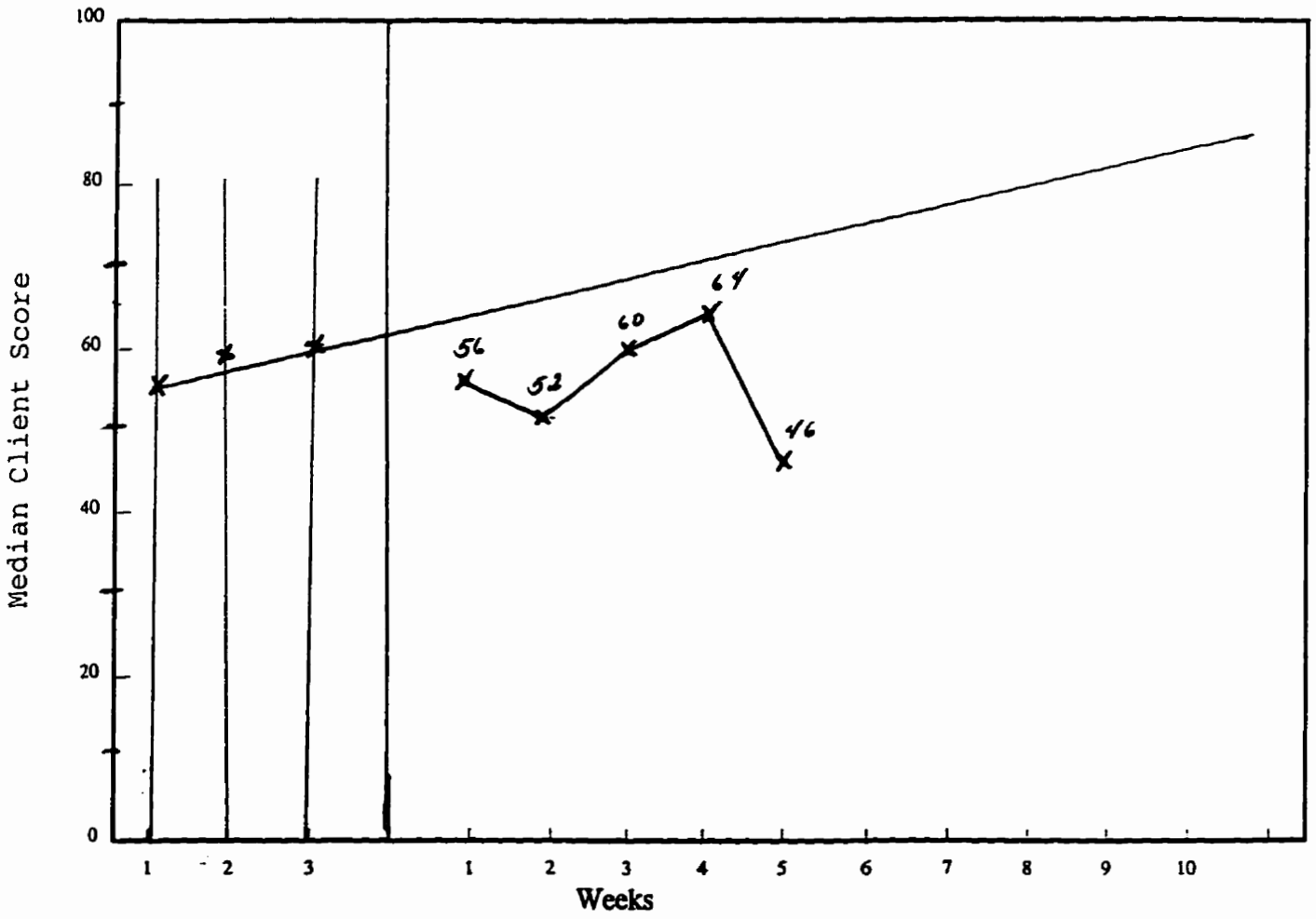
Client No 4 Score on Generalized Contentment Scale



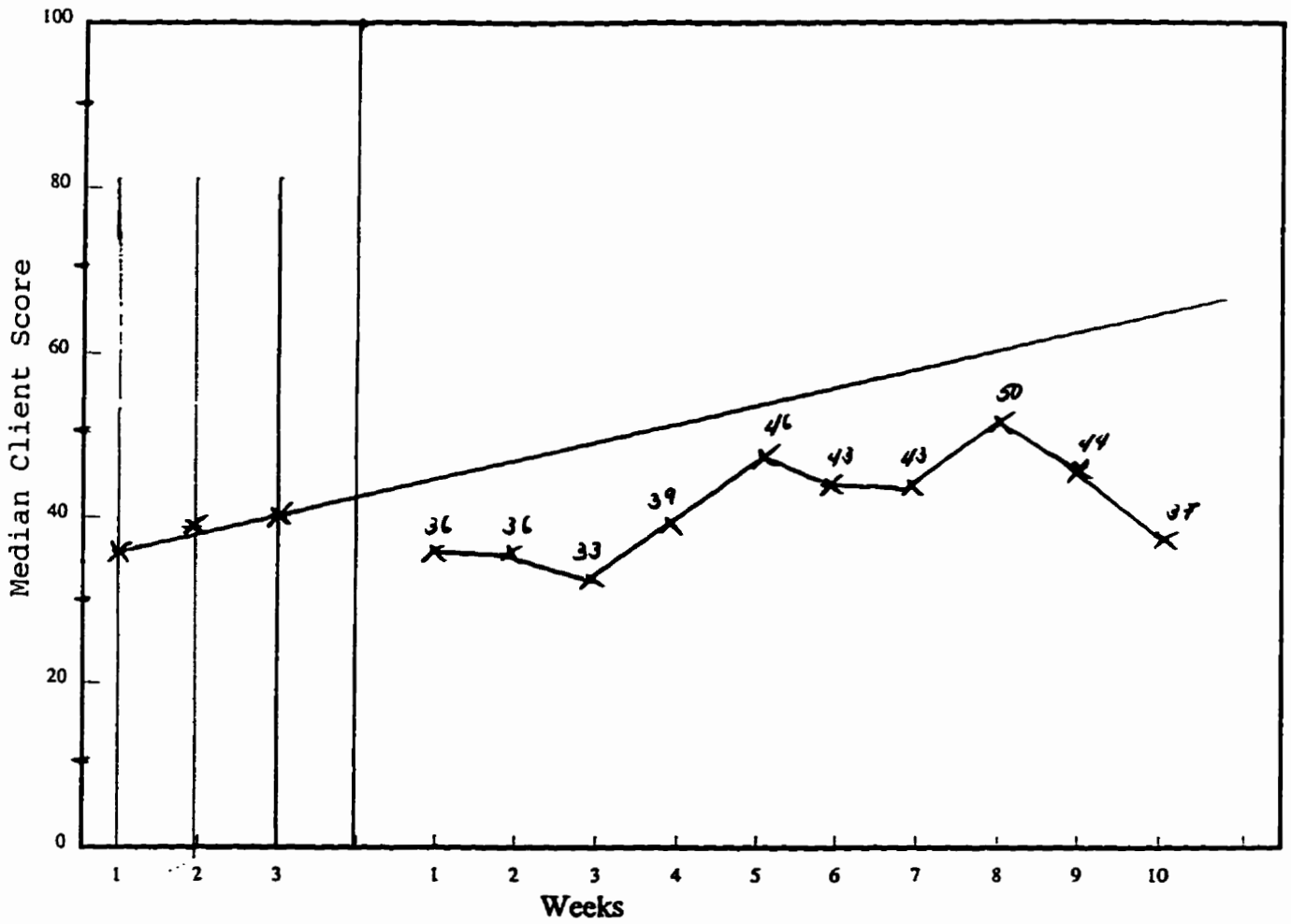
Client No. 5 Score on Generalized Contentment Scale



Client No. 6 Score on Generalized Contentment Scale



Client No. 1 Score on Generalized Contentment Scale



MEDIAN SCORE ON KNOWLEDGE SCALE

CLIENT	PRE-TEST	POST-TEST
2	59	80
3	75	88
5	65	77
7	67	81
1	64	79
4	64	77
6	85	96
MEDIAN	**65**	**80**

APPENDIX 3

Measure II

Generalized Contentment Scale (GCS)

NAME: _____ TODAY'S DATE: _____

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

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

Please Begin:

1) I feel powerless to do anything about my life ____
2) I feel blue ____
3) I am restless and cannot keep still ____
4) I have crying spells ____
5) It is easy for me to relax ____
6) I have a hard time getting started on things that I need to do ____
7) I do not sleep well at night ____
8) When things get tough, I feel there is always someone I can turn to ____
9) I feel that the future looks bright for me ____
10) I feel downhearted ____
11) I feel that I am needed ____
12) I feel that I am appreciated by others ____
13) I enjoy being busy and active ____
14) I feel that others would be better off without me ____
15) I enjoy being with other people ____
16) I feel it is easy for me to make decisions ____
17) I feel downtrodden ____
18) I am irritable ____
19) I get upset really easily ____
20) I feel that I do not deserve to have a good time ____
21) I have a full life ____
22) I have a great deal of fun ____
23) I feel that people really care about me ____
24) I feel great in the morning ____
25) I feel that my situation is hopeless ____

Hudson, W. (1974)

For each of the following questions indicate the numbered response that most clearly reflects your opinion. Please answer by numbering each box in each question.

1 = Strongly agree
2 = Agree
3 = Not sure
4 = Disagree
5 = Strongly disagree

1. Child abuse only involves:

gestures	[ ]
exhibitionism	[ ]
intercourse	[ ]

2. Child abuse does not imply:

force	[ ]
violence	[ ]
cohersion	[ ]
threats	[ ]

3. Breaking the silence or disclosure is:

a powerful healing tool	[ ]
to experience release	[ ]
to get into trouble	[ ]

4. To you shame means:

being inferior	[ ]
being a failure as a person	[ ]
feeling humiliated	[ ]
feeling totally worthless	[ ]

5. As a survivor of childhood sexual abuse you can grieve for:

the loss of your feelings [ ]

the relationships ruined [ ]

the oportunity you lost as a child [ ]

6. Being a survivor of abuse, you have been taught that anger has to be supress because:

anger is violence [ ]

anger is a negative response [ ]

anger is self-destructive [ ]

7. The healing process is facing changes:

inside yourself [ ]

your lifestyle [ ]

your self-perception [ ]

8. Healing would change your relationships with:

your family [ ]

your children [ ]

your partner [ ]

9. If you healed, you will give up:

people feeling sorry for you [ ]

blaming your parents for all your problems [ ]

always being strong [ ]

10. Survivors have the right to :

make changes	[ ]
make choices	[ ]
set limits	[ ]
be respected	[ ]

Please answer these questions on a separate piece of paper and return next week. Answers and comments will not be discussed in the group unless so requested. Please explain as completely as you can.

1) What I liked best about the group:

2) What I liked least about the group:

3) Wlhat kind of things were especially helpful to you?

4) Wer the facilitators helpful to you?

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