CHILD SEXUAL ABUSE AND THE NON-OFFENDING PARENT: A PSYCHOEDUCATIONAL SUPPORT GROUP FOR MOTHERS WHO HAVE CHILDREN WHO HAVE BEEN SEXUALLY ABUSED

BY

STEPHANIE ANN SCHMOR

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in Partial Fulfilment of the Requirements
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ABSTRACT

Child sexual abuse remains a serious concern for social workers, practitioners and researchers. Literature regarding sexual abuse continues to focus predominantly on the victim. Empirical and clinical research clearly identifies short- and long-term physical and emotional effects for the child as a result of child victimization.

The importance of the role of the mother in the disclosure and intervention process for the child has been identified. Only recently has recognition been given to the understanding of the mother's personal emotional impact from the victimization. Unfortunately, limited resources and interventions have been implemented to effectively address these issues for the non-offending mother. The purpose of this practicum was to develop, implement, and evaluate an intervention that would assist mothers of children who had been sexually abused. The model of intervention utilized a psychoeducational group format informed by small group theory and a feminist perspective. The aim of the intervention was to provide an avenue for emotional ventilation and facilitation of positive coping strategies through the provision of mutual support, reduction in isolation, improvement in the parent/child relationship , and an increase in self-esteem.

The group intervention, implemented at Elizabeth Hill Counselling Centre, ran for fourteen weeks and initially consisted of nine women who

were non-offending mothers or caretakers of children who had been sexually abused. Seven participants completed the pre- and post-test measures. The practicum findings indicate that the group was moderately beneficial to the group members. The results indicate that the most significant impact of the intervention for the participants was the establishment of trust, mutual support, and reduction in isolation.

The non-offending mother neither expects nor is prepared for the victimization of her child. Interventions that service only the victimized child minimize and isolate the non-offending mother and limit the benefits of effective treatment. The results suggest that greater attention needs to be given to the emotional and therapeutic needs of the non-offending mother in the ongoing treatment of child sexual abuse.

CHAPTER 1

PRACTICUM OVERVIEW

Child sexual abuse has existed for centuries, crossing all socio-economic, educational and ethnic boundaries. Studies indicate that as many as one in four children have been exposed to some sort of sexually abusive behaviour (Finkelhor, 1994). Incest is defined throughout literature as any type of sexual activity between a child/adolescent and a person of close relation (i.e., parent, sibling, relative or individual who provides a role as parent, step-parent or care-giver; DelPo & Koontz, 1991; Maltz & Holman, 1987). The Canadian Criminal Code defines all sexual offenses against children, encompassing sexual interference, invitation to sexual touch, exposure, sexual exploitation and sexual assault (Standing Committee on Justice and the Solicitor General, 1993). Giarretto (1982) provides a broader definition of child sexual abuse, defining victimization as a relationship occurring between individuals that is considered to be exploitive in nature. This is characterized by psychological, developmental or social inequalities and power imbalances resulting in unequal and deviant sexual relationships.

Sexual abuse, statistically, has been proven to be predominantly committed by men (Bagley & Thomlison, 1991; Carter, 1993; Finkelhor, 1984). When the abuse that occurs is incestuous and committed by a parent or an individual in the role of care-giver, it is rarely the mother of the child. Existence of female offending is rare and has only recently caught the

attention of professional study. Statistics indicate that only 0.1% of cases of child sexual abuse is committed by mothers or mother substitutes (Hooper, 1992; Russell, 1983). Female children are at a higher risk of victimization and are more likely to be abused within the family unit. When considering offending behaviours by a care-giver, men continue to out number women in committing acts of victimization against children (Carter, 1993).

Despite the attempts in the 1990's to image fatherhood as more interactive, mothers continue to be portrayed as the primary care-giver. The abundance of documentation of early attachment, adjustment, and bonding emphasizes the role of the mother-child bond rather than the father-child relationship (Carter, 1993; Schonberg, 1992). Relationships displaying appropriate attachment are seen as pertinent in the development of the child's emotional and cognitive abilities and may influence the child's success in formulating other relationships (Hiebert-Murphy, 1995; Rice, 1990).

Presently, within the core area population of Winnipeg a high majority of children are being raised by single parents, more specifically by their mothers. Within the child welfare system many of the families presenting to the agency are combatting issues of instability, physical, emotional and sexual abuse, alcoholism, and family dysfunction. Due to this family instability, erosion, and separation, mothers often become the primary focus

of parental responsibility.

This is clearly indicated in cases of intra-familial sexual abuse or incest where the mother, out of necessity, becomes the primary care-giver. Research recognizes the importance of including mothers in the intervention of child sexual abuse (Carter, 1993; Dominelli, 1989; Elrod, 1993; Johnson, 1992; Leifer, Sharpiro & Kassem, 1993). Hiebert-Murphy (1995) indicates that mothers' reaction at the time of disclosure and post-abuse involvement with intervention and external systems can impact on the adjustment of their children. However, it is also relevant to appreciate and understand the impact of disclosure on the non-offending mother. Addressing the physical and emotional consequences of the abuse for the child, meeting expectations of the child welfare agency and external systems, and coping with the personal emotional impact of the disclosure can result in crisis for the mother. Understanding the experiences, addressing the emotions, and providing support which enhances coping strategies are essential in assisting the mother through this trauma.

The Intervention

The purpose of this practicum was to provide a resource for mothers of sexually abused children. More specifically, a group was offered for mothers whose children had been interviewed and sexual abuse was substantiated. The focus was to provide intervention and support to assist mothers in personally understanding the emotional aftermath and resolution

of child sexual victimization. This process would help enable and empower the mothers to confront the issues of sexual abuse and begin to advocate for their children's and their own needs. It was assumed that as mothers learned and became more familiar and comfortable with their efforts to protect their children, they would in turn provide the validation and trust necessary for the children to begin their own healing process. Group work is an appropriate forum in which mothers of victimized children can explore difficult and distressing experiences and initiate change.

A closed, time limited psychoeducational format was utilized for this group intervention. The group ran over a fourteen week period, for two and one half hour weekly sessions. Each session was video taped for supervision and educational purposes.

The Theoretical Frameworks

For the development and expansion of the theoretical framework, the literature review will provide a detailed exploration of the problem. This will include (a) a historical perspective of child sexual abuse, (b) a discussion of the effects of victimization, and (c) a consideration of the role of mother. It will also include a discussion of recent theories of sexual abuse including David Finkelhor's four preconditions of sexual abuse and the feminist perspective. The theories utilized for this intervention which included (a) small group theory, (b) feminist theory, and (c) feminist group theory will be reviewed. Specific interventions based on group work with the non-

offending parent will also be discussed.

The Practicum Objectives

The broad learning objectives that I wished to address via the group process are as follows:

1. To develop, implement and evaluate a support group for mothers of children who have been sexually abused.
2. To develop practice skills in short-term group counselling and become more familiar with the application of small group theory and feminist theory in group work practice.
3. To develop and acquire skills in gathering and analysing evaluation data.
4. To address protection of the child and the emotional needs of the non-offending mother.

CHAPTER 2

LITERATURE REVIEW- FURTHER EXPLORATION OF THE PROBLEM

Child Sexual Abuse

A Historical Perspective

Attitudes towards sexual abuse and children have changed over time. In the 1890's, professionals, including Freud, developed a special interest in child sexual abuse. Freud's work with female patients revealed consistent disclosures of sexual victimization. Freud concluded that his patients' disclosures were not real, but fantasy based on the women's unconscious desires to have sexual relations with their fathers (Asher, 1991; Birns & Meyer, 1993; Dominelli, 1989). By adopting the Oedipal Theory, Freud was able to avoid the father's responsibility in the abuse and trivialize and blame the adult female victim (Dominelli, 1989).

Although, to this date, the popular views of this era have been largely rejected, the influences of Freud remain today. This is reflected in a Garbarino and Gillian study (1980) that suggested that young girls play out their charms on their fathers and that paternal care-givers may misinterpret the meaning of their daughters' behaviours and subsequently molest them.

During the past decade there has been an epidemic of disclosures greater than at any previous point in history (Carter, 1993). A national Canadian survey found that 17.6% of adult females and 8.2% of males

recalled "unwanted" sexual touching or sexual assault prior to their 18th birthday (Bagley, 1985; Bagley & Thomlison, 1991). A more recent study of 750 women ages 18 to 27 in Calgary, Alberta determined that 32% of the women reported some form of unwanted sexual touching before their 17th birthday, 6.9% reporting that the abuse continued for more than one week (Bagley & Thomlison, 1991).

Research in the U.S. has reported that 38% of women have been sexually abused (Russell, 1983). Currently, this estimation is considered a conservative figure by experts in the field of sexual victimization (Carter, 1993). The concern regarding sexual abuse has presently become a major social issue, reflected by the increase in public awareness, devotion to education, media attraction, and professional attention.

Effects of Victimization

Recent literature on child sexual abuse has argued that there are a number of serious physical and psychological ramifications resulting from the experience of victimization (Black, Dubowitz, & Harrington, 1994; Black, Dubowitz, Harrington, & Vershoore, 1993; Browne & Finkelhor, 1986; Carter, 1993; Conte & Berlinger, 1991; Dominelli, 1989; Einbender & Friedrich, 1989; Finkelhor & Browne, 1983; Nash, Zivney, & Hulsey, 1993; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1992). These include emotional, physical or somatic complaints, sexualized behaviours, effects on peer relations and social functioning.

Finkelhor and Browne (1983) provide a valuable review of child sexual abuse and identify four core reactions or traumagenic dynamics resulting from victimization. These include traumatic sexualization, betrayal, stigmatization and powerlessness. These dynamics negatively impact on the child's cognitive and emotional state, hampering his or her perception of self and society and incapacitating effective coping strategies.

Traumatic sexualization or the development of inappropriate sexual behaviours or attitudes includes observable behaviours like sexual preoccupation, repetitive sexualized behaviours (e.g., masturbation), developmentally inappropriate sexual knowledge or interest, sexualized aggression and victimization of peers. Betrayal, manipulation and breach of trust of a child by caregiver, can result in depression and grief due to loss of innocence, separation from the offender or removal from family. Stigmatization refers to issues of shame and guilt that can become internalized in a child's self perception resulting in isolation from the norm and gravitation towards preexisting stigmatized behaviours including addiction, delinquency or prostitution. Powerlessness, the final dynamic, involves the process by which a child's determination and abilities are consistently sabotaged resulting in fear, anxiety, nightmares, phobias, dependency, somatic complaints, ineffective coping skills, depression, and suicide. Powerlessness can also be directly associated with the potential risk for further victimization.

Empirical and clinical literature has also addressed and evaluated adult victims of child sexual abuse to determine the long term impact of victimization (Asher, 1991; Birns & Meyer, 1993; Brown & Finkelhor, 1986; Carter, 1993; Conte & Berlinger, 1991; Herman, 1981; Hildebrand & Forbes, 1987; Meiselman, 1978; Schaaf & McCanne, 1994; Woogler & Power, 1992). Research has identified a number of long term ramifications of victimization including (a) difficulty maintaining stable and long term adult relationships, (b) low self-esteem and negative self image, (c) depression and suicidal ideation, (d) addiction abuse, (e) ongoing difficulties with body image disturbance and potential eating disorders, and (f) risk of repeated victimization in adulthood.

Historical Review of Mother Blaming

The role of the mother in responsibility and intervention regarding child sexual abuse has been the centre of conflict for a number of years. Decades of publications and research indicates a legacy of mother blaming regarding the role in their children's victimization (Birns & Meyer, 1993; Carter, 1993; Dominelli, 1989; Faller, 1988; Humphreys, 1992).

A well cited study by Dietz and Craft (1980) of 200 social workers in the United States determined the extent of the entrenchment of mother blaming by professionals. Regardless of the fact that 78% of the protection workers believed that in cases of incest there was use of physical violence towards the non-offending parent by the offender, 87% believed that the

mother gave her unconscious consent to the sexual abuse and 65% believed that the mother was equally responsible for the victimization.

Previous views of literature regarding the role of the mother in issues of sexual abuse have identified two perspectives that have a mother-blaming tone (Asher; 1991; Birns & Meyer, 1993; Cammaert, 1992; Dominelli, 1980; Finkelhor, 1984; Furniss, 1983, 1991; Herman, 1981; Hildebrand & Forbes, 1987; Hopper, 1992; Humphreys, 1993; Kaufman, Peck, & Tagiuri, 1954; Piercy & Sprenkle, 1986; Schonberg, 1992). These include the dysfunctional family system and the mother as ineffective to protect.

The Dysfunctional Family System

From this viewpoint, the family is seen as disturbed or pathological and the mother is deemed to be at the centre of this dysfunction (Cammaert, 1992; Dominelli, 1989; Furniss, 1983; Hildebrand & Forbes, 1987; Hooper, 1992; Schonberg, 1992). Father-daughter incest is viewed as a symptom or a result of the family pathology. The incest serves a function of reducing the tension, providing an outlet for the family to maintain its balance and boundaries as a dysfunctional family arrangement.

Focus on the dysfunctional family intensified with the publication and popularity of family systems theory. Systems theory focuses on the interactions and dynamics within the family system. The theory argues that all members of the family affect the system creating circular causality (Birns & Meyer, 1993; Hooper, 1992; Schonberg, 1992). Within this theory,

particularly in regards to issues of sexual abuse, the influences of the larger community and society in general are often ignored (Birns & Meyer, 1993). Emphasis on the family system deflects responsibility from the offender and characterizes incest as a problem within the relationships of the family unit. Birns and Meyer (1993) categorize this labelling as a "three person crime" including the victim, perpetrator and the mother (p. 129).

The dysfunctional family system theory implies that the mother may have consciously or unconsciously been a colluder with the victimization (Cammaert, 1992; Furniss, 1983; Meiselman, 1978; Schlesinger, 1982; Sgroi & Dana, 1982). The definition of collusion from the Webster Dictionary (1994) is "a fraudulent secret understanding" (p. 226). From this perspective the mother has some form of knowledge of the incest and denies this knowledge to others and herself (Cammaert, 1992; Meiselman, 1978; Schlesinger, 1982; Sgroi & Dana, 1982).

The family systems approach expects neutrality within the system implying that all aspects of the system are equally contributing to the dysfunction (Percy & Sprenkle, 1986). Even though the correlation between incest and physical abuse of the non-offending mother has been documented since the late 60's, it has only been recently that incest has been placed in the context of family violence (Johnson, 1992). It can be argued that the mothers, powerless in a violent and patriarchal family environment potentially present as collusive. Yet, the issue of

powerlessness is rarely discussed within the literature related to the non-offending mother and more often negatively described as collusive behaviour.

Within the idealogy of the family systems approach is the argument that incest derives from, or is at least maintained by, disturbances in family relationships and that child sexual abuse can only be fully understood when it is located in the context of these disturbances. This approach has often created the expectation that mothers, by their actions alone, can protect and prevent further abuse from occurring (Schonberg, 1992). Johnson (1992) indicates that these expectations result in a feeling of failure and self-blame by the mother for the victimization of her child. Hiebert-Murphy (1995) contends focusing on the weaknesses of the mother as a potential cause of child sexual abuse is entrenched in mother-blaming. She also argues that this view provides little explanation for the large number of extra-familial assaults on children and why the majority of offenders continue to be male.

The family systems view diffuses the offender's responsibility in initiating and perpetrating the abuse. Similarly, the theory reinforces the expectation of neutrality within the system ignoring such factors as differences in power and influence implying that all aspects of the system are equally contributing to the dysfunction (Piercy & Sprenkle, 1986).

Mothers Incapacity- Characteristics That May Lead to Abuse

Past literature portrays mothers of children who have been sexual abused as self absorbed with emotionally limited/absent care and dysfunctional relationships with their own maternal caregiver (Asher, 1991; Humphreys, 1993; Piercy & Sprenkle, 1986). As adults, these mothers become incapable of providing appropriate communication and positive interaction with their partner and their children (Asher, 1991). Therefore, the mother, in her dysfunction, becomes a contributing factor and is unable to protect her children from sexual abuse.

There is some empirical evidence to support this perspective. Finkelhor (1984) found that having a absent or ill mother was an important predictor of the likelihood of sexual abuse. Herman (1981) interviewed 40 women incest victims and found that 38% of the women were separated from their mothers at some point during childhood due to a physical or mental ailment. As a result of the mother's own physical/emotional difficulties, she was incapable of recognizing the sexual abuse of her child and unable to initiate appropriate protection planning.

Consistent with this perspective is the argument that mothers are ineffective and irresponsible in their abilities to carry out their household tasks and sexual responsibilities (Asher, 1991; Henderson, 1972; Sarles, 1975; Schlesinger, 1982). Presumably this failure to perform the spousal role ultimately results in the husband seeking out the daughter to carry out

all aspects of her mother's role, including a sexual relationship (Asher, 1991; Sarles, 1975). Furniss (1983) argues that in these families of marital estrangement, particularly sexual estrangement, this dysfunction threatens to produce family breakdown. The family presents as incapable of coping with such break-up resulting in the creation of the incest to maintain the sexual role, removing the stress and maintaining the family unit in incestuous secrecy.

Literature has also continued to argue for an inter-generational link between having been abused oneself in childhood and having children who are themselves sexually abused (Furniss, 1993; Leifer et al., 1993). It has been suggested that female victims of sexual abuse will often fall prey to men who then go on to abuse their own children. The mother's history of unmet needs and issues of poor self-esteem make it difficult for her to meet the appropriately demanding needs of her child, resulting in anxiety, hostility, and resistance to interventions to protect the child.

Deblinger, Stauffer and Landsberg (1994), Hiebert-Murphy (1995), and Leifer et al. (1993) argue that there is limited research indicating that a mother's history of sexual victimization affects the mothers' abilities to provide appropriate support and protection to their children. Although there may be a correlation between mothers who have been sexually abused and the abuse of their children it should not be concluded that the relationship is causal.

The literature has also given little consideration to the reasons for the mother's absence and her inability to then fulfil her traditional role (Cammaert, 1992; Furniss, 1983; Johnson, 1992; Sgroi & Dana, 1982). In families, abusive and non-abusive alike, mothers are often overwhelmed with the responsibilities of employment, child care, and domestic expectations. Many also suffer physical and emotional consequences of such stress with no relief. Recognizing that an ill or absent mother could potentially inhibit the early identification of abuse does not imply that the mother's illness is the cause of the victimization. As well, although there may be a correlation between absent or ill mothers and dysfunctional sexual relationships between partners, this should not conclude that the sexual refusal of the mother is the cause of the incest (Cammaert, 1992; Johnson, 1992). This minimizes the responsibility of the father in initiating and perpetrating the sexual abuse on his child and fails to recognize his efforts to create an atmosphere of fear and secrecy in which the mother has effectively been excluded.

Summary

Although overt mother blaming is less popularly accepted by researchers and professionals in the 90's, Hooper (1992) claims two forms of mother-blaming continue in research and literature within the field. The first is the placement of responsibility on the woman for the perpetrator's sexually deviant actions or "wife-blaming". This continues to reinforce

historical perspectives that denounce the male's responsibility and proclaim that they are incapable of controlling their sexual desires and behaviours. It places the mother/female in the position of controlling or being responsible for the male's behaviour. The second involves the extent to which mothers are held accountable for the wellbeing and safety of their children. This can be defined more specifically as the unequal and often sole responsibility women are given for the health and welfare of their children.

Recent Theories

Finkelhor's Theory of Sexual Offending

David Finkelhor (1984) integrates much of the available literature regarding child sexual abuse into a model which identifies four preconditions of sexual abuse. This model attempts to address the shortcomings in previous theories by including knowledge about the offender, victims, and families. The model accommodates many different types of sexual abuse from father/daughter incest, to abuse by persons in positions of trust and third party abuse (both intra-familial and extra-familial). As well, it incorporates explanations from both psychological and sociological levels. The model is called the Four Preconditions Model of Sexual Abuse. The following are four factors/conditions that the author indicates contribute to sexual abuse and victimization:

1. A potential offender needs to have some motivation to abuse a child.
2. The potential offender has to overcome some internal inhibitions against acting on that motivation.
3. The potential offender has to overcome external impediments to committing sexual abuse.
4. The potential offender or some other factor has to undermine or overcome a child's possible resistance to sexual abuse.

Explanations of victimization require addressing all four components of the abuse and determine the interaction between individual, familial, and social factors at each stage.

In this model, the mother is not blamed for the victimization. The issues of the mother's inability/failure to protect the child or the child's inability to resist victimization are taken as contributing elements. Finkelhor identifies these factors as level and degree of supervision, exposure to risk, and vulnerability to the child. However, the model demonstrates that these singular factors are not the cause of the abuse, as the offender still has to take a number of crucial steps in the process of committing the victimization.

Feminist Perspective

Feminists see child sexual abuse, particularly incest, as an issue of power, not exclusively sex (Dominelli, 1989; Finkelhor, 1984; Herman,

1981; Johnson, 1992; Rush, 1980; Russell, 1983). Child victimization is viewed as a demonstration of sexualized power and coercion of women and children by male perpetrators for sexual gratification (Dominelli, 1989). By sexualizing these power relations the perpetrator successfully obtains control of the woman's and child's sexuality in order to meet his dysfunctional and deviant desires (Dominelli, 1989).

Regarding the role of the mother, the feminist perspective is distinguished by its view of mothers within the context of an unequal hierarchial structure and patriarchal society (Humphreys, 1992; Johnson 1992). The collusive mother paradigm is rejected by the feminist perspective due to its failure to accept and appreciate the existence and the impact of patriarchy on women (Johnson, 1992). Historically, men have had, and continue to maintain control over the economic decisions and determination of rules and conduct within the family system. As well, society reinforces and caters to the importance and value of the male's emotional and physical needs. Compounding this issue is the fact that many women are in the position of powerlessness or a conditioned state of helplessness (Johnson, 1992), and often present in a position of secondary status (Birns & Meyer, 1993). Therefore, women in these positions often lack the personal, economic, and societal resources to protect their children from victimization. Intrinsically linked to the issue of power is the issue of gender (Asher, 1991; Bagley & Thomlison, 1991; Dominelli, 1989; Johnson, 1992; Piercy &

Sprenkle, 1986; Wellman, 1993). Unlike the traditional approach, feminist theory does not determine that abuse is gender-neutral (Dominelli, 1989). Highlighting the factor that a majority of offenders are male, this theory estimates that only one out of one hundred perpetrators are female (Dominelli, 1989). Therefore, feminists argue that society has been socialized to adhere to a gender-split world and to ignore the fact child sexual abuse is a gender specific and a male crime (Johnson, 1992).

Summary

The literature contends that mothers are capable of providing protective care for their children and should not be sabotaged in this process (Hooper, 1992). However, previous perspectives which focus on the mother as playing a key role in the dysfunctional family system or assess her as colluding, disturbed, absent or ill continue to project blame on the mother for her failure to protect her child.

The benefits of recent theories including Finkelhor's model and the feminist perspective are that they reject the view that mothers are the cause of child sexual abuse. Finkelhor's four preconditions indicate factors of victimization that are dependent on the offender and his actions and not the characteristics or actions of the mother. The feminist perspective views mothers failure to provide the appropriate protection for their children as the direct result of the patriarchal society that leaves mothers incapable and immobile to attend to their children's needs (Humphreys, 1992).

Mothers and the Impact of the Disclosure

"While sexual abuse is perpetrated predominantly by men, the protection of children in the aftermath falls mainly on women" (Hooper, 1992, p. 3). Mothers are often the first to become aware of the abuse through direct disclosure (Hooper, 1992; Johnson, 1992). Carter (1993) determined that nearly 70% of reports to child welfare agency were made by mothers.

Literature on recovery for the child from the victimization and the initiation of the healing process continues to reinforce the importance of the mother's response to the disclosure (Carter, 1993; Dominelli, 1989; Elrod, 1993; Johnson, 1992; Leifer, Shapiro & Kassem, 1993). Margaret Myers (1984,1985) studied 43 non-offending mothers of sexually abused children and categorized three predominant reactions:

1. Protective mothers, who protected their daughter from further victimization.
2. Immobilized mothers, who did nothing upon disclosure.
3. Rejecting mothers, who rejected their daughters and aligned themselves with their partners.

Myers determined that well over half of the mothers took protective action following the disclosure. Pierce and Pierce (1985) determined that 84% of mothers in their study believed their child's disclosure. Sirles and Franke (1989) found that in a sample of 193 cases of sexual abuse 78.5%

of the mothers believed their child's disclosure. Hooper (1992) concluded that as a result of an increase in positive responses by child welfare agencies, public awareness, and education on child abuse, the number of protective and understanding responses of mothers to disclosures is increasing.

Understandably, mothers can exhibit a wide range of appropriate responses to the disclosure of sexual abuse. Johnson's (1992) study of six non-offending mothers identified cognitive disbelief/belief and emotional denial/acceptance as two initial response patterns that were often present intermittently. Humphreys (1992) interviewed twenty-two non-offending mothers and determined that "the mother's belief in the disclosure/discovery of the sexual assault on her child was characterized by fluidity and change" (p. 28). Regardless of the process of disclosure and discovery, all of the mothers were noted as experiencing periods where they were both unconvinced or ambivalent about the legitimacy of the abuse. Issues related to this fluctuating maternal response included: (a) the general societal disbelief in the occurrence of sexual abuse, (b) the influences of the abuser over the mother and child, (c) contributing factors that influence the belief (age of child, medical and physical evidence of abuse, reaction of authority, and mother's previous potential childhood victimization), and finally, (d) the natural crisis belief/denial response evident in any traumatic situation.

Carter (1993) noted all 24 non-offending mothers in her study

experienced a number of negative physical, emotional, and social consequences in the aftermath of the disclosure. These included physical ailments, weakness, and inability to concentrate/complete tasks, as well as emotional responses of guilt and self blame, intense anger, and denial. Seventeen of the 24 women recalled memories of childhood victimization. Social consequences included isolation from and by social networks, family, and economic stress due to removal of the offender.

Summary

Hooper (1992) notes that the mother's belief in the child and willingness to assist agencies with protective intervention are the two most important factors in treatment of abuse. Based on the significance of these factors it becomes apparent that mothers are in a primary and crucial role regarding the protection of their children.

Disclosure has a significant emotional impact resulting in a wide range of responses from the non-offending mother. These responses can have a direct impact on the mother's abilities to seek intervention and protection for her child. It is evident that it is essential to include mothers in the treatment process. This not only includes involvement in the child's therapeutic and protection process, but recognition of the mother's emotional status and attention to her intervention needs.

Theories Utilized for Intervention

Intervention for the non-offending mother can include individual work (Cammaert, 1992; Hildebrand & Forbes, 1987; Sgroi & Dana, 1982), mother/child dyad therapy (Faller, 1988; Timmons-Mitchell & Gardner, 1991) and group therapy (DelPo & Koontz, 1991; Hewitt & Barnard, 1986; Hildebrand & Forbes, 1987; Johnson, 1992). As the model of intervention in this practicum is group work, the literature review will focus on group intervention.

Group Work

Courtois (1979), Gill (1973), Toseland and Rossieter (1989), and Goodman (1991) all support the benefits of group intervention. According to these authors, group intervention:

1. Creates a supportive environment for members to share similar experiences and emotions.
2. Provides an atmosphere of mutual support, respect and understanding.
3. Encourages mutual aid and discussion regarding effective coping strategies.
4. Reduces issues of isolation, alienation and stigmatization.
5. Provides an atmosphere where members can be validated, affirmed, and have their life experiences normalized.

6. Assists members in recognition and insight of issues and problems and to access appropriate problem solving techniques.
7. Experiments and provides feedback regarding new behaviours.
8. Develops self-esteem and encourages empowerment.
9. Creates an environment that enhances personal discovery.

Group work with the non-offending mother can assist her understanding of the ramifications of the abuse, responsibilities of the offender, and the child's healing process (DelPo & Koontz, 1991; Hildebrand & Forbes, 1987; Johnson, 1992; Sgroi & Dana, 1982). Finally, group intervention can provide the opportunity for empowerment for the mother, reinforcing the positive and protective maternal role and initiating an appropriate protection plan.

History of Group Work

Although group work was incorporated into casework and education interventions in the early 20th century, it was not officially recognized and identified with the social work profession for some time (Toseland & Rivas, 1995). Between the 1920's to 1930's group work was often connected to interventions within adult education, recreation and community work. During the 1940's and 1950's group work was defined as "insight orientated" (Toseland & Rivas, 1995, p. 50), and became associated with therapeutic interventions related to mental health issues.

Hare (1976) defined the 1950's as the optimal period of the study of

group interventions when group work began to be associated with social change and community development. During the 1960's the value and progress of groups receded due to the extensive focus on educational training programs and the general trend to move away from specific interventions to more generic social work practice (Toseland & Rivas, 1995).

During the 1970's fewer professionals expressed interest in obtaining skill and experience in group work intervention (Toseland & Rivas, 1995). However, during the 1980's and 1990's interest expanded by the promotion of formal group work associations, conferences and publications devoted to the benefits of group work as an intervention within social work practice.

Principles of Group Work

Group work always incorporates values of social work and social work practice (Glassman & Kates, 1983). The direction and type of intervention provided within a group setting is directly affected and influenced by norms of society, the client's value system, and the facilitator's individual and professional beliefs (Morales & Sheafer, 1992).

A number of basic values are accepted and incorporated into social work and social work group practice. These include (a) respect for the dignity and worth of the individual, (b) respect for the right to autonomy and choice, (c) the right of the individual to be involved in the intervention process, (d) maintaining a non-judgemental position, (e) advocating for the

individual, and (f) assisting in the process of providing interdependence between the individual and society (Brill, 1990; Siporin, 1975; Konopka, 1983).

Toseland and Rivas (1995) have further identified three specific values of group work within social work practice. These include (a) the right to obtain mutual aid and support within the group intervention process, (b) respect for the group's right and ability to empower its members, and (c) the right and power of the group to assist in the process of obtaining insight and understanding for its members.

These generic values outline important aspects of social work and group practice. They provide a basic outline of boundaries, guidelines and responsibilities and should be implemented by those initiating a group intervention.

Treatment Groups

Although there are a number of reasons for formulating a group, the basic purpose can be broken down into two areas, the treatment and the task group. As this practicum is based on the implementation of a treatment group intervention, the remaining material will focus specifically on aspects of the treatment group and its process.

The treatment group provides a intervention for meeting members' social-emotional needs. The roles are not defined prior to the initiation but are determined via the group interaction and process (Toseland & Rivas,

1995). Evaluation is based on the ability of the intervention to meet the individual and group needs.

Various authors have discussed the benefits of group treatment in the practice of social work (Klein, 1972; Hartford, 1972; Milson, 1973; Northen, 1969; Schopler & Galinsky, 1984; Shulman, 1992; Toseland & Rivas, 1995). Positive aspects of treatment group work include the recognition of group commonalities, provision of mutual support, and an opportunity for members to practice effective problem solving (Toseland & Rivas, 1995). In relation to vicarious learning, group work has been highlighted by some as being more positive and effective then individual interventions (Northen, 1969; Shulman, 1992; Toseland & Rivas, 1995). Peer feedback provides members with information from a non-threatening source initiating positive change. Gilbert, Miller and Spercht (1980) further state that the incorporation of group discussion, role playing, and testing of new behaviours and reactions in a safe environment are specific and beneficial aspects of the treatment group process.

Corey and Corey (1987) outline conformity and dependency as some disadvantages of treatment groups. Furthermore, the use of self-disclosure can create vulnerability, format can become rigid, aggressive members can overwhelm more passive individuals, and members can sabotage the group process (Corey & Corey, 1992; Konopka, 1983; Shulman, 1992).

Empirical studies tend to support clinical observations and findings

related to the benefits of treatment group work (Klein, 1953; Hartford, 1972; Milson, 1973). Toseland and Siporin (1986) determined that group treatment was more effective than individual treatment in 25% of the studies reviewed. The combined clinical and empirical findings suggest that there are benefits to the use of treatment groups, particularly in relation to addressing difficulties within relationships and issues of social isolation.

Types of Treatment Groups

Within social work group practice treatment groups have a variety of agendas and goals. Toseland and Rivas (1995) outline five different types of treatment groups with specific characteristics and goals. These include: support, education, growth, therapy and socialization.

Support Groups

Support groups access supportive intervention strategies to assist members in coping with stressful situations and adopting effective coping strategies (Klein, 1972; Toseland & Rivas, 1995). The process of sharing collective experiences encourages empathy, emotional release, and the development of self awareness and understanding. As well, the intervention provides a sense of normality reducing alienation, isolation and helplessness.

Educational Groups

Purely educational groups focus primarily on the presentation of material and the acquiring of skills. Psychoeducational groups incorporate these techniques as well as addressing the developmental and emotional

needs of the individual group members (Barth, Yeaton & Winterfelt, 1994; Goldman, 1988; Toseland & Rivas, 1995).

Growth Groups

Growth groups provide an opportunity for individual growth via collective sharing, insight and understanding, and the provision of a safe environment to practice new coping strategies (Toseland & Rivas, 1995).

Therapy Groups

Therapy groups assist members to alter their behaviour, address personal issues, and adopt more effective coping strategies related to some difficulty or trauma (Hartford, 1972; Klein, 1972; Milson, 1973; Toseland & Rivas, 1995). Beyond support groups, therapy groups attempt to provide rehabilitation and behavioural change.

Socialization Groups

Socialization groups provide an opportunity for members to learn social skills and apply socially acceptable behaviours (Toseland & Rivas, 1995). An objective is to improve communication and interpersonal relationships via activities and structured exercises. The group is utilized for membership participation and cohesion.

Composing the Treatment Group

There are a number of decisions relevant in the creation and composition of a specific treatment group. Choices in regards to open and closed membership, homogenous or heterogenous selection, group size, and

diversity or demographic selection can have a major impact on the group dynamics and successful completion of outlined objectives and goals.

Open or Closed Membership

An open group provides a consistent size by maintaining the group numbers and replacing members as they terminate. An open door policy to group structure has a number of benefits. These include the ability (a) to serve more clients, (b) to access new ideas by rejuvenation from new members, and (c) to sufficiently address the group needs and identified goals.

There are also a number of disadvantages of the open door approach. These include (a) the repetitious format; (b) the potential loss of members; (c) the difficulty achieving group cohesion; and (d) the difficulty planning and implementing specific topics and goals for members at various stages in the group and healing process. Hartford (1971) further notes that open groups can create instability resulting in potential breakdown of leadership, group cohesion and identity.

In a closed group maintenance of membership and group cohesion is more probable, values and norms are more consistent and clear, and goal setting is more direct and stable (Heap, 1984; Toseland & Rivas, 1995; Yalom, 1985). Advantages of a closed group include a more positive group attitude, consistency regarding roles and expected group behaviours, and a controlled environment for the facilitators (Hildebrand & Forbes, 1987;

Toseland & Rivas, 1995).

Homogenous and Heterogenous Groups

Toseland and Rivas (1995) define homogenous groups as having similar goals and common experiences. Members share characteristics in relation to age, education, cultural origins, social interactions and the issues or problems being presented. Recognized similarities among members can increase identification and cohesion within the group (Heap, 1984; Toseland & Rivas, 1995). Diversity or heterogeneity of group members can create a positive learning atmosphere because of a variety of skills based on various life experiences, perspectives, backgrounds and abilities. The focus on diversity within the group can help members explore, understand, and appreciate various positive and effective coping strategies (Heap, 1984; Toseland & Rivas, 1995).

In defining the dimensions of a treatment group research appears to encourage a group that is homogenous regarding shared issues and concerns but heterogenous regarding background, life experiences and coping strategies (DelPo & Koontz, 1991; Hildebrand & Forbes, 1987; Toseland & Rivas, 1995). Literature indicates a number of characteristics that should be considered when determining group selection. These include age, gender, socio-cultural factors, developmental abilities, and communication and interaction skills (Carlock & Martin, 1977; Hildebrand & Forbes, 1987; Toseland & Rivas, 1995). The facilitator needs to determine

the appropriate composition in order to effectively meet group expectations and goals.

Group Size

Bertcher and Maple (1985) and Toseland and Rivas (1995) suggest that group size should be based on the objectives and goals of its members and their contributions to the group. Regarding treatment groups the size generally ranges from no less than three to more than ten.

Group Development

The concept of group development focuses on the process of growth, maturity, and cohesion that a group achieves as members interact and form relationships and roles within the group over time (Berman-Rossi, 1992; Mennecke, Hoffer, & Wynne, 1992). Three types of developmental models of group development include the linear-progressive (Bennis & Shephard, 1956; Tuckman, 1965), life-cycle (Garland, Jones, & Kolodny, 1965, 1972; Glassman & Kates, 1983; Tuckman & Jensen, 1977), and the non-sequential models (Gersick & Hackman, 1990; McGrath, 1991).

This practicum will focus on Garland, Jones, and Kolodny's (1965, 1972) life-cycle model of group development. This model is based on the assumption that groups develop through stages similar to that of life- birth, growth, and death (Mennecke et al.,1992). As well, this model emphasis the importance of a termination stage in group development. Garland et al. (1965, 1972) indicate that the central theme of the model is closeness. This

struggle is reflected in five stages of group development: (a) pre-affiliation, (b) power and control, (c) intimacy, (d) differentiation, and (e) separation.

Stage 1- Pre-affiliation

This stage involves the development of familiarity between members regarding life experiences and reasons for attending group. Trust and commitment are identified as members interact with each other and address issues of internal and external ambivalence and avoidance (Garland et al., 1965, 1972). Members attempt to obtain what they can from the group experience without taking any risks. Addressing safety and providing a non-intimidating atmosphere is essential for progress into other stages.

Stage 2 -Power and Control

As safety is reinforced members may choose to become more emotionally invested in the group process. Power and control among members and between members and the facilitator become apparent. Roles appear, patterns of communication become identifiable, alliances and sub-groups emerge, and challenges of other members occur (Garland et al., 1965, 1972). This is an inevitable process and necessary for members to establish their positions and exercise their power. The members struggle with autonomy regarding the worker's central power and control (Garland et al., 1965, 1972).

Stage 3- Intimacy

Within this stage there is an increase in individual and group demonstration of emotion and mutual support. The group becomes more like a family with expression of sibling rivalry and open references to the worker as a parent (Garland et al., 1965, 1972). The clarification of issues of power and control and increase in emotional intensity provide an environment free to address autonomy and intimacy and incorporate the group experience into personal growth and self change.

Stage 4- Differentiation

By addressing intimacy and acceptance of mutual and personal needs members become more able to differentiate issues, individual rights, and relationships within the group setting (Garland et al., 1965, 1972). Members demonstrate high levels of communication and mutual identification. The group becomes more efficient with functional roles, flexible status hierarchies, and shared leadership. The cohesive atmosphere focuses on provision of mutual support and experimentation of new coping strategies. Power and control issues are minimal.

Stage 5 -Separation

The final stage occurs when the purposes of the group have been accomplished and the process of separation and termination is initiated. Members begin to disengage and access new resources for meeting their personal needs. Within this stage members may demonstrate regression,

denial, and recapitulation as forms of coping with termination (Garland et al.,1965, 1972). If the group was successful, members may begin to demonstrate incorporation of the group experiences into addressing issues within their daily lives (Garland et al., 1965, 1972).

Tasks and Skills of the Worker

Knowledge of stages of group development is insufficient without definition and understanding of tasks of the social worker that bridge knowledge and action (Berman-Rossi, 1992). Toseland and Rivas (1995) and Garland et al. (1965, 1972) indicate a number of specific tasks of the worker throughout the group development. The following is an integration of these tasks as outlined by Toseland and Rivas' (1995) framework of group development. This includes (a) the planning stage, (b) the beginning stage, (c) the working stage, and (d) the ending stage.

The Planning Stage

Within this stage the worker must focus on tasks of (a) establishing group purpose, (b) determining and recruiting membership, (c) composing the group, (d) contracting, and (e) preparing the group environment (Bertcher & Maple, 1985; Garvin, 1987; Toseland & Rivas, 1995). The worker must support distance to encourage the development of trust and provide activities to create program structure (Garland et al., 1965, 1972). The planning process is influenced by the purpose of the group, potential needs of the members, and expectations of the worker (Toseland & Rivas,

1995).

The Beginning Stage

Within this stage the worker has a number of objectives including (a) introduction of members, (b) clarifying group purpose and goals, (c) reinforcing confidentiality and a safe environment, (d) guiding development, (e) balancing task and socio-emotional aspects of group process, and (f) anticipating obstacles (Berman-Rossi, 1992; Toseland & Rivas, 1995). The worker permits challenges to assist in creating a safe balance of shared power and control and autonomy (Garland et al., 1965, 1972). Addressing these tasks successfully within the initial stage of development will assist the social worker in transition to the middle or working stage of group development.

The Middle Stage

The middle stage of a treatment group is the stage in which members focus on group goals and objectives that were developed within the planning stage. Within the working stage focus is on (a) maintaining group goals, (b) motivating members, and (c) assisting members to obtain their treatment goals (Toseland & Rivas, 1995). This can be accomplished by completing social work tasks including providing structure, empowerment to members, and achieving group goals. It is important that the worker balance worker/group responsibilities as the members vacillate in abilities to accomplish group goals (Garland et al., 1965, 1972).

The Ending Stage

Toseland and Rivas (1995) are consistent with life-cycle models of group development (Garland et al., 1965, 1972; Glassman & Kates, 1990) regarding the importance of separation and termination of the group. The tasks of the worker at the time of termination include (a) consolidation and review, (b) reinforcing efforts of positive change, (c) promoting internalization (d) encouraging separation and independence, and (e) making necessary referrals and plans for the future (Garland et al., 1965, 1972; Toseland & Rivas, 1995). In treatment groups where there has been a high level of mutual support and self-disclosure a structured and clear termination may be required to reduce emotional intensity and encourage separation (Toseland & Rivas, 1995).

Group Dynamics

Group dynamics influence the behaviour of individual members and the group as a collective system. Awareness and appropriate implementation of group dynamics can have a positive impact on members and group process. Failure to do so can result in chaos and instability (Toseland & Rivas, 1995). Communication and interaction patterns, cohesion, social control, and group culture are essential for the development of positive group dynamics.

Communication and Interaction Patterns

Group centred rather than leader-centred communication and interaction is encouraged in a treatment group setting (Northen, 1969; Toseland & Rivas, 1995). Group centred interaction refers to open communication between the leader and group members and between group members (Hartford, 1972; Toseland & Rivas, 1995). A group centred approach has a number of benefits for the treatment intervention including increased social interaction, positive morale, and overall group commitment.

Interaction patterns can be affected by emotional bonds between members, sub-groups and alliances, the size and physical arrangement of the group, and the power and hierarchy within the group.

Group Cohesion

Group cohesion is the development of the feeling of group identity or group spirit (Hartford, 1972). Cohesion is a necessary aspect of maintaining a successful group environment. A number of principles for achieving positive group cohesion include open communication between members, identification of members' needs, and achieving group goals. Focus on positive reinforcement of members and maintaining an appropriate group size to encourage communication and interaction should also identified (Cartwright, 1968; Hartford, 1972; Toseland & Rivas, 1995; Yalom, 1985).

Social Control Dynamics

Social control describes the process whereby the group obtains compliance and conformity from its members to function in an orderly manner (Toseland & Rivas, 1995). According to Northen (1969) social control is a prerequisite for the creation and maintenance of a cohesive group. Social control is created by the influences and interactions of norms and roles developed within the group and status of individual members.

Norms are shared beliefs and expectations of specific and general patterns of behaviour that are acceptable in a group (Hartford, 1972; Klein, 1972; Milson, 1973; Toseland & Rivas, 1995). Norms emerge as the group progresses and members interact. The introduction of norms also reduces the need for power and control by the facilitator through the stabilization and regulation of group behaviour. Roles define behaviour according to a function or task that a group member performs (Hartford, 1972; Klein, 1972; Northen, 1969; Toseland & Rivas, 1995). Roles provide an avenue of social control by advocating division of labour and power. Status also provides a social control function by ranking members' positions within the group (Klein, 1972; Nixon, 1979; Northen, 1969). Hierarchies result in low, medium, and high status members who may deviate or conform to the group norms based on their established positions.

Group Culture

Group culture refers to values, beliefs, customs, and traditions held in common by group members (Olmsted, 1959). Group culture is produced by the diversity of values of its members. Facilitators who model a value system reflecting appreciation of independence, acceptance, and fairness can have a positive influence on the final achievement of individual goals and group outcomes. Group conflict needs to be mediated by the facilitator to avoid deterioration of group cohesion and membership loss (Olmsted, 1959; Toseland & Rivas, 1995).

Leadership

Models of leadership identified within the literature include the social goals model (Klein, 1953; Troop, 1968), the remedial model (Garvin, 1987; Rose, 1989), and the interactional model (Papell & Rothman, 1980; Toseland & Rivas, 1995). The interactional model was chosen for the purpose of this practicum. The interactional model identifies that leadership emerges through the interactions of the group, its members, the leader, and the environment (Toseland & Rivas, 1995). The facilitator accesses the group processes to create a therapeutic environment that encourages empowerment and change. By focusing on the needs of the members and the demands of society the interactional model encourages reciprocal sharing, explores new coping strategies, and creates a system of mutual aid (Papell & Rothman, 1980; Toseland & Rivas, 1995).

Summary

The understanding and implementation of small group theory provides the basic framework for effective social work group practice. Integration of the theory and practice skills is essential for the achievement of individual and group goals within the treatment group.

Feminist Approach to Intervention

Unlike a traditional approach, the feminist perspective encompasses the larger socio, historical, and psychosocial systems (Humphreys, 1992). The issue of power is central to the ideology. Feminism argues that there is an inequality of power present in all aspects of society. This includes relationships, the employment field, health and welfare, and the legal system. Throughout these systems, men have more power, resources and opportunities (Birns & Meyer, 1993).

History

The emergence of the industrial revolution in the 19th century resulted in the consequential separation of work and home life (Goldner, 1985; Hare-Mustin, 1978). Productivity was rewarded resulting in the higher social status of the male, while the more economically unproductive such as women, children and the elderly were left at home with ambiguous positions (Hare-Mustin, 1978). Over time this social process resulted in two separate gender spheres, the private expressive role of females and the public instrumental role of males (Goldman & Goldner, 1985; Hare-Mustin,

1978). The family became the speciality of the female. With the decline of the importance of the family within the last number of years, there has also been decline in the importance of the role of the wife and mother (Hare-Mustin, 1978).

Academic writings and publications have encouraged unequal roles and status hierarchies between the genders (Goldner, 1985). These have assisted in the preservation of the traditional female role to the point that women are equated with the home and are seen as embodiments or extensions of the family (Goldner, 1985).

Burden and Gottlieb (1987) indicate that traditional society influenced by gender and sex-role socialization has left women incapacitated to effectively deal with challenges in their daily lives. The authors outline six dysfunctional consequences of traditional socialization for women. These include:

Importance of Affiliation

This involves the reinforcement for women from early childhood to value and desire positive attention and approval from others more than internal satisfaction, self confidence and personal achievement.

Caretaking Role

This includes the expectation that women will adhere to the primary role of caretaking including both the physical (household maintenance) and emotional (support, nurturance and care) activities. In order to maintain

these roles and expectations successfully within the family system the woman will often have to forgo or minimize her own emotional needs and desires.

Power Imbalances

Women are taught from an early age to appreciate and respect the power differentials. They are also socialized to feel uncomfortable with a number of characteristics including aggression, determination, and self-reliance associated with power and authority. As a result women inevitably become associated with a lower class position within society.

Dependence

As a result of the need and drive for approval and power injustices the role of women becomes dependent. Women have also been socialized to be passive and compliant, to avoid risk-taking, and to maintain a predominant role within the home. Sex-role socialization has successfully hindered many women from feeling confident and effective in addressing many stresses and experiences beyond the scope of their traditional expectations.

Responsibility and Control

As a result of ingrained expectations women will often internalize blame and externalize successes. Therefore, any difficulties within the relationship, family or system will be a result of some personal failure and any successes as a result of some factors outside of their control. This

inability to appreciate personal contributions and environmental factors only further reinforces the woman's sense of lack of control and power over her life.

Conflict with Other Women

Socialization has reinforced women to devalue interactions with other women. Socialization has reinforced the obtainment of a husband and family for personal success and economic security. Therefore, other women are often considered adversaries and rivals in the quest for accomplishing this expectation.

Feminist Perspective and Social Work Practice

Feminist social work remains somewhat isolated from mainstream social work practice (Goldner, 1985; Hare-Mustin, 1978; Russell, 1989). Relevant issues such as gender and power imbalances continue to obtain limited attention or concern. Russell (1989) indicates a number of potential reasons for the minority of feminist values practised within the field of social work. She argues that an unclear and inconsistent definition of feminist theory results in vague generalities that can become difficult to define and implement in practice. Secondly, although social work is predominantly a female dominated profession, it maintains an often traditional, androcentric presentation with male domination regarding management and policy. Finally, the incorporation of feminist practice requires significant changes and shifts in power and hierarchy. The expectations of feminist practice can

often create resistance, particularly among those who are presently benefitting from the traditional structure.

Feminist Principles

"Social work goals and values are demonstrably compatible with feminist philosophy" (Russell, 1989, p. 69). Feminist social work, where the impact of sexual inequality, power and status are being recognized, is a valuable intervention within social work practice. Russell outlines the following basic assumptions that are key to the values of feminist social work practice:

1. The rejection of negative socially prevalent evaluations of women and the separation of valued and devalued tasks and attributes from gender.
2. The belief that the unequal distribution of power and authority of gender has been initiated and reinforced by the social and cultural environment resulting in sex-role stereotypes.
3. The feminist principle incorporates equality, equal participation and shared knowledge.

Russell further suggests that the definition of feminist practice includes five central skills that should be incorporated into social work practice. These include: positive evaluation of women, social analysis, encouragement of total development, behaviour feedback and self-disclosure.

Positive Evaluation of Women

This includes the recognition and reinforcement that a woman's skills and abilities have been and continue to be displayed in a negative light. Positive evaluation highlights strengths, defining the woman's perseverance and preservation regarding issues of isolation, discrimination, and restriction.

Social Analysis

This skill provides the opportunity for cognitive restructuring related to inequalities of gender, recognition of influences of traditional sex-role stereotyping, and appreciation of the restrictions prevalent in society. Assessment and change are redefined from personal weaknesses or pathology to unrealistic and inappropriate social and political expectations.

Encouragement of Total Development

This involves the practice and experimentation of new behaviours including those previously deemed restricted due to gender. The expectation is that this will provide opportunity for the assimilation of gender and gender behaviours or androgynynous development. The ultimate goal is the ability for each gender to obtain the positive aspects of each other's behaviours and remove the restriction of sex role stereotyping.

Behaviour Feedback

This skill defines and evaluates a behaviour in order to create change. The purpose is to point out behaviours that initiate effective change and to avoid labelling or diagnosis. Behaviour feedback is present focused,

providing an immediate point of reference and validation for the client.

Self-disclosure

Self-disclosure promotes client comfort, disclosure and personal insight. Feminist disclosures specifically reinforce an interlocking commonality between client and counsellor related to history and oppression for women within society. This commonality reinforces understanding, appreciation and consistency between counsellor and client regarding mutual goals and objectives of treatment.

Feminist Group Theory

Utilizing feminist theory in any group intervention provides the group members with awareness of the negative effects of a patriarchal society and encourages and facilitates skills to create positive change (Burden, Gottlieb, McCormick, & Nicarthy, 1983).

Burden and Gottlieb (1987) outline two basic tasks of group work with women affected by a gender-based society. The first task includes the addressing and counteracting the negative attitudes and behaviours women have learned as a result of gender specific roles and socialization. The second task of the feminist group is to process the historical experiences and responses of women in a traditional group environment, most notably in a mixed gender group. The authors outline four major strategies to assist in addressing these tasks.

Support to Decrease Isolation

Feminist group work provides an environment where women, often for the first time, can interact with others sharing similar experiences. The group process reinforces commonalities, positive non-competitive interactions, and the value of group members and other women. As well, a strong component of the feminist group is the opportunity for women to experience nurturance, caring and support.

Personal Versus Political Obstacles

Feminist group work attempts to address and reframe women's traditional attitudes of personal failure and inadequacies to encompass the political, social, and economic factors that contribute to the women's environments. The result is a recognition and understanding of the unequal and unfair expectations of the home, and economic and political systems. This awareness initiates the process of reducing self-blame and refocusing on positive and effective solutions.

Psychoeducation

Feminist group work further reduces the negative impact of sex role socialization via education and skill building. By the provision of education and the process of reframing and role modelling women can acquire practical skills and determine logical solutions. The group provides an open and safe environment for women to inquire about a number of concerns and issues not previously acceptable in their traditional socialization.

Problem Solving Techniques

These techniques break down and priorize issues for women into manageable and workable solutions. Moving from the verbal process to the physical implementation of the solution, members can learn from the experiences and successes of others. The group provides the environment to discuss strategies, practice new behaviours and discuss outcomes. The positive outcome of this problem-solving approach is a reduction of self-blame and increase in a personal sense of control.

General Components of a Feminist Group

The literature clearly reinforces that a key component to a feminist group intervention is an all female membership (Birns & Meyer, 1993; Burden & Gottlieb, 1987; Goldner, 1985; Gottlieb et al., 1983; Hare-Mustin, 1978). The primary purpose for an all female environment is to provide the opportunity for women to explore alternative and less stereotyped roles, to develop meaningful relationships with one another, and to incorporate skills that assist in greater control over one's own life (Gottlieb, et al., 1983). Clinical research has determined that in a mixed group women will often present as passive, deferring their feelings and discussion to men (Burden & Gottlieb, 1987; Gottlieb, et al., 1983). The absence of men is a constructive group strategy to avoid the reinforcement of traditional sex-role socialization.

Other components of a feminist group include a group focused

structure, use of role modelling and self-disclosure, and an emphasis on group empowerment (Burden & Gottlib, 1987; Hildebrand & Forbes, 1987). The main goals of these components include (a) to reduce power imbalances between the group facilitator and the group members, (b) to foster a safe environment where women are encouraged to participate and contribute to the group process, and (c) to strengthen group objectives and goals by emphasizing the commonalities between the facilitator and members and between the group members.

To assist with the process of empowerment of group members, the feminist group generally will concentrate on reducing any barriers to attendance. This can be accomplished by assisting with child care and transportation as well as providing a same sex group membership to avoid negative traditional sex-role socialization. The group's structure is often organized and time limited in order to counteract any dependency on the group or group leader (Burden & Gottlib, 1987). Finally, the group objectives are often explicit rather than individually treatment focused to reinforce the view that the women's problems are related to external forces and not personal inadequacies.

Summary

Feminist theorists argue that traditional society influenced by traditional sex-role stereotyping has inhibited women to cope effectively (Burden & Gottlib, 1987). Socialization has reinforced women to desire

affiliation from others, maintain a caretaking role, and accept responsibilities and power imbalances within the family system.

Through awareness and reframing of traditional sex-role stereotyping and appreciation of women's abilities, feminist practice rejects negative evaluations of women. By recognizing societal influences rather than assessing individual weaknesses, feminist practice attempts to change the context in which womens issues are addressed. Through experimentation of new behaviours, feminist practice validates the adoption of new skills and coping strategies and highlights existing strengths.

Utilizing feminist theory in a group intervention assists in providing an environment were women can determine commonalities, interact, and address traditional sex-role socialization. Feminist group work with the non-offending mother encourages equality and shared knowledge highlighting resources and responses necessary to empower women to begin to reconstruct their lives.

Group Work with Non-Offending Mothers

Groups offer a particularly suitable setting for helping victims of child sexual abuse and the non-offending parent. "The collective aspect of the group offers a reprieve from the isolation, secretiveness and shame that is central to the victimization" (Glaser & Frosh, 1993, p. 140).

Within the group non-offending mothers can begin to verbalize and share their pain, acquire skills in communication and problem solving

techniques, and gain confidence and therefore self-esteem in a safe and respectful environment. Empowerment assists in the diminishment of the non-offending mother's sense of vulnerability (Dominelli, 1989). This can impact on the mother's and the family's determination to cope, potentially decreasing the likelihood of further abuse.

In early work, Sgroi and Dana (1982) argue that any treatment program that addresses incestuous victimization must incorporate a therapeutic intervention directed at the non-offending mother. The authors outline a number of specific treatment issues and goals. These include (a) inability to trust, (b) impaired self-image, (c) denial and anger, (d) unrealistic expectations on children, (e) failure to establish and enforce limits, (f) impaired communication and socialization, and (g) external resources and supports.

The authors believe that the feelings of shame, isolation and stigmatization can be effectively addressed and potentially minimized in a group setting reinforcing collective experiences and mutual support. They also argue that confrontation is less threatening and more beneficial when obtained from peers. Finally, they believe that a group environment provides encouragement for members to acquire positive social skills and coping strategies.

Although the authors stress the relevance of group therapy, they acknowledge that it cannot address all of the therapeutic needs of the

mother. They encourage a multi-treatment approach with the initial implementation of individual therapy. They indicate that initial issues of low self-esteem and extreme isolation can often inhibit a mother from participating in a group. However, with the increase in perception of self-worth and treatment success many mothers can become more comfortable in a group environment.

Hewitt and Barnard (1986) acknowledge the importance of reinforcing the mother, her role, and the protection of the child within the family. The authors argue that group work is an effective intervention for mothers of incestuously abused children. They describe a time limited ten week group format. A number of treatment themes are identified including (a) loneliness and loss, (b) difficulty acknowledging anger, (c) economic disadvantages, and (d) relationship and boundary setting with children. The authors argue that the group setting provided the mothers with a safe atmosphere to address the personal emotional impact of the victimization.

Cammaert (1992) identifies the limitations of literature related to the non-offending mother and group intervention. She discusses a time limited seven week group intervention that provided education and information related to child sexual abuse and peer support. Themes included establishment of trust, adoption of effective coping strategies and addressing feelings of anger and blame. Finkelhor's model and members' aspirations and hopes for the future were also provided. Cammaert argues

that incorporation of this group model can reduce traditional mother-blaming, reinforce existing strengths, and empower mothers to maintain more positive coping strategies.

Hildebrand and Forbes (1987) also describe a model of group work for mothers of children who have been sexually abused. The authors indicate that mothers need education in order to acquire the skills to act in their children's defence. As well, they argue that the mothers' group can assist the non-offending parent in preparing and understanding the changes in her child's behaviours as the child proceeds through his or her own treatment and healing.

The authors conclude that there are three general stages that emerge within the group process. These stages include:

1. The ventilation of feelings, anger and frustration regarding the victimization and towards the male offender.
2. The process of establishing and understanding the ramifications of their own potential childhood victimization, issues of family of origin and the present abuse of their child.
3. The incorporation of the mother's healing and empowerment for the child in regards to potential further abuse.

The rationale and assumptions are that the supportive and emotional dynamics of the group process will assist in enabling the participants to (a) work through their trauma and accompanying anger at the offender; (b)

begin to address their own guilt, shame, and fear; and (c) establish understanding and appreciation of their role as the non-offending and protective parent.

DelPo and Koontz (1991) describe four recurring treatment strategies throughout their group work experiences with non-offending mothers. These include (a) non-critical acceptance and active listening, (b) provision of a structured environment with opportunities to observe and model appropriate behaviours, (c) restating and reframing group members' involvement with agencies and systems related to the abuse, and finally, (d) clarification of the mother's own role and involvement. The authors contend that increases in positive interpersonal interactions and experiences indicate the beneficial outcomes of the group process. Mothers listed some of the valued aspects of the group as including (a) increased self-awareness, self-worth, and confidence, (b) support and network building, and (c) the ability to express feelings in a safe and confidential environment. Group members were able to identify their expanded abilities and skill base in addressing issues related to their child's sexual abuse.

The Vancouver Incest and Sexual Abuse Centre completed an evaluation of The Integrated Treatment Model (ITM) for sexually abused children and their mothers in 1988. They reinforce that mothers are often challenged with denial and minimization due to the crisis of the disclosure. Their evaluation found that after the initial shock many mothers were

hampered with feelings of guilt for involvement with the offender, failure to detect and stop the victimization, and disbelief or misreading their child's cues. They also highlight that many mothers were also identified as victims of childhood physical, sexual abuse or neglect. This childhood deprivation increased the mothers' personal vulnerabilities and reduced their abilities to provide effective protection. This ultimately resulted in placing their children at more risk.

The report discusses an integration of individual, dyad, and group treatments. Themes of treatment included (a) exploration of family of origin and history of abuse, (b) self-esteem, (c) parent/child relationship, and (d) adoption of effective parenting skills and prevention. The group design was structured and educational in presentation and focus. The report outlines that histories of personal child sexual abuse, the emotional impact of court proceedings, and issues of poverty were all a direct challenge to the success of the intervention process.

Support groups can also be provided to both parents of children who have been sexually abused. This intervention can be effective when addressing extra-familial victimization. Winton (1990) identifies the limited research that evaluates the effectiveness of support groups for parents of children who have been sexually abused. The author provides a description and evaluation of a mixed gender, open-ended, educational/therapeutic group for parents that ran for 13 sessions. The focus of the intervention

was on addressing and understanding the emotional impact of the abuse and adopting positive coping strategies. The results indicated that the short-term intervention was too limited to effectively address the emotional aspects of the victimization but successful in increasing appropriate parenting skills.

DeVoss and Newlon (1986) also discuss a support group for parents of children who were non-violent and non-incestuously sexually victimized. They identified that the emotional impact of disclosure can immobilize parents at the very time their nurturance, strength and protection is most required. The authors discuss a separate supportive group format for both parents and children of the victimization. They encourage a short-term, structured format for 3 to 10 participants.

This group intervention for parents identified a number of therapeutic strategies for addressing issues. The group setting provided an empathetic and caring environment that allowed for ventilation of anger, guilt, and fears for the parents. The group also provided information on general child development, issues with the offender, and behaviour problems with their children. The group process encouraged establishment of positive support networks and assisted in reinforcing protection and long term prevention goals.

Although the results were not formally evaluated, DeVoss and Newlon (1986) argue that treatment of sexual abuse in isolation of the

parents is ineffective and inappropriate. They reinforce that a parent support group is a valuable treatment component for families. They identify that support groups of this nature assist in reducing parental stress and foster positive coping strategies for parents of children who have been sexually abused.

Summary

There is limited research pertaining to the use of group work with the non-offending parent. However, the available literature does suggest that there are benefits to group intervention with this population. Common treatment themes include ventilation of emotion, provision of mutual support, and acquiring new and effective coping skills.

Variations in the model of group intervention occur depending upon the type of sexual abuse. Support groups in the case of incest address issues specific to the non-offending mother. These include exploration and discussion of feelings related to the offender, the offender/child relationship, the marital relationship, and issues of loss. As well, when intra-familial sexual abuse has occurred, the non-offending mothers' group has a number of specific structural qualities. The most notable is the necessity for same-sex group membership. This characteristic provides mothers with the opportunities to meet with others in their position, to reinforce commonalities, and to learn that they are not alone.

Regarding further structural qualities of the non-offending mothers

group, the literature appears to value time limited (group duration of 10-14 sessions), psycho-educational and therapeutic group intervention (DelPo & Koontz, 1991; Hewitt & Barnard, 1986; Hildebrand & Forbes, 1987; Rempel, Hazelwood, & McElheran, 1989). However, most of the literature does not encourage the treatment of this issue in isolation. Recommendations of a multi-treatment approach including individual, dyad, and long term group therapy have been highlighted as valuable in effectively addressing the long term treatment issues.

CHAPTER 3

THE INTERVENTION

This practicum objective was to provide group intervention for mothers of sexually abused children. Based on a psycho-educational model, the purpose of the group experience was to assist mothers in understanding the emotional aftermath of sexual abuse for themselves and their children. Further aim of the intervention was to (a) encourage and facilitate positive and effective coping skills, (b) strengthen social support networks, (c) improve self-esteem, and (d) increase appropriate and protective parenting skills. The intervention was comprised of thirteen formal sessions and one informal celebration for closure. Pre- and post-group interviews were conducted to provide the opportunity to obtain relevant historical and contextual information and to assist in the evaluation of the group outcome.

Model of Intervention

The value of group intervention for members has been identified throughout literature (DelPo & Koontz, 1991; Hewitt & Barnard, 1986; Hildebrand & Forbes, 1987; Johnson, 1992). The group intervention was based on a feminist perspective, feminist group work, and small group theory.

The implementation of feminist values and feminist group work practice in a group intervention for non-offending mothers has a number of

benefits. The first involves the provision of supports to the caregiver to assist her in obtaining the resources to achieve control over her life. The second benefit of feminist group work is that it encourages the collective participation of the mothers to assist and address issues of social isolation, powerlessness and the emotional impact of the victimization. Through this process mothers can reevaluate their experience from a personal traumatic victimization into that of a survivor role and create a potential platform for change.

Thirdly, the feminist perspective encourages women to begin to recognize and acknowledge the social divisions including gender, race, and power. This includes how these forces impact on their general position in society and abilities to impact on their children regarding the issue of abuse.

Finally, the fourth benefit of this perspective is that it discourages the way in which children of sexual abuse and the non-offending mother are treated by other systems, challenging the traditional "victim", "mother-blaming" role of passive and ineffectual mothers and reinforcing the maternal caregiver as an active participant in the successful process of protecting and healing her child.

Group Objectives

The following were the specific objectives for the group intervention:

1. To develop an avenue for ventilation of feelings of anger and frustration regarding the victimization and towards the offender.

2. To develop and provide an environment of knowledge and understanding of children's emotions related to the abuse and to enhance abilities to address related behaviours.
3. To provide information and understanding regarding offending, offending behaviour and the offending cycle.
4. To develop and provide a process of establishing and understanding the ramifications of the mothers' own potential victimization and family of origin issues.
5. To use the group process to assist mothers in protecting their children and preventing future sexual abuse.

Themes of Intervention

Treatment of the non-offending mother can be conceptualized on many different levels (Sgroi & Dana, 1982). The goal of this intervention was to provide both education related to victimization and exploration into some of the issues impacting on the mothers. The following are treatment issues addressed within the fourteen week intervention. (For an outline of the 14 sessions please see Appendix A.) These issues have been recognized repeatedly throughout literature related to child sexual abuse and intervention with the non-offending mother (Cammaert, 1992; DelPo & Koontz, 1991; DeVoss & Newlon, 1986; Griggs & Boldi, 1995; Hewitt & Barnard, 1986; Hildebrand & Forbes, 1987; Johnson, 1992; Sgroi & Dana, 1982; Wilton, 1990).

Establishment of trust

Key to any group experience, the establishment of trust is of particular relevance to group intervention with non-offending mothers. Many members have had a history of physical, psychological or sexual abuse as children and as adults (Cammaert, 1992; Hildebrand & Forbes, 1987; Johnson, 1992; Sgroi & Dana, 1982). This is only further reinforced by the victimization of their child. As a result, many have difficulty with relationships due to issues of fear, hostility, suspicion or withdrawal (Sgroi & Dana, 1982). Intervention recognized these issues and provided an atmosphere where members could share their commonalities and experiences in a safe non-threatening environment.

Abuse- Past and Present

Discussion of child sexual abuse can provide a significant trigger to those mothers who have been previously victims of sexual or physical abuse within their family of origin (Cammaert, 1992; Hildebrand & Forbes, 1987; Johnson, 1992; Sgroi & Dana, 1982). As well, mothers may be further victimized by their present relationships. These negative experiences can directly impact on the non-offending mothers' abilities to cope and address the present concerns related to their children. Recognition of this history and appreciation of its impact was essential in determining the mothers' present capabilities and needs.

Dealing with the Emotional Impact of Abuse

Dealing with the emotional impact of the disclosure was a significant focus of the treatment. This included issues related to anger and denial. Treatment of these issues included identification of these feelings, acceptance and normalization, ventilation, and determining effective coping strategies.

Identifying Unrealistic Expectations

Intervention included identification of the unfair and unrealistic expectations placed on members within a patriarchal society. This included a recognition of the numerous roles and demands placed on members as women, partners, mothers and non-offending parents.

Addressing Children's Needs

Only after the mothers had been able to identify their own feelings, determine their own needs and establish their own goals were they effectively able to address issues related to their children. This included a recognition of the physical and psychological effects and coping behaviours of the victim.

Practice Effective Problem Solving and Coping Strategies

As a result of dysfunctional childhoods and often ongoing crisis, many non-offending mothers had limited coping and problem solving abilities. The intervention provided an effective and safe environment for mothers to address these issues, discuss options, and practice strategies.

Improving Self-Esteem

Due to numerous challenges past and present, these mothers often had difficulty identifying successes indicating a sense of failure, low self-esteem and self worth. The intervention process assisted the members in the process of externalizing the cause of these failures to inappropriate social and political expectations and standards and not personal inabilities or faults.

Decreasing Isolation and Maintaining Mutual Support

The group provided direct intervention in addressing issues related to lack of support and isolation. The group atmosphere provided an avenue for friendships and interaction both on a treatment and social basis. Members were able to provide mutual support and nurturing to each other.

Advocating with Systems

Many of the members could identify a number of difficulties with systems. The group provided a positive avenue to address issues related to the child welfare agency, police, court, and treatment services. As well, it addressed concrete services including housing authorities, city or provincial services, and schools.

Empowerment and Survival

The intervention process assisted mothers in recognizing and appreciating their strengths and abilities. By identifying them as survivors, not victims, the intervention reinforced their capabilities and rights to obtain

for their personal needs.

Description of the Practicum Process

Permission was granted by Winnipeg Child and Family Services to access clientele from the Winnipeg catchment area. Open, closed, voluntary or mandated protection cases were accepted. Referrals were also generated via the waiting list at the Elizabeth Hill Counselling Centre.

The plan was to accommodate 8 to 10 adult female birth-mothers or care-givers in a closed group. The group criteria included the expectation that each member would be involved in some aspect of care-giving for a child who had been a victim of sexual abuse. The group member was considered welcome regardless of the placement status of the child with the protection agency. There were no restrictions regarding referral of a client based on when the incident of sexual abuse occurred. However, the group selection criteria did require that the perpetration of sexual abuse be: (a) a parent or primary care-giver and child, or (b) a person in a position of trust (i.e., babysitter). The rationale for this criteria was that incidents regarding a care-giver or person in a position of trust would have emotional implications for the victim and non-offending mother different from a situation involving that of third party sexual abuse.

Group sessions were conducted at Elizabeth Hill Counselling Centre, 3-321 McDermot Ave., Winnipeg, Manitoba. The Centre is affiliated with the Psychological Service Centre of the University of Manitoba and provides

supervised training to students in social work and psychology in the areas of play, individual, marital, family, and group therapy.

Although status of group members with the child welfare agency could be voluntary or involuntary, participation in the group was voluntary. Initial referrals were obtained from co-workers, attached protection workers and community collaterals. A formal screening process was conducted to obtain more information regarding potential group members' willingness to attend group, to assess motivation and goals for attending group, and to evaluate potential contributions of group members in obtaining group/facilitator goals.

Consideration was not given to referrals where there was evidence of the mother participating in the sexual abuse. The rationale behind this restriction included the following: (a) that this was not an offender treatment group, (b) concern of scape-goating by other members, and (c) potential child protection concerns. Stipulations regarding addiction abuse were also enforced. Group members were accepted who had completed or were in the process of addressing addiction issues. Individuals who were successfully dealing with their addictions at the time of the group were expected to be actively engaged in treatment and were informed that they would not be allowed to participate in group under the influence.

Prior to the initiation of group sessions most of the participants were also provided with individual one on one sessions. The purpose of the

individual therapy sessions was to assist in establishing a therapist/client relationship and to define individual treatment goals. The appropriateness of multi-treatment options including individual, dyad, and family therapy were also discussed. The need for support services for the child were identified.

Dr. Diane Hiebert-Murphy from the Faculty of Social Work, University of Manitoba and Elizabeth Hill Counselling Centre was my advisor and provided supervision throughout the practicum process. Dr. Diane Hiebert-Murphy, Mr. David Charabin Director of Elizabeth Hill Counselling Centre and Ms. Janet Mirwaldt, Supervisor of Maryland Unit, Winnipeg Child and Family Services, Central were the advisory committee members for this practicum.

Each group session was documented and analysed for group participation, dynamics, reactions to content, issues of concern and group process. Video tapes of each session were reviewed in supervision. Finally, the specific recording procedures required by the Elizabeth Hill Counselling Centre were also completed.

Evaluation Procedures

To evaluate the effectiveness of the intervention group members' behaviours, attitudes and coping mechanisms were assessed prior to intervention and after the completion of the program.

Clinical research supports that mothers in abusive situations tend to have extremely low self-esteem (Carter, 1993; Hooper, 1992; Johnson,

1992; Myers, 1984-85; Schonberg, 1992). The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) was used as a pre- and post-test measure to evaluate the group members' levels of self-esteem. The ten item scale is designed for self-report and is easily administrated. The test is unidimensional requiring that the respondents be ranked along a single continuum ranging from those who have a very high (score of 0) to those that have a very low (score of 5) perception of self-esteem.

In addressing issues of reliability regarding the measure, Rosenberg (1965) reported a reproducibility coefficient of .92 in his sample. In general, "the RSES has satisfactory internal reliability because of its reproducibility coefficients" (Breytspraak & George, 1982). The convergent and discriminant validity of the RSES was examined by Silber and Tippett in 1965. The results provided strong evidence of convergent validity but only modest evidence of discriminant validity for this measure.

The second measure that was used for pre/post-testing was the Index of Parental Attitudes (IPA; Hudson, 1996). The IPA was developed to measure the parent-child relationship in regards to the degree, severity and magnitude of the problem. The IPA produces scores ranging from 0 to 100 and are regarded as true ratio scale values. A score of 0 indicates that the client does not have any of the attributes and a score of 100 represents the highest measurable distress level obtainable by the scale.

The scale has two clinical cutting scores, 30 and 70. Those who

score below 30 are determined to not be affected by the clinical problem being measured while those who score above are measured to have a significant problem in the area being assessed. Those who obtain scores of 70 or greater are considered to be experiencing severe distress potentially resulting in violence in this problem area. Regarding internal consistency, the scale has a reported alpha coefficient of .90 or larger. The scale almost consistently achieves validity coefficients of .60 or greater regarding content, construct, factorial and, known group validity (Hudson, 1996).

In conjunction with these measures, a consumer satisfaction questionnaire was completed at the end of the group sessions (see Appendix B). This simple rating scale included six questions measured on a scale from strongly agree to strongly disagree. It also included four open ended questions that were given to each participant to measure the client's satisfaction/dissatisfaction with the group and her success in meeting identified goals.

CHAPTER 4

ANALYSIS OF THE PRACTICUM PROCESS

Although recruitment encompassed all relevant Winnipeg social agencies, possible members for the practicum group intervention were mainly recruited via Winnipeg Child and Family Services and Elizabeth Hill Counselling Centre. Social workers from the numerous agencies were provided with information outlining the group experience and referral expectations. The initial list consisted of 17 referrals. Fifteen were contacted directly and two were immediately determined to not be appropriate because the sexual abuse was third party. Five of the 17 referrals contacted were not interested in the group due to time constraints or discomfort with the group intervention. Others notably had felt pressured from their social workers and were not interested or prepared to seek support regarding this matter at this time.

Pre-group interviews were scheduled up to two months prior to the commencement of group. The purpose of the pre-group interviews was to provide an opportunity for me (a) to assess participants' suitability and interest; (b) to obtain demographic, contextual and baseline information; and (c) to determine individual expectations and goals. The pre-group interviews also included provision of information regarding the practicum and expectations. The practicum consent form was reviewed and signed (see

Appendix C).

All of the 10 women interviewed were appropriate for the group intervention. Many were provided with a number of individual sessions prior to the initiation of the group process. Of the ten women, seven completed all of the group sessions. One woman completed two pre- individual sessions but did not participate in the group due to pending child protection issues. Two members did not complete the group; they terminated after the 4th and 8th sessions respectively.

The age range of the mothers in the group was from 23 to 59 with a mean age of 49. They consisted of 6 birth mothers, 1 grandmother and 1 foster mother. All of the mothers were involved with Winnipeg Child and Family Services at the time of screening either due to the sexual abuse or other child protection issues. Of the nine women, seven were voluntary participants, and two were mandated but consented in pre-interviews to become involved in the group. Eight of the nine women had children previously or presently in care of the agency due to the victimization and/or child protection concerns.

In addressing other therapeutic involvement regarding the sexual abuse three of the nine women were involved in individual counselling at the time of the group. Two women had their children involved in play therapy and had obtained some minimal direct support. Two women had completed a previous mothers' support group and two had not received any

intervention beyond the investigation and involvement of the child welfare agency.

Five of the group members were Aboriginal and four were Caucasian. Although they came from a range of socio-economic and educational backgrounds, six out of seven of the mothers were on social assistance at the time of participating in the group. All of the mothers had one or more children who had been sexually abused by a parent, relative or significant caregiver.

Six of the group members were provided with 1 to 2 individual sessions prior to the initiation of the group. These sessions provided an opportunity to connect and engage in direct intervention. These sessions assisted in the building of relationship and trust between client and therapist, influencing the ability of the client to follow through with the group, and reducing the chance of membership loss. Although attempts were made to provide all of the members with individual sessions, three members could not comply. Reasons included scheduling difficulties, a pending pregnancy, and in one case, reluctance on the part of the member to attend.

Following are individual profiles for each group member. These profiles are based on referral and self-reported information that was gathered during the referral and pre-group interviews. Group members' names and personal circumstances have been altered to protect the

confidentiality and identities of the group members.

Client Information Profiles

Jonie

Jonie was 42, Metis and born on a reserve. Jonie had never married and was a single parent of five children.

Jonie requested involvement in the group due to the sexual abuse of her 8 year old son, Jamie. Jonie indicated that Jamie was victimized physically and sexually by a foster parent while in care of the agency. An investigation was conducted and charges were pending. Jamie was also involved in an incident of inappropriate sexual play with a female child. This incident made Jonie fearful for her son's potential vulnerability to be re-victimized.

Compounding Jonie's fears for her son was her own childhood history of sexual abuse. Due to Jamie's sexualized behaviours, involvement with the agency, and treatment, Jonie had significant flashbacks and difficulty coping with her own memories. She indicated feelings of helplessness, guilt, and extreme anger regarding her own history of victimization. This was the first time Jonie had sought assistance for herself and her child.

Jonie identified that she had come from a dysfunctional family with issues of addiction, domestic violence and sexual abuse. Jonie disclosed that she was a multiple victim of sexual abuse as a child by numerous immediate and extended family members. Jonie indicated that she disclosed

these assaults to her mother but was not believed or protected.

Jonie identified previous addiction issues and indicated that alcohol was still a dysfunctional coping mechanism. Previously, Jonie was involved with Winnipeg Child and Family Services due to child protection concerns. Jonie presented as open and forthcoming regarding this involvement and indicated clearly that she lost her children for a period of time due to her inappropriate coping and addiction issues.

Dana

Dana was 49 and Aboriginal. Dana described her own family of origin as stable and appropriate. She denied any addiction issues or violence by either of her birth-parents.

Dana was a single parent and had three children, Todd (age 20), Cindy (age 19), and Barbra (age 16). Dana was common-law with the children's birth-father until the early 1990's when he left the relationship. Due to this stress, Dana became depressed and was placed on medication.

Dana became re-involved with her ex-partner in the mid nineties. It was during this time that she began to have significant behavioural problems with her children. Cindy began to become actively involved with alcohol and criminal activities. At age 12 Barbra self referred to CFS requesting placement in care. While in care, Barbra disclosed sexual abuse at the age of 8-9 by her birth-father. The birth-father denied the allegations. Dana presented as inconsistent regarding her belief of her daughter. She

continued to maintain a relationship with the alleged offender, outside of the home. At the time of group no charges had been laid and Barbra remained in agency care.

Dana, who had never attended a prior support group, was mandated by her protection worker to attend this group intervention. The referral source was concerned about Dana's presentation and doubt regarding her daughter's disclosure. Although mandated Dana admitted a need for further information and education regarding sexual abuse and offending behaviours. Dana's continued attempt to remain neutral had admittedly become an emotional challenge. Dana indicated feelings of frustration, anger, helplessness, and self blame regarding the sexual abuse and separation between her partner and her child. As well, Dana identified isolation and limited appropriate emotional supports.

Sherry

Sherry was 29 and Aboriginal. She identified a significant history of domestic violence, addiction and physical and emotional abuse within her family of origin. She also identified experiencing flashbacks regarding potential sexual abuse by her step-father.

Sherry was a single parent of four children. She was previously married on three occasions. She left her first partner after a few years of marriage due to extensive physical abuse. In Sherry's second marriage there were a number of problems including domestic violence and addiction. Her

husband was charged and convicted of physical abuse of Sherry and her daughter in the early 1990's.

In mid 1990 Sherry became involved with her third husband. The relationship went through an initial honeymoon period with few issues of violence. However, after a period of time the emotional and physical abuse began to intensify resulting in separation. Just after the separation Sherry obtained disclosures from a number of her children regarding sexual abuse by her ex-partner. The allegations consisted mainly of fondling and charges were stayed due to a lack of evidence.

After the disclosures Sherry went into a deep depression. She began to abuse solvents and her children came into agency care. At the time of the initiation of group Sherry was working towards her children returning to her care.

Sherry was self referred and extremely motivated to attend group sessions. She verbalized a need to obtain personal support to address the emotional impact of her children's victimization. It should be noted that Sherry did not attend group after the fourth session because of the reemergence of addiction issues. She was referred to appropriate support services by her protection worker at that time.

Cindy

Cindy was 30 and Metis. Cindy was the youngest sibling out of 6 children. Cindy did not report any concerns regarding addiction or violence

in her childhood.

Cindy was referred to the support group by an agency play therapist regarding her only child Edward (aged 4). Play therapy was being provided to Edward subsequent to a disclosure of ongoing sexual abuse by a female babysitter. Edward had provided limited information regarding these incidents and no medical evidence could be determined resulting in pending charges. Since the disclosure Edward had displayed a number of challenging behaviours in daycare and at home. Cindy reported difficulties and extreme frustration with managing Edward's behaviour.

Cindy admitted to being extremely emotionally invested in her son's situation. She presented as having difficulty separating her own fears, needs, and concerns from those of her son. She had developed a "fix it" attitude with limited appreciation of the dynamics and causes of her son's behaviours.

Cindy had previously attended a support group for mothers of children who have been sexually abused. She was interested and motivated in attending a second group to further address these issues.

Julie

Julie was 59 and Caucasian. She provided limited information regarding her family of origin, defining it as addiction free and stable. Julie indicated that when she was 18 she was sexually assaulted by her sister's boyfriend. She never disclosed this information to her parents or the police.

Julie was married to an Aboriginal male and resided on a remote reserve from adolescence until her mid thirties. She left this relationship due to his substance abuse, isolation, and poverty. Julie married her second partner and resided with him until his death due to cancer. It was after his death that her eldest daughter disclosed chronic sexual abuse by her step-father. Initially not supportive of her daughter, Julie has since become believing of her daughter's allegations.

Julie was referred to the support group by her agency protection worker. At the time Julie was applying for guardianship of her grandson Bobby (age 10). Bobby was sexually abused by his birth-father, Julie's son. Bobby was apprehended from his father and criminal charges were pending. Julie successfully obtained guardianship of her grandson prior to the beginning of group.

Julie had previously attended and completed a mothers' support group. She was voluntary and motivated to participate in this intervention. It should be noted that Julie did not attend group after the eighth session due to child care responsibilities. However, it was also determined that the group experience may have become too emotionally intense for Julie.

Susan

Susan was 38 and Aboriginal. Susan was a multiple victim of sexual abuse as a child and as an adult. Within her family of origin there were a number of victims, victim/offenders and offenders. As well, her immediate

and extended family have ongoing issues with alcohol and solvent addiction and violence.

Susan was a married mother of nine children. Susan left her first husband due to his violent behaviour. Susan defined her second marriage as being filled with extreme violence, verbal abuse, control, and sexual victimization. The couple attended counselling in attempts to address these issues but separated in 1992. Susan was re-married for the third time but had recently separated due to ongoing issues of violence.

There had been a number of repeated victimizations and offending concerns regarding Susan's children. Her eldest daughter was sexually abused a number of years ago by a male babysitter. She was re-victimized a few years later by a male family member resulting in charges but no conviction. Susan also expressed concerns that this daughter may have been sexually abused by her second husband, although there had been no disclosure.

Susan also became concerned regarding her youngest son's sexualized behaviours in the late 1980's. This child was previously sexually abused by a male family member. Escalation of sexualized play and potential offending behaviour between all of the children resulted in Susan requesting support from outside agencies. At that time the children attended treatment and a number of disclosures were made. Ongoing support continued with Susan and some of her children. In the late 1990's her youngest child was

charged with sexual assault of four female minors. At the time of group Susan requested support from CFS to place three of her male children in care due to concerns of violence and potential offender behaviour.

In the early 1990's Susan became involved with substance abuse due to flashbacks from her own victimization. She was able to complete treatment successfully a few years later.

Susan has had extensive individual and family intervention regarding sexual abuse. However, Susan indicated a limited opportunity to address her own family of origin issues due to the constant state of crisis of her own family unit. Susan was open and motivated to attend group.

Tina

Tina was 23 and Caucasian. She had three children ages 5, 4, and 3 placed with maternal grandparents and two infant children in her own care.

Tina indicated that she was a victim of sexual abuse for approximately an eight year period by her birth-father. She advised that she had not disclosed this abuse to her family or pressed charges. Tina only recently obtained individual support to address her history of child sexual abuse.

Tina became involved with the father of her first three children as an adolescent. Her second child was physically assaulted by the birth-father resulting in significant injuries. The children were placed in care at the time of the incident and the father was charged and convicted. The children were

later placed with their maternal grandparents who obtained legal guardianship. Tina continued to reside with the father until his incarceration.

In the mid 1990's Tina was awarded guardianship of the children. After his release the father became re-involved with the family. A short period after his release Tina obtained a disclosure from her eldest child that she had been sexually abused by her father. Tina did not report this incident and allowed contact between the children and the alleged offender. The children were apprehended and placed back with maternal grandparents after an anonymous report resulted in an investigation. The father pled guilty to the charge and was convicted and incarcerated.

At the beginning of group Tina was involved with a new partner and father of her two youngest children. She no longer denied the sexual abuse or was protective of the birth-father. She was able to identify her inability to protect her children from the physical and sexual abuse after the initial disclosure.

Tina demonstrated previous difficulty complying and completing group or individual interventions and was mandated to complete this intervention. However, at the time of pre-screening Tina presented as voluntary and motivated to attend the group. Due to pregnancy and subsequent delivery prior to group, Tina could not participate in individual sessions.

Vicky

Vicky was 48 and Caucasian. Vicky indicated that she was a victim of ongoing sexual abuse by her birth-father. She stated that she had previously obtained individual counselling regarding her history of child sexual abuse. Vicky also defined issues of addiction and violence within her immediate family and extended family.

Vicky became pregnant at age 14 and married her first husband at age 16. By the age of 18 Vicky had two young children in her care. Vicky indicated that her first marriage was filled with violence and mutual drug abuse. Vicky left her husband after a number of years and became a single parent on welfare.

Vicky reported that her second marriage was stable and violence free. The couple became foster parents in the late 1980's. Since that time the couple have had a number of foster children residing in their care. At the time of group the couple had 3 female and one male foster children ranging from 10 to 17 years of age.

The history of violence and sexual abuse for the foster children was chronic. The eldest was sexually abused by her birth-father for a number of years prior to a disclosure and only recently obtained treatment. The two younger female children were repeatedly sexually abused by extended family members and individuals in position of trust.

Vicky presented as voluntary and motivated to attend the group. She

was aware prior to the commencement of group that she was the only foster parent participating. Potential difficulties were discussed and Vicky indicated her desire to participate in the group regardless of her unique status. Although Vicky had attended individual therapy in the past and recently completed a foster parent support group, she had not completed any intervention directly related to non-offending mothers and sexual abuse.

Cheryl

Cheryl was 41 and Caucasian. She defined her childhood as positive and denied any issues of childhood abuse or addiction in her family of origin.

Cheryl was the birth-mother of six children ranging from 28 to 10 years of age. Three of the children remained in her home and under her care. Cheryl became involved with her first husband when she was an adolescent. Cheryl described the marriage as short lived due to her husband's violent behaviour. Cheryl indicated that her second eldest child was significantly hurt by her husband during one violent outburst. Cheryl became involved with her second partner in 1980. They separated in the early 1990's due to ongoing violence.

Cheryl indicated she had extensive involvement with CFS due to alleged neglect, addiction concerns, and domestic violence. Cheryl minimized these concerns and displayed a great deal of anger towards the agency.

In the early 1990's some of the children began to display concerning sexualized behaviours. In the mid 1990's two of her daughters disclosed sexual abuse by their eldest brother when they were 8-9 years old. Cheryl vacillated in her belief of the disclosure. During this time the children were apprehended because of contact with the alleged offender and issues of neglect. Cheryl's youngest child was later re-apprehended due to extreme sexualized behaviours. She remained in care for a period of time and received individual treatment and support. No direct disclosure was ever obtained. This child was returned to her mother's care just prior to the start of group.

Although Cheryl was encouraged to attend the group by her agency worker, participation was voluntary. Cheryl received some previous support for her daughter via play and individual therapy. Although Cheryl expressed interest in attending the group, she displayed an inability or unwillingness to follow through with any of the arranged pre-group interviews.

Summary

In reviewing the client profiles a number of similarities were clear. All of the participants shared a commonality regarding their history of struggle and disadvantage. At the time of the interview and individual sessions some of the members had disclosed histories of child sexual, physical abuse, and neglect. Many had histories of inter-generational alcohol, drug, and solvent addiction. A number of the mothers had personal experiences with

dysfunctional coping methods including substance abuse and drug addiction. All of the mothers had experienced domestic violence and emotional abuse from former or present partners. All of the mothers had experienced single parenting and financial struggle due to separations from partners and ongoing poverty.

Brought together because of the sexual victimization of their children, all of the women had experienced involvement with the child welfare agency and police. Many of the mothers were also involved with the agency due to dysfunctional coping, parenting issues, and other protection concerns. As a result, a number of the mothers had children who had been in care or who were still in the custody of the agency at the time of group.

Differences between the mothers included (a) variation and length of abuse for their child, (b) time since the disclosure, (c) age of the victim(s), and (d) the position of the offender (i.e., birth-parent or babysitter). Recent disclosures, limited therapeutic supports, and pending investigations by the child welfare agency and police resulted in mothers presenting in emotional crisis at the time of the pre-interview and individual sessions. Some of these mothers were observed to still vacillate between belief and denial. Mothers who had more time since the disclosure appeared to have already gone through some of the initial stages of denial, guilt, and self-blame. These mothers appeared to have adopted more effective coping strategies and were more motivated to address healing and long term goals.

My assessment was that the content and activities of the group could result in some emotional triggers for some members who had only recently begun to address these issues. I determined that the group interaction may potentially be overwhelming for some members who demonstrated difficulty with emotional intensity or who were still demonstrating aspects of denial. As a result, I recommended individual counselling to a number of mothers who were initiating therapeutic intervention. I indicated my availability for individual sessions throughout the group and provided referrals for external support. I also supported those who had alternative supports (i.e., individual therapy, play therapy) to maintain these interventions.

The interviews and individual sessions identified the multi-problems these mothers encountered on a regular basis. My challenge was to provide a short term intervention that would effectively balance content and emotional intensity to address issues while avoiding group crises and potential membership loss.

Group Sessions

The focus of this section is to provide an analysis of the group sessions. The issues addressed and themes identified within the group will be discussed. Each group session will be broken down into a number of subsections. These subsections include the focus of discussion for the group session, specific themes that emerged, discussion of group development, and analysis of group dynamics.

Session 1- Starting the Group: Introduction, Education and Defining Goals

Number of Members Present: 9

Focus of Session

The main purpose of the first group was to provide an introduction and welcome to group members, and to encourage and facilitate group interaction in creating and defining group boundaries and rules. I spent a significant amount of time fleshing out group expectations, aims, and goals for following group sessions.

The first session began with the introduction of the group philosophy for the group members. This monologue allowed the group members to focus specifically on the facilitator, reducing the necessity and discomfort of direct interaction with each other. The philosophy of the group included a recognition and reinforcement of the group composition (i.e., women, non-offending mother, protector, caregiver). This provided members with an opportunity to identify and appreciate group commonalities, reducing feelings of tension and fear. Opportunities were also given to group members to identify personal knowledge or expertise that could contribute to the group process. This included recognition of previously completed programs, groups, or interventions. The members were able to identify benefits and disadvantages of these previous interventions. This also assisted in providing a clearer outline of the expectations regarding responsibilities of myself as facilitator, group structure, and ongoing group

process.

Themes

Themes of isolation and establishment of trust began to emerge within the first session. Members were able to identify embarrassment, stigmatization, and rejection. Mutual issues of trust regarding the offender, opposite sex, and family members were identified. Power struggles with systems and frustrations with obtaining appropriate resources were also recognized.

Members were able to clearly define group themes including (a) addressing the emotional aftermath of disclosure, (b) functional and dysfunctional coping mechanisms, (c) identification of children's coping abilities and behaviours, (d) offending behaviours, and (e) involvement of the numerous systems. Valuable aspects of the group identified by members included (a) the provision of information related to child sexual abuse, (b) the creation of a safe environment to provide emotional release, and (c) the opportunity to experience and benefit from mutual support. The group also expressed a desire to address empowerment and change, themes consistent with a feminist approach to group work.

Within the second half of the session a further theme of mothers' personal histories of victimization emerged as many group members disclosed childhood memories and emotions related to sexual abuse. The emergence of this theme within the first session was surprising due to the

infancy of the group and lack of established trust and commitment.

Treats were provided for the group. I took responsibility for provision of the snacks on a weekly basis. In meeting this need a theme regarding nurturing and self-care emerged. This small token appeared to have a significant impact on the group members, identifying the limited opportunities they have had as mothers and women to be nurtured and cared for.

Group Development

Within the first session the group members were in the pre-affiliation stage of group development. The members demonstrated mutual attraction and avoidance as they attempted to address the new environment and fellow group members. Although members were notably wary of each other, many presented as immediately comfortable with me. This may have been a result of the number of intake and individual sessions that assisted in creating a positive relationship between me and group members. These sessions appeared to reduce some fears and anxieties for members regarding the group process.

In this initial stage of group development I maintained a clear leadership role. This reduced the necessity for premature interaction and avoided discomfort and intimidation between members. It also provided clarity and structure to address the group philosophy and goals.

Discussing group members' previous group and treatment experiences

addressed members' "expertise". This instilled confidence and provided a positive reframe of their experiences as knowledge and wisdom and of value to the group process. This discussion also provided a limited form of exchange between members regarding group structure, boundaries, and expectations. As a result, a fairly mundane and often facilitator directed exercise of creating and outlining rules and expectations became a member directed exercise.

Garland et al. (1965, 1972) describe the first stage of group development as identifying and locating commonalities between group members. Within the first session it was evident that the group members were surprised but pleased to identify and discuss common issues and experiences. At various points within the first session group members would often respond with comments including "I always thought I was the only one" and "I didn't realize others would feel the same way I do".

Providing a non-intimidating environment and reinforcing safety has been identified as one of the most important tasks of the social worker in the first stage of development (Garland et al., 1965, 1972; Toseland & Rivas, 1995). Within the first session I focused on tasks and activities that outlined group expectations and reinforced confidentiality. This assisted in defining a safe and structured environment for the new and anxious members.

Group Dynamics

Communication and interaction patterns between group members became more comfortable and spontaneous as the session continued. After the break members were requested to share their reasons for attending the group. This led to a number of detailed and emotional accounts of childhood sexual abuse. Susan began to be identified as a natural leader within the first session. Her previous individual and family treatment experiences were evident in her comfort in addressing me, the topic areas, and the group.

Susan was also the first to provide a detailed and emotional account of her and her children's histories of victimization. This disclosure represented the beginning of a group norm regarding emotional intensity and self-disclosure. Positive reinforcement of Susan's disclosure appeared to permit a number of members to be more forthcoming and emotional regarding their own reasons for attending. As a result, a number of group members disclosed personal victimization.

The disclosures created an emotional and cohesive group environment much earlier then expected within the group process. In check- out the group members admitted their surprise regarding the disclosures. I provided positive reinforcement and verbal support to members for their self-disclosure and risk-taking. This model of behaviour was quickly identified and accepted by the membership. By the end of the session all of the members were demonstrating the beginning of mutual support.

I utilized the role of "expert" to identify and normalize the group members' reactions and outlined potential emotional aftermaths or challenges for group members. This directive was initiated to reduce embarrassment, avoidance, and potential failure or inability to return to further sessions due to the emotional intensity of the first session. At this point Susan was able to provide a personal account of avoidance regarding her addiction use. She discussed how her embarrassment and avoidance inhibited her from obtaining support and further increased her isolation. This personal account reinforced Susan's leadership and status within the group. It also provided a perfect opportunity to realistically identify members' fears and provide encouragement for their return.

Session 2 - Exploring Abuse: General information and Discussion of Child Sexual Abuse

Number of Members Present: 6

Focus of Session

The purpose of the second session was to provide an environment for group members to begin a discussion of child sexual abuse moving from a general to a more personal level. This session was to begin with group member re-introduction and individual description of the impact of the previous group session. Members were to watch a video "Incest: The Family Secret" which defines aspects of abuse from the perspective of an adult victim, non-offending mother, and offender. The film was to provide an

opportunity for members to obtain information and witness the emotional impact of child sexual abuse from an external source.

It was immediately assessed that group members were still emotionally affected by the self disclosures of the previous week. In check-in members presented as agitated and anxious. They identified emotional struggles (i.e., displays of anger and sadness) and physical difficulties (i.e., sleeping, nightmares, eating problems) since the disclosures. The group also appeared to be concerned about the absence of three group members.

Due to group members' presentations I determined the need to focus on "where the group was at", directly addressing coping strategies and effects of the previous session. The first half of session was used to discuss and normalize these feelings.

In the second half of the session, I provided the group with information related to the video. I requested a collective decision from group members regarding their desire and ability to view the film. It was mutually agreed that the members were not able to observe the film at that time.

The rest of the session was spent addressing positive and negative coping strategies, focusing particularly on the recent disclosures and the impact of group sessions. Numerous personal and group strategies were determined with agreement to evaluate the effectiveness in the next session. The use of journals was discussed and individual scribblers were provided.

It should be noted that by the session break I had obtained feedback from all three women not present regarding the cause of their absence. These explanations provided legitimacy for the women's absences, reinforcing their commitment to group and significantly reducing the members' fears of rejection.

Themes

Childhood victimization and trauma were identified, clearly outlining the need for recognition of these stories and the impact victimization has had on these mothers' lives. Further, these disclosures and the discussion that followed began to address themes regarding coping strategies and the adoption of appropriate protective parenting skills for one's child.

The self disclosures and discussion of the impact of these disclosures on the individuals and the group again touched on the themes of trust and safety. Many members identified that they had thought that they had previously addressed their own issues of childhood sexual abuse either independently or via treatment. They expressed surprise that the disclosures of others and themselves could still create such a emotional trigger. Jonie indicated "I never intended to speak about my own victimization, just my son's" and Susan stated "speaking about my abuse and listening to other's brought all of those emotions back as if it were yesterday".

The group members were able to identify the impact their child's disclosure had on their own recovery and history. Vicky commented " I

knew I was coming to this group for my girls. I never realized that I was also greatly affected and that I would also be coming for myself". The mothers' discussion reinforced the similarities in group members' histories. As well, by bringing these difficulties and struggles to group for open discussion, members experienced the group as a place of safety and mutual support. This realization appeared to strengthen group commitment, participation, and motivation to attend and address group goals.

The theme of mistrust and fear of abandonment by fellow group members was clear in the group's initial discussion of the three absentee group members. Immediately issues and questions of self-esteem and self-worth were identified. Jonie indicated " Have I done something wrong?" and Vicky stated "I thought when I spoke of my history of abuse I may have embarrassed the other members and made them uncomfortable." After discussion of group members' reactions to the absences the group presented as more settled and committed to the group process.

Group Development

As in the introductory session, the members presented as somewhat uncomfortable and aloof with each other, turning to me for direction and support. This avoidance may have been the direct result of the members' discomfort with the emotional intensity of the previous session. However, this avoidance and ambivalence was also an appropriate and expected reaction in light of the group being in the pre-affiliation stage of group

development (Garland et al., 1965, 1972).

When opportunity, recognition, and permission was provided to the members to express their fears and concerns, the group demonstrated collective relief and members further discussed their issues and anxieties in a forthcoming manner. This communication continued to be directed predominantly towards me.

I maintained a clear leadership role and identified a number of worker tasks throughout this exercise. These tasks included providing a safe group environment, containing group emotional intensity, and encouraging the development of positive coping strategies. These tasks were necessary in order to avoid further premature emotional escalation before a clear foundation of trust and mutual support could be established.

Group Dynamics

In the initial stages of the session, members only engaged directly with me. However, after addressing the anxieties and issues resulting from the introductory session and members' absences, communication became more interactive, engaging, and supportive. Group members were observed reinforcing each other's feelings, normalizing their fears, and providing positive feedback in addressing coping and effective problem solving. An example was Jonie's comment that she could not sleep all week since the disclosure. Other members acknowledged that they also had sleeping difficulties, or had other similar problems. The members assisted in

normalizing Jonie's difficulties and proceeded to provide her with appropriate solutions (i.e., hot bath or cup of tea before bedtime).

Acceptance of the expression of emotion and vulnerability within the group was established as a norm within this session. By recognizing and addressing these issues I identified the value of addressing the members' emotional needs over presentation of content. This was reinforced by the members' abilities to identify and process their feelings, normalize their reactions, and explore and practice positive coping alternatives.

Susan and Vicky indicated their own triggers and difficulties with the previous session. However, due to Susan's previous treatment experiences and Vicky's foster parent status, both displayed more emotional control and personal insight as to the cause of their reactions than the other group members. Susan indicated "I realize I have spent a great deal of time focusing on my children's therapy and recovery. I now know that I need to address my own healing". Vicky indicated "I did not think about my own abuse when dealing with my foster children and their victimization. This group makes me think more about my childhood for the first time in a number of years. Although that is scary, I know that I need to do this for myself and for my children". This further reinforced the developing group norms of sharing and expressing of feelings and defined status and clear "expert" roles for these members.

Cohesion was initially affected by the small group size and absence of

certain members. Mistrust and rejection had a negative impact on the initial development of mutual support. Members presented as avoidant and ambivalent to engage in the first half of session. However, after the issues were addressed and the reason for the absence of members was identified the members appeared to re-group into a more cohesive unit.

Session 3 - Personal Stories of Victimization

Number of Members Present: 8

Focus of Session

The purpose of this session was to continue to move away from generalities and basic information related to child sexual abuse and begin to define personal situations and reasons for attending the group. The session was comprised of the telling of individual stories and discussing the impact these incidents had on the mothers' lives.

The focus of the first half of session was on reviewing homework on the use of positive coping strategies and providing a brief review to those members who missed the previous session. The three members who were absent in the second session were able to indicate their reasons for not attending and restate their commitment. Within check-in each member was requested to provide details about one positive coping mechanism and how this was effective. Each group member was able to contribute at least one positive coping strategy and provide feedback to other group members.

To begin the story telling process I provided a brief brainstorming

session to outline general aspects/details of sexual abuse to provide a basic guideline to the mothers to assist them in telling their stories. This activity provided a safe avenue for introducing the topic of abuse. It also assisted with defining appropriate boundaries for the mothers in their story telling. The women outlined a number of appropriate specifics related to the victim, non-offending parent, and offender. They also extended the boundaries of the exercise to include details related to the post-abuse period including (a) the placement of the child, (b) legal components, and (c) treatment.

This activity led into a discussion of personal abuse situations. The women used the guidelines when telling their stories to fellow group members. These guidelines appeared to provide the group members with some external sense of direction and control. This was of particular importance due to the intensity of emotions and potential anxiety the topic induced.

Themes

The predominant theme of this session was the personal impact of child sexual abuse. In telling their individual stories the members were able to verbalize and discuss this tragedy from a personal perspective. Issues including guilt, self blame, responsibility, and self-worth began to be labelled and identified.

The story telling began to address a significant theme related to the identification of unrealistic expectations and power imbalances. Members

discussed and explored expectations placed on them as individuals, women, parents, and non-offending mothers by society.

Group Development

Check-in was positive and emotionally contained. This appeared to be related to my direct leadership to avoid emotional escalation and reinforce positives. Session material was activity focused and goal directed.

Although the group appeared to be moving out of the pre-affiliation stage of group development, reinforcing safety was necessary due to the emotional intensity and level of self-disclosure of the first two sessions. This was evident when Tina indicated " I want to share more with the group but I need more time to feel safe and secure". Dependence on me as the facilitator was also still observed. This was consistent with my leadership role in addressing the members' emotional crises and providing stability in the first sessions.

Group members continued to explore their own experiences. They presented as more comfortable and forthcoming in their disclosures and identification of the emotional impact of these events. This increase in trust and disclosure reinforced and strengthened the group commonalities and purpose. It addressed issues of ambivalence and avoidance regarding commitment and follow through with group goals. This indicated that the members were moving slowly towards the middle or working stage of the group. In this session I continued to concentrate on the task of balancing

emotion while pursuing group content and goals.

Group Dynamics

During the story telling process I began to encourage interaction and between group members. Although the communication was still predominantly leader directed, this process reduced the tendency of members to only tell their story directly to me and provided engagement and feedback between group members.

It was noted that some of the group members who had missed the previous week were still addressing anxieties and issues related to the first session. One member, Sherry, presented as particularly emotional and overwhelmed. Although Sherry was extensively involved in both individual and family therapy prior to and at the time of the group, the introduction of childhood victimization in conjunction with present stressors appeared to have a significant impact on her. Unfortunately, her difficulty coping with the issues resulted in significant emotional escalation within the session and ongoing attempts to dominate the group discussion. It became evident that the group was uncomfortable with Sherry's level of emotion and resentful of her monopolization and assumption of the victim role. Sherry's reaction and subsequent coping behaviours was the onset of her decline in functioning, re-engagement in addiction use, and eventual termination from the group.

My response to Sherry's emotional demonstration was to immediately attempt to "save" Sherry by normalizing her feelings and

providing her with attention and support. As a result of my actions, I further defined Sherry's victim role and reinforced her behaviour. By not including other members in this process, I reinforced my position as "expert" and limited opportunities for the development of a group directed approach.

Group members continued to maintain seating arrangements initiated within the first session. However, it was noted within this session that members were beginning to form sub-groups and friendships. Jonie and Sherry and Susan and Vicky appeared to be forming separate alliances. Jonie and Sherry were noted returning from the break discussing contact with each other outside of the group. Vicky and Susan repeatedly supported each other's statements with verbal or physical indications of agreement. The display of emotional neediness by Jonie and Sherry and the developing status of Susan and Vicky as experts emphasized transition into what Garland et al. (1965, 1972) call the second stage of group development, power and control. It was during this stage that members began to establish clear positions, struggle with autonomy, and exercise power. This was evident by the struggles for attention between the members and emerging status and roles.

Due to the development of these roles and my ineffective intervention with Sherry, the level of group cohesion within the session was negatively impacted. My almost exclusive focus on Sherry encouraged individual therapy and individual goals and reduced the level of interaction, feedback,

and provision of mutual support within the group. Attempts to provide Sherry with intervention outside of the group (i.e., via referral to a therapist or individual sessions with myself) were not successful.

Session 4 - Disclosure: Exploring Emotional Impact of Child's Abuse as a Non-offending Mother

Number of Members Present: 8

Focus of Session

The focus of the fourth session was on providing opportunities to further identify the emotional impact and feelings for mothers as non-offending parents. This included impact at time of the disclosure and during the post-abuse period.

Check-in was immediately crisis orientated due to the physical and emotional state of one group member. It became apparent immediately that Sherry had suffered from some form of injury. She presented as angry and agitated and attempted to provide a lengthy and unrealistic account of the events leading up to her injuries.

Although other group members demonstrated anxiety regarding Sherry's disclosure, it was evident that they were also struggling with the desire to be supportive and appropriate due to her condition. Based on Sherry's dramatic and inconsistent presentation, I became concerned about the legitimacy of her story and her emotional stability. Recognizing the inappropriateness of a direct challenge within the group setting, I attempted

to diffuse the emotional intensity by incorporating other members' stories of domestic violence and generalizing the topic area. This reduced the individual focus, provided a sense of safety, and re-involved the other group members. I also directed the conversation to focus on issues of empowerment to discourage the group from remaining in a powerless state and to encourage exploration of potential avenues for change. My hope was to address safety and concerns with Sherry on an individual basis after the group session.

The second half of the group session was very structured. Members identified and discussed feelings related to disclosure and post-abuse. By use of a flip chart the members identified and discussed the stages of denial/belief, reviewing the emotional impact at each stage. The activity normalized each stage as part of an emotional process and provided permission to the members to discuss all feelings related to the abuse including: (a) guilt around the failure to the protect child and ignorance of victimization; (b) anger toward self, the child, and the offender; and (c) denial of the child's disclosure, agency involvement, and breech of trust by the offender.

Themes

Themes that emerged within this session included the recognition of stress and crisis experienced by these women in their daily lives. This potential for chronic crisis included not only the emotional aspects of the

sexual abuse but issues of violence, financial burden, and parental responsibility. This was further compounded by addiction and poor self-esteem. A focus was on the extensive coping and survival mechanisms that these group members have been forced to develop in order to attempt to address these demands.

The extent of disclosure and escalation of emotion within the first four group sessions also highlighted the isolation that was evident for all of these mothers. As a result of inappropriate emotional support, isolation, and limited accessible resources these women were often addressing some of these issues for the first time. Due to the lack of appropriate alternatives the group became the only avenue to discuss these crises. Balancing individual issues and group crises while maintaining and proceeding with the objectives and goals was an emerging challenge.

Group Development

In this session the group appeared to complete the transition into the stage of power and control. The members were observed challenging one another and myself as the facilitator in attempts to obtain control. Alliances previously formed to address power imbalances between group members appeared to be in conflict. New strategies to obtain power were observed. An example of this was the personal friendship that had developed between Jonie and Sherry. Jonie presented as visably upset with Sherry's presentation and crisis. Although she did not verbally challenge Sherry

within the group, she demonstrated her disapproval by her facial and physical reactions. At one point, Jonie literally removed herself from the room in obvious anger when Sherry attempted to again re-engage the group in her story.

At the session break, Jonie requested to meet separately to advise me of her issue with Sherry. Although Jonie had legitimate concerns, it also appeared that she was uncomfortable with the attention Sherry was obtaining from other members. In attempts to address this power imbalance Jonie suggested that she and I align and challenge Sherry in session. Jonie accepted that a confrontation and defacing of Sherry's credibility within the group was inappropriate. However, throughout remainder of the session Jonie continued to verbally discredit Sherry and attempted to align with other members.

Sherry tried to maintain her victim role and achieve power and control by sabotaging interaction and group focus. Although Sherry continually attempted to challenge my leadership, she would accept direction and refocus onto the appropriate activities and discussion.

This session identified a number of important worker tasks. Sherry's attempts to dominate the group reinforced the need for me to effectively address power and control. I was required to recognize and address obstacles (i.e., Sherry's and Jonie's behaviours) while acknowledging individual and group needs. As well, this session challenged me to question

the appropriateness of group involvement for some members and suggest alternative interventions.

Group Dynamics

The group had a collective history of tragedy that had assisted in the process of developing group cohesion and mutual support. However, that very history easily became a trigger for one or more members during times of individual crisis. Therefore, the vulnerability of one group member could create a number of significant issues for the group as a whole. This was compounded by the fact that most of the group members had been identified as being in the initial stage of the treatment process, participating in an intervention for the first time. These mothers had previous limited opportunities to effectively address issues related to the abuse or other life crises.

The theme of perpetual crisis, potential for subsequent triggers, and easy escalation of emotional intensity were identified as ongoing challenges for both me and the group members. The ability to effectively cope with this process resulted in further group commitment, opened communication, cohesion, and risk taking for some members. For others, the group ultimately became too intensive resulting in avoidance and/or termination.

The members were observed moving from a general to a more personal and interactive discussion. Although initially leader directed, the discussion of domestic violence soon became group directed and controlled.

At times members were observed initiating discussion, introducing issues, and providing solutions without directives or guidance.

Session 5 - Addressing Issues of Group Conflict

Number of Members Present: 7

Focus of Session

Initially, this session was to complete the section on mothers' feelings and the emotional impact of the sexual abuse. Due to the emotional intensity in the fourth session, time was taken in the fifth session to address these issues. The group presented as relieved to be provided with the opportunity to discuss their issues and concerns.

Within the second half of the group session members requested the opportunity to discuss some general concerns regarding participation. The group identified that Dana had missed a number of sessions. They discussed potential discomfort and difficulty Dana may be feeling about returning. It was agreed that a note of support would be sent to Dana encouraging her to return to the group. There also was concern that Susan had not received appropriate support in the previous session due to the emotional intensity and distraction of Sherry's presentation. Therefore, the group agreed to take time the following week to apologize to Susan and voice their support. Finally, the group expressed concerns regarding the emotional stability of Sherry and the appropriateness of her maintaining group participation. The members were advised of attempts to meet with Sherry privately to

determine the most appropriate treatment plan.

Themes

Although the activities planned for this session were not completed, significant themes of conflict, effective problem solving, and empowerment for change emerged. By providing opportunities to voice their concerns and generate solutions this process reinforced members' abilities to determine effective and appropriate strategies for change.

Group Development

The abilities of the group to individually and collectively address issues of conflict and effectively problem solve identified that the group was moving into intimacy, the third stage of group development (Garland et al., 1965, 1972). The members were becoming much more comfortable in addressing their own feelings, struggles, and vulnerabilities. They presented as more assertive in initiating direction regarding facilitation and structure of sessions. They provided positive input and feedback to each other, requiring less direction and encouragement from me.

The group members appeared to have become more solidified after their successful crisis intervention. They began to identify themselves as a collective and family. They also appeared more motivated to return to the outlined agenda and goals. Their active participation in the intervention and focus on task and accomplishment indicated that they had successfully moved into the middle or working stage of group development.

At this time I focused on highlighting the group's conflict and resolution. Worker tasks included balancing the leadership and responsibilities between facilitator and group members based on the abilities and confidence of the members. Another task was to reinforce group goals and to provide direction and structure for the members. The need for my leadership and intervention in guiding the group development was becoming less direct and leader focused and more group centred.

Group Dynamics

Identification of my own personal struggles with the fourth session initiated the discussion. I spoke of the challenges I encountered as a facilitator in completing worker tasks in the previous session. I noted my struggle with providing empathy and support to the individual while still being conscious of the group agenda and goals. By expressing my own difficulties and vulnerabilities, the members appeared to begin to identify with me as a woman, personally affected by the issue, and less as an expert. This further reduced the perceived power imbalance between worker and group members.

I also identified the continual struggles and challenges of many of the group members in their ongoing quest to survive. I normalized the group vulnerabilities and the potential emotional impact as a result of individual or group crises. This self-disclosure permitted members to be able to identify their own struggles with personal vulnerabilities and triggers while

attempting to provide mutual support. Members recognized that their abilities to effectively provide peer support was dependent on their personal comfort level and emotional stability at that time. My self-disclosure and discussion of the group struggles further reinforced the norm of acceptance and vulnerability within the group.

Encouraged by the level of intimacy and accepted group norms, Tina indicated that she now felt comfortable disclosing her history of childhood victimization. This discussion was group centred and directed. It also did not result in further emotional escalation or triggers for other members indicating the growing stability of the group. Members demonstrated active listening and effective mutual support.

The group was also able to recognize that they did not want my role as facilitator to remain static. Therefore, the need for direct facilitation or leadership was dependent upon the situation and the members' needs. They identified their need to have me maintain a leadership role in times of crisis.

The communication was open and interactive. Members complimented each other on their contributions and success implementing the crisis intervention. They discussed what they had learned from this conflict and resolution. Tina indicated that she " always wanted to be this successful in addressing problems". Cheryl indicated that she "had never had such a positive experience in making a decision".

A significant group culture was emerging. Although the members

varied somewhat regarding ethnic, cultural, and racial heritages, the group presented as predominantly homogenous in membership based on their common life experiences (i.e., childhood abuse, domestic violence, financial struggles, dysfunctional coping mechanisms). Commonalities regarding general interests and likes/dislikes were identified further at session breaks. These breaks provided an important opportunity for the members to interact, socialize, and develop group cohesion without my direct facilitation.

Session 6 - Addressing Roles of the Non-offending Mother

Number of Members Present: 8

Focus of Session

At this point the group was behind two sessions according to the proposed outline. Therefore, some changes were made for the forthcoming group sessions to include the relevant material. The sixth session was to provide a wrap up to activities and issues related to the non-offending mother. In the first half of session group members explored and discussed roles and responsibilities. This encompassed their numerous roles and expectations as women, parents, and non-offending mothers within society. The second half was a review and the completion of a letter they would hypothetically send to a mother of a child who had recently been sexually abused. Group members requested to complete this activity collectively.

Dana returned to the group and spoke of her appreciation for

members' consideration and efforts in encouraging her return. Although she presented as somewhat uncomfortable with returning to group after the number of missed sessions, it was evident that she was touched by the group members' demonstration of commitment.

As requested, the group also spent time after check-in apologizing and voicing their support to Susan. I advised of Sherry's decision to terminate further group sessions and my attempt to advocate for individual intervention to her social worker. The group presented as relieved and indicated their belief that group intervention would not have been a benefit to Sherry at that time.

Themes

Review of issues and emotions raised the themes of guilt, self blame, and responsibility. A further theme was the numerous and multi-faceted roles and expectations placed on group members as women and parents. This theme included the recognition and discussion of the dysfunctional consequences of traditional socialization for women. The emergence of this theme was consistent with feminist literature (Burden & Gottlib, 1987; Cammaert, 1992; Gottlieb, Burden, et al., 1991) that encourages the recognition of negative sex-roles in female groups to empower and to create positive change. A further theme related to care-giving and the non-offending mother included the perception of self and ability to provide prevention and protection to the child. Finally, power imbalances and the

impact of systems were defined.

The themes related to the dysfunction of a gender-based society were addressed and included themes of empowerment and change. This involved discussion of ways to begin to counteract negative societal influences and attitudes. This included (a) the provision of mutual support; (b) reframing personal inadequacies to encompass political, societal, and economic factors; (c) recognizing the value of information and education; and (d) the adoption of positive problem solving techniques (Burden & Gottlib, 1987).

The themes identifying issues of care-taking and the non-offending mothers provided opportunities for group members to discuss specific issues and concerns related to their own responsibilities as care-givers and protectors. Discussion included personal evaluation of parenting and abilities to protect, reactions of extended family members and systems, and the impact of children placed in agency care.

Group Development

The group was becoming increasingly more intimate and familial. This level of intimacy indicated that they remained in the third stage of group development. Members began to refer to each other as family instead of group participants. Tina commented "You are all like sisters to me now" and Cheryl stated "I feel like you are my family after all we have been through". They also demonstrated growing awareness and mutual recognition of the significance of the group experience for personal growth and change. Cindy

indicated "I can't believe how much this group has helped me cope with my son" and Susan stated "I am learning so much about myself".

I noted that members presented as more comfortable and appropriate regarding challenges of the my position and of each other. The members presented as very engaged during the discussion of roles and expectations. They appeared focused and eager to carry out the session activities and group goals. As well, the members appeared to have retained a great deal of the material provided in previous sessions incorporating the themes and principles into the discussion. This reinforced that they remained in the working stage of group development.

Tasks of the worker within this session included balancing structure while still providing for opportunities to process personal experiences. By using a structured brainstorming activity I was able to introduce content, while maintaining intimacy by encouraging discussion of personal experiences and examples. Using self-disclosure, I was able to identify and provide information on various coping strategies. By reliving a personal event I identified the commonalities between myself and the group members. My dysfunctional coping mechanism reinforced my vulnerabilities and provided insight and understanding to the members from a personal focus.

Group Dynamics

Members presented as more comfortable in questioning and challenging each other. Tina was observed asking questions directly to group members instead of through me. This was noted when she asked Julie "How did you feel as a mother when you learned that the offender was your son?" and again when she questioned Dana "Do you feel that it is possible that your husband may have sexually abused your child? " These interactions represented an increase in confidence of the group collectively and individually, demonstrating open communication and group directed interaction.

Group cohesion remained strong. The group demonstrated the ability to work together and achieve group goals. Members displayed a significant bond, presented in good morale, and appeared to give high priority to the group. Recognizing that group cohesion had intensified during Dana's absence, members reduced her discomfort by supporting her return and reinforcing her importance.

Julie was noted to be increasingly more quiet and withdrawn in group sessions. Due to her limited social and verbal skills, age, and passivity she appeared to have limited status within the group and did not appear to be accepted within the developing group culture. As well, Julie appeared to be uncomfortable with the emotional intensity and level of disclosure that had become the group norm. Always maintaining a role of calm and control,

Julie was unable or unwilling to address the emotional impact of her own or her grandson's victimization at this time. Her discomfort could be observed by her physical agitation and increasingly limited imput into the group discussion. Due to these difficulties, I suspected that Julie would eventually choose to terminate her involvement in the group.

Session 7 - Focus on Child of Sexual Abuse

Number of Members Present: 5

Focus of Session

This session provided a general introduction to the discussion of the child and the impact of victimization on children. The session began with a cartoon video "Good Things Can Still Happen" depicting the aftermath of sexual abuse within a family setting. The movie portrays the feelings that children may experience and behaviours that they may exhibit when they have been sexually abused. Members identified specific feelings and behaviours associated with their own child and explored ways of addressing these issues.

Themes

This session addressed themes related to parenting and the non-offending mother. This included recognition and understanding of the child and the emotional and behavioural impact of sexual abuse from the child's perspective. The introduction of this section also resulted in the re-emergence of many themes addressed within the mother's section. These

included guilt, anger, and self-blame.

Group Development

The level of intimacy remained high in this session. The members began to comment on the value of the group experience and the meaning of the group or "what the group was all about". Jonie indicated "I have learned so much from this group" and Cindy indicated "This group has given me information and support ". These comments indicated that the group remained in the third stage of group development where clarification of the group experience and value to personal change is identified. The members presented as more confident, testing new skills, and gaining more independence. The group motivation and focus indicated that they remained in the middle or working stage of group development.

Flexibility regarding leadership and responsibility was an ongoing worker task. As the members vacillated in their abilities to carry out their new behaviours and group goals I provided direction and guidance when required. I also provided clarification and positive reinforcement to the group regarding the level of intimacy and increased accomplishment of individual and group goals. This highlighted the members' achievements and motivated them to continue to experiment and explore new abilities and behaviours.

Group Dynamics

This session reflected the further development of group identity and culture as members became more comfortable with sharing and discussing similarities and differences regarding their children's coping and behaviours and identification of parenting and intervention styles.

With Sherry's termination a number of dynamics changed within the group. Sub-groups that had previously been forming were no longer apparent. Power struggles between members and attempts to triangulate me diminished. The group again presented as a cohesive unit.

Jonie was clearly adopting the "tough guy" role in the group. This included her dress, presentation, and ongoing references to her physical strength, and gang affiliation. This presentation was noted within the last group sessions and appeared to act as a coping device when Jonie was emotionally distraught or overwhelmed. By reframing and maintaining a direct and clear role I assisted in minimizing these behaviours and reducing other members' discomfort.

In this session Jonie spoke of her issues with Sherry and impulse to confront her. The members supported Jonie for not challenging Sherry in the group session. They advised Jonie that her aggressive behaviour could be intimidating and uncomfortable. They reinforced the importance of maintaining a safe and secure environment for the members. They also discussed the influence of her actions on her children. These comments

encouraged Jonie to begin to identify her aggressive behaviour, recognize the impact on others, and explore alternative solutions.

Cheryl provided another significant role as care-taker of the group's needs. This was observed in Cheryl's nurturing and support of other mothers in times of crisis. This role also appeared frequently when Cheryl was challenged or uncomfortable with personal feelings. When in the emotional hot seat, Cheryl would immediately adopt her care-taking role directing the discussion onto another member. As Cheryl and Jonie had a relationship prior to the commencement of group, Cheryl would often use Jonie to avoid her own feelings and issues. Comments included "I'm doing O.K., but I'm really worried about Jonie" and "I'm not worried about my daughter and her behaviours, but I know that Jonie is really concerned about her son". Jonie would further reinforce this cycle by her own attempts to monopolize discussion whenever Cheryl provided opportunities.

By intellectualizing and minimizing her feelings Cheryl successfully avoided any personal exploration and insight. By incorporating the care-taker role Cheryl could feel of competent and in control, while successfully maintaining her avoidance and denial. Attempts to redirect and challenge Cheryl were often unsuccessful. It was evident that Cheryl was attending the group for social interaction and was not able to address the personal impact of sexual abuse.

The patterns of communication and interaction were initially facilitator

directed. However, as the members became more comfortable they began to demonstrate more group centred interaction. The mothers were able to address a number of relevant issues regarding feelings, coping, and behaviours for their children. Many were able to provide feedback and suggestions to other mothers struggling with similar concerns, or who were at stages in the process that these mothers had already successfully addressed with their children. The various stages of development regarding the process and aftermath of sexual abuse within the group allowed the mothers to provide direct intervention with other members based on their own experiences and "expertise". This interaction provided positive reinforcement, acknowledging successes, experience, and wisdom. It also fostered hope and created an effective learning environment for those receiving the information.

Session 8 - Focus on Child's Coping and Specific Behaviours

Number of Members Present: 7

Focus of Session:

The eighth session was designed to discuss specific issues of behaviour and coping regarding the members' children. Members were requested to complete the Sexual Abuse Impact Checklist (Harborview Sexual Assault Medical Centre, Seattle). This checklist identifies 65 behaviours that some children may exhibit if they have been sexually abused. The form includes potential behaviours that may be exhibited at

various developmental stages and chronological ages.

Themes:

The central themes in this session were anger, fear, and loss. Anger was identified towards (a) the offender for victimizing, (b) the child for not telling, (c) the systems for not appropriately intervening and providing treatment, and (d) themselves for failing to recognize, protect, and prevent the abuse from occurring. Fear was related to (a) concerns regarding their children's present behaviour, (b) the potential for their children to be re-victimized, and (c) concern regarding the potential for their children to develop offending behaviours. Issues of loss included (a) the loss of the child's trust, (b) the loss of innocence for the child and the parent, and (c) the loss of safety and control.

Members were able to identify specific behaviours displayed by their children via the check-list and discussion. Many were able to re-define the behaviours as coping and less as struggles for control and power. Some of the mothers who had more then one child impacted by sexual abuse were able to identify the differences in coping for each child. Many also found it positive to identify the behaviours that their children have not displayed. The theme of empowerment and change was incorporated into the discussion by the recognition and discussion of strengths and survival skills instead of an exclusive focus on negative behaviours.

Group Development

Through this discussion the members were able to define commonalities and differences regarding their children and their childrens' coping abilities. Similarities and differences were also identified regarding parenting styles and expectations. The child's age, accessibility to treatment, and length of time since the abuse also highlighted variations. This increase in autonomy and intimacy within the group permitted the display and acceptance of individual needs, rights, and opinions. These accepted differences between members' experiences and members' opinions marked the movement into the fourth stage of group development, differentiation (Garland et al., 1965, 1972).

The members' perceptions of the group also appeared to be becoming more appropriate and less influenced by prior experiences. Members began to discuss the group as a new and distinct experience separate from past or familial references. The members began to define the group as a "mothers support group" or "self-help group" with less references to being "sisters" or "family".

By identifying and re-evaluating their children's behaviours the members were able to normalize and appreciate their children's feelings and needs much in the same way that they were able to process their own. Members were able to incorporate the knowledge and information gained in the first section into this discussion. The ability to process previously

presented information, the high level of motivation, and the focus on group goals indicated that the members remained in the working stage of group development.

In this stage, I continued to highlight the group process, how it developed, and how it was unique. I also made references to the individual group members, how they were similar, how they were different, and what they learned from each other. These comments reinforced group identity and interdependence.

Group Dynamics

The cohesion that existed in the group made it possible for the members to explore their different experiences, unique value systems, and coping styles in relation to their children. Different interventions and concerns were identified. Susan and Cindy wanted to discuss concerns regarding potential offending behaviour and warning signs. Vicky and Jonie were more concerned that their children would be re-victimized and wanted to explore prevention and safety. Although this session addressed differences as well as commonalities, the level of acceptance and intimacy among the group members suggested a high level of cohesion.

Throughout this session I presented as open and flexible in my leadership. Initially, I maintained a more central figure as each member had an opportunity to comment on their results and concerns and be provided with feedback. This resulted in leader/member interaction. To reduce this

pattern I attempted to engage other members in the feedback process. This included comments such as "Has anyone else had this concern?" or "What would the group suggest?" As the discussion proceeded other members began to take more responsibility for direct feedback, resulting in group-centred communication and interaction.

The shift to discussing children and the educational focus appeared to result in a reduction in the level of emotional intensity. Members did not appear to struggle with the frequent emotional triggers noted in the previous sessions. As a result, roles adopted to cope with this emotional intensity (i.e., Jonie and Cheryl) were not visable during this session. This also resulted in a reduction in my need to redirect, reframe, or provide direct intervention to address these dynamics.

Session 9 - Interventions for Children of Sexual Abuse

Number of Members Present: 5

Focus of Session

The focus of the ninth session was to provide ways of addressing the needs of the child who had been sexually abused. This included addressing feelings and intervening appropriately with negative behaviours such as aggression and sexualized or harmful behaviours. Using check-lists and group discussion, group members continued to focus on their own children and specific examples to develop strategies that would assist with parenting.

Nina Tackaberry, play therapist from Winnipeg Child and Family Services attended to address the topic area. Opportunities were also provided to explore, discuss, and practice techniques and interventions.

Themes

The ongoing themes of empowerment and positive change were reinforced by the opportunities to obtain information and develop skills regarding support and safety planning.

Group Development

Consistent with the fourth stage of development, members began to feel more comfortable relating to their external environment and community. Members began to display curiosity about other opportunities to explore self-growth as a group and independently. Strategies for maintaining the group after termination, Jonie's plan to continue with individual therapy, and Vicky's desire to obtain play therapy for her foster child were all examples of this developmental process.

The group was advised of Julie's termination due to pending child care responsibilities. Members were able to identify that Julie's termination may also have been a result of differing value systems and discomfort with the level of emotional intensity in the group. The group discussed their regret for not addressing these concerns and the loss of this member.

I provided recognition of the group's stage of development and movement from the middle or working stage to termination and celebration

within the next few sessions. This task allowed members to identify relevant topics and goals that they would still like to address prior to group closure. It also provided members with the opportunity to recognize and address closure issues in order to assist them with the termination process.

Group Dynamics

Interactions were largely comprised of comments towards the speaker with limited to no interaction between group members. This may have been directly related to the members' unfamiliarity with the speaker and/or her somewhat didactive presentation.

There were only five members attending this session. This appeared to create more intimacy between the members. The participating mothers specifically requested information regarding concerns expressed by group members who were not present. This demonstrated the ongoing high level of cohesion and support within the group environment.

Within this session, my role as facilitator became more necessary than in previous sessions due to shyness and reserve towards the speaker. At times I would have to initiate discussion and note concerns to be shared. An example of this was "Dana, why don't you tell Nina about your concerns about your daughter?" or "Cindy, that sounds just like what you are going through with Edward. Why don't you describe them to Nina and find out if she has any suggestions?". It appeared that many members required permission from me or the speaker in addressing these concerns.

Group members began to discuss the potential impact of group closure and post-group support plans. I noted that discussion of termination created anxiety for some group members. This anxiety was most notable in Cheryl. It was evident that termination of group sessions was difficult for Cheryl due to the loss of her role as care-taker and the social interaction. This role had provided Cheryl with a sense of purpose and assisted in her ongoing avoidance of her own issues related to sexual abuse.

Session 10 - General Overview and Education on Offending Behaviours

Number of Members Present: 6

Focus of Session

This session provided education and a general overview on why sexual offences are committed. Members were provided with a review of theories related to offending behaviour. I provided information related to offender behaviour and protection issues. Introduction and description of Finkelhor's Four Preconditions Model of Sexual Abuse was incorporated into the discussion.

Themes

Reoccurring themes related to anger, betrayal, and loss were identified. All of the women were able to identify intense feelings of anger and hostility towards the offender. Significant issues of betrayal were identified due to the trust and emotional commitment the mothers had with the offender prior to the disclosures. The members were able to recognize

that they were also victims of the offender's manipulation and grooming process. Finally, the mothers were able to identify loss as a significant but difficult theme. This included (a) loss of a partner and sexual companion, (b) loss of financial support and stability, (c) loss of the child's parent or family members, and (d) loss of innocence and trust.

Group Development

All of the members were very interested and engaged in the topic. Members asked a number of general questions pertaining to offenders and offending behaviours as well as personal inquiries related to their own situations. It appeared that as a result of the building of interpersonal relationships and group cohesion members had become more comfortable and effective in addressing issues and goals. They were more capable of exploring, testing, and problem solving which are defined as aspects of the working stage of group development.

Within this session members continued to accept each other as distinct individuals with unique experiences. However, with this level of understanding members appeared more comfortable in gently challenging the beliefs and value systems of other members. Dana, previously neutral regarding her daughter's victimization, became pro-active asking a number of questions regarding offending behaviours. She verbalized her increasing doubt regarding her partner's innocence. Fellow group members challenged Dana further by asking specific questions. The incorporation of this

information into the members' questions and discussion demonstrated their understanding and internalization the information. As well, they spoke of their own personal struggle when addressing Dana's belief and denial. These statements reinforced understanding and respect for Dana's feelings while encouraging her to challenge her beliefs and reassess the situation. By incorporating their own experiences and difficulties, the members normalized Dana's struggle and challenged her in a non-threatening and supportive fashion.

In this session tasks of the worker included ongoing reinforcement of the learning and skills achieved by the individual and group members. In recognition of pending termination I began to make reference to maintaining these skills in a post-group situations.

Group Dynamics

Clear differentiation of status and roles was evident within this session. Members (i.e., Susan and Vicky) who had more experience and were further along on the belief/denial continuum were able to provide guidance and direction to members who were still in the initial stages of the healing process (i.e., Jonie and Dana). These members adopted the role of facilitator, providing information and challenging beliefs. This process was effective because of the cohesive environment and the strong supportive and emotional bonds that had developed within the sessions over time. Members were able to apply problem solving techniques in an effective,

non-threatening manner.

Finally, the group continued to demonstrate significant group-centred communication patterns. This dynamic appeared to strengthen the social interaction between group members and commitment towards group goals.

Session 11 - Continuation of Offender Information and Personal Accounts

Number of Members Present: 6

Focus of Session

Within this session group members were provided with video footage regarding specific offenders and victimization patterns. This video incorporated many of the theories and information provided in lecture and discussion format in the previous session. This visual presentation appeared to reinforce and solidify the information.

Members watched the video "Rapists: Can They be Stopped". Although the tape specified situations related to adult sexual assault the group members were able to identify the behaviours and grooming patterns for child sexual abuse. Members became notably angry by the personalized accounts in the video and were able to speak more openly about their own situations. The members were also able to address further issues related to the offending including involvement of systems, pending charges, and limitations of treatment for the offender.

Themes

This session reinforced themes related to anger and loss. As well, it identified themes related to interactions with the impact of systems, power imbalances, and control.

Group Development

Within this session the members continued to demonstrate behaviours consistent with differentiation and the middle stage of group development. This included a collective focus on the topic and a clear sense of purpose and group function. Group cohesion appeared to intensify with the discussion of offenders and the mutual expression of anger. Clearly, the group was comfortable demonstrating strong feelings and intimacy. As well, the group demonstrated further maturation in their abilities to provide internal support and effectively problem solve.

Focus on empowerment and completion of group goals reinforced the members' individual and collective abilities. By highlighting strengths and group accomplishments I continued to promote growth and change in preparation for movement towards the last stage of group development, termination.

Group Dynamics

Within this session, members were notably more anxious and crisis orientated. Some members began to demonstrate behaviours that had not been seen for a number of sessions. For example, within the last few

sessions Cindy had presented as more positive in her discussion of her son and his behaviour. She demonstrated more insight and understanding regarding his coping and was effectively able to separate the child from his behaviours. Within this session Cindy demonstrated some regression, re-adopting her view of herself as a victim powerless in controlling her son's behaviours.

Some members demonstrated an increase in already observable roles and behaviours. This was most notable regarding Jonie and Cheryl. Cheryl's level of denial made it impossible for her to personalize the discussion on offenders. Throughout the discussion she intellectualized and separated herself from the emotion displayed by other members. To address the significant emotional intensity Jonie re-adopted her "tough role". When feelings became too difficult she attempted to obtain power and control by discussing her gang affiliations, status, and revenge schemes.

These reactions could have been the result of the emotional impact of the topic and/or be due to pending termination. This regression indicated that the group was moving into the final stage of group development resulting in separation and termination.

Session 12 - Discussion of Offender Patterns and Closure

Number of Members Present: 6

Focus of Session

Within this session members were provided with information related

to the offender cycle and grooming behaviour. Members were able to identify the cycle and provide personal accounts of the cycle and grooming process. The members also completed collectively a letter to a hypothetical offender. Members were provided free rein regarding description of feelings and impact of the sexual abuse. The last section of the letter focused on members' survival and strength. At the end of the session prevention, protection and future goals were discussed.

Themes

This session revisited themes related to empowerment and positive change. It reinforced significant themes for the non-offending mother including prevention and protection. It incorporated the important themes of strength, survival, perserverance, and hope that would be further emphasized in the two termination sessions.

Group Development

This session demonstrated the completion of the working or middle stage and the transition into separation, the final stage of group development. Again, members presented as task focused, exploring, and incorporating information. Throughout the sessions related to offenders and the offender cycle the group members presented as emotionally reactive and angry. However, as they were provided with opportunities to address these feelings via accounts of personal situations and completion of the offender letter, members presented more relaxed and in control. Many spoke of how

the provision of information and opportunities to explore individual situations was enlightening. These sessions appeared to contribute to their understanding of the dynamics of offending behaviour. This information and education appeared to provide them with knowledge and ultimately a sense of control. It also further highlighted the necessity for prevention and protection. The letter to the offender and subsequent brief discussion of preventative tactics appeared to be an appropriate closure to the discussion on offender behaviours.

Tasks of the worker at this time were all related to preparation for termination. I assisted the members through the natural termination process of denial, regression, and recapitulation through discussion and personal self-disclosure. I normalized anxieties and feelings of loss while reinforcing strengths and independence. I identified effective coping strategies and encouraged their use outside of group in an attempt to tie the group more directly to members' lives.

Group Dynamics

Communication and interaction remained open and group directed. The observation of old coping mechanisms and roles appeared to decrease within this session. This may have been the direct result of focus on self growth, prevention, and control at the end of the session. By identifying obtained knowledge and strengths, members presented as more assured and confident in addressing termination. Although cohesion was still observed

members appeared to be beginning the process of distancing and separation. This could be noted by the limited references to the group and more emphasis on individual plans and goals for the summer. Focus was on termination, recognition, and celebration.

Session 13 & 14 -Termination: Self-care, Rebuilding, and Review

Number of Members Present: 6

Focus of Session

Session 13 provided review and reinforcement of self care. Members explored new ways of addressing their own needs. We reviewed what had been learned, the impact on group members, and future objectives and goals. The group completed the exercise "How Can I Tell When Things are Getting Better" incorporating and discussing positive change. They expressed the significance of the group experience, friendships, and maintaining mutual contact.

This session marked the end of the formal sessions. A written evaluation form was given to each group member to fill out before the completion of the session.

I also provided each member with a card that I had carefully selected for that individual. I provided personal and closing words of support to each member in these cards. Members were requested to pass cards around providing the opportunity for each group member to provide closing comments and goodbyes. When this was completed each member received

her own card and a certificate signifying that she had completed the group.

The final session was the termination party that was conducted outside of the agency setting. This party was planned by the group members who organized the event. The party took place at a group member's home, moving the support network towards a more informal and natural setting. Members discussed plans to continue contact and support beyond the group setting.

Themes

These final sessions reinforced the themes of mutual support, empowerment, and change. It focused on themes of healing, hope and accomplishment.

Group Development

Recapitulation provided the members the opportunity to evaluate, review, and assess the value and meaning of the group experience. The review provided members with the opportunity to assess their successes and achievements. It provided an overview of their accomplishments throughout the working stages highlighting personal objectives and mutual goals. The review, specific activities, and the formal celebration clearly reinforced that the group had completed the last stage of group development.

Tasks of the worker in the final two sessions were related to closure. This included maintaining and generalizing efforts for positive change,

evaluation and summary of the group experience, and promoting independent member functioning. I made alternative referrals for individual and play therapy for certain members. It was also at this time that I defined my post-group accessibility to the group regarding questions, concerns, or future referrals.

Group Dynamics

The group's focus appeared to be on celebration and movement forward beyond the sexual abuse. Although communication patterns remained open, members avoided discussions resulting in emotional intensity or vulnerability. Conversations remained on a light and social level, focusing on the future and independent goals. Separation, individualization, and decrease in group identity became evident. The group discussed how they planned on incorporating the group experience into their own lives.

Summary

Themes that presented as most relevant to the group included dealing with the emotional impact of the abuse, establishment of trust, and maintaining mutual support. Emphasis on these themes identified the isolation and mistrust produced by sexual abuse. It highlighted the limitations of present resources in recognizing and addressing the emotional impact of the disclosure for the non-offending mother. Members identified the discomfort and inability in discussing the abuse with family, friends, or the child welfare agency. The group provided an environment for the

members to share their experiences and ventilate their feelings in a safe, nonjudgmental environment.

Themes related to the emotional impact of the abuse and childhood victimization emerged quickly within the first session. This was surprising due to the lack of established mutual aid and trust. The emotional intensity produced by the disclosures resulted in triggers and flashbacks for a number of the group members. This emotional escalation and group crisis was further amplified by the infancy of the group and lack of mutual support. As a result, a number of the first sessions were focused on addressing the members' needs and determining immediate coping strategies.

Themes related to self-esteem, advocating with systems, and empowerment and survival were observed throughout the group. Consistent with feminist group work, these themes assisted in identifying negative sex-role behaviour, dysfunctional coping strategies, and unrealistic expectations by society. Addressing the roles and expectations of the members assisted in the recognition of commonalities and the establishment of mutual support. The group provided a safe avenue to discuss and challenge existing value systems and initiate change.

Although the sessions related to the group's crises and conflict were not pre-determined, they were significant to the group's dynamics and development. Ambivalence, avoidance, and mistrust were substantial in the early stage of group development due to the early disclosures and emotional

intensity. Opportunities to successfully address these issues allowed the members to identify their feelings and recognize their needs. Addressing these issues resulted in a reduction of distress and increased group commitment and cohesion. It was also successful in avoiding initial membership loss.

By the fourth and fifth session the group had moved into the second stage of group development. During this time a number of roles, alliances, and sub-groups were established in attempts to address power imbalances between members and between me and the members. Initially, I maintained leadership and direction in addressing these conflicts. However, by the fifth session the group had the opportunity to directly address conflict and determined appropriate solutions. This increased members' confidence and commitment to each other and to group goals. It encouraged the development of more group centred communication, interaction, and shared leadership.

By the sixth and seventh sessions the group displayed a high level of intimacy and strong group identification. The familial setting provided a safe environment for the ventilation of feelings and establishment of mutual support. The display of various roles and behaviours appeared more related to coping and addressing emotional intensity then social control and power. Group norms encouraging disclosure, vulnerability, and emotion had been clearly established. The group culture identified shared commonalities

regarding life experiences, struggles, and value systems.

During the last sessions addressing the child, the offender, and offender behaviour, members demonstrated strong cohesion, open communication, and shared leadership. Within this fourth stage of group development the members were able to differentiate individual needs and experiences. Group priority appeared to be the completion of group tasks and goals with minimal crises or conflict. The necessity for roles and behaviour to address coping were reduced due to the decrease in emotional intensity and increase in focus on goal completion.

Prior to termination many of the members displayed regression, denial, and need for recapitulation. Many old roles returned (i.e., Jonie and Cheryl) while other members regressed in their skills and development (i.e., Cindy). Normalizing these feelings, reviewing group goals, and reinforcing individual and group accomplishments reduced anxiety and prepared the group members for termination.

The remaining sessions were successful in addressing termination. Identification of growth, strengths, and future goals encouraged members to internalize what they had learned. Members were able to discuss how they would access skills, coping strategies, and resources obtained from this group in future life experiences and challenges. The final session was informal and located at a member's home, reinforcing the completion of the formal intervention.

CHAPTER 5

EVALUATION

Chapter 5 will present and analyze the information obtained from the pre- and post-test measurements used to evaluate this practicum. These measure included The Rosenberg Self Esteem Scale (RSES), the Index of Parental Attitudes (IPA), and a consumer satisfaction questionnaire.

Rosenberg Self-Esteem Scale

As shown in Table 1, pre-test scores varied from 0 to 5 with a mean score of 2.4 (SD = 2.070). The post-test scores ranged from 0 to 3 with a mean score of 1.3 (SD = 1.112).

The pre-test indicated that three women (Jonie, Dana and Susan) had scores between 3 and 5 indicating a low perception of self-worth. Two of the members (Cindy and Tina) had scores of 2 indicating average self-esteem. Two members (Vicky and Cheryl) had a score of 0 indicating that prior to intervention their perception of self-esteem was high.

Regarding the post-test results, there was improvement for four of the seven members. Although the post measures indicate an improvement for all but one participant (Cheryl), the variation between the pre- and post-test scores was marginal. Susan displayed the most significant improvement with a pre-test score of 5 and a post-test result of 0. Tina demonstrated marginal improvement in her scoring moving from an average to a high

Table 1

Results of Pre-test and Post-test Measures for Group Members

	Rosenberg Self Esteem (a)		Index of Parental Attitude (b)	
Group Member	**Pre**	**Post**	**Pre**	**Post**
Jonie	3	2	16.7	32
Dana	5	3	28	18
Cindy	2	2	30.7	42
Susan	5	0	42	22.7
Tina	2	1	24	8
Vicky	0	0	14.7	5.3
Cheryl	0	1	8	4.6

Note:

(a): A score of 0 indicates high self-esteem, a score of 2 indicates average, and a score of 3-5 indicates very low self-esteem.

(b): A score below 30 indicates no clinical problem with the parent/child relationship, scores between 30-70 indicate a significant concern, and scores above 70 indicate severe distress potentially resulting in violence in the parent/child relationship.

perception of self-worth. Two of the members (Cindy and Jonie) had scores of 2 indicating an average perception of self-worth. Cindy's scores did not change from pre- to post-testing. Jonie's post-test indicated that she had moved from a perception of low to average self-esteem. Dana was the only member who continued to display low self-esteem at post-test. However, it should be noted that she also demonstrated improvement from her pre-test score of 5 which indicated the lowest measure of self-esteem. Vicky maintained a pre- and post-test score of 0 indicating that she had no issues with her self-esteem.

Out of the group members who demonstrated improvement in their pre- to post-test scores, Dana was the only member with inconsistent attendance. Of the other women, Jonie, Cindy, Susan and Vicky rarely missed a session and Tina had perfect attendance. It is my belief that their commitment and motivation to attend was demonstrated by their consistent attendance. Further, this participation and commitment seemed to have a positive impact on their self-esteem. These members were observed as more engaged, self assured, and confident as the sessions progressed.

It can also be argued that members' self-disclosures of child sexual abuse had a positive impact on their self perception and self-worth. Out of the five women with improved or consistent scores, Dana was the only member who did not disclose a previous history of victimization. Although Jonie had no intentions of disclosing her personal victimization

prior to the initiation of group sessions, she appeared to become more comfortable and self assured after her disclosure to the group members. Jonie appeared to benefit greatly from the knowledge that she was not alone in her struggle to cope with her victimization. Jonie responded positively to sessions related to effective coping strategies and would attempt to integrate these strategies into her day to day life. Positive feedback from her peers appeared to have an effect, although minimal, on Jonie's level of self-esteem.

Tina also appeared more confident after her disclosure of child sexual abuse. Like Jonie, this was one of the first times Tina had publicly addressed her victimization. This disclosure and acceptance of fellow group members appeared to provide Tina with confidence to begin to address the emotional consequences of the sexual abuse for herself and her children. After the disclosure Tina presented as more engaged and interactive with group members. She became notably more verbal and challenging of certain members' issues and denial. She also demonstrated the initiation of effective problem solving by her attempts to facilitate a case conference to discuss visitation with her children.

Susan demonstrated the most significant improvement in her measure of self-worth. It is possible that this change was related to the positive interactions and mutual support Susan obtained within the group sessions. Susan had previously obtained a number of supports to address

her and her children's emotional needs. As a result, Susan presented as system aware and knowledgeable regarding many of the aspects of the group format and intervention. However, Susan had never had the opportunity to address the personal impact of the abuse within a group setting with a number of her peers. The collective atmosphere and mutual support offered by the group appeared to have a positive impact on Susan's coping and perception of self-esteem.

Although Dana's pre- and post-test scores both indicated low self-esteem, her scores demonstrated improvement by the termination of the sessions. Dana attended only seven out of fourteen sessions missing the most sessions of any of the group members. Although initially a mandated member, Dana participated freely and appeared to enjoy sessions when she attended. Dana continued to have attendance difficulties, not due to her mandated status, but due to the intensity and emotional impact of the group.

Significant attention was given to Dana during these absences to reassure her and encourage her re-involvement with the group. Letters and a card of well wishes appeared effective in assisting Dana's return to group and sense of belonging. These attempts also communicated support for Dana in her emotional difficulties and gave her the message that she was not alone. Without these direct interventions it is doubtful that Dana would have had the confidence and ability to return to group. Although

participation often appeared to be a challenge, it is suggested by the test results that Dana's perception of self-esteem did improve and she did benefit from her limited involvement with the group. If Dana had been more consistent in her attendance there may have been a more notable and positive change in her perception of self-worth.

Vicky's pre- and post-test scores remained at 0 indicating no problems with self-esteem. These results were not surprising when reminded of Vicky's position with the agency and reasons for attending the group sessions. Due to her foster parent status, Vicky was not in an adversarial relationship with the agency. As a result of the permanent status of all four of her foster children, Vicky did not have any direct involvement with the offenders or extended family members of the children in her care. As well, Vicky did not have any attachment or loyalties to the offenders and consequently did not struggle with any issues of anger or betrayal as a result of the victimization. Further more, although she was the primary caregiver, Vicky was not the non-offending parent within the home at the time of the abuse. As a result, Vicky did not have to deal with personal issues of guilt, responsibility, and blame.

Vicky attended group sessions to obtain further information regarding child sexual abuse and to develop skills to help her address the abuse with her foster children. Both her pre-interview presentation and her pre-test scores suggested that Vicky entered group feeling confident and

self assured. Due to her pre-existing positive self view and the lack of direct emotional contact with the victimization, it appears appropriate that her scores would remain consistent. As well, by demonstrating consistent positive scores it can be argued that the group intervention was beneficial in maintaining her positive assessment of self-worth.

One other member's scores remained consistent from pre- to post- test. Cindy's scores remained at 2 indicating that there was no change in her self-esteem. Cindy's scores remained low for both the pre- and post-test measures, indicating that she entered the group and left the group with an average perception of self-esteem. Cindy had just completed a similar group related to non-offending parents and child sexual abuse. The pre-test score may have been a result of Cindy's completion of that group and an indication of the benefits of that intervention. It can also be argued that completion of this group appeared to have no negative effects and assisted in maintaining Cindy's self-esteem.

Cheryl was the only group member who demonstrated a decline in self-esteem from pre- to post-test. Cheryl's pre-test score of 0 indicated no problems with self-esteem and a post-test score of 1, although a decrease in self-esteem, suggested that she was still above average. This result could suggest that the group was ineffective in helping Cheryl maintain her self-worth. However, when interpreting this finding it is important to be aware of certain observed characteristics of this member.

Cheryl demonstrated ongoing difficulty addressing her son's offending behaviours and her youngest child's potential victimization. She consistently projected blame and responsibility onto the child protection agency and repeatedly avoided and deflected challenges within session. As well, Cheryl's presentation within sessions demonstrated a strong desire for peer acceptance and approval and an ongoing need for personal control. Therefore, it could be argued that due to Cheryl's issues with avoidance, denial, and peer approval she was not forthcoming on her tests resulting in an inflated score on her pre-test measure. While the score of 1 on her post-test could be evaluated as a decline in her self-esteem, it also could be argued that Cheryl had become somewhat more aware of her difficulties and denial as a result of attending the group. This awareness could have resulted in a slight decline in Cheryl's self-esteem. Based on my assessment, observations within sessions, and Cheryl's pre- and post-test scores, the group was evaluated to have had only a limited impact on her issues. It was argued that Cheryl still remained in only the early stages of addressing her issues of avoidance and denial.

Six out of seven of the members attended consistently and all of the members, except for Dana, provided explanations for absences prior to group sessions. All of the group members presented as comfortable with a notable increase in group interaction and confidence as sessions continued. As well, there was an observable improvement in all of the

members' physical appearances including dress, make-up, and energy level as sessions progressed. All of these observations and the test results could indicate that the group intervention was somewhat effective in increasing or maintaining most of the members' self-esteem.

Index of Parental Attitudes

The IPA was used to measure the group member's parent-child interactions and the potential degree, severity and magnitude of perceived problems within that relationship. The pre-test mean score was 23.4 and the post-test score mean was 18.9.

In reviewing the pre-test and post-test scores it becomes apparent that most of the group members were near or below 30. This would indicate that most of these members did not have any significant problems regarding their parent-child relationship even prior to the group intervention. These scoring outcomes could be related to previous supports or interventions provided to their child by the protection agency or external supports. As well, the scores could possibly be related to the time lapse since the disclosure. For all of the group members, discovery of the abuse had occurred months or years prior to this intervention. This extensive period of time may have alleviated the initial crisis and emotional impact, potentially allowing the members time to address certain parent-child issues.

Cindy and Susan's pre-test scores fell within the 30 to 70 range. Although only slightly over the cut off for effective coping, these

scores indicate that these members were having some difficulty within their parent-child relationship at the time of the initiation of group. These test scores were consistent with Cindy's and Susan's presentations within pre-screening interviews and early interactions within group sessions. Both members identified behavioural and control issues as significant concerns. As well, both mothers recognized risk regarding offending behaviour for their children. As a result, both parents were directly involved with the protection agency to obtain support and services to address these concerns. Therefore, it can be argued that their direct involvement with these struggles were identified by their scores on the IPA.

Two women who indicated very low pre-test scores were Vicky and Cheryl. These results are consistent with the low scores noted for both mothers on the RSES. Vicky's short-term relationship with her foster children and emotional protection from the abuse would reduce the potential for the victimization to impact on the parent-child relationships. As well, Vicky had identified that her foster children were stabilized in care and were obtaining treatment to address their victimization. It is possible that separation from the guilt and self blame, removal of the offender, and stabilization and treatment of the children would have a direct impact on Vicky's perception of parent-child relationship difficulties.

Based on Cheryl's avoidance and denial it was not surprising the she obtained a very low pre-test score. Cheryl's ongoing need for peer

acceptance may have impacted on her test results, affecting the validity of the findings. This is consistent with her avoidance of pre-screening interviews and individual sessions, as well as her ongoing denial and projection of blame.

Both Vicky and Cheryl indicated improvement from their pre-test to post-test scoring. It may be an indication that the intervention provided a positive impact on their perception of their relationship with their children. Regarding Vicky's improvement from pre- to post-test I would argue that the intervention was of some benefit. Based on Vicky's pre-existing strengths, motivation, and receptiveness throughout the group process, it is probable that the group intervention was of limited success in reinforcing her already positive and consistent perception of her relationships with her foster children. Based on Cheryl's noted difficulties, avoidance, and denial throughout the group process, however, it is likely that her slight improvement from pre-test to post-test was only an indication of this response style and not a measure of the limited success of the intervention.

Two group members (Jonie and Cindy) had post-test scores that increased indicating an escalation in difficulties within their parent-child relationships. These increases were fairly significant placing both members in the range of clinical significance. Jonie's increase in scores from pre-test to post-test could have been related to where she was in her treatment.

This was the first time Jonie had ever attempted any kind of treatment for herself in relation to her own victimization and her son's alleged abuse. Prior to this intervention Jonie admitted to investing a great deal of time and energy into avoiding and pushing down her feelings. As well, she acknowledged using dysfunctional coping strategies including substance abuse to avoid addressing parenting issues and challenges. The decrease in avoidance and increase in recognition and awareness of issues between herself and her son could have resulted in an increase in her awareness of difficulties within the parent-child relationship.

Cindy's increase from pre- to post-test could reflect concerns regarding her son's disclosure and acting out. Throughout the group process Cindy's concern about her son's behaviours and potential offending behaviours remained consistent. However, at the time of termination Cindy and her son were re-addressing significant issues in relation to the sexual abuse. Her son had provided further disclosure in his play therapy, resulting in an escalation in his behaviour in the home and day-care. Complicating these concerns, Cindy developed a number of health issues resulting in medical exams and surgery. This temporarily limited her energy level and could have impacted on the parent-child relationship.

It should be noted that although Jonie's and Cindy's IPA scores increased indicating a perception of more difficulties with the parent-child relationship, their RSES scores both indicated improved or consistent

perceptions of self-esteem. Therefore, it could be argued that although their perceived parent-child relationships did not improve, peer interaction and provision of mutual support appeared to provide a marginal positive impact on these members' perception of self-worth.

Finally, as with the results of the RSES, Susan demonstrated the most significant positive change from pre- to post-test on the IPA. Susan indicated a pre-test score of 42. As previously noted, this is within the clinical significant range of parent-child problems. Susan's post-test score was 22.7 which indicated that she no longer perceived the parent-child relationship as being a clinical problem. This finding suggests that the group intervention was successful in addressing this member's perception of the parent-child relationship.

Client Satisfaction

The Client Satisfaction Questionnaire (see Appendix C) was completed at the end of the thirteenth session. Six out of seven of the group members completed the questionnaire.

Of the five scaled questions, all of the group members indicated agreement or strong agreement to each question. The questions "From participating in this group I have learned more information about child sexual abuse" and "I found the topic areas related to mothers helpful in dealing with my own thoughts and feelings about sexual abuse" obtained the most positive ratings of "strongly agree" for 4 out of 6 of the women. The final

four questions related to members' comfort level in group, child behaviours, and protection planning obtained the lowest scores consisting of 3 out of 6 "agree". The questions related to the mothers and the impact of the sexual abuse may have received higher ratings due to the intensity and number of sessions invested in this topic area. As well, these scores could have been an indication of the limitations of previous interventions in addressing issues specifically for the non-offending mother and a recognition of the need for including these in the aspects of the treatment plan.

Responses to the open ended questions were all positive. Listed under what members had learned included a number of comments regarding positive interactions and communication within the parent-child relationship. Information regarding the offender was noted in 3 out of 6 of the responses. The most noted response was comments indicating assertiveness, awareness, and prevention as skills obtained through the group intervention. These responses suggested that the group intervention was successful in incorporating aspects of feminist group theory, particularly, empowerment and prevention.

Regarding the question "What was most helpful about the group?", all of the group members identified the recognition that they were not alone, and mutual support as the most beneficial aspects of the group intervention. Regarding responses related to "What was least helpful" or "suggestions for change" most of the group members indicated no concerns.

Some recommendations for future group interventions included extending the group sessions and providing more supports of this nature within the community. These comments were significant because they identified the needs of this population and the limitations of previous interventions in providing support for the non-offending parent.

Summary

The purpose of this practicum was to develop, implement and evaluate a group intervention for mothers whose children had been sexually abused. The results of the RSES, IPA, and Client Satisfaction Questionnaire suggest that the group provided a marginally beneficial intervention for the non-offending mother. Although the measure of positive change was limited, results suggest that the intervention was successful in addressing areas related to self, coping, and prevention. As well, the findings indicate that the provision of peer interaction and mutual support were the most beneficial aspects of the intervention. The more limited results pertaining to parent-child relationships could be related to the limited time and attention provided to that section.

The results can also be interpreted in light of where the members were at in the treatment process. Many of the members were only at the beginning stages in addressing childhood sexual abuse, family of origin, or exploration of the personal emotional impact regarding the victimization of their child. The results suggest that the group was

successful in meeting the members' basic therapeutic needs. As well, the high level of motivation and participation observed could suggest the members' satisfaction with the group experience. This intervention could be considered as a stepping stone in the ongoing intervention process of addressing the group members' individual and collective therapeutic needs.

CHAPTER 6

DISCUSSION AND CONCLUSION

This Chapter will focus on the observed and benefits of the group intervention. It will also review the intervention themes and explore how they emerged within the practicum.

Benefits of a Group Format

The literature review has already discussed the benefits and disadvantages of the use of a group intervention (Corey & Corey, 1987; Northen, 1969; Shulman, 1992; Toseland & Rivas, 1995). The results of the evaluation of the practicum have confirmed that the use of the group format for intervention can have beneficial results. Quantitative data gathered from the RSES indicated a slight improvement in members' perception of self-esteem. Results from the IPA indicated a consistent or improved score for most members regarding their perception of the parent-child relationship. Feedback from the qualitative data further supported the value of utilizing the group format for this particular population. All the members who completed the client satisfaction measure identified the provision of mutual support as the most helpful aspect of the intervention.

The tendency to develop vulnerability as a result of high self-disclosure has been noted as a disadvantage of the treatment group process (Corey & Corey, 1987). Although self-disclosure did not have a substantial

negative effect on the group, it did impact on the group's dynamics. As outlined in Chapter 4, self-disclosure and high emotional intensity within specific sessions had a significant impact on group members. This required direct intervention and ultimately changes in format in order to effectively address the emotional reactions. The support/psychoeducational format assisted in providing a balance to the emotional impact and self-disclosure process by including more structured activities and discussion. This reduced and stabilized the emotional intensity and ultimately the feeling of vulnerability of the members. Working through these issues collectively appeared to increase group interaction, cohesion, and mutual support.

In forming the group a number of decisions were made regarding the composition. These decisions related to having an open or closed structure, homogenous or heterogenous status, and group size (Toseland & Rivas, 1995).

It is my argument that the positive cohesive atmosphere noted within group sessions and in the evaluation was a direct result of the incorporation of the closed door policy. Members shared a number of difficult emotions, disclosed personal events, and relived traumas from their lives within the group setting. The closed door policy allowed members to develop relationships, establish trust, and express commitment to each other. This level of intimacy would have been difficult to achieve in a setting where membership was inconsistent and unstable.

It is also my argument that cohesion was enhanced by both the homogeneity and heterogeneity of the group members. The group was homogenous in that all of the members were mothers or care-givers of children who had been sexually abused. They also had all experienced similar socio-economic difficulties and emotional challenges within certain stages of their lives.

Toseland and Rivas (1995) outline that diversity can enhance learning and adoption of a variety of coping strategies. Although the heterogenous aspects of the group created initial discomfort, they soon provided an opportunity for positive learning and exploration. Vicky's foster parent status was significant because the majority of the mothers had experienced their children being placed in care. The group environment allowed the mothers to explore and discuss issues related to foster care and placement with an individual and foster parent whom they had come to appreciate and trust.

Another example of the heterogeneity within the group was the various stages of healing for the mothers regarding the child sexual abuse. These variations allowed the members to see their experience within a context that acknowledged the healing as a process. It also provided an opportunity for members to be supported in their struggles and successes, and to provide a positive learning environment for those who still required time to develop these skills.

The group remained small to maintain an atmosphere conducive to establish trust and mutual support. The number of initial members was limited to ten with seven participants in the group at termination. I do not believe that a treatment group of this nature should exceed ten members. I also believe that treatment of a population of this specific nature requires time and energy to effectively address members' issues. Group intimacy and interaction appeared to increase as sessions continued. Although these positive characteristics can be identified as the direct result of group development, the reduction in members appeared to also have a positive effect on intimacy and interaction.

Intervention involved thirteen formal sessions and one informal session for celebration and termination. The time-limited format was useful in providing structure for goal setting and topic areas. It was also essential in assisting the members with arrangements for child-care and transport. As these resources were provided by the child welfare agency, a specified length of services and termination dates were required. Although some members identified the desire to continue the group process, others presented as ready for the termination. More sessions would have given members time to address specific issues and topic areas in more detail. As well, it would have allowed me to follow the original group format. However, issues such as school summer vacation, limited child care resources, and external responsibilities would have eventually impacted on

attendance.

Model of Group Intervention

The model used for this group intervention incorporated aspects of small group theory and the literature on feminist group work. The integration of these theories assisted in providing structure for the intervention and identification of key issues and themes to be addressed.

The identification of (a) communication and interaction patterns, (b) group cohesion, (c) social control dynamics, and (d) group culture provided an important framework for the assessment of group dynamics. These specific aspects of small group theory assisted in understanding a group environment that was predominantly group centred, highly cohesive, and generally positive regarding issues of social control and group culture.

The literature on feminist group work was essential in developing the themes and treatment goals of this intervention. Burden and Gottlib's (1987) six dysfunctional consequences provided a clear outline of the potential pitfalls of socialization and of a previous gender-neutral interventions. Recognition of these issues allowed me to become more observant and understanding of certain dynamics, interactions, and coping styles demonstrated within the group setting. The degree of isolation, lack of appropriate supports, and difficulties with trust were reflected in the women's initial reactions and behaviours. Many members valued affiliation

and external reinforcement of self-worth while internalizing blame and responsibility. Finally, all the members had accepted the primary role of caretaking, minimizing or ignoring their own emotional and physical needs. Due to my own gender and socialization, awareness of these issues also provided me with some personal understanding when evaluating my own struggles and reactions within the group process. As a result of this awareness, reinforcement of negative traditional values and beliefs were usually successfully avoided.

Feminist group work principles and skills outlined in the literature review provided the backbone of the group intervention. Awareness of these principles and implementation of these skills had a positive impact on the group. The benefits of positive evaluation, social analysis, and encouragement of total development were reflected by the increase in self-esteem by the group members. The use of self-disclosure reinforced commonalities of the members as non-offending mothers and as women within society. My use of self-disclosure appeared to reduce members' anxieties and tendency to view me as the "expert". Self-disclosure also had a significant impact on establishing trust and cohesion within the group setting.

The psychoeducational structure of the group had a number of benefits. By providing knowledge, awareness, and the opportunity for role modelling the members were able to positively reframe their perceptions of

themselves as individuals and collectively as women in society. The group provided a safe and consistent environment where the members could discuss a number of concerns and identify and practice effective solutions. Many of the mothers were then able to implement these acquired skills in their external environments.

Empowerment of group members is incorporated into both small group theory and feminist group work. The members themselves identified mutual support and empowerment as the most significant aspects of the group process. Both observable interactions within the sessions and client feedback suggest that these components were essential for the success of the intervention.

Gender

Dysfunctional consequences of socialization can have a major impact on women and on women in a group setting (Burden & Gottlieb, 1987). This practicum provided an intervention to a group composed of only women. This was deemed necessary to instil feminist values and principles and to avoid further reinforcement of negative sex-role socialization.

The group setting was initially a stressful environment for these participants. Many traditional behaviours were observable including (a) the need for peer approval, (b) an inability to identify their own needs, and (c) the tendency to act out care-taking roles within the group setting. The same sex setting allowed the opportunities for these issues to be identified and

discussed. The members were able to challenge their belief systems and address issues from a political and social viewpoint and see them not solely as a result of personal failure.

Population

The seven women who completed the group were Caucasian and Aboriginal. They varied in age, experiences, and beliefs. However, all the participants shared a commonality regarding their history of struggle and disadvantage. These experiences resulted in a high degree of individual and group crises for members. Discussion of specific topics and activities triggered unresolved issues and emotions. This was most notable regarding the disclosure of personal histories of child sexual abuse and domestic violence. These women were also faced with everyday challenges that could easily result in crisis. Dysfunctional coping patterns were often displayed within the group setting.

Many of the members were also new to receiving treatment. The group process was the initiation to addressing these issues and obtaining external resources. Many of these women had spent a significant amount of energy previously denying and blocking their feelings. Many had also used addictive behaviours to dull the pain. Almost all of the women had involvement with the agency and had children placed in care due to child protection concerns.

These histories and ongoing crises had a direct impact on the

implementation and facilitation of this intervention. I would argue that the group assisted in creating individual and group crises by identifying issues and reducing the avoidance and denial of the members. It is also my belief that these issues created a number of challenges that would not have been present in a group consisting of a middle class population. Just the reduction in issues related to financial restraints and the access to more positive internal and external resources would have resulted in a more consistent environment.

As the facilitator of this disadvantaged population I was challenged with providing empathy/support while maintaining direction/leadership in individual and group crises. Too much investment in the crisis led to a leader-member focus with limited group participation. As well, it ultimately resulted in triggering other members. Too much emphasis on leadership created a controlling, uncaring environment that resulted in limited self-disclosure and ventilation of feelings by the group members. The ongoing problems and disadvantages of these members assisted me in my awareness of the need for balance between facilitator and group leadership and challenged my approach to intervention.

Finally, I would support that intervention for the non-offending mother, particularly of a disadvantaged population, cannot occur in isolation. There is clearly a valid argument for the importance of the implementation of multi-interventions and support services for mothers of

children who have been sexually abused. Issues of extreme isolation, emotional impact of disclosure, and ongoing negative sex-role socialization all impact on the non-offending mother. One intervention, specifically a brief group model, cannot be effective in addressing these long term issues. Any group intervention process should be integrated with individual counselling. Although this was incorporated into this model of intervention, the brief individual sessions were provided to assist with assessment and engagement. In review, there should have been more time to provide access to individual sessions prior to the group. Formal individual sessions should also have been incorporated throughout the group sessions. I could have provided this intervention in conjunction with other support services. Although individual support was offered and encouraged, many of the contacts with the members between sessions were informal or on a "drop-in" basis only. More extensive and structured individual sessions would have assisted in addressing the emotional stability and treatment needs of the members.

Practical Elements

Attention to practical aspects of the intervention were essential in the ultimate success of the group. This included providing transportation and advocating for child care. Based on the members' already existing daily challenges and limited resources, the expectation that they independently obtain transportation and babysitting was unrealistic and

inappropriate. Rather then entrench further negative sex-role socialization of caretaking and responsibility, I chose to reinforce the members' rights to obtain support and assistance. Requests for homemaking services was made to the protection agency prior to the group commencement. The provision of taxi services also reduced potential financial and environmental barriers for the members in attending the group.

As women, the members had all been socialized to be responsible for meeting the care and needs of their children, partners, and extended families. I took responsibility for providing a weekly variety of snacks and refreshments to the participants. These provisions appeared to have a positive effect on this disadvantaged population. It became very clear by the reactions and appreciation of the members that few had ever had the opportunity to be taken care of and nurtured.

I believe that these basic provisions reduced potential barriers that may have limited the members' abilities to attend the intervention. I also believe that these provisions assisted in providing an important message to the members reinforcing their value and self-worth.

Achievement of Learning Objectives

The practicum experience provided me with an opportunity to have a positive and challenging learning experience. The knowledge, skill, and experience that I have gained completing this process has impacted on me in both a personal and professional manner.

Chapter 1 outlined four broad learning objectives that I wished to address through the group intervention process. The first objective was to develop, implement, and evaluate a support group for mothers of children who have been sexually abused. This objective was successfully implemented from April 1997 to August 1997.

My second learning objective was to practice skills in short term group counselling and become more familiar with the application of small group theory and the feminist perspective in group work practice. This experience provided opportunities for me to practice existing skills such as leadership, advocacy, and mediation as well acquire new interventions including social analysis, behaviour feedback, self-disclosure, and problem solving.

Through the creation and implementation of the model of intervention, group members were provided with the opportunity to assess their situation from a different viewpoint. Patriarchal values and negative sex-role socialization can often be reinforced in traditional interventions. The incorporation of feminist principles assisted me in diverging from some aspects of traditional social work group practice. It also provided the opportunity for members to address their issues from a different perspective.

Within my learning process, my professional skills were enhanced by the support and guidance of my advisor Diane Hiebert-Murphy.

Her supervision and direction assisted in reinforcing existing strengths and abilities as well as challenging me to take risks and expand my learning horizon. Her suggestions and feedback assisted me in addressing the group dynamics and process as well as identifying my own personal values and goals.

My third learning objective was to develop and acquire skills in gathering and analysing evaluation data. The quantitative measures administered including the RSES and the IPA assisted in determining changes in self-esteem and in perceptions of the parent/child relationship. Although improvement as measured by the instruments was small, the measures did indicate that the group experience was beneficial in maintaining or marginally improving the members' self-worth and perceptions of the parent/child relationship.

The quantitative measures accessed for evaluation were fairly simple and straight forward. I would continue to use the RSES for this particular model of intervention and target population. This tool is clear and quick in providing a pre- and post-test measure of self-esteem. In the future, I would use a more extensive measure such as the Parenting Stress Index (Abidin, 1995) for evaluating the parent/child relationship. This test is lengthy and more complicated then the IPS and may present as somewhat overwhelming for this target population. However, it does provide much more information and depth into specific aspects of the parent-child

relationship and potential intervention success.

In reviewing the members' participation and motivation within sessions and the results of the qualitative measure I believe that the members of the group benefited more from the intervention process than the quantitative measures would suggest. As a disadvantaged population many of these members were dealing with a number of issues beyond the scope of the intervention. These difficult and chaotic lifestyles resulted in ongoing stress and crisis for many of the members. This fourteen week intervention was incapable of effectively addressing this ongoing instability and chaos. However, it did provide a brief and positive outlet for members to begin to identify their feelings, obtain mutual support, and explore positive coping strategies. Regardless of these external stresses, many of the members demonstrated integration of themes addressed within the group. It can be argued that further appreciation and application of these skills and coping strategies could take much longer to internalize than the brief group intervention provided and the post measures could determine.

My final learning objective was to develop and provide a knowledge base for issues associated with the difficulties of meeting protection needs for the child and emotional expectations of the non-offending mother. Through study of the clinical and empirical literature and the development and implementation of a model of intervention I have advanced my practical knowledge and clinical experiences regarding child

sexual abuse and issues for the non-offending mother. The most valuable experiences were learned through the interactions and dynamics within the group. Through the members willingness to share, express their feelings, and test their abilities and internal resources I learned about the non-offending mother and her challenges in addressing child sexual abuse. This provided essential information for future effective implementation of this model of intervention with mothers of children who have been sexually abused.

Implications for Future Social Work Practice

In reviewing the literature on child sexual abuse, and in completion of this practicum, there are a number of themes that emerge concerning intervention with the non-offending mother. These themes reinforce the value of the direct intervention with the non-offending mother. These themes include (a) specific support systems required for the protective parent, (b) the relevance of focusing on the emotional impact of child abuse on the maternal role, and (c) the impact and importance of the adoption of a feminist perspective in the treatment and intervention with child abuse and the non-offending mother.

The research available on the non-offending mother clearly demonstrates the limited amount of study directed to intervention and group work with the protective mother. Yet, researchers and professionals alike, continue to proclaim the importance and necessity of the non-offending

mother's participation in the child's healing. The ability of the mother to provide this assistance is questionable when she has not been provided with the education to appreciate the cause and effects of child sexual abuse and the environment to allow the mother to vent her own emotions regarding the impact of the disclosure. Multi-treatment support systems for the non-offending mother need to be integrated into the treatment plan. These interventions will increase the success of treatment for the child and assist with long term prevention. This should include individual, dyad, and group intervention. The benefit of a group model of intervention is that it can reduce isolation and provide an atmosphere of mutual support for the non-offending mother.

The vulnerability and emotional needs of the mother in the aftermath of a disclosure of child sexual abuse cannot continue to be ignored. Understanding must be given to the level of guilt and blame the mother may be experiencing. Beyond the immediate emotional effects of the abuse, there needs to be support for the maternal figure when addressing further complications which may include the abuser's potential denial of the abuse, the frustrations and limitations of court prosecution of sexual offenses, and finally, the social isolation that the mother may face upon the disclosure.

Practitioners and researchers need to recognize the gaps in understanding the emotional impact and the limited provision of support.

Without direct interventions to address the personal emotional impact of child sexual abuse there will be further undue stress, confusion and blame placed on the non-offending parent. Ultimately, the mother's ability to cope and protect her child will be compromised. The group provides direct intervention in identifying and normalizing the personal emotional impact of the victimization. The group environment reinforces commonalities, building trust and breaking down social isolation for the mother.

The use of a feminist perspective in intervention with non-offending mothers needs to be recognized as having a number of significant benefits. By rejecting the traditional approach that attempts to assess and label family dysfunction while placing the individuals within the family into traditional roles, the feminist perspective challenges the imbalances of power relations and sex-role stereotyping. It recognizes issues of child care and the division of labour and the restrictions these place on women in meeting their own needs. It provides a reframing of previous views of the mother as deviant and the cause of the victimization. It redefines the role of motherhood to encompass political, not personal obstacles, acknowledging patriarchal restrictions within society. Finally, a feminist perspective assists the mother in recognizing and highlighting individual strengths and encourages her process of determining independence. This empowers the non-offending mother to value and assert her own needs and strengths in order to assist her child in a protective/caring environment.

Addressing feminist issues requires consideration of treatment and prevention, not only on an individual and group level, but also involving the incorporation of massive social change. Many social and legal systems continue to instill traditional values. Society continues to encourage the adoption of traditional sex-role socialization and hierarchy. The limitations of existing support services and treatment options for the offender, beyond those complying with legal requirements upon conviction, indicate the continual deficiencies and reinforcement of traditional values by the present systems regarding the intervention of child sexual abuse. The model of intervention adopted in this practicum has reinforced that the evaluation, treatment, and prevention of child abuse cannot occur without placing the responsibility for the abuse on the offender.

In conclusion, interventions of this nature must continue to be explored in order to assist professionals in their knowledge and pursuit of effective treatment and support regarding child sexual abuse and the non-offending mother. Unfortunately, child sexual abuse remains a significant problem in society. As a result, mothers continue to be placed in the position of addressing the victimization and protecting the child. Identification and appreciation of the emotional impact of the abuse and direct provision of support for the mother is essential in obtaining and maintaining these treatment goals.

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APPENDIX A

Outline of Group Sessions

Stage 1- Ventilation of Feelings and Emotions

Week #1: Starting the Group

Hosting and welcoming group members and provision of group philosophy and format. Group rules are discussed and created with participation of group members. Focus is placed on group goals and objectives. After this process, group members are requested to introduce themselves, telling a little about themselves and reasons why they have attended. Facilitator stresses context of group and key components. The facilitator spends the rest of the group session working with group members to establish group aims/objectives to be determined for following sessions.

Group Goals

The facilitator raised the following potential group goals regarding content for discussion within the first session:

1. To provide a environment in which group members can feel safe and comfortable to share common experiences, express feelings and be provided with validation and support.

2. To provide an opportunity for the group members to address and to ventilate their feelings and understand and appreciate their personal impact in relation to their child's sexual abuse.

3. To promote a environment of education and awareness of issues and concerns related to child sexual abuse and offending behaviours.

4. To provide an process for the mothers to learn and appreciate

the emotional and behavioural impact on their child regarding the victimization and determine effective ways to address and cope with this process.

5. To address issues of family of origin including potential past and present victimization for the non-offending parent.

6. The provision of opportunity to heal and empower the non-offending parent.

7. To facilitate awareness and education regarding effective protection and prevention abilities for the non-offending parent and her child.

8. To provide the group members with opportunities to experience a positive support network and practice effective coping strategies for future life challenges.

The group members also presented the following group goals:

1. Intimacy and trust issues

2. Legal and court procedures

3. Impact of system involvement

4. Concerns regarding potential offending behaviour of victimized child

Ground Rules of Group

The following ground rules were created by the group members and facilitator at the initiation of the first session. They included:

1. All information and discussions shared within the group sessions are to remain confidential.

2. Each group member has the right to express her own thoughts, feelings and opinions and be heard.

3. Each group member will respect each other regardless of agreement of disagreement with that member.

4. Each group member will have the option to speak in group session. Participation will be voluntary not mandatory.

5. Group will provide a safe environment. There will be no threats or violence within the group sessions.

6. If a member is unable to attend a session, she will notify the facilitator prior to the group in order that other group members are aware of the cause of her absence.

7. The group will have a 10-15 minute smoke break during the 2 1/2 hour sessions.

Activities

1)	Myths-	As group, complete true/false exercise.
2)	Parent Coping-	Hand out package for members' information and private use.

Week #2:

1)	Movie-	Incest The Untold Secret- Portrays the emotional impact of disclosure of sexual abuse for both victim and non-offending parent.
3)	Discussing Abuse-	In early weeks, sharing experiences is main focus.
	Define Stages-	Use flip chart, brain storm and discuss denial/belief as a process.
4)	A Safe Place-	Request group members to recall at least one

		place, person or thing that feels safe or comforting.
Week #3		
1)	Coping-	Review coping strategies and external supports/isolation. Direct each group member to practice use of list of positive coping mechanisms throughout week.
2)	Society-	Discuss values and impact of society on women.
3)	Coping-	Information related to general coping
Week #4		
1)	Roles-	Explore numerous roles for members as: women, mothers and non-offending mothers.
2)	Coping-	Discuss use of positive coping strategies, effectiveness and impact for each group member.
3)	Letter Writing-	Write a letter to a mother who recently had a child disclosure sexual abuse.

Stage 2- Understanding Child's Emotions Regarding Victimization and Related Coping Behaviours

Week #5

1)	Movie-	Good Things Can Still Happen- Depicts aftermath of sexual abuse within a family setting. Have group members identify the behaviours and feelings their own child is expressing and explore ways of addressing these issues.

Week #6

1)	Parent/child	Complete behaviour checklist. Discuss similarities, differences and strategies.

Week #7

1)	Guest Speaker-	Nina Tackaberry, Play Therapist- Speaker will provide information and discussion on ways of helping children express their feelings and intervening with negative behaviours

Stage 3- Issues of Offender and Offender Behaviour

Week #8:

1)	Education on Offending-	Discussion and information on why people commit sexual offences. Review theories of sexual offending. Introduction

		of offending cycle, grooming and protection issues.
2)	Model-	Introduction of David Finkelhor's Model of Sexual Abuse.

Week #9

1)	Movie-	Rapists: Can They be Stopped- Identify personal feelings towards the offender Discuss treatment options.

Week #10

1)	Letter to Offender-	Request that group members write a brief letter to their child's offender outlining emotions related to victimization.

Stage 4- Focus on Family Unit and Family of Origin

Week #11

1)	Family-	Discuss the impact the abuse has had on the family and the relationships within the family.

Week #12

1)	Genograms-	Explore patterns of abuse and family of origin.

Stage 5- Incorporation of Mothers' Healing and Empowerment and Termination

Week #13

1)	Self-care-	Explore with mothers ways of addressing own needs and self-care.
2)	Review-	Recapitulation on what has been learned/ changed- Review of what has been discussed in group, the effects on group members, recognition of symptoms and ways to prevent further abuse by use of role plays, task setting and discussion.
3)	Exercise-	How to Tell if Your Family Is Getting Better- Incorporate check list with mothers underlining items that would demonstrate positive changes in family unit.
4)	Complete measures-	Complete outcome measures. Discuss what has impacted on mothers to create change.

Week #14- Closure

1)	Mother's Choice-	Focus on celebration and closure.

APPENDIX B

CLIENT SATISFACTION QUESTIONNAIRE

Thank-you for your participation in this practicum experience. In order to assist with evaluation it would be appreciated if you would take a few moments to answer the following questions. If you require more space, feel free to use the back side of the questionnaire.

1.) From participating in this group I have learned more information about child sexual abuse.

1	2	3	4	5
strongly disagree	disagree	not sure	agree	strongly agree

2.) I found the topic area related to mothers helpful in dealing with my own thoughts and feelings about the sexual abuse.

1	2	3	4	5
strongly disagree	disagree	not sure	agree	strongly agree

3.) I was comfortable speaking about my own thoughts and opinions in group.

1	2	3	4	5
strongly disagree	disagree	not sure	agree	strongly agree

4.) I found that the topic areas related to children and their behaviours helpful in dealing with my child's behaviour.

1	2	3	4	5
strongly disagree	disagree	not sure	agree	strongly agree

5.) I have learned skills that will help me provide protection for my child.

1	2	3	4	5
strongly disagree	disagree	not sure	agree	strongly agree

6) If yes, list what skills you have learned.

_____

_____

7) Has the relationship between you and your child changed since participating in group? If so, how has it changed?

8) What was the most helpful about group?

9) What was the least helpful about group?

10) Do you have any suggestions for the group?

11) Any other comments?

APPENDIX C

INFORMED CONSENT

INFORMED CONSENT FOR PARTICIPATION IN MOTHER'S GROUP FOR CHILDREN WHO HAVE BEEN SEXUALLY ABUSED

I understand that the purpose of this group is a part of a Masters of Social Work practicum. I understand that the facilitator Stephanie Schmor is a Masters of Social Work Student at the University of Manitoba. This practicum will be supervised by University faculty member Dr. Diane Hiebert-Murphy. I understand that all information pertaining to these sessions will be kept in a locked facility. Records of proceedings will only be accessed by the facilitator and practicum committee. I understand that a report will be written upon the completion of this group. I understand that my identity will not be disclosed at any point within this report and that I may have access to a copy of the report upon completion.

I have been advised that I may benefit from participation in this group and that the group process may raise some emotional issues for me.

I consent to participate in a initial individual assessment, fourteen group sessions, and a post interview with the facilitator. I understand that these sessions will be video taped for the purpose of supervision. I also understand that all information about my participation is confidential and will not be provided to my social worker or Winnipeg Child and Family Services without my consent. However, I have been advised that the facilitator is obligated to provide information regarding any risk of child protection to my protection worker if disclosed during sessions. I understand that I will be notified of this procedure in confidence and prior to this information being relayed.

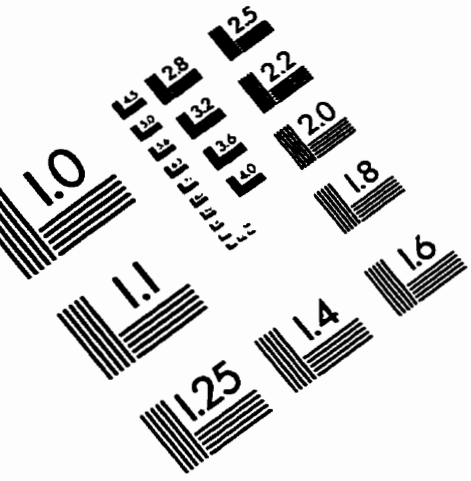
I understand that my participation in this project is voluntary. I understand that I am free to discontinue involvement with this project at any time and this will not affect the services I may receive from Elizabeth Hill Community Centre. I have been provided with the opportunity to ask questions related to this project and feel that they have been appropriately answered by the facilitator at this time.

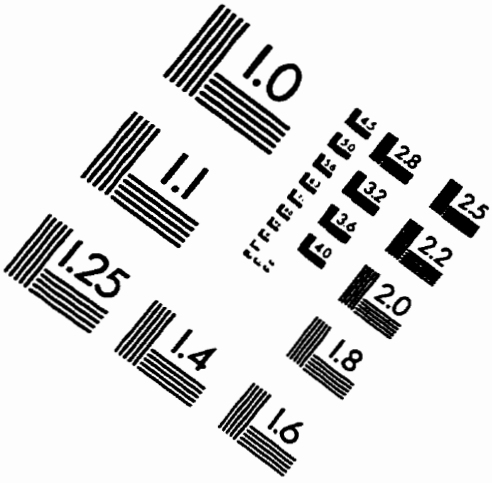
THIS IS TO CERTIFY THAT I, _____
(print name)

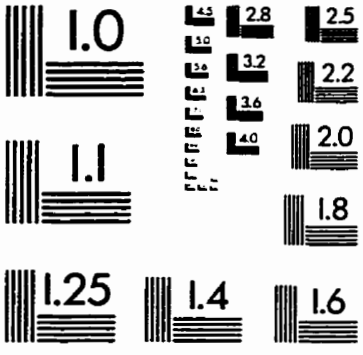
HAVE READ AND UNDERSTOOD THIS CONSENT AND HEREBY AGREE TO PARTICIPATE AS A VOLUNTEER IN THE ABOVE NAMED PROJECT.

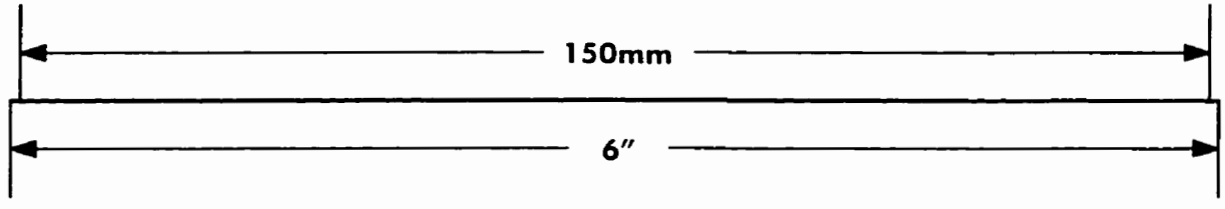
_____ _____
(participant signature) (date)

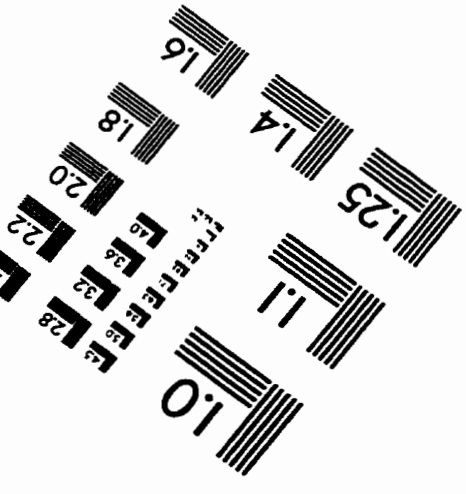
IMAGE EVALUATION TEST TARGET (QA-3)

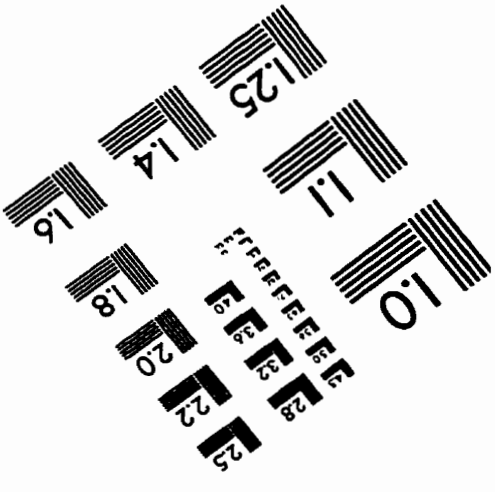












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