BOUNDARY DEVELOPMENT IN SURVIVORS:

A GROUP INTERVENTION

by

Lydia Loewen

A Practicum Report

submitted to the Faculty of Graduate Studies

in partial fulfilment of the requirements for the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

This practicum intervention focused on boundary development in adult survivors of childhood sexual abuse. A time-limited structured group modality provided the basis for the practicum intervention. Seven women participated in twelve weekly group sessions which were conducted at the Women's Health Clinic in Winnipeg, Manitoba. The session topics focused on the development of both internal and external boundaries. Related to internal boundary work were issues of self-identity, self-care, the inner child, anxiety, self-esteem and feelings of guilt, anger and loss. External boundary work included topics focusing on responsibility, conflict management, interpersonal relating and reconnection. Several methods of evaluation were used, including both quantitative and qualitative measures: the Hudson Index of Self-Esteem; a Boundary Scale; weekly rating scales; and two self-report questionnaires, one on group experience and one on group boundary development. Overall results of the practicum indicated an increase in self-esteem, a beginning understanding of the concept of boundary, and growth in the development of internal and external boundaries. Participants were pleased with the empathy, non-judgemental support, and understanding of their disclosures of child abuse. Finally, rating scales and self-report questionnaires indicated significant satisfaction with the overall group experience.

ACKNOWLEDGEMENTS

I would like to thank the seven women who participated in this practicum. Without their commitment, regular attendance at group sessions, and their willingness in completing several scales and questionnaires, this study would not have been possible.

I would also like to express my appreciation to the staff at the Women's Health Clinic for their support and for providing the space for me to work in their agency. Thank-you to the members of my practicum committee, Sheila Rainonen, Maureen McIntosh, and my advisor Kim Clare. Their wisdom and understanding of group work and women's issues enriched my growth as a student and a practitioner.

Finally, I would like to thank Eddie, Candace and Jean-Stephen, Russell and Kathryn, Roger and Diane, and Patrick for their love and support.

DEDICATION

This work is dedicated to my parents, John Aaron Reimer and Elizabeth Unger Reimer whose compassion and concern for little children continues to inspire me in my work, and to my grandchildren, the little children in my life, Andrew, Elizabeth, Anne and Sarah, and Francis-David and Claire-Lydia.

TABLE OF CONTENTS

List of Tables

Exhibits

CHAPTER 1

INTRODUCTION

> Boundaries regulate closeness and distance in a relationship. They regulate physical and sexual touch, the kind and amount of information that is shared, and all other behaviours that occur between people (Nielson, 1990, pp. 203-204).

The purpose of this practicum was the implementation and evaluation of a twelve week group program, with a focus on the development of boundaries in adult survivors of child sexual abuse. The practicum, which took place at The Women's Health Clinic in Winnipeg, included seven female participants. The practicum also served as an opportunity for me to develop and explore personal learning goals within the practicum experience.

When individuals have been deprived of the opportunity to develop boundaries during the formative years of childhood, they are denied the opportunity to develop an awareness of the demarcation between self and other. Abuse during the developmental years of childhood leaves the child confused and without a sense of being separate from the perpetrator's plans and wishes. Seeing someone who is her trusted care-giver, as choosing to hurt her, threatens the core of the child's existence. The safer path is to doubt herself (Blume, 1990). Without the ability to trust her own perceptions and judgements, the child becomes the adult whose understanding of reality is directed by the external content in her life.

Although the adult survivor shapes her experience and perceptions to conform to others, therapeutic intervention rebuilds a sense of confidence and trust in her own "interpretive skills" (Davies & Frawley, 1995). As she begins to develop boundaries that

are right for her, a sense of self emerges and she moves from helplessness and low self-esteem to increased self-responsibility and autonomy. The building of internal and external boundaries is central to the growth and healing of the effects of abuse that occurred during the developmental years of childhood.

BACKGROUND

The decision to focus on survivors and boundary development was based on several factors. Although the literature explains how child sexual abuse prevents the "normal" boundary developmental process from taking place, there is a paucity of literature addressing interventive strategies useful in the reparation and development of boundaries and in measuring boundary development. Given the above findings it became apparent to me that the literature alone did not adequately address the topic of boundary development. I then began to focus on what I had learned from working with individuals and groups of survivors of child sexual abuse. This experience enabled me to identify patterns which I believed to be relevant in the development of boundaries.

As a group facilitator in previous situations, I had met many women who identified issues related to boundary ambiguity. For example, in one group of six women, several of them identified situations indicative of internal and external boundary difficulties. "Anna" disclosed that she had difficulty taking care of her own needs but had no difficulty attending to the needs of others. Another woman said she struggled with setting limits for her children, and when she did set limits, she was unable to enforce them. "Jane" echoed the

group's feeling in a tentative voice, "sometimes, I don't know who I am, or if I am." Without an understanding of self, the women had difficulty with decision-making, assertiveness and interpersonal relating.

In addition to the above expressions of boundary confusion, I had also encountered an alarming number of women who described revictimization in relationships of imbalanced power. Out of a total of twenty-four women representing five groups, which I had facilitated, eighteen women disclosed revictimization. In agony they described revictimization by coaches, educators, counsellors, clergy, doctors, pimps, and partners. Having difficulty in being assertive and in trusting their own judgement, they continued to experience a violation of their dignity and worth. For most of the above women the group experience had been the first time they had felt safe in sharing the details of the secret trauma they had carried since childhood.

RATIONALE FOR GROUP WORK

Group work practice has been a valued part of the social work profession for a long time and is a commonplace practice in most social and health-care settings today. It continues to grow at a fast pace as a method of intervention designed to meet treatment and growth objectives in mutual support. Social workers with group work experience and an understanding of small group dynamics have much to contribute to the growth of the social work profession.

The rationale to utilize a group model for this practicum was based on the

therapeutic potential of groups. According to several authors, group interaction may be of particular benefit in ameliorating symptoms experienced by adult survivors of child sexual abuse (Courtois, 1988; Donaldson & Green, 1994; Gil, 1988; Herman, 1992; Saxe, 1993).

The group experience presents a range of opportunities to facilitate internal and external boundary work. Internal boundaries are established when the survivor gets in touch with her core feelings and moves toward self-definition. This is best accomplished in group as the "development of self is ultimately a social phenomenon" (Saxe, 1993, p. 44). External boundary work involves learning new interpersonal skills, such as communication, conflict resolution, and setting limits. The group setting is an ideal environment for the modelling and practice of interpersonal relating. As women connect with one another in an atmosphere of mutuality, a growing interaction occurs, and they begin to work together towards goal oriented change.

PRACTICUM OBJECTIVES

The primary interventive goal of this practicum was to provide an opportunity for women survivors of child sexual abuse to begin to understand the concept of boundary and to build and strengthen internal and external boundaries. It was also hoped that the development of boundaries would increase participants' self-esteem and promote healing from the effects of child sexual abuse. A safe group setting was seen as an ideal environment within which to achieve the proposed goal.

The group intervention included the following objectives: a) to provide an opportunity for survivors to share in commonality their feelings of isolation, shame, and guilt, and to practice new ways of interpersonal relating b) to offer exercises and educational components describing issues related to boundaries c) to model and maintain group boundaries.

My personal learning goals for this practicum included: first, to enhance my skills in group work intervention with survivors of child sexual abuse. I wanted to facilitate the group in a way that would enhance safety and trust within the group members. Specific goals included the following: a) to develop skills in balancing structure and flexibility in group work b) to focus on the themes and objectives set for each session c) to be more clear about my personal facilitation style.

A second learning goal was to increase my understanding of: a) group work with survivors b) the long-term effects of child sexual abuse c) the concept of boundaries and how this concept might apply to, and affect survivors d) evaluation procedures. As a means to increasing my knowledge of the concept of boundaries and evaluation procedures, I proposed to design and use a scale to measure boundary development. Additionally, I proposed to develop and to use the following methods of evaluation:

a) self-report questionnaires on members' group experience and members' boundary development within the group experience.

b) self-report rating scales to evaluate procedural reliability and participants' response to each group session

The application of an existing scale, already tested for reliability and validity, was an additional goal of this practicum.

THEORETICAL FRAMEWORK

The time-limited group model created for this practicum incorporated the principles of survivor therapy; principles that include an emphasis on safety, on strengths, education, and empowerment. Survivor therapy, which originated in feminist theory and trauma therapy, includes an understanding of oppression and of society's influence on the development of child sexual abuse. A group model within a feminist framework aims to empower women to find healing from the wounds of child sexual abuse in commonality with other women. A feminist approach does not view the long term effects of child sexual abuse as pathology, but as innovative coping strategies. Feminist group work allows survivors to explore the difficulties and symptoms in a safe and supportive setting. The intervention model also draws from a developmental approach, which promotes individual growth and differentiation through "self-assessment and the development of new skills and abilities" (Courtois, 1988, p. 200).

The values of social work, with the belief in the inherent worth and dignity of all human beings, are also incorporated in this practicum. The Canadian Association of Social Workers Code of Ethics (1994) states that:

> Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination, and respect of individuality. They believe in the obligation of all people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity. (p.7)

While the social work code of ethics emphasizes the interconnectedness and interdependence between the individual and the environment, a feminist perspective challenges social work to look at oppressive therapeutic strategies which continue to stress adjustment to traditional beliefs about women's place in society.

Although both objective and subjective measures were used in the evaluation of the intervention, the subjective measures are more consistent with a feminist framework and were viewed as significant in the evaluation of the practicum.

THE PRACTICUM REPORT

This practicum report reviews issues and interventions related to the development of boundaries in adult survivors of child sexual abuse. Chapter 2 is a review and discussion of the relevant literature, including group work with survivors, boundary development in children, an overview of long term effects of child sexual abuse, and the theoretical framework of the practicum. A reference section of the literature reviewed is included in the report. Chapter 3 reviews the practicum methods and procedures and includes information on the setting where the practicum was conducted. One of the sections of Chapter 3 provides an overall description of the intervention plan and the group model utilized. An overview of the weekly group

sessions with the seven women who participated in this practicum is discussed in Chapter 4. Chapter 5 is a summary of the results of the practicum and includes several implications of the intervention. The final chapter is an evaluation of the overall practicum experience. It summarizes the major learning themes that were addressed in the practicum and makes recommendations for future group work.

CHAPTER 2

LITERATURE REVIEW

This chapter is a review of the literature relevant to the development of boundaries in the adult survivor of childhood sexual abuse. The literature reveals that boundary issues, which are common in women who have been abused as children, has been given limited attention. While little research has focused on the impact of boundary confusion in the woman survivor, even less attention has been given to the development and strengthening of boundaries in the survivor.

There are, however, several authors who discuss and define the concept of boundary and those who describe different types of boundaries. The work of some of these authors is included in this review. The definition cited in the Social Work Dictionary (Barker, 1987) is also included. Secondly, this review makes reference to limits and boundaries in the psychological development of women. A summary of the literature on the development of the self and of boundaries in the child is followed by a review of the long-term effects of child sexual abuse with an emphasis on boundary violation and its related symptoms. A model which describes the fostering and reparation of boundaries in the woman survivor is included in the section on group work with survivors. Finally, reference is given to boundaries within the context of the therapist - client relationship.

DEFINITION OF BOUNDARY

Germain (1991), in discussing the notion of boundary from a systems theory perspective, describes a boundary as "an organized whole usually defined as a set of interacting parts enclosed within a boundary that separates the system from its environment" (p. 463). She states that not all systems are as clearly marked off and that a system may take on different shapes at different times or under different conditions. Thus a boundary specifies what is inside or outside a system, depending on who does the defining; for example, membership requirements of a group or language that includes some and excludes others, according to the knowledge of the language (Germain, 1991, p. 464).

The Social Work Dictionary (Barker, 1987) defines boundaries as:

> regions separating two psychological or social systems...A function of boundaries, which are analogous to the membranes of living cells, is to differentiate systems and their subsystems and permit the development of identity. Healthy family functioning largely entails clear boundaries; less healthy functioning is seen where boundary subsystems are either inappropriately rigid or not consistently clear (that is, in a disengaged family or an enmeshed family). (p.17)

Family therapist, Marion Mason (1986) defines a boundary as the "invisible shield surrounding us something like a capsule; the invisible line marks where we end, and the rest of the world begins" (p. 178). This definition is similar to that given by Walker (1996), "a boundary can be described as a 'psychic wall' that emotionally separates each of us from another person" (p.327).

According to Brown and Gilligan (1992), the definition of boundaries is "highly variable" and related to the developmental process and life's experiences. They use the term continuum as a way to view boundary. This implies that the subjective experience is important in relation to boundaries and that there are no universal rules about what is a "healthy" or an "unhealthy" boundary. Ball (1991) agrees that there are no "wrong" or "right" boundaries but that each individual must judge for herself what is appropriate given the situation and resources. Katherine (1991) refers to roles and relational boundaries and explains that certain relationships establish certain role expectations. Thus boundary setting is both an individual and relational process. For example, a woman with clearly established boundaries, who is a doctor, will be able to set limits for herself and for the patient-doctor relationship. In her role as a wife she will set boundaries appropriate for a husband-wife relationship.

In summary, boundaries may be defined as regulating closeness and distance in a relationship. Boundaries allow for self-protection and meaningful interpersonal relationships and "regulate all behaviours that occur between people" (Nielsen, 1990, p. 204).

TYPES OF BOUNDARIES

Evans (1987) describes two types of boundaries, physical and psychological, giving an example of skin as a physical boundary. "Skin separates our insides from our outsides" (p. 26). Other examples of physical boundaries are doors, gates and

fences, and possessions such as keys, diaries and clothes. Psychological boundaries, although invisible, are equally important and are defined by Evans as a "psychic bubble" that surrounds us and helps keep us separate from other people. Farmer (1989) notes that psychological boundaries include a sense of "self" or "me", protecting our uniqueness and individuality. Other authors refer to physical, personal, sexual and emotional boundaries (Blume, 1990; Evans, 1986; Courtois, 1988; Utain, 1989; Whitfield, 1993).

Rosenberg and Rand (1989) discuss three different types of boundaries: self-boundary, defensive boundaries, and absent or vague boundaries.

> Self-Boundary: is a sense or experience of self that is separate from the world yet exists in harmonious relationship with it. It is strengthened by proper reflection and continued interaction with the environment. (p. 175)

Utain (1989) refers to this type of boundary as flexible, allowing "us to remain responsive to our present environment", where the "outside does not impinge too much on us and we do not impinge too much on it" (p. 194). Thus a self-boundary is permeable and one that allows people to choose and to set limits for themselves and others in relationships. Second, the authors define a defensive boundary:

> Defensive Boundary: is a substitute for a Self-boundary that fails to develop through lack of proper reflection and successful learning. It keeps people out in the same way as one's defensive armour protects the self hidden within. (p. 175)

Other authors define the defensive boundary as rigid, like a wall or a brick fence, keeping everything and everybody outside. This armour protects the person from negative judgements of others (Blume, 1994; Kunzman, 1990). Third, Rosenberg and

Rand describe an absent boundary:

> Absent or Vague Boundary: occurs when a person has insufficient sense of self for him to know where or how to set a boundary. (p. 176)

An absent or vague boundary is referred to as an enmeshed or blurred boundary by Kunzman (1990). "There is too much `we' and not enough `I' in this style of interaction" (p. 31). Evans (1988) states that this boundary ambiguity "fosters fusion, hampers individuation and promotes symbiotic relationships" (p. 66).

According to the above descriptions, an individual with vague boundaries may have difficulty protecting her integrity and choice as she interacts with others, while one with a defensive or rigid boundary may keep others at a distance or impose on the boundaries of others. However, a self boundary is one that is permeable, maintains individual integrity, and allows for choice in relationships.

WOMEN AND BOUNDARIES

Although there is a paucity of literature on the development of boundaries in adult survivors of child sexual abuse, there are several authors who discuss the development of the self and the issue of limits and boundaries in the psychological development of women (Belenky, Clinchy, Goldberger & Tarule, 1988; Brown & Gilligan, 1992; Butler, 1991; Goodrich, Rampage, Ellman & Halstead, 1988; Kaschak, 1992; Walters, Carter, Papp & Silverstein, 1988).

Kaschak (1992), who discusses the distinction between limits and boundaries, notes that a "girl child's early training involves numerous prohibitions and limitations

that do not apply to the male child" (p. 137). Although Erikson (1980) designates "basic trust" as the first developmental stage in the formation of the core self in children, Kaschak states that, as Bart (1985) has aptly noted, the first developmental stage for girls should be mistrust. She says that mistrust, fear and restriction become "integral parts of the developing identity" as early female training involves "learning of the danger and intrusiveness with which they must contend" (p. 138). The female child learns that some males will protect her, others will hurt her and some will do both and that "only through relatedness to a man can a woman be visible or boundaried" (Kaschak, 1991, p. 138).

In a study on the development of self in girls and women, Brown and Gilligan (1992) "listened to the voices" of 100 girls between the ages of seven to eighteen. This research revealed how the journey out of girlhood is a journey into silence; that the voice which stands up for the self and for what is believed becomes deeply buried.

Similar findings were reported by Belenky et al., (1988). Based on in-depth interviews with 135 women, the authors reported that women must overcome many roadblocks in developing the power of their minds. Even the most privileged women in the sample expressed the need to be accepted as a "person" as opposed to being "oppressed or patronized". "Privilege does not ensure freedom from oppression; incest, for instance, occurs in the `best' of families and achievement does not guarantee self-esteem" (p. 196). Kaschak (1992) states that like the self, self-esteem has been defined with "masculinity as the norm, without a view of context" (p. 155). Butler and

Wintram (1991) state that the study of self has in the past been preoccupied with the separation/individuation from others. Separation, however, is threatening to women, and for women, the self is developed in connectedness, not separation (Belenky et al., 1988; Butler, 1991; Kaschak, 1992). In her critique of the construct of a separate and individuated self, Kaschak says that we cannot ignore the context and interconnectedness in the development of a sense of self.

Kaschak (1992), in her discussion on limits and boundaries, makes a distinction between the two.

> Limits define the extent to which one may grow, expand, or explore. Limits identify the point beyond which one may not venture due to internally imposed deficits such as lack of skills or talent, or externally imposed injections, such as those introduced by gender training. Limits eventually become internalized and embedded in the concept of self and others. (p. 131)

Strong externally imposed limits lead to weaker psychological boundaries while weak limits lead to broader and less well internalized psychological boundaries. According to Kaschak, these limits contribute directly to the development of boundaries or to "knowing who one is and who one is not" (p. 131).

In summary, several authors agree that there can be clear boundaries in connectedness and that when a woman finds her voice, she finds a boundary, not prescribed for her, but one described by her.

BOUNDARY DEVELOPMENT AND CHILD SEXUAL ABUSE

Developmental stages in children and the formation of boundaries has been

discussed by several authors (Blume, 1990; Briere, 1992; Courtois, 1988; Davies & Frawley, 1994; Erikson, 1980; Evans, 1987; Herman, 1992; Utain, 1989; Walker, 1995). In this metaphorical vision of life stages, each of the developmental stages builds on a previous stage and, as noted above, begins with the most basic, trust versus mistrust (Erikson 1980). Trusting in a care-giver allows the child to develop a secure attachment to a loving and protective adult. This attachment provides a solid foundation for the young child to begin to relate to a complex world. Davies and Frawley (1992) indicate:

> This secure relationship becomes the haven from which children draw their confidence in their capacity to control external events; the omnipotence, if you will, that potentiates the child's active engagement in what might otherwise seem to be overwhelming developmental tasks. It is also the retreat to which the child withdraws for soothing and comfort when that omnipotence is challenged or thwarted by experiences of failure and frustration (Davies & Frawley, 1992, p. 46).

Herman (1992) describes this "haven" as an "inner representation of dependent care-givers that can be retrieved in times of distress" (p. 107). As the child develops she achieves a sense of autonomy and is able to develop as a separate and unique individual having her own thoughts, beliefs, feelings and behaviours (Blume, 1990). This process of differentiation, according to Blume, is paramount in the development of boundaries and in the development of the self.

Briere (1996) identifies this self as a "collection of internal skills and capacities" (p. 65). He notes that three of the skills are especially important to the individual's response to aversive events: identity, boundary, and affect regulation. He refers to

identity as a consistent sense of personal existence; boundary, which is closely related to identity, as "an individual's awareness of the demarcation between self and other;" and "affect regulation as important to the individual's management of traumatic experiences and negative internal states" (Briere, 1996, p. 66).

The development of the self during childhood, is essential to the development and maintenance of appropriate boundaries and limits. According to Whitfield (1993), "the child learns both of these - self sense and boundaries - earliest from its family of origin and later from people outside of its family" (p. 50). Briere (1996) notes that, as the child progresses through the developmental stages in a generally positive environment, he or she continues to take risks in dealing with discomfort, while learning to tolerate greater levels of emotional pain.

> In the context of sustained external security, the child learns to deal with the associated uncomfortable (but not overwhelming) internal states through trial and error, slowly building a progressively more sophisticated set of internal coping strategies as he or she grows and confronts increasingly more challenging and stressful experiences. (p. 67)

It is reasonable to assume that this increasing ability to deal with frustrations and stressful situations enables the child to build a positive self concept with feelings of adequacy and worth.

In a family where the child's sexual boundaries are violated, the child is unable to develop this sense of adequacy and worth. Without the internal security and ability of self-function, there is no order and predictability in the child's life. The perpetrator betrays and violates the dependent child's integrity and worth. The message to the

child is clear. She is the property of another without the right to develop a secure sense of independence. The perpetrator controls the child's thought process and belief system, and the child cannot develop the self as separate from his wishes and agenda (Blume, 1992). As cited in Blume (1990), this enmeshment is described by Rieker as a "disordered and fragmented identity deriving from the accommodation to the judgements of others" (p. 19). This accommodation, however is a creative and resourceful way of protecting the self. According to Pearlman and Saakvitne (1995), "it is fascinating to discover the many natural mechanisms that can be activated to protect the self...the various aspects of the self are remarkable" (p.403).

In intrafamilial child sexual abuse the child thus has a formidable developmental task to achieve. She must find a way to form primary attachments to caretakers. In order to accomplish this she identifies the parents as good and herself as bad and deserving of the parent's treatment (Briere, 1992). Evans (1988) notes that the child understands she cannot survive without a dependable loving care-giver and that she has no choice but to see herself as the bad one. As noted below, the fear of abandonment drives this belief.

> In that parents are the most important relationships (for better or for worse) that children have, their very survival depends on making sure those relationships are maintained. Children will do almost anything to survive, even blame themselves if there is trouble in the family. They will even pretend to be someone else if who they are is unacceptable. (p. 4)

This false self may become a part of the individual's interaction with others in "people-pleasing" ways in order to belong and not be rejected, or merely to survive.

Herman (1992) suggests that, because the inner sense of badness "preserves a relationship, the false self is not easily given up even after the abuse has stopped, rather it becomes a stable part of the child's personality structure" (p. 105). Throughout the developmental years the child continues to relate from a "highly developed role-self, which is a substitute for personal boundaries" (Mason, 1993, p. 41). Hence, the child creates a contextual structure in response to "more and more confining conscious and unconscious decisions about who she is and what is acceptable and what is not" (Utain, 1989, p. 185). Utain notes that this contextual structure of "inner badness" is the framework which governs the child's response to the content in her life. She adds,

> Then add to all of that the fact that you cannot admit to yourself that mother does not love you because you need her for your survival. Children need to believe they will be taken care of, and their need to survive does not allow them to see anything negative about the parent that might threaten that survival. (p. 190)

Many children thus experience a gradual shutdown of their sense of self in their effort to suppress the reality of the sexual abuse in their lives, a reality that continues to be denied and suppressed by society, in spite of research findings which provide evidence of its prevalence.

Research in the field of child sexual abuse has received significant attention over the past 15 years both in the public and the private sector. However, as noted above, little children continue to be denied the opportunity to flourish and to develop the core self. According to Schadler (1992), child sexual abuse is taboo in our society but it happens in epidemic proportions, is frequently denied, unreported and

unprosecuted. Surveys of women in general population samples estimate prevalence rates of child sexual abuse at about 20-50% (Badgley, 1984; Briere, 1992; Russell, 1986). Variations in results may be "attributable to differences in definitions of abuse, sampling, sample size, or methods of obtaining retrospective data" (Donaldson & Cordes-Green, 1994, p.2).

An extensive Canadian study found that one in two females and one in three males will experience unwanted sexual acts before the age of eighteen (Canada, 1984). The Canadian Committee, chaired by Badgley, broadly defines sexual abuse to include everything from exposure to intercourse. In response to the Commission's recommendations, the federal government appointed a special advisor on child sexual abuse, Rix Rogers, to the Minister of Health and Welfare, in 1987. In his report, "Reaching for Solutions" (Canada, 1991), Rogers begins with some personal reflections on the impact of child sexual abuse on the adult survivor.

> My life has been deeply marked by my experiences of the last two years as Special Advisor on the issue of Child Sexual Abuse. I have been shocked by the anguish and pain of so many victims and adult survivors. (p. 11)

He goes on to say that the incidence of child sexual abuse, although widespread, is largely hidden. "I am troubled that despite 30 years of work in a major child serving organization, I was not more aware of child sexual abuse as I entered this assignment two years ago" (p. 12).

The above quotes support the literature discussing the long-term effects of child sexual abuse and the silence and denial in society; a society where victims of abuse have no choice but to suppress the self so they can survive and continue to function.

This loss of self results in long term difficulties with internal and external boundaries in the life of the survivor.

THE LONG TERM EFFECTS OF CHILD SEXUAL ABUSE

Although each survivor responds to the abuse in her own way, research indicates there are common themes (Briere, 1996; Courtois, 1988; Herman, 1984; Walker, 1995). The most consistent of long term effects includes anxiety, depression, feelings of guilt and shame, low self-esteem, self-destructive behaviour, interpersonal difficulties, distrust, sexual difficulties, lack of assertive skills, and chemical dependency (Briere, 1992; Courtois, 1988; Gil, 1988; Herman, 1992).

Several authors have categorized the symptomatology of common long term effects into groups (Briere, 1996; Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988). Gil (1988) based the categorization on a clinical sample of 99 individuals who came to her for counselling. She refers to the categories as:

1. psychosocial problems
2. physical and eating disorder problems
3. relationship and sexual problems.

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

1. post-traumatic stress
2. cognitive effects
3. emotional effects
4. interpersonal effects.

He discusses what he terms "core effects", one of which is "other-directedness". The survivor becomes an expert in hypersensitivity with "extreme emotional reactivity to others" (p. 54). The second core effect he identifies as "posttraumatic intrusion",

which includes flashbacks, nightmares, panic attacks and other intrusive symptoms (p.107). Donaldson and Cordes-Green (1994) in their review of the literature on long-term effects consider the following categories:

1. emotional and cognitive effects
2. social and interpersonal functioning
3. physical and sexual functioning
4. psychiatric diagnoses.

In her book "Healing The Incest Wound", Courtois (1988) discusses several findings of self-report studies and of methodologically sound empirical investigations. She states that "incest has been found to impact the victim intrapsychically and interpersonally" (p. 107). She has categorized the two broad effects into six groupings:

1. emotional reactions
2. self-perception
3. physical somatic effects
4. sexual effects
5. interpersonal relating
6. social functioning.

Courtois states that long-term effects may be "chronic manifestations of acute after-effects or develop in a delayed fashion" and that some "appear and remit sporadically and rather spontaneously" (p. 104). van der Kolk et al., (1996) cite Kardiner who proposes that once traumatized, an individual

> acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion. This means in effect that his conception of the outer world and his conception of himself have been permanently altered. (p. 196)

As noted in an earlier section, Herman (1992) offers further support of these

conceptions. She notes that they are not easily given up but form a part of the individual's personality.

Although not all of the above authors name boundary issues as an effect of childhood sexual abuse, all identify interpersonal difficulties and psychological effects. From the review of the literature, and according to the "definitions" and "types" of boundaries described in a previous section, most of these effects are interrelated with boundaries. Several authors however, do name boundary problems as a direct result of childhood sexual abuse (Briere, 1996; Courtois, 1988; Davies & Frawley, 1994; Herman, 1992; McEvoy, 1990; and Simonds, 1994). Herman (1992) notes that it is extremely difficult for the survivor to establish safe and appropriate boundaries with others as she struggles with issues of betrayal and a longing for nurturance and care. "Boundaries are either non-existent or rigidly maintained, as survivors cannot allow their images of self and others to wander freely" (Davies and Frawley, 1994,p. 49).

Finkelhor (1990) has developed a traumatization model which identifies four areas of development that impact on the adult survivor of child sexual abuse. He indicates that the post traumatic stress disorder (PTSD), defined by the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", fourth edition (DSM-IV), is an inadequate diagnosis for child sexual abuse victims. Herman (1992) agrees that the present definition of PTSD does not fit accurately enough for survivors of prolonged, repeated trauma and that PTSD may be a diagnostic mistake as it does not address the underlying issues of trauma. However, Dolan (1991) maintains that the PTSD diagnosis provides the best description of the psychological

symptom of abuse survivors, that it has a normalizing effect and is clinically accurate. Walker (1995) adds that survivor therapy takes the position that the diagnosis of personality disorders, as defined by the DSM-IV, is not relevant to survivors of child sexual abuse. "Many of their symptoms disappear after supportive therapy that takes a feminist and trauma survivor focus, suggesting that these disorders were actually learned coping strategies and not integrated within victims' personalities" (p. 126).

In summary, boundary problems "arise from a relative inability to conceive of self without reference to others and the reverse" (Briere, 1996, p. 54). The developing child's personality structure, which was formed in response to victimization, was deprived of the opportunity to form a core self from which to determine her understanding of the world. The survivor's understanding of reality therefore continues to be directed by the external content in her life.

CONSEQUENCES OF BOUNDARY DIFFICULTIES

As noted above, a sexual boundary violation leaves the survivor with a loss of self, resulting in fundamental problems, both intrapsychical and interpersonal (Blume, 1988; Briere, 1992; Courtois, 1988; Evans, 1986; Herman, 1992; Katherine, 1991; Kirschner, 1993; Simonds, 1994). For the purpose of this paper boundary issues are divided into two categories, similar to the distinction made by Evans (1986). In her boundary work with women, she refers to internal boundary work as movement toward self-definition, and external boundary work as learning new behavioral skills.

Internal boundary difficulties are those which are at the core of the survivor's

sense of loss and personal identity (the self) or as Utain (1989) explains, the contextual structure which shapes a child's response to the content in her life. Courtois (1988) refers to internal issues as intrapsychical symptoms. The consequences of internal boundary symptoms, which relate to the survivor's self-identity are listed:

1. suppression of feelings (especially anger)
2. negative self-evaluation
3. anxiety and fear
4. feelings of loss, shame and grief
5. subordination of rights
6. difficulty in decision-making
7. feeling powerless and helpless.

These internal boundary symptoms have a profound effect on survivors. Feeling powerless in the world, they have difficulty asserting their wishes or making demands on others. As well, they have difficulty expressing their feelings, perhaps due to "an awareness that on the other side of emotional deadness lies a searing and uncontrollable pain" (Davies & Frawley, 1994, p. 49). They may also be aware of the possibility that they could explode or impose on others when they risk expression of feelings. In both "clinical and non-clinical samples, survivors have been found to have greater levels of anxiety or tension" (Donaldson & Cordes-Green, 1994, p. 3). Low self-esteem and negative self-evaluation may be induced or exacerbated by the victim's assumptions of guilt and responsibility (Briere, 1992).

This negative self-perception relates to the survivor's tendency to subordinate rights to those of others (Jehu, Klassen & Gazan, 1988; Oakley, 1996). van der Kolk (1996) notes that many people, because of "trauma-based internal schemas, have great difficulty taking care of their own needs for rest and protection, even as they are

exquisitely responsive to other people's needs" (p. 196).

> The survivor often develops an elaborate false self, designed to gain approval from others and to hide the bad, shameful self. She may be very responsive to others' requests or needs or demands of her, thankful for any help or attention, overly generous, and eager to curry favour with significant others. (p. 59)

Oakley (1996) suggests that the lack of self-care and self-evaluation in the survivor is the result of boundary violations, experienced as major disruptions in a woman's life. She states:

> In addition, the problems that bring women to therapy are related to boundary access issues (both internal and external boundaries) and the ability to define one's own time and space, including physical and bodily space. Boundary violations have occurred through abuses of power and bodily space... These boundary violations are experienced by women as severe disruptions that can affect their sense of themselves physically, sexually, and psychologically and have impact on their sense of safety, confidence, and competence in the world. There is a consequent lack of positive self-evaluation, self-empathy, and self-definition. (p. 265)

Furthermore this lack of self-definition may result in difficulties with intimacy and interpersonal relating. According to Clinchy (1997), "it is reasonable to argue that without intimate knowledge of one's self one cannot enter into intimacy with another" (p. 230). In summary, these internal boundary difficulties are at the basis of the survivor's interpersonal relating and other external boundary issues.

External boundary difficulties include social and interpersonal relating, for example:

1. general relationship difficulties
2. lack of assertiveness
3. mistrust of others
4. parenting difficulties
5. isolation and aloneness
6. lack of self-care
7. revictimization.

The consequences of external boundary difficulties can result in "intensely negative

affects and feelings-especially in the context of interpersonal relationships" (Briere, 1996, p. 53). According to van der Kolk et al. (1996), "perceptions of relationships tend to become filtered" through the experiences of traumatic events (p. 197). Relationships of betrayal and helplessness in a child result in fear and mistrust of others (Briere, 1992; Herman 1981; Jehu et. al., 1988; van der Kolk et al., 1996). In a study by Jehu (1988), 88 percent of his clinical sample reported feeling insecure in intimate relationships. Several authors report that this insecurity may result in sexual problems and sexuality issues (Briere, 1988; Courtois, 1988; Donaldson & Cordes-Green, 1994). It is interesting to note Jehu's point that treatment of sexual dysfunction "requires prior alleviations of other symptoms such as depression and mood disturbances" (p. 305). Although van der Kolk does not discuss sexual concerns and treatment, he does state that "treatment cannot address past trauma unless its reenactment in current relationships is taken up as well" (p. 197). Whip (1991) reports that survivors say that work on "sexuality is a last and in some cases optional stage in a fifteen to twenty year recovery program" (p. 48). For these women "having a sense of self, a reason to live, learning to say no and setting limits comes first" (p. 48).

Survivors who have children may experience anxieties in relation to their children and often have difficulty setting limits for them, and when they do set consequences are unable to enforce them. They may also have difficulty recognizing and intervening when their own children are abused (Courtois, 1988; Dolan, 1991; Kirschner, 1993). However, many survivors also feel a deep pressure to make up for their inadequacy as parents, and are "good and even exceptional parents, driven by

their determination not to do to their children what was done to them" (Courtois, 1988, p. 113).

Another area that is problematic for survivors of child sexual abuse, and directly related to interpersonal relating, is that of communication and conflict resolution (Whitfield, 1993). When a person has experienced sexual abuse in early life, the feelings may leave the child unable to make sense of what happened, and impacts on the adult survivor's ability to freely express herself. Whitfield discusses the difficulty in understanding feelings around conflict within relationships when boundaries are vague or enmeshed. He notes that "we take on pain that is not ours as we learned to do from our family and society of origin" (p. 107). Walker (1995) adds that survivors frequently experience blocks to assertive behaviour and may have difficulty communicating from their own and not society's perspective.

Numerous authors note that survivors of child sexual abuse are more vulnerable to revictimization than non-victims (Briere, 1996; Courtois, 1988; Donaldson & Cordes-Green, 1992; Herman, 1992; Kirschner, 1993; Jehu et. al., 1988; Russell, 1986). In Russell's study, 68 percent of survivors had been victims of either rape or attempted rape. Runtz (1987) suggests that "factors specific to child sexual abuse, particularly the traumatic sexualization, impaired ability to identify others who are trustworthy, and learned helplessness, render abuse victims vulnerable to repeat episodes of sexual exploitation" (Courtois, 1988, p. 115). Revictimization by a wide range of professionals has been reported in the literature and will be reviewed in a later section.

In summary, the consequences of boundary difficulties in the adult survivor of child sexual abuse are profound and often serious enough to cause a survivor to become involved in long term individual therapy and group work.

GROUP AND BOUNDARY WORK WITH SURVIVORS

Group work is a common and beneficial form of intervention used by a wide variety of helping professionals such as social workers, nurses, psychologists, teachers and clergy (Toseland & Rivas, 1984; Donaldson & Cordes-Green, 1994). Bernard and McKenzie (1994) report that outcomes of group psychotherapy have been demonstrated to be as effective as outcomes in individual therapy.

Herman and Schatzow (1984) note that group work with survivors of child sexual abuse appears to be a particularly appropriate intervention for incest survivors. A rationale for the survivor group is its potential for the alleviation of secrecy, isolation and stigma (Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988; Herman, 1992; Jehu, 1988; Walker, 1995; van der Kolk et al., 1996). Child sexual abuse is about secrecy and isolation. Group work is about sharing and reliving experiences with others who have had similar experiences of abuse, shame and isolation. This bonding and connection to others within group is referred to as "universality" by Yalom (1985). The discovery that one is not unique in having flashbacks, anxiety attacks, and feelings of guilt and shame is more likely to happen in group than in individual therapy.

According to Courtois (1988), the recognition of the commonality of the

experience of after-effects and coping strategies tends to normalize what survivors have endured. The ability to develop bonds with other members may reduce feelings of helplessness and facilitate a sense of personal power in the survivor (Donaldson & Cordes-Green, 1994). Herman (1992) describes this commonality among group members as looking into a mirror.

> When groups develop cohesion and intimacy, a complex mirroring process comes into play. As each participant extends herself to others, she becomes more capable of receiving the gifts that others have to offer. The tolerance, compassion and love she grants to others begin to rebound upon herself. Though this type of mutually enhancing interaction can take place in any relationship, it occurs most powerfully in the context of a group. (p. 216)

As well, the group process encourages members to experiment with boundaries, "to allow in more of who others are and to let in more of who one is" (Page, 1994, p. 52). Finally, the group process is an effective and appropriate method to facilitate both internal and external boundary work.

Addressing internal boundary work involves encouraging the woman toward self-definition, teaching decision-making, and cognitive restructuring around issues of self-blame, shame, guilt and anger (Evans, 1986). To change early distortions around boundary violations the survivor must "recontextualize herself and change the boundaries that have been developed about who she is and what is acceptable" (Utain, 1989, p. 186). This may be difficult and long-term work. In order to do this the "survivor must go back to reexperience and complete the early traumas out of which she created those decisions" (Utain, 1989, p. 186). This inner work, referred to as internal boundary work by Evans (1986), is best accomplished in group as "the

development of self is ultimately a social phenomenon" (Saxe, 1993, p.44). When group members support one another in the appropriate expression of feelings they break the feelings of stigma, isolation and denied affect.

Internal boundary work in group provides the opportunity for the survivor to express feelings of anger, feelings that are often directed inward. As the survivor learns to express her anger she begins to understand that feelings of anger are "appropriate considering what happened to her" (Courtois, 1988, p. 209). McKay (1991) suggests that "boundaries can be improved by helping individuals own their feelings, identify their needs and wants, and define their personal rights" (p. 9).

In addition to the internal boundary work the survivor must learn new behavioural skills such as self-care behaviours, assertiveness and setting limits. Evans terms this healing "external boundary work." While Evans (1996) discusses external boundary work in the context of individual counselling, McEvoy (1990) describes the reparation and strengthening of boundaries within the group context, using the SEPSA model, (Support, Education and Prevention of Sexual Abuse of Children). She discusses the model's goals to repair the personal boundaries of group members who are survivors and she states that a "variety of opportunities present themselves in group work to foster boundaries" (p. 72). For example, McEvoy (1990) encourages the women to find a safe and private place to store their personal group materials. Other examples of techniques and exercises include drawing boundaries, imagery to develop metaphors for personal boundaries, decision-making, connecting the pain of childhood to current functioning and allowing the woman to "find her own voice and her own

path, thereby finding her own boundaries" (p. 78). As women start to find their voice within the group, they say they cannot go back to the false-self even outside the group (Page, 1994). Learning to be assertive instead of passive and/or aggressive promotes growth and healing beyond the group setting.

STRUCTURE AND ORGANIZATION

When reported in the literature, groups for survivors of child sexual abuse have been noted to range in length from four to twenty sessions (Cole, 1985; Gil, 1988; Herman & Schatzow, 1984; Saxe, 1993). Oakley (1996) states that time-limited group therapy is highly suitable for women because "women are able to engage quickly with emotional and relational issues" (p. 280). According to Courtois (1988), short term groups may "limit the level of anxiety experienced by a survivor considering joining a group" (p. 250). Gil (1988) notes that clients "may feel more able to make this short-term commitment" (p. 205). However, groups of only four to six sessions have very limited utility. In the early sessions members concern themselves primarily with the task of establishing safety and developing trust. If the focus of building safety is lost, members can easily "frighten each other with both the horrors of their past experiences and the dangers in their present lives" (Herman, 1992, p. 219). Gil (1988) offers a short-term group of twelve sessions and then "recontracts with the same clients for additional sessions" (p. 204). Most of Gil's groups last for three series after which "members may decide to become a long-term group" (p. 235). Herman (1992) supports the time-limited format and states that a short-term group provides pressure

that "expedites bonding".

Others argue that, although short-term groups promote trust and bonding, true growth and lasting change may require more time and experience. According to Donaldson and Cordes-Green (1994), long-term groups (more than twelve weeks) allow for continued growth and more time to process issues and gain coping skills.

Although the literature on group work with survivors is rich with ideas and techniques relevant to addressing the issues of survivors, there is limited research and information available on the relative merits of lengths of group treatment. However, most members in both short and long-term groups "complain about the time limit issues no matter how long the group lasts" (Herman, 1992; p. 222; Marziali, 1994; Schadler, 1992).

STAGES IN GROUP WORK

The available literature on group work is unanimous in the development of relatively distinct stages of group development (Briere, 1996; Bernard & MacKenzie, 1994; Blume, 1994; Courtois, 1988; Donaldson, 1994; Gil, 1988; Herman, 1992; Marziali & Munroe-Blume, 1994; Page, 1994). According to several authors the process in time limited survivor groups is similar to the stages in individual recovery (Courtois, 1988; Gil, 1988, Briere, 1996).

Although authors differ in the number of group stages (or phases) they identify, "there is a consensus that groups begin in a stage of universalization where members make initial connection with one another by identifying similarities" (Cohn 1996, p.

168). Because the group has not yet become a cohesive unit it is important for the facilitator to concentrate on the establishment of safety and trust in the first stage. This is the time to focus on "introductions, descriptions of ground rules, didactic information on sexual abuse (both orally presented and in the form of reading lists or handouts), summary disclosures of molestation, and the development of group cohesion and identity" (Briere, 1996, p.178). During this formative stage, members are searching for boundaries as they reveal an abuse history, sometimes for the first time within a group. The group, in this early stage "must develop the capacity to help its members both individually and collectively" (Wickham, 1993, p. ix), and offer each member maximum control (Courtois, 1988).

The second stage of group work is devoted to the discussion and sharing of the childhood trauma experiences, with support and feedback from other members and the group facilitator. This stage is referred to as a stage of mourning and remembering, by Herman (1992). Hopefully there has been enough safety and structure established so that the members feel less guarded about their stories (Gil, 1988). In this stage the facilitator must help the survivor to develop skills to tolerate emotional pain as she reexperiences the trauma and connects to the feelings of childhood. This stage has been referred to as internal boundary work in a previous section.

The final stage, that of external boundary work, follows the grieving process and the release of anger. It is the period of rebuilding and learning new skills (Gil, 1988), to practice new behaviours within the group, and then to generalize the skills to outside the group. During this stage members are reminded of the impending

termination of the group. A formal celebration and closure take place at the last session (Briere, 1996; Courtois, 1988; Donaldson, 1994; Gil, 1988).

While several authors have used a model of stages to describe the sequential progression of groups, Page (1994) cautions group workers about moving to the next stage. She says,

> if a group leader recognizes that the conceptualizations of stages simply provide a convenient framework for the theoretical analysis of process, she or he will allow each group to find unique paths that fit individual members' movements toward integration of love, power and justice within relationships. (p. 192)

Although several authors include all three stages in the short-term group, Herman (1992) proposes three groups for each of the three stages described above. She notes that each of the groups matches the stages in individual recovery. Stage one groups concern themselves primarily with the task of establishing safety throughout the duration of the group. They focus on basic self-care, one day at a time. Second-stage groups concern themselves primarily with the traumatic event. They focus on coming to terms with the past. Third-stage groups concern themselves primarily with reintegrating the survivor into the community and with reconnecting with social organizations. According to Herman (1992), "they focus on interpersonal relationships in the present. The structure of each type of the groups is adapted to its primary task" (p.217).

SELECTION AND SCREENING

Although group work is a preferred method of many survivors in their healing

from childhood sexual abuse, some women have difficulty functioning in a group. Screening group members before enrolment in a group allows the group worker an opportunity to assess the women's readiness and suitability for group work (Courtois, 1988; Donaldson & Cordes-Green, 1994; Walker, 1995). Screening also gives the survivor the opportunity to gain information and have questions answered. In Donaldson's groups, the therapists discuss the importance of the survivor's participation in the decision about joining the group. Cole and Barney (1987) articulate reasons for the screening:

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

The pre-group interaction with the facilitator is a vital component of future group intervention. Donaldson and Cordes-Green (1994) note that "preparation for group begins with the first individual session" (p. 46). In addition to a formal assessment in the pre-group screening, the therapist in Donaldson's groups gives general information about child sexual abuse and the adult survivor.

Schadler (1992) cautions against including survivors who are suicidal or psychotic. Several authors agree that potential members must demonstrate the capacity to tolerate questions about their experience as a prerequisite to group participation (Courtois, 1988; Donaldson and Cordes-Green, 1994; Cole and Barney, 1987;

Marziali, 1994; Schadler, 1992). Those women who are not selected should be given the opportunity to recontact the screener (Courtois, 1988).

THE GROUP WORKER

Although the literature discusses both one and two worker teams for group therapy, there are no empirical studies that support the relative merits of one or the other. Courtois (1988) notes that the "intensity of the group process and emotional content places great demand on the therapist" (p. 263). She proposes a female co-therapist team, as does Saxe (1988). Deighton and McPeek (1985) support the use of a male/female co-therapist team.

Wickham (1993) discusses both the benefits and disadvantages of co-leadership. Benefits include sharing responsibility, supporting each other, modelling interaction, and assisting each other for "objectivity during complex dynamic interactions" (p. 115). Disadvantages of co-leadership include the possibility that one worker may reduce the effectiveness of the other, that the " relationship between co-leaders may not be of benefit to the group process as co-leaders do not always complement each other" (p. 117). Glassman and Kates (1990) maintain that unless there is excellent rapport between two workers, one worker is more effective.

What is crucial for the therapist in group work with survivors is to have an understanding of child development, of the impact of incest on the adult survivor, and an understanding of group dynamics. It is not acceptable for therapists to learn about child sexual abuse and its effects from the survivor (Courtois, 1988; Dolan, 1991).

According to Dolan, if a worker is a survivor, it is crucial that she has worked through her victimization. Courtois (1988) adds that the survivor therapist "must be able to work objectively with the group without her own issues being stimulated and getting in the way" (p. 265). Some survivors may feel that non-survivors "cannot empathize or understand them". Others, according to Courtois, prefer a therapist who has not experienced child sexual abuse; they see her as a more positive role model with a "normal" childhood.

Walker (1995) questions whether therapists who have not been abused during their childhood are at a disadvantage working with survivors. She questions also whether that "inhibits in any way the therapist's ability to empathize with, and to respond effectively for those who have experienced particular forms of victimization" (p. 215). Although feeling compassion for another's pain is important, according to Walker, it does not mean the therapist has the skills to transfer her concern or that she can diminish and act to stop the pain of the survivor. However, the worker must be willing to share relevant information with the survivor in order to facilitate the development of safety and intimacy. A traditional neutral stance may hinder the development of the survivor's experience (Davies & Frawley, 1994).

Pearlman and Saakvitne (1995) discuss the importance of a therapist to address vicarious traumatization issues. They state that an essential first step is for the therapist to recognize and accept vicarious traumatization as a "natural outcome of trauma work" (p. 382). Creating balance in work, play, and rest can be an "antidote to the bleakness that can entrap a therapist" (p. 383). It is important to "develop and nurture

spiritual lives outside of our work" (p. 396). They suggest that therapists pay attention to self-care, nurturing the physical, intellectual, emotional and spiritual aspects of their lives. Taking care of the self contributes to development and maintenance of boundaries.

In summary, workers must nurture the self, and have the capacity to model internal and external boundaries. They must have a good understanding of themselves and of the influence they have on others, "especially their clients" (Wickham, 1993, p. 29). A therapist who is able to model appropriate boundaries will help group members establish clear boundaries in their lives and thus move toward change and healing of the childhood violation.

THEORETICAL FRAMEWORK

A group intervention guided by a feminist orientation aims to empower women and "is a way of linking women's personal struggles with the political context" (Levine, 1983). It examines the "societal perspective and its influence on the development of incest" (Courtois, 1988). It acknowledges power imbalances and seeks for ways to change the imbalance between men and women in society. A feminist approach seeks to include the experience of women in all areas of their lives. There is a commitment to giving women the opportunity to make informed choices and decisions. According to Brickman (1984), the subjective knowledge of a victim's experience is central and must be validated. This theory rejects the adjustment model of traditional therapy and the effects of abuse as pathology. Personal change is primary

within the framework of feminist counselling and there is a clear assumption that this change should be seen in the direction of increased autonomy and self-determination (Sturdivant, 1980, p. 163).

This personal change and re-empowerment occurs when women come to some "understanding of justice" (Walker, 1995; Fortune, 1991). Justice-making, according to Fortune, is a series of steps that include truth-telling, acknowledgement of truth, accountability, protection for the vulnerable and compassion. Walker asserts that the survivor must connect with this understanding of justice and that justice-making is "important in therapy work with survivors" (p. 325).

Butler and Wintram (1991) present an overview of feminist group work that questions all that is familiar and predictable. They list several elements of feminist group work useful in breaking down the walls of injustice. One of the elements they identify provides a "balance between group structure, planning and spontaneity." Furthermore, this balance provides boundaries within which "safety, warmth and compassion can flourish" (p. 187). Another element encourages the use of a large variety of exercises and activities to help draw out women's potential. The authors indicate that women's groups need group conflict to enhance learning and to establish "alliances between women based on a recognition of each other's differences" (p. 187). The feminist group worker will encourage the women to be authorities on themselves and help them come to an awareness of their individual power and of being a part of a community of women. This approach leaves room for choices while still maintaining some structure and control (Butler & Wintram, 1991). The authors emphasize that no

group member should be coerced to contribute in a group session but that the woman must be given the space to make choices.

Several authors show that women define themselves in the context of relationships and that they are encouraged to develop their sense of self through relations to others (Belenky et. al., 1988; Butler & Wintram, 1991; Davies & Frawley, 1994; Kaschak, 1988). Herman states that, because the sense of self has been shattered within an abusive relationship "that sense can be rebuilt only as it was built initially, in connection with others" (p. 61). Page and Berkow (1994), add that self-definition in the context of relationships "can be described as a formation of boundaries" (p. 175). According to Butler and Wintram (1991), women define for themselves who they are and find their self by listening to themselves and seeing how others respond to them in group.

While the literature on abuse regularly mentions the effects of child sexual abuse on development, abuse is hardly mentioned in the developmental literature (Courtois, 1988). However, Courtois notes that abuse alters the full development of the child and that self-developmental theory has much to offer an adult survivor in her search for self-identity and healing. She notes that developmental techniques such as reparenting, inner child work, and self nurturing exercises are developmental as the "false self is dissolved in search for the hidden true self" (p. 124). This developmental work may be recontextualized in a safe and nurturant group environment as "many survivors view the group as a new family in which they are reparented as they help to reparent others" (Courtois, 1988, p. 247).

Survivor therapy, a new form of intervention with origins in feminist theory and trauma therapy is an "approach that is designed to help heal victims of mostly man-made traumas" (Walker, 1995, p. 285). The treatment approach of survivor therapy "is grounded in both empirical research and a psychological clinical tradition of two decades of treatment" (p. 328). It has been used successfully for several years but was recently named by Lenore Walker (1995). The goals of survivor therapy are:

1. safety
2. re-empowerment
3. validation
4. exploration of options
5. cognitive clarity and judgement
6. make own decisions
7. heal trauma effects.

The key principles include an emphasis on strengths, education, and understanding oppression. (Walker, 1995, p. 303). One of the tenets of this approach is the restoration of control over the woman's life. Women who are survivors of child sexual abuse will have difficulty building internal and external boundaries without gaining a sense of personal power. According to Walker (1995), "the issue of boundaries and limits is important in survivor therapy" (p. 327). She emphasizes that appropriate boundaries must be continuously monitored throughout the therapeutic process in both individual and group therapy.

In summary, the goals and principles of survivor therapy, emphasizing re-empowerment and giving control back to the victim, are the basis for autonomy and healing of the self. As the survivor begins to experience her own internal state, the building and reparation of boundaries can flourish.

BOUNDARIES AND THE THERAPIST-CLIENT RELATIONSHIP

Several authors have stressed the importance of maintaining appropriate boundaries between the therapist and client (Brown, 1994; Davies & Frawley. 1994; Donaldson & Cordes-Green, 1994; Herman, 1992; Nielsen, 1988; Walker, 1995). Boundaries are "essential components that help define the therapeutic relationship and setting, and they exert a profound influence over whether the client feels secure enough to begin the healing process (Walker, 1995,p.217). Relationships between professionals and those over whom they have authority within institutions of education, health, religion, sports and the military are relationships of imbalanced power. Within this therapist-client relationship there are certain role expectations, including the prospect of receiving services, knowledge, and certain resources from the professional (Fortune, 1991). Due to the power differentiation the client cannot give consent to potential boundary violations (Briere, 1992; Nielsen, 1988). All violations of boundaries are the responsibility of the one providing the services. Walker (1995) adds that the attention to power imbalances helps "to avoid intentional or unintentional victim-blaming that arises from inappropriate questioning" (p. 46).

The therapist must be clear about her own boundaries and not violate the client's boundaries (Walker, 1995). Herman (1992) states that boundaries "exist for the benefit of both therapist and client and that the therapist does not insist upon clear boundaries in order to control, ration, or deprive the patient" (p. 149). According to Briere (1996), the therapist must communicate to the client the importance of boundary appropriateness. Furthermore, the possibility of client sexualized behaviour must be

responded to in ways that do not reinforce sexualization but remain supportive and helpful (Briere, 1996, p. 98). Vague or blurred boundaries in the therapeutic relationship leave the client confused and unsafe (Donaldson & Cordes-Green, 1994).

Although boundary violations within the therapeutic context are a source of great harm to the client, sexual exploitation has been reported in several studies (Briere, 1996; Courtois, 1988; Fortune, 1991; Rutter, 1989; Strean, 1993; Walker, 1995). Walker (1995) notes that, according to the research, "as many as 86-92% of such instances involve male therapists and female clients" (p. 165). She adds that this imbalance of gender "may reflect issues of sex-role stereotyping and bias that are found in the culture at large" (p. 165).

Strean (1993), in his review of the literature, reports that data existed in the 1950s and 1960s on "sex between therapists and patients" (p. 22). However, the topic appeared too controversial to present at conferences or to publish in journals and books until the 1970s.

Walker (1995) cites a study by Pope and Vetter (1991), describing the characteristics of 958 patients who had been sexually involved with a therapist. Several (105) required hospitalization which was considered to be partially a result of the sexual involvement. A higher number (134) attempted suicide and seven committed suicide. More than three hundred (309) had "previously experienced incest or other child sex abuse" (p. 181).

A 1993 survey by the Canadian Mental Health Association (CMHA) in Winnipeg sought information from consumers of mental health services about a wide

range of professionals. The information was gathered by means of a written survey distributed throughout Manitoba in which women could self-identify their experience. One hundred and fifteen people responded to the survey including four men. Eighty-two indicated they had been abused. Thirty-one women indicated that they had been abused by more than one service provider. In agony they revealed shameful secrets of revictimization by a wide range of professionals.

Particularly vulnerable to professional boundary violations are those clients who have experienced sexual boundary violations during the developmental years of childhood; survivors who were deprived of the opportunity to develop a sense of the inner self from which to form clear boundaries. According to Magan, (as cited in Briere, 1992), sexual abuse survivors who are sexually victimized by their therapists suffer greater symptomatology than their cohorts who were molested as children but not during therapy.

Although there is a beginning awareness of issues related to sexual abuse, there are powerful social institutions such as insurance companies and the armed forces, as well as perpetrators who have a vital interest in denying the prevalence and impact of trauma in professional relationships (van der Kolk et al., 1996).

According to Shoener and Luepker (1996), existing codes of professional ethics forbid all sexual contact with clients in both group and individual therapy. The Social Work Code of Ethics (CASW 1994) has established guidelines and duties in the ethical responsibilities of social workers to clients. Section 4 discusses limits within the professional relationship and states that "a social worker shall not exploit the

relationship with a client for personal benefit, gain, or gratification" (p.13). This professional obligation is further clarified in Section 4:3; "The social worker shall not have a sexual relationship with a client" (p.13). The clarity of this statement offers both clients and social workers a sense of security. "Simple 'do' and 'don't' rules... are inadequate... and offer both clients and therapists a false sense of security" ... about overlapping relationships and boundary violations" (DeChant, p.489). Boundary violations and the exploitation of trust by the professional may harm the client and undermine the therapy itself. It is always the "group therapist's responsibility, not the client's, to define, establish and to consistently implement the boundaries" (Shoener & Luepker, 1996, p. 376).

CONCLUDING SUMMARY

The literature on the development of boundaries in the adult survivor of childhood sexual abuse provides evidence that sexual boundary violation disrupts the normal development of a sense of self in the child. As well, when the victim's existence as a separate self is violated, she experiences a world in which she has no control and is unable to set appropriate boundaries in her interactions with others. The long-term impact of boundary issues may affect every major area of the woman's life. A review of the group literature supports the use of group work for the healing and strengthening of boundaries in the adult survivor. Boundaries betrayed in the context of a relationship can only be rebuilt in connection with others. A feminist orientation to group work is one that empowers women in commonality with other women. It

seeks to include the subjective experience of women and is a way of linking women's struggles with the political context of their lives. Sexual boundary violation by a therapist has a major impact on the survivor, and the maintenance of appropriate professional boundaries is a key requirement of any counselling or therapy relationship (Nielsen, 1990).

In summary, boundary issues are a part of all relationships, and how we deal with these issues can either cause great harm or promote growth and an enhanced ability to build and strengthen boundaries.

CHAPTER 3

THE PRACTICUM PROCEDURES

This chapter provides a brief description of the agency where the group intervention was conducted, a section on screening criteria and member selection, with a summative description of the women selected to participate. The chapter concludes with an overview of the group model, the stages and the session format of the 12-week group program.

THE SETTING

The setting for this practicum was the Women's Health Clinic located at 419 Graham Avenue in downtown Winnipeg, Manitoba. Women's Health Clinic facilities are on the second and third floor of the building and are accessible by an elevator or a flight of stairs. Several rooms, with a nearby kitchenette, are appropriate for small and large group sessions.

The Women's Health Clinic, an organization guided by a feminist orientation is a community-based health centre, providing medical services, community outreach, and counselling. A multi-disciplinary team of physicians, nurse practitioners, nutritionist, counsellors and client service workers provide individual care and some groups for a wide range of services.

According to a pamphlet put out by the Women's Health Clinic, the clinic offers the following services:

-health and wellness services which are woman-centered, non-judgmental and fully confidential
-public advocacy and research on health issues of concern to women
-health education to community and professional groups
-resources and information
-training and experience for volunteers and students.

The Women's Health Clinic was selected based on the agency's commitment to providing services within a framework that empowers women and validates the experiences of women as central to their lives. Other considerations included the agency's broad mandate, the availability of individual counselling for group members if needed, the staff social worker's expertise in group counselling, the agency's central location and the availability of space for individual and group counselling.

The room we used at the Women's Health Clinic played a key role in the group members' abilities to work towards the overall objectives and goals of the group. It was located at the end of a corridor and had a lock on the door. Nearby was a washroom for the exclusive use of the group members. The locks on the rooms provided a significant source of safety for the participants. The chairs in the room were soft and moveable, the lighting controllable and the windows covered with blinds. The windows, although covered, were an important factor, as they allowed the women to check for street safety before leaving the building at the end of the sessions.

THE PRACTICUM COMMITTEE

The clinical supervisor at Women's Health Clinic, Sheila Rainonen, who also was a member of my practicum committee, was available for consultation throughout

the practicum. Her assistance with the routine of room bookings, doors, lock-up and clinic schedules provided a valuable link to the practicum setting. Maureen McIntosh, from the Faculty of Social Work, provided further consultation in the form of discussion and constructive written feedback. Primary advisor, Kim Clare from the Faculty of Social Work and the Director of the Inner City Social Work Program, provided support and direction for the group intervention on a regular basis.

All three committee members have graduate degrees in social work, experience in women's work, and knowledge of group dynamics. Supervision and consultation were provided according to a proposed weekly schedule.

MEMBER SELECTION AND CRITERIA

Women coming to Women's Health Clinic for services became aware of the group project through a poster which was displayed on the clinic's bulletin board for two weeks (see Appendix A). The poster, which was self-designed, identified the primary criteria; "group counselling will be offered for women survivors of child sexual abuse." Fifteen women contacted me by telephone prior to the first group session and two called after the group had already begun. The fifteen women who made telephone contact before the start of the group, were given basic information about group content and process over the telephone. Although interested in a group program, five women for various reasons, made the decision not to participate further in the selection process. One was unable to attend evening sessions, another had arranged for a two week vacation, and three women called for information, but felt

they were not ready to participate in group counselling at this time.

Following the telephone contact, the remaining ten women attended the first of two individual screening sessions at Women's Health Clinic. The first meeting consisted of a reciprocal exchange of information where the women received additional written information about the group (see Appendix B), as well as information on available resources if not selected.

Information concerning the women's histories was gathered from a questionnaire which addressed factors related to the abuse, and the women's resources in dealing with the problem (see Appendix C). The questionnaire addressed criteria which included the following:

1. The motivation and ability to attend twelve weekly group sessions
2. A beginning ability to discuss issues related to child sexual abuse
3. Have someone identified as a support person
4. Be willing to consent to the use of session content and practicum evaluation findings in a written report.

The above criteria may not screen out survivors who are involved in substance abuse, or those who have multiple personalities, suicidal ideations, or dissociative symptoms, nor were they intended to do so. The criteria were established as guidelines only. As Briere (1992) suggests, screening out all those with major long term effects of child sexual abuse might result in a group of survivors who have less need of treatment.

Those survivors who were motivated to commit to group work and able to discuss personal issues of child sexual abuse, were encouraged to participate in the group program. Three women out of the ten interviewed, made the decision not to participate in group counselling at this time. One had recently been released from the

hospital; one felt she was not ready to "face a group;" and the third woman was involved in a crisis unrelated to her history of abuse. All of them, however, expressed a sincere interest in a future group program. The seven women selected completed a brief intake form which provided further opportunity to assess readiness and suitability for group participation. Finally, appointments were made for the seven women selected to meet with me for a second individual meeting the following week.

The second interview with those selected was conducted for the purpose of pre-testing and for further discussion on the topics and objectives of the group. The Hudson Index of Self-Esteem (Bloom and Fisher, 1982) and an exploratory Boundary Scale (see Appendix D), which I had designed in an attempt to measure the level of boundary ambiguity in adult survivors, were completed. During this final pre-group interview the women reviewed the group objectives and a tentative topics list, with the understanding that these were given as guidelines only, and that revisions would be encouraged during the first group session. The women were also encouraged to think about personal goals they hoped to achieve while a member of the group. As well, several non-negotiable ground rules were discussed, such as length and dates of sessions, location of sessions and confidentiality. All pertinent information was given to each woman as a handout, so she could review the information at home.

Finally, the women were given time to read the consent form and to discuss any possible concerns about the form (see Appendix E). The form makes reference to the importance of attendance and confidentiality. It also states that the project is part of an M.S.W. practicum and that a written report will be submitted to the University of

Manitoba upon completion of the practicum. The women were assured that all information received would be kept confidential, and that any written information would be stored in a locked cabinet.

Although the selection process was time-consuming and involved, it was an important and necessary part of the group practicum. According to McEvoy (1990), "the energy required to conduct screening interviews is compensated for by the assurance that those who attend are ready for group work" (p. 65). An opportunity for survivors to meet with me prior to group commencement was seen as an important addition to the intake sessions and to the overall satisfaction of the group program.

THE WOMEN

The seven women who participated in the twelve week group ranged from ages twenty-six to forty-nine. Three of the women were divorced, three were married and one had never been married. Three of the five women who had children were sole-support parents.

The educational background of the women varied from a grade eight level to four years of post-secondary education. Three had completed university degrees, one was a second year university student during the duration of the group and one was in a high school upgrading program. One of the women had completed professional training towards a diploma in a human service field. Five of the women were employed part-time or full-time, one was supported by her partner, and one was on social assistance.

All of the women had experienced intra-familial child sexual abuse at an early age. Five of the women had clear memories of the abuse. Although two women were unclear about details, they had always known that the sexual abuse had occurred. One was not sure whether there had been one or two perpetrators because the fondling usually took place after she had fallen asleep at night. Five of the women had been sexually abused by their biological fathers, one by her step-father, and one by both mother and father. The most frequently reported abuse was fondling. Out of the five women who reported fondling, two had also been subjected to regular intercourse as young girls, one had been forced to submit to fellatio at a very young age and two were digitally penetrated and forced to touch the perpetrator's genitals. Four of the women had been revictimized as adults by a variety of professionals in the medical and counselling field.

The long term consequences of child sexual abuse described by the group members were very similar to the effects reported in the literature. Internal boundary issues, such as suppressed guilt and anger, a low sense of self-esteem, and a loss of self-identity were expressed by each of the women. External boundary issues identified by the women included difficulties in interpersonal relating, in setting limits, in decision-making, and anxiety around medical examinations.

Three of the women reported multiple childhood victimization by different perpetrators. Two of the women had attempted suicide and five of them disclosed periodic bouts of depression. While to the outside world the women appeared to "belong" to a cohesive family unit, not one of the women had an ongoing relationship

with her father and only one of them reported a satisfying relationship with her mother. Three had run away from home several times but were regularly returned by authorities. One noted that the R.C.M.P. officer who had brought her back home was a good friend of her parents. Another woman had been put up in a hotel by her father till she gave birth in the hotel room to his child.

It is interesting to note that all of the women identified more difficulty with enmeshed or vague boundaries and less with rigid or defensive boundaries. However, two women acknowledged that the fear of "losing it" and exploding with anger was a real concern and that the self-control learned as a child was becoming more difficult to maintain. The growing awareness of what had happened to them when they were helpless and vulnerable children was the space where the group began its journey. This beginning of awareness was often a difficult stage in the healing process and one that caused great concern for the women as they felt more comfortable being compliant and enmeshed with others. The movement, however, from suppression of anger to its appropriate expression was a productive transitional stage for the women in the group program.

THE GROUP MODEL

This section presents an overview of the SAB model (Self and Boundary) initially created for this practicum. The model, which I designed, arose from a synthesis of ideas drawn from descriptions of specific group models (Gil, 1998; McEvoy, 1990; Saxe,1993), and from my previous clinical experience with survivors

of child sexual abuse. The model was structured to focus on the original trauma, on reframing the symptoms of that trauma, and on the development of skills to enact clear boundaries. For example, as she re-experiences the original childhood trauma in a safe place, the survivor gains a sense of control over the trauma instead of "it" controlling her. Ideally, as early developmental experiences and events unfold, the survivor begins to build "a healthy sense of self and to become aware of boundaries, what they are, how to set them and let them go, which are healthy and unhealthy, and when and how they are useful in our lives" (Whitfield, 1993, p.157).

As boundaries are developed, the survivor is able to live from the true self instead of the "people pleasing self". She is able to accept responsibility for other issues in her life, to develop relationships that are fulfilling, and to become more differentiated while staying in relationship with others. Given the above, I decided that a time-limited closed group setting would promote and integrate both the development of self and of boundaries in the adult survivor of child sexual abuse.

Time-limited group models of ten to twelve weeks in duration have many advocates and appear to have several advantages for women with a history of child sexual abuse. A group with a clear time limit encourages firm and clear boundaries and a sense of safety from the beginning. This is of special importance for survivors who were deprived of the opportunity to establish boundaries during the developmental years of childhood. According to Courtois (1988), the time-limited group makes it easier for members who are apprehensive about making a commitment to an open-ended group. As well, a time-limited group provides a positive, hopeful outlook for

members helping them to move from victim to responsible survivor. Although survivors unanimously agree that most groups are too short, they also express apprehension about commitment to a longer term group.

Survivor therapy, with its origins in feminist theory and trauma therapy, provided a framework for the SAB group model. Survivor therapy includes the principals of safety, empowerment, validation, education, and making one's own decisions (Walker, 1995).

I organized the SAB Model into 12 weekly sessions of two hours each. The sessions were divided into three sequential stages. Stage one includes sessions 1-3; stage two, sessions 4-7; and stage three, sessions 8-12. The conceptualization of stages is given as a guideline only, and merely for the purpose of group facilitation. Stages may overlap or be missed entirely, as each group travels its own unique journey. The sessions and topics of the representative stages, based on the SAB model, are listed below.

STAGE ONE - INTRODUCTION TO BOUNDARY CONCEPT

Topics proposed for the first three sessions were devoted primarily to the introduction of the boundary concept.

Session 1 - Introduction to Group
Session 2 - Self-Care and Boundaries
Session 3 - Effects of Sexual Boundary Violations

STAGE TWO - INTERNAL BOUNDARY WORK

Exercises during this stage were designed to encourage the expression of suppressed feelings such as loss, shame and anger.

Session 4 - Remembering the Child
Session 5 - Shame and Guilt
Session 6 - Anger
Session 7 - Forgiveness and Justice

STAGE THREE - EXTERNAL BOUNDARY WORK

During this stage, exercises were planned to focus on the development of new skills in interpersonal relating.

Session 8 - Communication Skills
Session 9 - Conflict Resolution
Session 10 - Revictimization
Session 11 - Family of Origin
Session 12 - Termination

The stages and sessions are explored further in Chapter 4.

Because the enhancement of safety and trust development in survivor groups is often a slow process, the provision of structure is important, especially in the early stages of a group program. The focus on session themes in the model was intended to provide a sense of structure, enhancing safety and stability in the group. A Session Guide (see Appendix F) was designed to lessen anxiety by giving group participants information about what to expect. The Session Guide, while enhancing safety, trust and structure, was not intended as a rigid guide in the SAB model. The goal was to balance structure, session planning, and spontaneity. Because the restoration of control is an important principle

of this model, the goal was to give precedence to individual and group decisions over the worker's proposed schedule and topics list.

The SAB model was designed to include six to eight participants, facilitated by one worker. Although some models suggest two workers as ideal (Saxe,1993), others state that trust is developed more quickly with a smaller number of members and one worker. Glassman and Kates (1990) maintain that unless there is excellent rapport between two workers, one worker is more effective. The worker must be able to maintain a sense of direction with the ability to attend to each member's needs while nurturing the group as a whole.

I will now provide an overview of the session format of the group facilitated for this practicum. The time-limited structured group program, based on the SAB model, ran for 12 sessions with one post-group session held seven weeks after the regular weekly sessions. The group sessions were two hours in length and usually followed the Session Guide (see Appendix F) which was posted on the wall in the group room. An overview of the plan with time guidelines for each section follows:

CHECK-IN: (5 minutes)

When it was time to begin the session, the door was locked and the session began with a check-in. The check-in was usually a short and focused component of the session. Group members were offered a chance to briefly share how they were feeling in the present, and whether they wanted to discuss any concerns that arose during the week. They were also given the option of "passing" check-in. At the end of the check-in the group members decided whether more time would be distributed among the members

or whether the planned educational component (topic) would be discussed. The decision was based on individual and group needs.

HOUSEKEEPING: (5 minutes)

This was the time when details such as homework, journals, break-time, book returns and parking were brought up. Occasionally workshop announcements were shared and discussed.

DEBRIEF LAST SESSION: (10 minutes)

Members were encouraged to share any unfinished business from a previous week's session. This was an opportunity for the women to connect with feelings of hurt and anger and to practice interpersonal relating around these concerns within the group. It was also an opportunity for the worker to link these concerns to internal and external boundary development. Occasionally a session topic would evoke troublesome issues around relationships with families and colleagues at work. This sharing of mutual concerns encouraged commonality and supportive caring within the group. Occasionally the need to debrief a previous session or to problem-solve, continued beyond the scheduled time. However, in order to help members establish clear boundaries, the break time was adhered to consistently, and all but one session began and ended at the scheduled time. Members negotiated to extend session seven by fifteen minutes.

SESSION TOPIC: (5 minutes)

This was the time when I introduced the educational theme, usually in the form of a mini-presentation, an exercise or a group "go-around." The topics were prioritized

with the less threatening topics ranked for the beginning sessions of the group. A handout of topic ideas had been given to the members before the group's beginning and was revised at the first session. The revised list was then given to the women at the second group session. Members were unanimous in their wish to add the topics of revictimization and forgiveness to the list.

EXERCISE: (15 minutes)

Exercises to promote boundary development flowed from the educational theme with the intent of further exploration of the topic during the discussion period. A variety of strategies and techniques, imagery, role plays, collage-making, videos, music, and cognitive restructuring were utilized. Although exercises were pre-planned, they were revised or discarded, according to the wishes of the women.

BREAK: (10 minutes)

A 10-minute break half-way through the session gave the women an opportunity to leave the group setting for a change of pace. Beverages were available and provided an opportunity for the women to make informal contact, reinforcing feelings of belonging and group cohesion.

DISCUSSION: (60 minutes)

During the discussion period the women shared and discussed their personal concerns related to the session topic. During the early stage the discussions revolved around general issues of child abuse. As the group evolved into a safe and cohesive unit, the sharing became more intimate and personal, however all members were encouraged to move at their own pace and no one was coerced to participate. The discussion period

was the longest part of the session, usually lasting about one hour. Although my participation was limited throughout the discussion component, I attempted to link the development of boundaries to the individual and group issues as they arose.

CLOSURE: (10 minutes)

During the last 10 minutes of group I read a "bedtime story" in an atmosphere of candles and soft music. Several choices regarding a closing exercise were presented at the first session. After some discussion the women agreed upon a reading of "The Velveteen Rabbit" (Williams, 1993). The enchanting story has been embraced by generations of adults and children and reminds us all what it means to be real. " 'Real happens to you' said the Skin Horse to the Velveteen Rabbit. When a child loves you, not just to play with, but really loves you, then you become Real'" (p.8). One woman said no one had ever read her a "bedtime story" before.

An additional task after closure was the completion of a brief check-off rating scale with space for further comments. A sample scale is offered in Appendix G. Although the women were given a choice between completing the rating scale immediately following the session, or at home, most finished it in a few minutes before leaving. At the end of the session each woman was given a self-care plan as an incentive to care for herself throughout the week (see Appendix H).

The group ended with a celebration and a formal closure at the last session. The process of ending was a significant experience for the women and provided an opportunity for them to adjust to the ending of a meaningful chapter in their lives.

In conclusion, the SAB Model, with it's emphasis on trust and safety, was a valuable model for addressing boundary issues. In connection with others, women were able to explore the self and to rehearse new ways of interpersonal relating.

CHAPTER 4

THE GROUP PROCESS

This chapter presents an overview and discussion of the 12 weekly group sessions with the seven participants. As noted in the previous chapter, I have divided the 12 sessions into three sections, each section representing one of the three stages of the group model. As described in Chapter 3, stage one includes sessions 1-3; stage two sessions 4-7; and stage three, sessions 8-12. Each section is preceded by a brief description of the representative stage. Stage one was primarily concerned with the establishment of trust and safety and focused on introductions, objectives, and the concept of boundary. The second stage was devoted to active grieving and remembering. In expressing the feelings of childhood, the women moved toward self-definition and the development of internal boundaries. The final stage, which focused on rebuilding and on new ways of relating to others, encouraged the reparation and development of external boundaries. While three stages of group and boundary development were proposed, there was room for flexibility and change, depending on individual and group needs.

The sessions, which are described below, were guided by a session format and an overall group plan. In addition to occasional brief recording of the women's own words during the session, I summarized in writing, the group process at the end of each session. Some of these comments and phrases in the women's voices are included in the description of the sessions below. In no case are any of the women's identifying

circumstances or names disclosed in the discussion. At the end of each session the women completed a brief self-rating evaluation relating to the content and process of the session. The weekly evaluation provided an opportunity for the members to respond to their understanding of the boundary concept and its relationship to the session's topic. The results of these evaluations are included at the conclusion of each of the session's summary.

STAGE ONE: (SESSIONS 1-3) Introduction to Boundary Concept

Throughout the first stage the concept of boundary was linked to the content and process of each of the three sessions. For example, when I locked the door to begin the sessions, I commented on the physical boundary separating the group from the outside world. Another example of a boundary was the reference to time schedules and confidentiality.

Although the establishment of a safe place was a primary goal throughout all of the sessions, in the early stage it took precedence over all other tasks. In order to minimize the feelings of anxiety and tension, feelings which are characteristic of early sessions in survivor groups, I provided structure by reviewing the Session Guide, the ground rules, and the matters of punctuality and confidentiality.

Structure was further enhanced by focusing on general themes of child sexual abuse such as common effects, definitions, statistics and exercises that identified common themes. The exercises, which were preceded by an educational component, led to early interaction among the group members, thus facilitating the process of

commonality and bonding.

A second goal of the first stage of the group intervention was the restoration of power and control to the members. Re-empowerment was facilitated by having the members discuss and then come to a consensus on group goals. During the individual pre-group meetings each of the women had received several handouts, including ideas for session topics, ground rules, and group objectives. In the early sessions there was much interaction regarding the handouts. In addition to clarifying the purpose of a particular theme or exercise, I consistently supported and validated the views and tentative ideas of the women during the revision process. Several new themes emerged and these were added to the topics list, which was then rank-ordered by the group members. A few minor changes occurred around rules and objectives, with the term "ground rules" changed to "group agreements" (see Appendix K). After clarification of individual and group goals, discussion centred around methods of working towards the attainment of goals.

Another primary task of the group facilitator during the beginning phase is to "demonstrate competence" in the ability to guide the group through the early phase of the group's development (Wickham, 1993). In a gentle but direct approach I attempted to provide a sense of structure and competency as well as a sense of compassion for the child within the survivor.

SESSION 1: Introduction and Goals

The purpose of the first session was to introduce the goals and objectives of the group, and to encourage the women to participate in the revision of the topics, the

group agreements and the group objectives, and to identify personal goals.

The women came to the first session with a mixed range of emotions. They came with hope and trepidation, glancing at one another while filling their cups with something to drink. The expressions on their faces conveyed apprehension and anxiety, but also an occasional feeling of kinship. One member wrote later that this first meeting had been confusing for her, due to her ambivalence about attending the group. She wrote:

> ...moments were scary, but at the same time I felt okay. I felt scared because I knew why I was here. I also knew why others were here. I felt ashamed. Without saying anything, my secret was out to five women...The pre-group meeting with the group leader kept me from bolting out ...I could hardly wait till I found my chair.

As the women cautiously proceeded into the group room, they sat down in the circle of chairs. I asked them to introduce themselves, and if they felt comfortable, to add some thoughts about being a member of this group. Four women said they were very anxious but also happy to be present. The other two women introduced themselves and then nodded in agreement several times. Although the seventh member could not be present at this first group meeting, the six women present agreed she was a member of the group and would be welcomed at the next session.

I then proceeded to welcome them, focusing on the commonality of past experiences.

> Each one of you has a right to be here and to be heard. Each one of you was once a little girl who was a captive in her own home with nowhere to go. The pain of sexual boundary violations affected you deeply. It was never your fault and you were not to blame. In this group we have each other, we will stand together, comfort the little girl, and build boundaries that move us from helplessness to self-identity and healing.

The "welcome" led to general discussion of society's denial of child sexual abuse, with an emphasis on the secrecy and denial in families.

The "myths" exercise (see Appendix L) which followed, was another effort to facilitate bonding and to move from the pre-group encounter to the group phase. The statements were first completed independently by each woman and then discussed within the group. One of the statements reads, "It is easy to heal from child sexual abuse once it is disclosed." A stimulating and lively discussion followed the exercise, enhancing the comfort level of the women, while increasing awareness of personal beliefs about child sexual abuse. The exercise was completed quickly by the women and there was almost immediate consensus on the statements.

Following the exercise, I introduced the Session Guide (see Appendix F), the ground rules, the topics list and the group objectives (see Appendix M). During the second pre-group screening session I had suggested that we would revise them together at the first session. One member suggested two additional topics be added. When the women came to a consensus on group themes, the topic of revictimization and forgiveness were added and then all topics were rank-ordered by the group members.

In addition, each of the women defined a personal goal they hoped to achieve by the end of the group program. The proposed goals included: telling my story in the group, telling one person about the abuse, learning to set limits and boundaries in my life, expressing feelings of guilt and anger in the group, feeling better, and finding out who I am. Goal sheets were distributed, then collected and copied for a future session (see Appendix N). The women were very supportive of one another during the goal

setting process. One of them said that she could have picked all of the goals for herself and that she would like to achieve them all. Her ability to be open and vulnerable triggered similar responses from several of the other women. A brief discussion on the linkages between the stated goals and boundaries ensued in response to one member's question, "Isn't the purpose of this group to learn to set boundaries?" Several women indicated that they were beginning to understand the concept of boundaries, and how child sexual abuse (see Appendix O) had deprived them of the opportunity to develop self boundaries.

Session one closed with a brief relaxation time, as suggested by one of the women. Several suggestions were considered for future closing exercises, with the intent of exploring this further in the next session. Just before the women left the room, they completed a brief evaluation on how well they understood the overall goals, how they felt about their personal goals and whether they had felt safe during this session.

Evaluations indicated that generally members had felt safe after the session started, but that they had been very anxious during the pre-group coffee time. One of them wrote that session one met all the objectives and that she had appreciated the educational component because it was given in "lay person terms." Another woman noted that "boundaries were a new idea for me, but already I am hopeful I will feel more comfortable with my own boundaries. They make it all a little clearer." Careful planning during the pre-group stage helped lay the foundation for each individual member and moved the group to a fast-working start.

SESSION 2: The Boundary Concept and Self Care

The goals of the second session were to provide an educational component on

the concept of boundary and to introduce a program of self-care. The process continued to focus on developing group cohesion and to help the women feel safe in the group. This occurred through an emphasis on common experiences. For example, in synthesizing the divergent personal goals set at session one, I once again commented on the common themes of the goals and how they all related to the development of boundaries.

An exercise to help clarify the concept of boundary added to the process of bonding as the women interacted with a partner in a role-play. The exercise consisted of putting a string circle on the floor, with one woman in the centre either increasing or decreasing the circle, according to the role played by her partner; father, friend, child, doctor, mother, etc. For six of the women the room was not large enough to contain the circle when their partner played the role of the perpetrator, their fathers. This observation enlightened the women's understanding of boundaries and of the betrayal in their childhood. One woman thoughtfully made a profound statement, "We never had a chance."

This comment was followed by a lively discussion initiated by one of the women when she shared feelings and thoughts around the difference in size between a small child and a father. Instead of focusing on herself she started by including the other members in her observation.

> When we were small they took advantage of us, twisting everything...When I did the string exercise, I realized it would have made no difference what I did. He "pulled all the strings" (laughter) but I still don't trust my judgement. Maybe if I had told my mom...

While none of the women disclosed personal experiences about "telling mother," several were quick to respond that "telling mom" would have been impossible.

Although I had hoped that the interventive goals of survivor therapy (empowerment, validation, exploring options) would consistently enhance the self-esteem of the women throughout the group program without devoting a specific session to the topic, I did make reference to the topic of self-esteem during this session. This was followed by considerable discussion. One woman wondered why she couldn't "snap out" of feeling "no good." I asked whether anyone else felt the same way. One woman's response was to sit up and say, "I don't feel good about myself because that would be lying to myself." I posed a question to the group as a whole, "Is the woman sitting to your right a good person, one who is worthy of respect and love?" There was silence and most of the women did not make eye contact with the one to their right, but continued looking down or straight ahead. This was followed by some shuffling and mild tension. "Is anyone worthy in this room?" I asked. This prompted the woman to my left to say, "I think you're worthy and good." This statement was soon followed by similar affirmations all around the circle.

One of the women responded to her affirmation with disbelief. "Others deserve the positive words, but they are not for me. It's very hard to believe them." As I looked around the room, I nodded to one woman who leaned forward in her chair, as if to respond. Her response prompted me to draw two circles on the flip chart, one circle within the other. I then asked the women to fill the centre circle with the daily content of their lives. Included were such words as job, friends, children, school, public

speaking, shopping, family events, and taking a bus (external boundary issues). The larger circle surrounding the content was filled with feeling words such as guilt, shame, sadness, mistrust, low self-esteem, anxiety, isolation, and fear (inner boundary issues). The diagram led to a discussion about changing the context (larger circle) so that the content (small circle) and the interaction within the content could change. While one of the women remarked that the content was easier to change then the context, others questioned whether anything would ever change for them. I responded to these comments by instilling a sense of hope with regard to the healing of boundaries and of self-esteem. I noted that as boundaries are developed women begin to feel worthy and vice versa.

After the circle discussion, I explained how taking care of our self contributes to the development of boundaries. I noted that treating the body with care was one way of caring for the self. Upon distribution of a weekly plan (see Appendix H) one of the women said she felt this would be more work for her but that she would attempt to complete it. Two women claimed that the "self-care chart" was just what they needed to follow through with self-care; they challenged each other to return the plan on a weekly basis for review. The plan includes aspects of sleep, nutrition, exercise, and relaxation needs. Each group member was given a "Canada's Food Guide to Healthy Eating." The women were encouraged to get back in touch with their bodies and to reclaim the control that had been taken by their fathers. However, I stressed that each one could make her own decision about participating in the plan.

While I consistently integrated the theme of women in society through exercises

and handouts, I had not planned a specific session on the topic. However, the topic of self-care evolved into a focused discussion of women's place in society and how women's boundaries are often not respected. One woman noted that the handout on boundaries had illustrated for her, the powerlessness of the child and how revictimization of adult survivors is a second violation of boundaries. I then asked group members if they could give examples of boundary violations in women's lives. Their responses included: touching and kissing without permission; hitting, pushing and raping. The discussion concluded with one woman making a connection between self-care and boundary violations. "If I don't care for myself, no one else will."

Near the end of the session I gave each woman a soft-covered book for the purpose of keeping a personal and private journal. All of the women indicated they would record their journey of healing in the book and store it in a safe place. One woman said she would write an affirmation on the first page. "What will you write?", asked one group member. The woman responded by saying, "the affirmation we discussed tonight." After some probing she acknowledged the difficulty she had in saying it, "but I'll write it." This exchange resulted in each group member repeating a personal affirmation out loud. Although this was not an easy task they began to recognize how negative thoughts can be replaced with positive ones. The woman who had put hers in writing eventually read it, "I am worthy of self-care."

Just before the session ended, I gave the women a file folder to store the handouts and the journal guidelines. After the closing they completed a brief rating scale on their understanding of the boundary concept, on how they felt about a personal

self-care program, and whether tonight's session helped them understand the relationship between boundary violations and feelings of self-esteem and worth.

In their evaluations, the women confirmed that the session generally facilitated well their understanding of the boundary concept and its relationship to feelings of self-esteem and worth. One of the women wrote that a "light went on when I did the string exercise. Now I know something about boundaries." The self-care plan was not seen as very useful in the development of boundaries. Two members indicated that, although the linkage had been clearly explained, they had difficulty believing they had the right to take time for themselves. One woman noted that she felt "quite comfortable in the group, because one of the women brought me the box of Kleenex." The other woman wrote that she had felt heard "when the topic of forgiveness was added to the list." According to Butler and Wintram (1992), sharing of control for planning with group members allows for self-expression and decision-making by participants.

SESSION 3: Effects of Child Sexual Boundary Violations

The third session focused on the long term effects of child sexual abuse and on the identification of boundaries within the group. A sub-goal was to prepare the women for personal sharing of their childhood experiences in the sessions to follow.

Although one member had not yet arrived, this session started on time beginning with the round of check-ins. I began by saying that anyone could begin and that they were free to pass check-in. No one passed, and the check-in continued for much longer than planned. However, in my assessment of the divergent expressed

feelings, I focused on a common theme: the effects of child sexual abuse (tonight's topic). The check-in feelings included: scared, depressed, anxious, alone, angry, and guilty. I wrote each word on the chart as the women continued naming the impact of child sexual abuse on their lives. One of the women started crying as she said,

> I still believe it's my fault. I'm always guilty that somehow I started the sexual abuse even though I was a pre-schooler when it began. He would take advantage of me by telling me I was bad. Then he spanked me on my bare bottom and fondled me till I stopped crying. I tried to be good all the time.

One woman emphasized that no child is to blame for adults' abusive behaviour.

> You're not to blame. Your mom should have protected you; you were just a little child...today I know that, but I didn't always....I left home as a young teen because I was told I was the bad one. I honestly believed that. I rationalized that if I would run away the dysfunction in the home would end and my younger siblings would be protected.

The discussion continued within a very supportive and empathic atmosphere, while the women continued naming the effects of the abuse.

In addition to the inner feelings of guilt, badness, anger, and depression, the list of effects included those related to external boundaries:

- difficulty being assertive
- can't get along with my mom
- going to family gatherings and being scared
- speaking aggressively and then alienating myself.

One woman suggested that anxiety should be on the list, "I'm anxious all the time, especially when I hear others talk about their childhood. I get scared, very scared." She concluded that maybe she did not belong in the group, to which most of the women responded, "You do belong; you are one of us and we would miss you if you left." She said she was "very relieved" she had disclosed her fears. "I never belonged

anywhere and it's hard to believe I do now." Several women reached for the Kleenex and cried with the woman. They appeared to understand feelings of rejection and isolation.

The break followed and I unlocked the door to the bathroom and made more tea and lemonade. As we stood around the sink the atmosphere was cheery and "light", very different from the group environment a few minutes earlier.

The collage exercise which followed was a fun time for most of the women. As they sat on the floor and cut out symbols of the effects of child sexual abuse they laughed and moved around. One of the women said she felt like a child in kindergarten. Two of the women said the exercise was merely "okay." Butler and Wintram (1992) suggest that a variety of methods be used, as not all exercises are equally helpful to all members. When the collages were completed the women took turns explaining the effects of child sexual abuse on personal boundary development and then looked at the similar themes in the collages. Most of the pictures showed images of bondage, captivity and terror. For example, one had included a picture of prison bars, one had a "popsicle" being given to a little child, and one had a young girl bent over on a school desk. The figure was cut in half in a zig-zag line. All pictures were retrieved from popular family magazines.

Sharing my collage with the women offered an opportunity for me to acknowledge how much I had learned from adult survivors of child sexual abuse. I told them that I had cried for the little girl in "Kiss Daddy Goodnight" (Louise Armstrong, 1978), a personal account of trauma and incest. I told them how the

compelling story was written with courage and honesty and that no little child should suffer in the way this author had suffered. I then emphasized that the author had journeyed from the suffering and victimization to a meaningful and responsible life. Most group members were subdued and silent, while one said she too had read the book. Sharing my feelings of sorrow for the child in the book prompted one woman to say she could "really trust" me. This comment provided an opportunity for me to disclose to the women that I was not an incest survivor.

I told the women that this group was for them and that, although I was not a survivor, I was committed to walking the journey with them. I added that I had training and experience in the area of child sexual abuse and of the long-term effects; that I wanted to listen to their stories and to validate their experience so that together we could speak out to stop the tragic legacy of child abuse. When I asked the women how they felt about my disclosure, and whether it made a difference to them, they appeared to take a neutral stance. After some probing one woman responded by saying she might have "thought twice about joining the group" if she had known prior to the first session. However, she concluded with "now I know you and your style and I hope you'll soon do another group." Responses from the other women included: "...your attitude is more important than whether or not you've been abused,"..." I'm just grateful I'm able to be here,"... "it doesn't make a difference to me." One woman said she knew I was "safe" when I said I had cried for little Louise Armstrong. The above discussion prompted me to acknowledge the inherent power imbalance between a facilitator and a group member. I told the women that I hoped to use the power to

their benefit and never to take control of the power that belonged to the group. Near the end of the session the group members shared examples of experiences in the group that demonstrated boundaries. Some examples given were: beginning and ending on time, regular break, locking the door, respecting each other, keeping journals private, making decisions together, and no secret meetings. The session closed with a relaxation time and a reading from "The Velveteen Rabbit." A handout on the concept of boundaries (see Appendix P) was given to the women after "story time."

Tonight's evaluation rated the women's understanding of the effects of child sexual abuse and their awareness of group boundaries. Self-rating scales indicated an increased understanding of the impact of child sexual boundary violations on the adult survivor. Several women noted that the collage exercise had clarified in a concrete way how very devastating intrafamilial sexual abuse had been for them. Additional written comments indicated the handout on child sexual abuse had been very useful in facilitating the understanding of the impact of sexual boundary violations. One woman wrote, "the more I began to understand, the more my attention span decreased. I didn't want to know the full truth." Five women identified group boundaries that helped them feel safe: locking the door, no new members, respect for one another, and "our own room."

Although there had been little response during the session from the women to my comments about the power imbalance between a facilitator and a group member, one woman later wrote that she respected my reference to that difference. Butler and Wintram (1992) state that it is important to address the issue of power imbalance

between the facilitator and group members, and not to minimize that difference.

STAGE TWO: (Sessions 4-7) Internal Boundary Work

The purpose of the sessions in stage two was to focus on the development of internal boundaries. This was accomplished through the identification and expression of feelings such as guilt, shame, and loss, feelings linked to the trauma of the child. Exercises focused on getting in touch with the feelings of childhood, on reframing beliefs, and on self-identity.

Safety and structure had been built in stage one, so that members were able to be less guarded in the second stage about sharing their stories of trauma and sadness. As trust continued to increase among the group members during this stage they began to take small risks and to help each other bear the pain of loss. While the women continued to share intimate feelings of terror associated with the original trauma, I continued to be supportive and to emphasize the importance of attending to their own needs of care and safety.

Issues of self-blame and negative perceptions of self gradually changed, as childhood distortions were recontextualized. However, the women, while quick to challenge others around issues of self-blame, had real difficulty in rebuilding a new context for themselves. When they were able to do so, they began to gain a sense of autonomy and to develop a sense of self within the safety of the group.

Although stage two began with disclosures and remembering, present symptoms and problems were also explored as the women connected past abuse to difficulties in

their present lives. Dealing with the past and the present required some flexibility as the women moved from yesterday's trauma to current life events and vice-versa. Expressing buried emotions enabled the women to think and to be conscious of present day needs and alternative courses of action. This dual track work was presented as being similar to a railway track; one track representing the past and one the present, with ties connecting the child and the adult. I will now discuss the sessions of stage two and the development of internal boundaries.

SESSION 4: Remembering the Loss

The topic for session four focused on themes of loss and grief. One of the goals was to introduce an awareness of the young girl and to make contact with the childhood feelings through a letter writing exercise.

The session started on time with a brief check-in and an overview of last week's session. I introduced this session as the beginning of stage two, a stage "where we may move into the experiential and feeling stage. This is the stage that will help in the development of internal boundaries."

One woman, whose goal was to be more assertive in one situation, was able to demonstrate assertive communication in an interaction with another group member regarding an issue around the philosophy of cadet training. Just before the break she told the member beside her that her son had joined cadets, "a really good organization." Another woman said that her son had also joined but she had "pulled him out" because of "put downs about women." Soon three women were involved in the exchange which continued into the break. Just before the group was ready to

reconvene, the women "agreed to disagree" although an element of competition was still present when they sat down. I asked them how they felt about the exchange and commented on how well they had resolved their differences, "you listened to each other and you stood up for what you believe about cadets." I asked them how this exchange related to their goals. One of them referred to the wall poster on the three styles of communication, stating, "You're okay, I'm okay", implying that they had practised assertive communication.

Prior to the break, one of the women shared her story of childhood abuse, a goal she had set at the first session. This replaced the educational component I had prepared on the topic of loss and grief. As the woman told her story of the little girl being molested in her own home and then again by an older boy on the school yard when she was ten, the group members listened and cried softly, grieving with her. In an eloquent way the woman named many of the losses she had suffered. She stated:

> I had no idea I could say no to the boy when he molested me. Friends told me not to let him do that and I remember being surprised. I had no idea I could say no. I thought that's what I had to do.

Several other women added to the list of losses endured, such as:

- I lost my childhood, my life
- I have no real friends
- no sexual relationships
- not feeling safe in the world
- fear for my children
- no extended family.

One woman stated she was soon going to court to fight for custody of her children after leaving an abusive relationship. She disclosed she had made a bad choice in a partner, and after separation had experienced difficulty coping with the loss of the

relationship. All of the women supported her in her decision to make it on her own. One woman shared how her loss of a recent relationship reminded her of other grief in her life. "I thought I had dealt with the loss but it keeps coming back", she said. Several women responded in agreement. One woman said, that for her, healing happened in "spells" and never really stopped. I explained the stages of grief and encouraged them to read the handout on loss at home (see Appendix Q).

Although the Session Guide was not followed tonight, the topics of grief and remembering evolved as planned with minor comments from me. My comment that we had agreed to focus on the childhood pain tonight and to give voice to the child was met with silence. I responded by validating their silence, assuming that the silence was a signal they had unanimously changed their mind. One of the women said she had brought a childhood photo expecting to use it tonight. Others eventually joined in, suggesting this was a topic they had waited for. The silence and subdued atmosphere appeared to underlie the significance of the child's troubled world. One woman who was experiencing family conflict, said she had difficulty coming to this session but, when she realized the session topic was "an important one", she made arrangements to come after all. I then introduced the theme of loss and remembering, and the session exercise on the grieving process and the development of boundaries.

> Making contact with the feelings of the little girl will put you in touch with the inner self, your own feelings, thoughts and decisions. As you become aware of your inner self you will become more clear about your boundaries. The true inner self grieves the losses in a way that will help you move beyond the sadness. Living from the true self will give you a sense of autonomy the hidden or false self could not.

I suggested that the well-being of the self includes self-care and self-definition. As self-identity grows, internal boundaries begin to develop.

As the women relaxed in the candlelit room, with the music of Steven Halprins, "Lullabye Suite", I introduced the exercise. They were told that each of their experiences would be special and unique and that negative perceptions would change as they continued on the journey of healing. I asked the women to close their eyes if they were comfortable doing so, and to visualize their childhood home...to imagine they could see a little girl playing with her toys...take a close look at her...what is she wearing...After a time of visualizing the child, we sat in a circle reflecting on the experience. As they cried silently and mirrored each others' feelings I assured them that as adults they could comfort and take care of the child self. The women that had brought childhood photos, gazed into the face of the small child; the child that was soft and tender and living in captivity, and understood that tonight they were not alone.

After this exercise the women each wrote a letter to the young girl they so vividly remembered. Most of the women told her she was deeply loved and would never again be alone. One of the women said the child she had been was "bad" and she did not love her. However, she said she had had an occasional feeling of pity for her, while I had read the visualization. One woman wrote:

> Dear little Alice,
> I wish I had been there for you when you were small. You were waiting to be loved and held. I would have smiled at you and you would have known you were not alone.
> Big Alice

This letter to the child was followed by writing a letter to the adult woman from

the child. These letters were short and child-like. Most of the women read the letter out loud but two were unable to do so. One of them wrote:

> Dear Adult Susan,
> I feel very alone. No one loves me because I am bad. Please come and hold me. I'm scared. Can you come soon?
> Little Susie

The debriefing that followed the exercise focused on the feelings of sadness and loneliness the women had experienced as children. Two women initiated the discussion, eliciting comments from most of the other women. Comments such as "me too" ... "that's how it was..." and "I was just like that" emphasized the cohesiveness which had developed in the group.

After closure the women completed a brief evaluation on how well they understood the theme of loss and grief, whether the writing exercise had been helpful in understanding their childhood and whether they had felt supported in their grief at tonight's session.

Evaluations indicated that this session had been very meaningful for six of the women. Several noted they would have liked to explore the world of their childhood further, " but not tonight." They commented on the helplessness they had felt during the exercise and how that exercise had been helpful in understanding the child's inability to develop appropriate boundaries. One of the women wrote that she had been too afraid to focus on the feelings of her childhood, but "I know if I could bridge that gap, it would all come out. It's too hard to face it." Several women indicated that they were not yet fully aware of all the losses they had suffered. One woman wrote that she

had left her siblings and parents and that this was an additional major loss. She added that she had felt an inner strength when I had emphasized that father's were fully responsible for violating the sexual boundaries of little girls.

SESSION 5: Shame and Guilt

The objectives of session five were to present the topics of shame and guilt and to introduce an exercise on changing negative self-talk to positive affirmations. The session's check-in included a review of last week's session. One woman commented on the significance of going back to the childhood experience; how she had been scared for years about making that contact while knowing that it was crucial to her healing. Another woman made reference to the distinction between shame and guilt, terms I had described on the flip-chart.

Tonight's educational component on shame and guilt (see Appendix R) triggered a discussion on the reasons for the child sexual abuse in the women's lives. Although the women had agreed in a previous session that little children were not to blame for the sexual abuse, tonight several women suggested that deep down they had always felt they were to blame for the abuse. One of them commented on the "total confusion" she had felt when her father called the nightly fondling, love. When I asked whether any other members would like to share their feelings about love and abuse, two of the women said their experiences had been similar, "always I was guilty, something was wrong with me, I was scum and I knew it was my fault, so why would I tell?" Reactions from other members conveyed similar feelings of negative self-identity. One woman said she told her father she hated him for "making me do it". This hate for her

father confirmed for the woman that she was "very bad." Several group members helped the woman see the issue more objectively by questioning whether her father behaved as a father. Throughout the discussion, I focused on helping the women gain insight into their negative self-perceptions, and on how the invasion of their boundaries had resulted in a shamed sense of self.

One of the women enlightened us all when she said, "that's why we hide the real self, we're ashamed". This comment was followed by a question from one of the women, "how can we let her out; the real self is scared." Another woman said the group was helping her take risks and that she had recently dared to take off her mask. "I can't live a lie any more and smile and pretend nothing happened. My Dad abused me and it's real, even today." Another member said she had recently told her boyfriend that she went to a survivors' group. "Telling him the truth breaks the secret and is a way of facing the shame."

One member said she had recently told her father, "You sexually abused me when I was a little girl. I know you did it and you know you did it." The members all clapped spontaneously and the woman softly added, "Giving voice to how I felt long ago feels really good." I responded by affirming her actions in releasing shame, "Letting go of shame is the development of an internal boundary." After the discussion the group members made a decision to go back to the scheduled exercise of changing self-blame to positive affirmations. This cognitive restructuring exercise identified reasons why the women blamed themselves for the childhood sexual abuse, and concluded with positive affirmations (See Table 1).

Table 1

Self Blame / Affirmation Paradigm

A. IT WAS MY FAULT BECAUSE...	B. IT WAS NOT MY FAULT BECAUSE...
1. I didn't say no	1. I didn't know I could say no
2. I didn't run away	2. I was too small to run away
3. I wanted to obey	3. He told me children must obey
4. I always forgave him	4. If I didn't forgive I would go to hell
5. I kept the secret	5. I couldn't tell. They said I lied
6. I wanted attention	6. All children must have attention
7. I was seductive	7. No little child is seductive
8. I went to his bed	8. He said he would read me a story
9. I was not that young. I was in grade two when it started	9. My father had all the power regardless of my age
10. I fell asleep	10. All children fall asleep
11. I ate the candy he gave me	11. Candy is meant to be eaten
12. I "blanked" out when he did it	12. "Blanking out" was a way to survive
13. I said "it feels good"	13. He made me say "it feels good"

After tonight's closure, the women completed an evaluation on how well they understood the themes of shame and guilt and whether the exercise increased an awareness of their negative thinking.

Evaluations indicated this week's session had been "excellent--very fruitful." All women indicated with a score of five that the agreed upon objectives had been met. Generally, the women noted that shame felt "like I'm always bad." Five women indicated that the discussion on the topic of shame helped them realize that they were not to blame for the abuse. One woman wrote, "I know it with my head, but my inner being still tells me I was at fault." Another one wrote she felt supported by the group members, "The support and safety was what I needed to release the shame and recognize my internal boundary." Six of the women indicated "absolutely yes" on the scale regarding the changed feelings in response to positive affirmations. One woman, however, wrote she "felt like garbage. I wish I was DEAD." This disclosure concerned me when I read it the next day. However, I did not contact her as I was aware she had an appointment to see her individual counsellor the same day that I read the statement.

SESSION 6: Anger and "Bill of Rights"

The objectives of session six were to offer an educational component on the theme of anger and to introduce an exercise on a "Bill of Rights" statement (see Appendix S). I had also planned to prepare the group for the visit by the faculty advisor at the next session.

The session began with the usual round of check-ins, followed by some housekeeping issues, such as book returns, journal writing and street parking. All group members then participated in exploring the theme of anger. The enthusiasm and participation with which they shared and discussed their definitions and feelings on the topic of anger demonstrated a genuine sense of security and cohesion within the group. The definition of anger included: a feeling, yelling, scary, helpless, being very strong or powerful. All definitions were acknowledged and linked to the group goal of building and repairing internal boundaries.

Anger was seen as a negative emotion by most of the women and no member acknowledged it as a useful emotion. While I agreed with the uncomfortable feeling of anger, (see Appendix T), I described anger as a common feeling expressed by survivors of child sexual abuse, and that expressing this anger in a constructive way can help in the establishment of boundaries.

> Anger may be a response to being helpless and hurt. The anger of a child who is sexually abused is often suppressed. However, eventually it finds expression. If it is denied and unacknowledged it may be expressed in destructive ways. Sometimes it is directed inward causing depression and anxiety. Expressing anger in a constructive way will give us energy and motivation to say "no" and set boundaries or limits in our lives. A key to boundaries is knowing the inner feelings and experiences.

The educational component was followed by a woman asking how she could express the anger she felt towards her father for "always hurting me." She continued,

> He would come to the bathroom when I was in it and take off his pants. Then he forced me to kiss him again and again. He told me to kiss deeper and deeper, and if I didn't he pushed me against the wall and almost suffocated me. I hated it when he smiled and touched me with his hands all over. I had no choice. I just stood there trying not to look at his private parts.

Several women cried while they listened. When there was silence, one woman after another asserted..."it was not your fault,"..."you were just a child."

One member suggested the group members confront her father as a collective and chase him out of town. The woman responded to this idea with disbelief, "you would really do that for me?" She said she would like to face her father and be very powerful and strong and "let him have it." Another woman said she had tried to confront the father, but that he had completely and convincingly denied the abuse. She was then labelled a liar by her sister and her mother. "I only wanted the truth; instead I was separated from my family and hurt again. I also got more angry."

In response to my suggestion of a role-play, one of the women said she would like to "yell and scream at her father, once and for all." Several women said they would help her. I assured the women they would be safe and that I had witnessed several similar role-plays. The woman then faced a large stuffed animal on a chair and hit the animal with a force that banged him into the wall, across the room. The woman was shaking and wailing from the heart of the child with a powerful strength uncharacteristic of this quiet, withdrawn woman. As she shook and released deep seated anguish, anger, and pain, I carefully watched the rest of the women, most of whom were crying and watching the role-play intently.

When it was all over, I asked the woman if there was any thing we could do for her. She asked for a hug and gripped me for quite sometime. She said she felt a release she had not felt before, and "this was the first time I could do it." She explained that it was like reliving the childhood experience and that this role-play had

accomplished a lot more than constantly trying to forgive and forget. "This was the truth, no lies... I'm tired." She later wrote in her evaluation that without the release of rage "I could not get over the abuse."

A few of the other women said they too had released and expressed anger denied for many years. I asked the members whether they had been afraid and unsafe. None of them acknowledged fear. One of them said "it had to be forceful or it wouldn't have helped or be real." One woman said she hoped the release would help her feel less angry with people generally.

After the role-play a statement of rights was read by each of the women (see Appendix S). For example, "I have the right to feel anger and express it appropriately", and "I have the right to feel and express love and affection." There was a firm consensus that each of the women in the group had the rights which were read. However, not one of the women was convinced of her own rights. Changing negative self-perceptions was an arduous task for most of the women.

Near the end of the session I raised the planned visit of the faculty advisor at our next session. I assured the women of the advisor's understanding and experience with group work and of her kindness and integrity. There was silence. I then asked them to share how they felt about the visit, assuring them that the advisor would sit a distance from the group and merely observe my facilitation. The first response was a weak "I'm okay with it." This was followed by "Me too, I just won't say anything next week." Meanwhile, I was beginning to feel uncomfortable. My encouragement and explanations began to feel like coercion. Several women said they would not be

comfortable but that they would attend. One woman said she would not be there if the advisor attended and one woman said she would feel fine if we had a guest at the next session. It became quite clear to me that the women did not want a new member attending the group at this stage. I felt they were trying to please me and not relating from the true self. I then asked them to close their eyes and concentrate on making a clear decision about the visit. I reminded them that they had rights and that their decisions mattered. The response that followed started with one member saying her decision was "no." Five of the other women clearly agreed with her decision. However one woman said she would not mind if the advisor was present. With the majority of the women expressing discomfort with a new person at the group, the decision was made to respect the group boundaries and not invite the advisor to a future meeting.

After relaxation and story-time the women completed the weekly evaluation scale, rating their understanding of anger and their beliefs about personal rights. The evaluations were completed very quickly tonight with all of the women indicating significant learning on the theme of anger. The members noted several ways they could use to express anger in a constructive way: go for a walk, talk to a friend, exercise, writing, crafts, sewing, singing. All of the women indicated with a score of five (absolutely yes) that other "group members have the rights that were read tonight." However, each one indicated a "no" or "maybe" to the question, "Do you feel you have the rights we read?" There was a wide variation expressed on whether or not the handout on journal writing was useful. Two wrote "no/maybe" and two wrote

"absolutely yes," with three saying "somewhat helpful." Just before submitting this week's evaluations, the women briefly discussed their beginning awareness of feelings such as anger and shame and how "keeping it in makes me insecure." Butler and Wintram (1992) note that "the awakening of self-awareness runs parallel to women's self-esteem which itself is connected...to self-definition" (p.116).

SESSION 7: Forgiveness and Justice

Session seven focused on the theme of forgiveness and justice-making. Forgiveness was one of the topics suggested by the women and added to the list at the first session. Several women, who had disclosed abuse had been pressured by family members and others to forgive their fathers for the childhood sexual abuse. One of the women said she had forgiven her father every time he had molested her because he had told her she had to do it or "God won't forgive you." This understanding of forgiveness caused the developing child to deeply ingrain a negative self-concept. The burden to do something was placed on her shoulders.

Another woman said she had gone to her physician because of a depression, "The doctor told me I needed to forgive my father." From then on "I desperately tried to forgive, because I wanted to stop feeling so depressed and dirty." The experience another woman had was quite different. Her physician had told her that she had nothing to "make right," that she had done nothing wrong. This was a great relief for her; a turning point in the survivor's life and the first time that she was not held responsible for the abuse. It was the catalyst that moved the woman to begin dealing with the childhood issues and to let go of the bondage. This experience was similar to

an experience shared by another woman in a previous session. When I commented on the similarity, the two women entered a discussion which ended with the exchange of telephone numbers.

Another woman said that "every time I talked about healing from the abuse, I was told by my mother and others to forgive." This disclosure prompted one of the members to share her desperation for some kind of relief from the child abuse memories and the more recent physical abuse from her husband and how she finally went to her pastor for help. I was told two things, "to pray for him and to have more faith so I could forgive him; that's when I left the church. I was very hurt and wounded when he said I had married him for better or for worse. I ended up in the hospital two times."

Another woman who had gone to her pastor was encouraged to go to an abuse shelter as soon as possible. The pastor arranged for relocation of the children and household necessities and then met with the husband to confront him and to assist him with counselling and resources to help him change. The family had eventually been reunited as they had hoped for. "My pastor never asked me to forgive; he asked my husband to repent. He explained that repentance meant changed behaviour, not merely confession. Forgiveness took place over the years after he stopped the abuse and I stopped being afraid of him."

The group members continued to struggle with the idea of forgiveness and the discussion turned to the meaning of forgiveness. "What is forgiveness for you?" Does anyone want to share their definition or understanding of the term", I asked. Most of

the women had strong feelings concerning the issue and all of them agreed that if forgiveness meant "getting better" they would do it today if they could. For the Christian women it was something they had done again and again. "What did you do again and again?" one of the members asked. The response was "forgive." This comment raised many questions. "Why do you have to do it more than once?" The animated discussion continued with one woman saying, "I think I said I had forgiven because that's what people wanted me to say, and I certainly was open to it, but I felt like a failure because it didn't help." One of the women, in her evaluation, wrote, "The process of understanding what, why, where, etc., it happened, and its effects must be accounted for first, like a harvesting - then perhaps transcending and forgiveness." Other comments included: "Forgiveness should be renamed accountability." ... "If asked to forgive I may block out all my feelings." ... "Pre-meditated ongoing sexual abuse is unforgivable."

One of the women said she had forgiven her father but that the forgiveness occurred within a context. A counsellor had listened to her truth and acknowledged it, holding her father accountable. "I could never have `let go' of all the pain and anger if someone else had suggested I do so. It was a process I needed to work through in my own time."

Working through the issues of child sexual abuse was seen as a growth experience by several women. They claimed that, as they continued to be actively involved in their own healing, they began to experience periods of peace. One woman said she faithfully practised a daily relaxation meditation as had been suggested in a

previous session and that it helped her to heal physically and spiritually. This sharing led to a brief discussion of holistic healing: physically, intellectually, emotionally, and spiritually.

The Justice-Making exercise (see Appendix U) that followed the discussion on healing and forgiveness contains six elements, each of which needs to be addressed in order for the survivor to experience a sense of justice. The exercise, (adapted from Fortune, 1991), emphasizes that survivors need an experience of justice. Addressing each one of the elements, as they relate to a survivor's experience, fosters self-worth and self-esteem for self and others. It holds people accountable and promotes healing in individuals, families and communities. One of the women maintained that "there is no justice unless the perpetrator tells the truth and admits what he did." This comment inspired an exchange that was later referred to as "very educational" by the women. "Isn't justice about returning money when you steal?", one member questioned. This remark prompted further interaction about how justice-making holds us all accountable.

The ensuing group discussion was directed towards a father's responsibility and how acknowledgement and accountability could make it easier to let go of the inner anger and pain. One woman asked if it was possible to "let go" without the father's admission of guilt. Several said it could be but that the relationship could not be restored until he accepted responsibility and demonstrated changed behaviour. While one woman's father had recently acknowledged the abuse, the member said it would take some time for her to develop a relationship with him. While she hoped he would find a safe counsellor who would help him heal, other women questioned her concerns.

When it was time to end this session three women asked to extend the session by fifteen minutes. I checked for responses from the other women; all agreed to extend the session. The last portion of the session was spent reviewing the justice model and its capacity to promote healing. One of the women concluded that an experience of justice must include society's acknowledgement of child sexual abuse. After the time was up, I read a portion of the bedtime story and we ended the session.

Finally, the women completed the brief weekly scale evaluating their understanding of forgiveness and justice. Evaluations indicated that this was an important topic for six of the women. One woman stated that she had never considered the topic because "I left my family and that was when I stopped thinking much about them. I need to forgive me." All of the women scored a five (absolutely yes) in response to "can healing be blocked if...asked to forgive?" All women responded with "absolutely yes" to the questions "Was the exercise on justice-making clearly introduced?" and "Is it a helpful guide towards boundary development?".

STAGE THREE: (Sessions 8-12) External Boundary Development

The sessions in stage three focused on the development of external boundaries and on living today. The educational component and exercises were related to interpersonal communication skill development, and to the difference between internal and external boundaries. There was less expression of painful feelings and a more positive, hopeful atmosphere generally.

During this stage the women continued to demonstrate supportive caring for one

another. They became more aware of the similarities of the impact of their families of origin in the forming and shaping of the internal and external boundaries in their lives. While one of the women occasionally revisited the painful childhood memories during this stage most of the group members focused more on present day concerns and less on the aspects of the loss and trauma.

Having re-experienced the child's feelings of isolation and fear while in a safe place, the women began to feel some control over the childhood abuse. As the members discussed and practised new ways of interrelating within the group, several women acknowledged a sense of autonomy and a desire to practice new behaviours outside the group. The goal during the sessions in stage three was to move away from the victim role towards the positive events in the women's lives. I will now discuss the sessions of stage three and the development of external boundaries.

SESSION 8: Communication

The focus of session eight was to discuss the theme of communication and to introduce an exercise on assertive communication practice in dyads. The session began with the usual round of check-ins. This was followed by a debriefing of the previous session's theme of forgiveness, a debriefing which evolved into animated sharing within the group. One of the women's comments evoked a variety of responses, mostly about bonding and commonality within the group. "So why are survivors seen as unforgiving people; maybe we are unforgiving." Most of the women commented on how quickly and easily they had forgiven many times in other situations and that it had been a positive experience." Sexual abuse of small children is not like any other

offence. It's different. We were all deceived. We were impressionable, as we were meant to be, so we could learn about life," said one woman. I remarked on the similarity between her words and those of other group members at last week's session, "... is this how you felt last week when you shared feelings of betrayal as a child?" My comment elicited expressions of "being in this together" and "we didn't even know what was wrong or right." The emphasis was on "we", and on the similarities in their lives today and as children, regardless of religious or cultural differences.

After reviewing the outline on communication styles (see Appendix V), which had been put up on the flip-chart, I asked the women to practice assertive communication in dyads. For example, they were asked to think of a situation in which they had difficulty communicating their wishes in a way that allowed them to achieve their goal. This involved decision-making, asserting wishes and role-playing the desired communication in the group setting. Before they began I reminded the women that assertive communication involves clearly stating your wishes, your feelings and what you want, without violating the rights of the other person. I also explained that "no" is a sentence and that they had the right to say, "I don't want to." Although I gave suggestions on various problem situations, each dyad was encouraged to define their own problem situation. Social situations I suggested included, "Your friend has called you on the telephone and you need to end the conversation so you won't be late for an appointment." This example was typical of most of the situations practised by the dyads.

After ending the exercise, one woman said she hoped " to do this for real," but

that she needed more practice. This comment provided an opportunity for her to assert her wish and for group decision-making around granting the request. After the group agreed to the woman's request, the woman and I rehearsed a typical telephone conversation in which she had trouble asserting her wish to end the conversation with her mother. This role-play was evaluated by the women as a good example of setting boundaries and limits. They also maintained that setting boundaries in "this group is not the same as out there." However, all seven women agreed to take a risk outside the group and use assertive communication in one situation during the week.

Before the closure one woman asked whether the advisor was expected to observe the group before its ending. I indicated that the decision had been made by the group not to invite her. This comment prompted a discussion on the identification of emotional and physical boundaries within the group. All of the women participated in the identification of group boundaries which were recorded on the flip chart (see Table 2). The boundaries identified were similar to the examples discussed in session three.

TABLE 2 GROUP BOUNDARIES

Physical Boundaries	Emotional Boundaries
1. Lock the door	1. Confidentiality
2. Keep journals safe	2. Respect each other
3. No new members	3. Don't take on others' pain
4. No hugging without permission	4. No gossiping / triangulation
5. No secret meetings outside group	5. Group agreements
6. Food shared	6. Choices
7. Keep time schedule	7. Being responsible
8. Chairs in a circle	8. Various opinions okay

Tonight's self-rating scale addressed the women's understanding of the three styles of communication and how they felt about the group experience generally. The responses to the self-rating scale indicated that the topic of communication had been very helpful in the understanding of external boundaries. All members noted that the discussion on assertive communication, and saying "no" was especially useful to them. Each woman indicated "Absolutely yes!" to the question "Is the group experience helpful to you?" One added,

> Group is helpful--being with and talking to others who really know how you feel and sharing thoughts and not being judged... And having (facilitator) make you feel safe enough to talk about the abuse and yet not pressure you at any time.

Another wrote "just to be with the other women and share and learn helps me understand myself."

SESSION 9: Conflict Resolution

Session nine focused on the topic of conflict resolution and decision-making. One of the objectives was to introduce an exercise engaging the women in a decision-by-consensus process. As part of the educational component I asked the group whether anyone would like to share their understanding of conflict. Several descriptions were given: discomfort, fights, disagreements, bad feelings.

Prior to the exercise most of the women acknowledged they were feeling anxious and apprehensive about participating in an exercise dealing with conflict. When I indicated we could discard the exercise they began to discuss alternate activities. However, after further exploration on the management of conflict, they concluded that the topic was an important one and that practice in dealing with conflict

could be an opportunity to set boundaries in their daily lives with partners and friends. The Group Decision-making exercise (see Appendix W), which was self-designed, consists of 12 phrases, each one preceded by the statement, " To Heal From Child Sexual Abuse The Victim Must..." Each statement is carefully considered by each member and then, without consulting others, ranks the statements. After completion of individual rankings, the group then must reach one overall ranking of the statements. This ranking must be agreeable to all members of the group. Suggestions for participation and sample questions were very helpful to the women, according to their evaluation. One woman indicated that the question, "How do you feel about my point?" had not been in her vocabulary until this week.

Near the end of the exercise a disagreement erupted about the process of the exercise. According to one of the members not everyone had followed the instructions. As she attempted to be assertive, she was interrupted by another member who informed her that the instructions were given as guidelines only. After inviting the two women to further express concerns and feelings, I shifted the focus to the group as a whole, "perhaps I was not clear in the exercise introduction. Were others confused about what to do?" Most of the women expressed positive feelings about guidelines and the exercise. One member said it had forced her to practice speaking from within. "I didn't agree with the others, but it was okay", she concluded.

After the completion of the exercise the focus turned to a discussion on the difference between managing conflict within the group and on the outside. According to the women, family interaction usually ended in conflict unless they related from a

highly developed false self, trying to please others. Mason (1993) describes this false self as a "role self which is a substitute for personal boundaries" (p. 41). "Growing up in a family where I was abused, I learned as a young child to avoid conflict whenever possible", stated one member. The women encouraged each other to face the conflict today. They agreed that, as adults they didn't need to withdraw to survive. One member said, "Today we can stand up for ourselves."

One woman said if she was "truly honest from my real self, I would be aggressive, not assertive." This disclosure was followed with a review of last week's topic on communication and how the different types of communication are linked to different types of boundaries. Although the woman's wish was to be assertive she said it was much easier to set up a wall, "like a defensive or a rigid boundary," in certain situations. "That's only with certain people," responded one of the women. "Pick who you go with." Letting go of the rigid and vague boundaries makes room for the self boundary, the flexible one. This insight was shared by the group members and clarified the difference between the different types of boundaries.

Today's exercise moved the group to challenge and confront each other, helping the members meet the objectives of the group. Confronting from within the self encouraged the setting of an internal boundary, while the challenge was identified as setting external boundaries. Before leaving tonight the women each receive a handout of "Affirmations" (see Appendix X).

After the closure of the session, the women completed a self-rating scale evaluating their understanding of conflict management and their feelings about the

consensus exercise. While all of the women rated their understanding of conflict resolution at a level of four or five, they added that they had found it very difficult to disagree during the exercise. They identified "lack of courage" ... "low confidence in myself" and "I'm never sure if I'm right" as inhibiting their ability to express disagreement. One woman wrote that "the exercise was good practice in a safe place...a place where we were told it is okay to disagree." Five women rated "absolutely yes" in response to, "Was getting in touch with your core self helpful in saying no?" One woman added, "connecting to myself makes me feel secure...like I've got a boundary."

SESSION 10: Revictimization

This week's session concentrated on the relationship between the self and revictimization. Check-in time was brief tonight and quickly focused on the diagram which depicted the core self as the hub of a large wheel. One woman said she was "more in touch with my true self." Another member identified with this comment and noted that she too felt "more real inside," but that it was not easy to live from this internal awareness. I indicated that it may be difficult for survivors to gain access to a sense of self, a self that could not develop during childhood. "It's very painful to speak from my real self and then not be supported. But when I do take the risk it is a freeing experience for me," said one of the women. This reference to an autonomous self indicated an ability to set a clear boundary, thus freeing the woman to focus on self-care and interpersonal relating.

One of the more quiet women questioned the above comments on the true self,

stating she had "to keep it (self) hidden because it hurts when I get put down." As she cried, several women reached over to give her a Kleenex. I asked her if there was anything she would like from the group. She responded by disclosing her fear of court proceedings the next day. Everyone listened intently to her story of revictimization by the father of her children. She concluded by expressing a feeling of helplessness with no control. I asked how these feelings were similar to the feelings of the little girl. Several women acknowledged that the fear of the "little girl" surfaced whenever threatening situations arose in their lives today.

Prior to the break I introduced an exercise on the identification of the true self. I described this core self (see Appendix Y) as the authentic self, genuine and spontaneous, often covered by constricting layers of the false self, a self that avoids feeling pain, that isolates and accommodates to the wishes and judgements of other people. I asked the women to take deep breaths, to relax and find their core self " a self we all have." This was followed by expressions of feelings, of speaking from within. Statements from the self were brief but uttered with much feeling and thoughtfulness: "Dad, you hurt me ..."it still hurts" ... "this is who I am" ... "I want to have a friend" ..."I feel me."

As the group members reflected on the exercise, they appeared subdued and thoughtful. One of the women said speaking from the self would take much practice before she could be consistent with her friends and colleagues at work. She described a situation at work where she was constantly doing other people's jobs, even though she was the supervisor. Her resolve to change this was an inspiration to another

woman who applauded the motivation. Once again the women commented on the difference in being real inside the group versus outside the group. "Here we have each other and we know we are believed and that makes all the difference."

Following the debriefing, the women disclosed the many ways they had been sexually revictimized as adults. The perpetrators included a pastoral counsellor, medical doctor, partner, father's friend, grandfather and an educator. In agony and with shame they disclosed the bondage, blaming themselves for being unable to "get out of the chains". They recalled a pervasive hopelessness and a wish they could have died. I asked the women what, if anything, was different today. One of them said she felt more positive after feeling so much of the suppressed pain, "Letting it out is necessary to a new outlook on life." In their evaluations, two women referred to the linkage between their revictimization and a lack of a sense of self.

Before the sessions's closure, I reminded the women that, in releasing the feelings and in relating to each other from the inner self, they had started building self boundaries. As the women continued taking risks and increasing self-awareness they gradually became more aware of the demarcation between self and other.

After listening to how the velveteen rabbit became real, the women completed a brief evaluation on their understanding of the core self and how internal and external boundaries protect that self. All of the women noted that the diagram of the core self had been clearly presented and that it had been helpful in understanding the difference between the false self and the true self. What had been especially helpful according to the evaluation was the interaction with each other and "just learning from one another

that we can walk away from victimization."

SESSION 11: Family of Origin

The objectives of this week's session were to introduce the concepts of rules and boundaries in families and to encourage the women to share suggestions for coping with family issues today.

After the check-in and a brief introduction to rules and boundaries in families, the session evolved into a time of sharing. Although deep feelings of sadness and pain were expressed about family relationships today, there was also a positive combative attitude toward family relationships in some members. A major issue for the women was: "Why did this happen?" The reasons cited by the women in this session were different from those given in session five. There was less self-blame and more responsibility attributed to the father.

Several group members described constant feelings of confusion and hyper-vigilance throughout their childhood. One woman said she had longed for her father to love her, "because in a distorted way I actually loved him while he hurt me." Another woman acknowledged that she too had loved her father as a child. She said "I don't know what love is; aren't we supposed to learn about love from our parents?" Several of the women disclosed stories of "feeling dreadful, knowing it would happen, with no way of escape." Sharing very similar stories of captivity within their childhood environment enhanced bonding among the group members. One of them described her loneliness within a large extended family:

> I would look around at family gatherings for someone, anyone with some kindness in their eyes, the kind of eyes my teacher had. But I knew I couldn't tell even if I found someone. As a very young child something told me to keep the secret and I did and I was always alone.

I asked whether others had similar experiences and if so, whether the secrecy had been an unspoken family rule. "Oh yes, we knew what we could do and what was forbidden," said one woman. At the end of the group program this woman wrote "I couldn't tell a lie, my parents could. The image our family presented to others was always very important." Two other women wrote that they had had no choice but to live from the false self, the conforming self. One of them wrote in a poignant way, "[Facilitator], why weren't you there when I was eight?"

Although the women expressed deep anger about their treatment as children, they shared in common much agony about not belonging in their own family. One woman, who was impregnated by her father said she had just wanted to belong, "but today I'm feeling much rage and hostility at everyone, my colleagues, my partner, friends and my mother." Other members responded with: "remember, it's okay to feel the anger"..."I understand your rage"..."I wish I could express mine too"..."I ran away too, at least the friends accepted me"..."you helped me a lot"..."I never felt much till this group." The woman who expressed her anger in a role-play at a previous session commented on how helpful it had been, but she added, "when I yelled from inside, it was only one-millionth of the anger and pain of the child." Near the end of this discussion the woman who had given birth to her father's child as a young teen expressed " thanks for letting me say all that."

Boundaries within the families were generally described as "none" and "one-way boundaries" by the women. Although boundaries had begun to change as the women gained more control over their lives, most of them said the struggle to change family dynamics today was a difficult one. Several women had initiated visits to the family home with hope of some contact with siblings. However the experience was typically viewed as unfavourable. Although triangles had been common during childhood, the women became more aware of triangulation among family members upon disclosure of the incest. Generally both perpetrators and other family members denied the incest had ever taken place.

This week's session ended with a time of relaxation and visualization before the story reading. The brief self-rating scale included questions on the women's understanding of boundaries in the family and whether or not they had felt supported in the group. Evaluations indicated that the sharing within the group had been a major help in the building of external boundaries. One women wrote that she felt "much support in group to be real." Another woman wrote she "felt close enough to care and feel others' pain, stories and hopes (or despair)." All seven women responded with "Absolutely yes!" to the question: "Is relating with families helpful in building external boundaries?" They were beginning to understand they had a right to be treated as adults and to leave when their boundaries were violated within the family.

SESSION 12: Ending

This session focused on saying good-bye and on celebrating the courage and strength demonstrated by the women throughout the 12 weeks. The regular Session

Guide was not followed during this session.

I had prepared the room for the celebration with candles and flowers. Each of the women brought a special dish to the session. All of the plates, casseroles and dishes were elegantly prepared with garnishes and decorations. Without previous consideration about what to bring it was surprising to have all courses represented; appetizers, salads, entrées, and desserts. This was of special significance to the women and they commented on how this menu was a sign they belonged together.

Prior to the meal, we reviewed the overall group experience and discussed the subject of separation. Feelings of sadness about endings were expressed, followed by a discussion of what they would miss after tonight's last session. After the food and a reading of the last chapter in "The Velveteen Rabbit", the women were given the opportunity to evaluate the group experience in the form of two self-report questionnaires. Two women completed the forms in the group room and four moved to the larger board room to complete the forms. Finally, as the women submitted their forms one by one, appointments were made for individual follow-up sessions with each of the women, for the purpose of completing the Index of Self-esteem and the Boundary Scale. Before leaving tonight's session, the women made a unanimous decision to meet one more time as a group, in two months. They asked me to reserve the room for the gathering and to confirm this at the follow-up individual sessions.

POST-GROUP ACTIVITIES

As noted above, each of the group members met with me one week after the last

group session for the purpose of completing the two quantitative evaluation measures. These individual sessions also provided an opportunity for members to share their personal experiences of the group program and to further debrief around termination and ending. Generally, the women expressed significant satisfaction with the overall group experience. Some of the women acknowledged much anxiety at the first group meeting. They commented on the sense of safety and belonging in the group. Two women said that the concept of internal and external boundaries had "motivated and inspired" them to make an effort to "begin a new life". For most of the women the experience of being with other survivors was a major factor in their healing and growth and in "finding my self." One woman commented on the feelings of isolation and loneliness throughout her life. She said she had "never dreamed of being in a room with others who had a bad secret." She felt she could "move on" because she had been able to go back to the world of the child in the safety of the group. " Without facing that trauma my changes were short-lived in the past." Several of the women, however, left the meeting concerned about their abilities to use the tools and skills they had learned, outside the group setting. One of the member's expressed sadness about leaving. She said she was ready to start a second group program immediately and that she was " more ready then when I started this group."

The final group gathering, which had been initiated by the group members was attended by six women. The meeting took place seven weeks after the last session of the group program and was an opportunity for the women to reconnect and to talk about current events in their lives. There was limited reference to their childhood

experiences and no discussion about their abilities to implement and maintain new boundaries with others. After exchanging telephone numbers and saying "good-bye" some of the women went for coffee in a nearby restaurant.

SUMMARY OF GROUP PROCESS

The 12-week group model was an appropriate model for the development of internal and external boundaries. As well, the members appeared to move towards additional personal goals within the group experience. The two pre-screening meetings were significant in the development of early group cohesion. Sessions included a variety of educational components which facilitated the women's understanding of boundaries and the development of personal boundaries. Exercises provided an element of playfulness where the women were free to relax and to participate toward the meeting of some specific goals. The ending session provided an opportunity for the women to review the changes they had made. Instead of saying goodbye at the last session, the members initiated a follow-up session, indicating to me they had some difficulty dealing with separation. As discussed above, the individual post-group sessions provided an opportunity for the women to give both positive and negative feedback about their group experience. According to the verbal feedback and the women's written evaluation, the group intervention was a useful program in the reparation and development of internal and external boundaries.

CHAPTER 5

RESULTS AND IMPLICATIONS

This chapter provides a rationale for the evaluation process with a brief description of the measures utilized. It also presents the results of the intervention and discusses the findings and concludes with implications of the intervention.

Evaluation procedures, both quantitative and qualitative, were completed by each of the seven group members. According to Compton and Galaway (1989), evaluation is the application of scientific methods to measure both change processes and the results of outcomes of change efforts. This description of evaluation refers to the objective or quantitative aspect of measurement where observations "lend themselves readily to numerical representations" (Rossi & Freeman, 1985, p. 223).

The qualitative approach, on the other hand, generally results in data that can "best be described in words rather than numbers" (Heinonen, 1995, p. 10). Qualitative data is based on gathering information through direct quotations from respondents in open-ended questionnaires, observation, and face-to-face interviews and "tends to be less easily summarized in numerical form" (Rossi & Freeman, 1985, p. 223). In qualitative evaluation the subjective experience of the respondents is acknowledged. This method of evaluation is more compatible with the feminist philosophy of the group intervention.

While a feminist approach to evaluation encourages women to be authorities on themselves through qualitative methods of research, it recognizes the need to be

accountable and to evaluate the process of change within group work on a regular and consistent basis. Butler and Wintram (1992) suggest that the lives of women are improved through the ongoing assessment of the process of change for both the group and the individual members. They state that a variety of assessment tools, such as open-ended questionnaires, self-assessments, direct observations, women's personal statements, and rating scales, are useful in group evaluation. Although there is an increasing awareness of the rich potential of qualitative research, Butler and Wintram (1992) indicate that "progress in knowledge about the range of therapeutic effects of groups will come by identifying precise, yet measurable changes in functioning" (p. 9). Reinharz (1992) concurs that combining several methods of research increases the "likelihood of obtaining scientific credibility and research utility" (p. 197) and that objectivity and subjectivity can serve each other. The development of new knowledge is invaluable to the social worker's current and future efforts in the amelioration of communal and personal suffering. Clearly, it would seem that the explicit use of both quantitative and qualitative data serve to strengthen the evaluation as a whole.

MEASUREMENT TOOLS

Several methods, both quantitative and qualitative, were used to measure the process and outcome of the group practicum. The quantitative aspect of the evaluation included two scales. Both scales were used on a pre and post intervention basis.

1. The Hudson Index of Self-Esteem
2. Boundary Scale

Given the impact of child sexual abuse on the self-esteem of the adult survivor, the

widely used Index of Self-Esteem (ISE) was utilized. As well, I made the assumption that the self-esteem of the participants would increase with an increase in boundary clarity and thus selected a measure of self-esteem to test this assumption. Bloom and Fisher (1982) state that the worker should select a measure in which expectations for change are high.

The ISE is a 25 item scale designed to "measure the degree, severity, or magnitude of a problem the client has with self-esteem." (Fisher & Corcoran, 1994, p. 283). The scale, which was developed by Hudson in 1974, is easy to administer and easily scored. Dr. Hudson has granted permission to reproduce the scale in any quantity needed provided that the following three conditions are met: "the format and wording of each scale must not be altered, the copyright notation at the bottom of each scale must be retained and none of the scales may be reproduced for commercial purposes" (Bloom & Fisher, 1982, p. 162).

The ISE measure has a reliability of at least .90 and very good face, concurrent and construct validity (Fisher & Corcoran, 1994). The scale has two cutting scores, one at 30 and one at 70. A higher score indicates a more severe problem with self-esteem. Individuals obtaining a score above 30 are said to have a clinically significant problem with self-esteem. Those scoring above 70 are defined as "having severe stress with the clear possibility that some type of violence could be considered or used to deal with problem" (p. 283).

The 27-item Boundary Scale (see Appendix D) was self-designed in an attempt to measure the extent of boundary ambiguity in the adult survivor of child sexual

abuse. The higher the score the more difficulty with boundary issues. The statements of the scale are written in simple language and easily administered. The internal boundary statements refer to the intrapsychical issues; issues that relate to a person's self-identity, such as feelings about self-perception, anxiety, shame, fear, and helplessness. An example of an internal boundary statement reads: "When I am close to others I lose my self." External boundary statements refer to social and interpersonal relating such as communication, conflict management, and revictimization. An example of an external boundary statement is: "I have difficulty ending a telephone conversation when I want to." Respondents indicate the extent to which each statement pertains to them personally on a scale from one to four. Each item is considered of equal weight as no previous clients or group members have been tested using the beginning exploratory instrument. The boundary scale was scored by first reverse-scoring items listed at the bottom of the scale (2,4,6,8,10,12,14,19, 20,25,27), summing these and the remaining scores for the total (see Appendix D).

The two scales were completed one week before the first group session and again one week after the final group session. The participants were asked to respond to the statements as accurately as possible. I informed them that there were no right or wrong answers on either scale. I told them that the Index of Self-Esteem was designed to measure how they felt about themselves at the time of the scoring. I also explained to them that I had designed a Boundary Scale in an attempt to measure the level of boundary clarity and that they were the first participants to use the scale.

In addition to the above measures, self-rating scales were administered on a

weekly basis, thereby allowing for regular reassessment of the goals and of my facilitation. The rating scales, although similar in design format from one week to the next, were linked to the topic of each session, with the content of questions changed on a weekly basis. Tozeland and Rivas (1994) note that changing the content of questions provides workers with the specific information they need about a particular group's work. The weekly rating scales were easily and quickly administered using a check-off format (scale 1-5), with space for additional comments, incorporating both quantitative and qualitative aspects. The form measured the members' responses to the session, and was a method of evaluating whether or not the intervention plan, to which we had agreed, was carried out by the facilitator. A sample of week 10's scale is offered in Appendix G.

Two self-report questionnaires were used for completion at the final session.

1. An open-ended questionnaire of the overall group experience by the members of the group (see Appendix Z_1).

2. An open-ended questionnaire on the way group dynamics facilitated the development of boundaries for the members (see Appendix Z_2).

Both of the questionnaires were completed by the women at the end of the last group session. The self-report questionnaires on the overall evaluation gave the group members the opportunity to comment on both intended and unintended changes.

In addition to the above methods of evaluation, summary recordings which I completed after each session, added a valuable dimension to the evaluation process, as did the women's verbal feedback. As noted in a previous chapter, a form to monitor self-care was distributed at eight sessions to each of the women who wanted one.

These forms, which encouraged the members to begin a plan of self-care, provided additional information in the overall evaluation of the practicum. Individual goals, which were identified by the women at the second session, added a vision of hope for personal change.

The following section presents the findings of the evaluation tools that were used in the practicum intervention. Results and discussion of both the quantitative and the qualitative data are given below.

QUANTITATIVE FINDINGS AND DISCUSSION

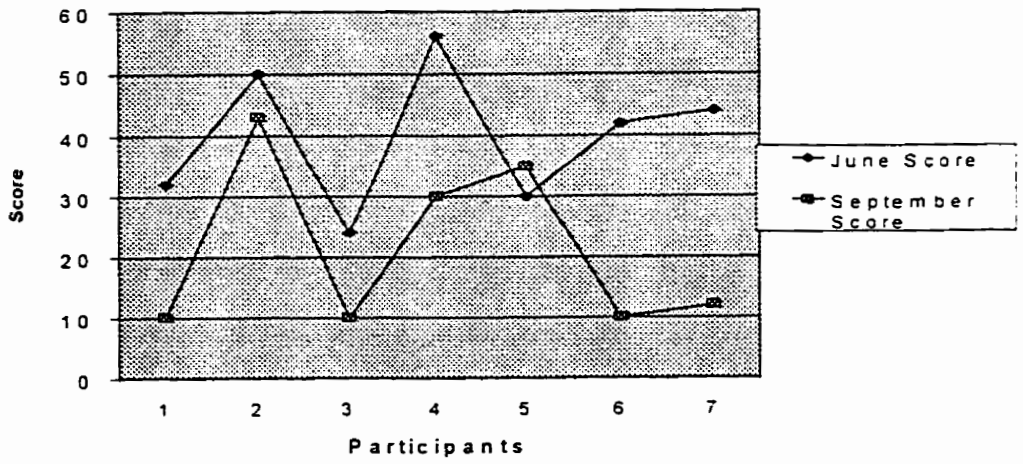
This section presents the results of the quantitative evaluation tools that were used in the intervention. A discussion follows the findings. The quantitative findings include the results of the Index of Self-Esteem, the Boundary Scale, rating scales, attendance, the self care plan, and individual goals.

All seven members of the group program completed the Index of Self-Esteem (ISE) one week before the first session and again one week after the termination of the group program. Table 3 shows the individual scores of the pre and post-group measures. A score above 30 suggests the presence of a clinically significant problem with low self-esteem. The table indicates that all but one of the group members scored above 30, with the scores ranging from 24 - 56 at the time of pre-testing. This shows that six participants appeared to have problems with low self-esteem before the group intervention. The post-group scores indicate that six of the seven participants showed an improved level of self-esteem. Participant five scored 30 on the pre-test and 35 on

the post-testing indicating a slight increase in low self-esteem. (A higher score indicates a more severe problem with self-esteem). The group averages for the Index of Self-Esteem were 40 at the pre-group and 23 at the post-group testing.

Table 3 -- Index of Self-Esteem

Participant	June Score	September Score	Change in Score
1	32	10	-22
2	50	43	-7
3	24	10	-14
4	56	30	-26
5	30	35	5
6	42	10	-32
7	44	12	-32



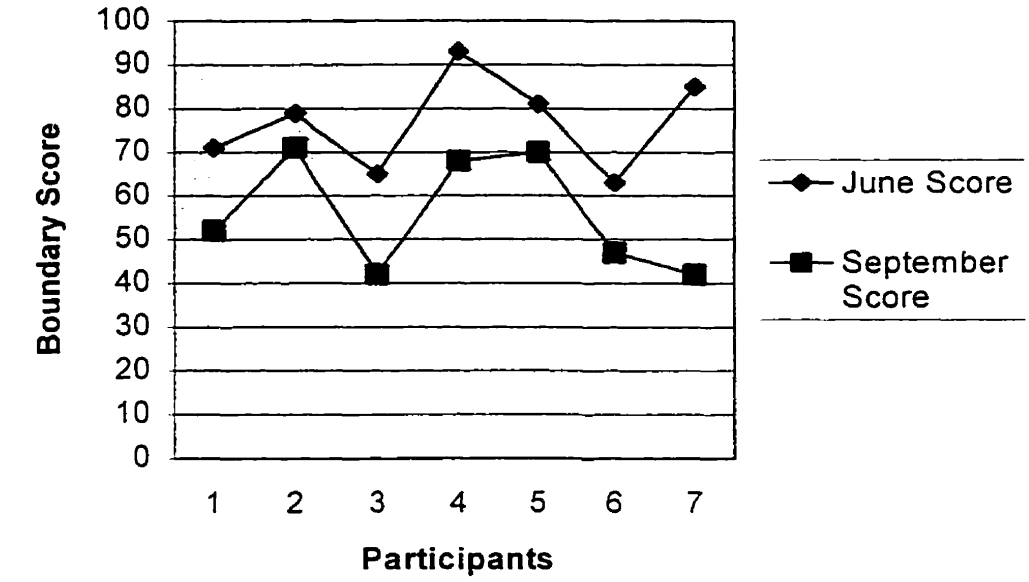
The Boundary Scale was completed by all seven group members one week before the group started and one week after the final group session. As can be seen in Table 4, participants show scores ranging from 69 to 95 at the time of the pre-test.

The post-test scores indicate a range of 42 - 71. Participants two and five show minimal decrease in boundary difficulties at the post-group testing. These two group

members also showed the least change on the Index of Self-Esteem, according to Table 3. Group averages for the Boundary Scale were 78 for the pre-test and 56 for the post-test score.

Table 4 -- Boundary Scale Scores

Participant	June Score	September Score	Change in Score
1	75	52	-23
2	75	71	-4
3	69	42	-27
4	95	68	-27
5	79	70	-9
6	68	47	-21
7	86	42	-44



In addition to the overall results of the boundary scale, I have separated the internal and the external scores for each of the participants. Fourteen statements refer to internal boundaries and thirteen statements refer to external boundaries. The results for each participant are shown in Table 5 and Table 6. These scores are presented for interest only, with no analysis provided.

Table 5 -- Internal Boundary Scores

Participant	June Score	September Score	Change in Score
1	41	26	-15
2	42	41	-1
3	42	25	-17
4	48	33	-15
5	46	44	-2
6	36	28	-8
7	47	25	-22

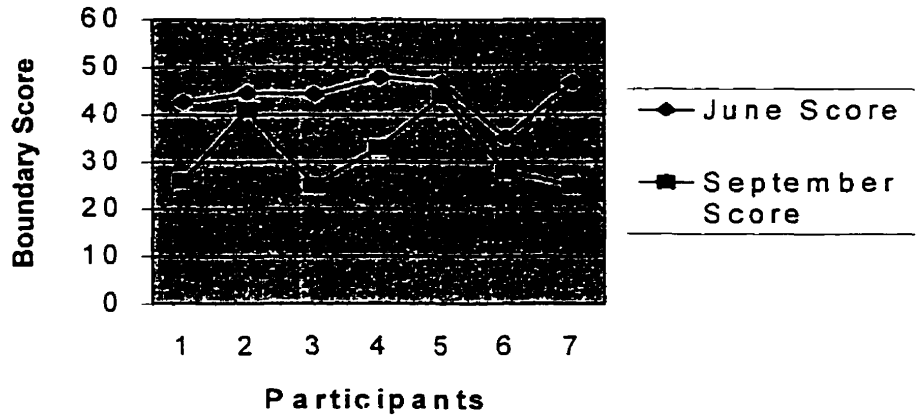
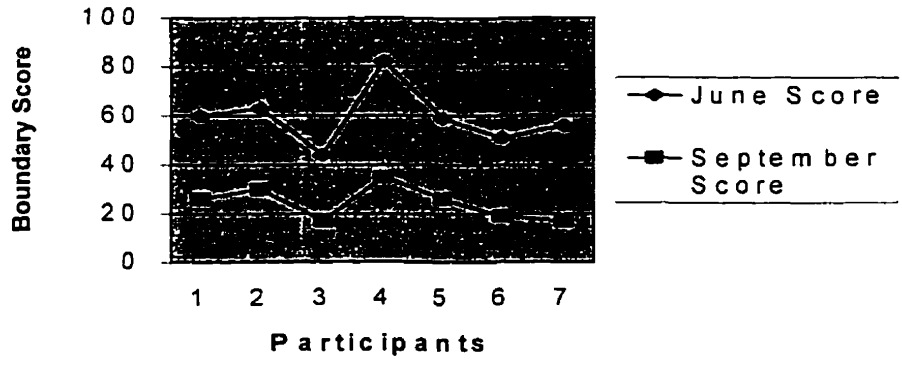


Table 6 -- External Boundary Scores

Participant	June Score	September Score	Change in Score
1	34	26	-8
2	33	30	-3
3	27	17	-10
4	47	35	-12
5	33	26	-7
6	32	19	-13
7	39	17	-22



Self-rating scales were completed by the participants at the end of sessions 1 to 11. As described above, the forms were a method of evaluating the participants' general response to the group session and their understanding of the session's educational component. Secondly, they were conducted to ensure that the objectives and agreed-upon plans were followed by the facilitator. The scales use a check-off format (scale 1-5) ranging from "definitely no" to "absolutely yes" with space for additional comments (see appendix G). The findings of the rating scales have been included at the end of the discussion of each of the eleven sessions in Chapter 4.

Attendance by the group members was fairly consistent with all seven women attending most of the sessions for a total of 94% attendance. However, one woman missed the first session because she had been scheduled to work prior to the group's beginning. Another woman left for two weeks to take care of her daughter in another province, and one was unable to attend two sessions because of child care responsibilities. Attendance numbers are included in the outline of the weekly sessions (see Appendix I).

The self-care plan (see Appendix H), which I had designed to encourage the women to begin a program of holistic self-care, was distributed at eight sessions. Although I encouraged them to use the forms, the women were told they were not required to complete a form every week if they chose not to do so. However, two women completed all eight plans; one woman returned only one plan; two others completed four, and two women completed six out of a possible eight forms.

At the second session each of the group participants had set a personal goal,

hoping it would encourage them in their growth and development. There was no specific focus on intervention methods, and achievement of the goal was not the primary objective. The women agreed that the process of growing and becoming was more important than the attainment of the goal. However, after the last session I asked the women to what extent their expectations had been attained, on a scale level of 1 to 5, 1 being low and 5 a high level. As Exhibit 1 indicates, the responses ranged from a level of 3 to 5.

Exhibit 1

INDIVIDUAL GOALS

Participant No.	Goal	Response
1	To tell my story in group	5
2	To demonstrate setting one boundary	5+
3	To begin to feel instead of being numb	4
4	To find out who I am	4
5	To discover something new about myself	3
6	To increase my self-worth	4
7	To tell one person outside the group that I am a survivor	5

The above results indicate that the 12-week group program, with a focus on boundary development, had a positive effect on the self-esteem level of most of the participants. A lower score indicates a more positive self-esteem. One of the women

who showed a slight increase in her score (30 to 35) on the post-group measure had been in court the previous day due to family problems and was feeling quite anxious on the day she completed the evaluation. This may be an indication that the score is sensitive to situational factors and that testing on another day may have yielded more positive results.

The post-group scores of the boundary scale indicate an increase in boundary development for all seven participants. Although the instrument appears to measure boundary development, the results should be viewed with caution. The scale had not been used with any previous participants and there are many questions regarding scoring, reliability, and validity. It is interesting to note, however, that the results obtained closely parallel the results of the Index of Self-Esteem. While there was no direct intervention with a focus on self-esteem, I had assumed that the self-esteem of participants would improve with improvement in boundary clarity.

The quantitative results of the weekly rating scales, according to the ratings by the participants, indicate very positive findings. The positive feedback regarding my facilitation and the members' understanding of the educational components must be viewed with caution, however. The women finished the scales very quickly at the end of each session, while I was in the room. Secondly, several of the women frequently expressed their gratitude in being a part of a group with other women who had experienced similar childhood abuse. According to Butler and Wintrom (1992), just being in an all women's group has a powerful effect on participants.

The responses to two questions in session five's weekly scale were somewhat

unusual when compared to the rest of the scores. The first question, "Do you believe the women in this group have the rights that we read from the "Bill of Rights?," was answered with "absolutely yes" (5) by all seven women. However, in response to the question, "Do you believe you have the rights we read tonight?," the response by most group members was "definitely no" (1), with one member scoring a "maybe" (3). The responses bespeak of the low sense of worth and self-esteem of the survivors.

The good attendance (94%) was another indication that group members were forming relationships with one another and feeling safe in their own space at the Women's Health Clinic. That no one dropped out of the program confirms that the energy spent on pre-screening was compensated for by the motivation and commitment of the participants. The commitment to the group by the participants undoubtedly had a positive impact on group development.

Individual goals, which are identified in Exhibit 1, were met to varying degrees. The goals which were identified by the women at the second session were not monitored or revised during the program. However, the three goals that were most realistic were attained by the individual women. For example, "telling my story"... "setting one boundary," and "telling one person I'm attending a survivor's group", were all attained according to the women's responses. The attainment of goals was a factor in the increase of self-esteem, according to the verbal feedback. The women felt they had the ability to grow and make changes.

Finally, the self-care plan added a dimension to the group program by providing an opportunity for the women to "take into account their own needs, interests, or

capacities in their perceptions of themselves or in living their lives" (Oakley, 1996, p. 264). Several women did not use the plans regularly, possibly because they did not have the extra time to participate in the daily activities. The two women who consistently completed the plan had no small children but noted that self-care, although useful, was time-consuming. They agreed that self-care helped them begin to see that they had "some worth." They also acknowledged they could see the linkage between self-care and the development of boundaries.

In general, the scores of the quantitative results concur with the findings of the qualitative results which are presented in the next section.

QUALITATIVE FINDINGS AND DISCUSSION

This section presents the results of the qualitative evaluation tools that were used in the group intervention. A discussion of the qualitative findings follows.

The qualitative findings of the practicum intervention include the results of the weekly rating scales' comments, two self-report questionnaires, verbal feedback, and my summary recordings. The qualitative findings of the practicum intervention are more consistent with a feminist framework, and were viewed as a significant part of the evaluation process. The two non-standardized, self-report questionnaires, and the comments section in the weekly rating scales, were intended to capture the women's subjective meanings and evaluation of their experience in the group program. The women were told that their feedback and input in the evaluations was highly valued and important in helping me improve future group programs. Both the Group

Evaluation (see Appendix Z_1) and the Group Boundary Evaluation (see Appendix Z_2) were completed at the end of session 12 by the seven women. The weekly rating scales, completed on a session-by-session basis, provided an evaluation of the process of the group program and of the overall results of the practicum intervention.

The information gathered through the use of weekly summary recordings of the interactions and behaviours of the participants, and of their informal verbal feedback was an additional useful component of the evaluation process. The information provided insight into the development of the group over the program's duration. While this method of evaluation was filtered through the lens of my experience and perception, and therefore biased and limited, it was used in conjunction with the results of several other measures. According to Reinharz (1992), "a range of methods allows a range of individuals or circumstances to be understood in a responsive way" (p. 213).

The following section includes a summary of the qualitative findings of the practicum intervention and includes the women's words which speak directly to their experience of the group program. According to Rossi and Freeman (1996), descriptions of group experience from direct quotations constitute data. Several themes, identified in the literature, emerged in the women's weekly comments and in their responses to the self-report questionnaires. The four themes include:

1. The Group Program
2. The Self (Internal Boundary)
3. Interpersonal Relating (External Boundary)
4. Boundary Development

The findings are presented and discussed below, according to the above four themes.

One of the primary themes evident was the significance of the interaction with other women in the group program. Their comments included reference to safety, trust, belonging, and "a place to be myself, after all those years". In the early sessions the women had reported feelings of isolation, fear, and anxiety.

The following includes women's written comments about the group program:

- the sharing with other women who had the same experience was great. I felt real.
- being in a safe place with a safe guide allowed me to clarify all those scattered thoughts in my mind. The pre-group sessions set the tone for group.
- the group was my release but it should have been longer. Please do one soon again.
- the boundaries were there in the topics and in the exercises. They made it clear for me. Knowing what to expect was a boundary for me.
- I liked the exercises that connected me to the child I once was. There's a lot more for me in this.
- the handouts were good. Very educational. They reminded me of the group from one week to the next.
- It's important to have safety from the leader who is guiding the group. It's who you are, not what you are. Thank you for believing in me.
- my goal was developing self-worth and self-esteem and I have succeeded. The affirmations helped.
- there was real respect for everyone. Respect for our boundaries in the group. You agreed with us that the advisor would not be present.

A second theme that surfaced in the women's responses to the qualitative measures included the reference to self, with sub-themes of feelings of loss, guilt, and shame. Additionally, several women made reference to the buried self as a protective measure in their early adult lives.

Comments reflect an understanding of the self as an internal boundary:

- I do feel much better about my worth but sometimes it is scary to listen to the inner self that was put away a long time ago. I know that it is all in there. But sometimes it is too overwhelming to acknowledge it.
- I can't even talk about it. My fear is, what if I'm not believed. This inner

boundary is what I need to work on. It's been a long secret. I denied it to my psychiatrist in my 20's. I wasn't ready to tell anyone.

- the clear picture of boundaries, the idea puts some meaning to all my struggles, the struggles inside me and the struggle with other people, internal and external.
- I'm seeing an improvement in who I am but I had no self so how could I know I was violated.
- there was no "I". Everything was a secret. The justice exercise helps to know truth is important.
- I can see the boundaries in the group, I mean the self or internal boundaries. The way we respect each other.
- actually I got in touch with the self when I turned 30. Before that I lied about being a survivor to a psychiatrist. It wasn't a safe boundary.
- my dad still looks at me in a sexual way. I react with inner terror and leave.
- I know I'll get better because now I know it's not me who's sick. The self is a boundary. It is everything to have a self-boundary.
- the inner boundary part is the hard part. The outer (external) boundary I can think through in my head.
- the shameful feelings are helped by affirmation. As my shame gets dealt with I begin to know who I am. As I develop an internal boundary I am able to set some limits with my kids.

The third theme reflected in the women's written comments was the concern about interpersonal relating. For example:

- It's real difficult to think of all the times my boundaries were violated as an adult. Not having learned I had a right to say no has cost me and my children.
- the revictimization makes me feel shame. I thought I had to comply. That's how it used to be. It takes time to learn that you can make decisions about who touches you when you grew up having no choice in it. Now I have some ideas.
- I am changing in my communication, not so aggressive with my mom. I think of the conflict statements we did.
- I'm learning to speak from within my core self. But it is not easy. The group helped me very much to practice this.
- I'm not using the communication very well. I am aware though and that is a hopeful feeling.
- Without admitting the truth, I cannot be close to my parents. Sometimes I want a family though.
- I try not to be as aggressive with people. It's hard to change. I feel very angry and lash out. But reading the handouts keeps me on track.

Finally, the Group Boundary Evaluation indicated that for all seven women the development of boundaries was a significant part of their healing and growth. Their

responses to questions 4 and 5 of the questionnaire follow:

How did the experiences in the group contribute to the development of boundaries in your life?

1. It helped me see that having boundaries is not just my right but my responsibility to others around me. It helped me know my limits and then letting others know my limits, too. I notice I cross my sisters' boundaries sometimes.

2. They made me re-evaluate my sense of myself. The leader's respect for each group member's boundaries and the sense of safety with her helped, e.g., expression that there would be no secret meetings if members met outside of group. Group would be informed. Also guidelines set out at beginning and starting and stopping on time.

3. The boundaries in my life are now more defined. They are more understandable to me. I also let others (rightly or otherwise) know when they are stepping on my toes and then ask if they can see it. This is most of the time but not always. Not yet!

4. I can be honest with group members and now I can be honest with my husband. I think now I am an okay person. Others in group looked normal so I am no freak either.

5. I feel more connected to people now. I don't feel so different and alone. Less anxious and able to do well in my job.

6. It helped me feel better about myself, which in turn helped me to value me. So if I have the same value as everyone else I have the same rights. Also I am still working on my boundary issues but at least I have started.

7. Made me aware that I have worth and so I can protect my own boundaries, now that I know what they are. They have a place in my life. Thinking about one term, internal boundary, is more clear than thinking about the many feelings inside. I'm starting to think more about my treatment of others too.

In your opinion, does the development of boundaries help the healing process in the adult survivor?

The seven women responded with:

1. Yes. I am beginning to see that boundaries were lacking in both of my parents and were the cause of my abuse and in me and its effects. In other words, across the board, not knowing our limits, our family crossed them freely, victimizing one another. So it is essential and important to development boundaries.

2. It is essential in healing but it is very difficult and tenuous. It does not happen quickly but over a lot of slow and arduous time. Learning what boundaries are is a beginning.

3. Boundaries I believe, is one of the major issues for survivors. HUGE, in fact because this was so confused early on in life and must now be reconstructed. But you know I am almost "glad" in a way, over considering all the injustices and gifts of growth because it gave me the opportunity to meet with real survivors, women who were sexually abused to understand on a special level; this has added yet another dimension and strength to who I am. THANK YOU!

4. I never thought I had the right to ask for anything. Self care helped me think about me. Liked the relaxation and music and story. I was calmed down, more so than in the psych ward.

5. Yes. Because you learn how to be in control of your own life and boundaries. Sometimes it is safe not to have the boundaries and sometimes you need the boundaries. You can open and close if you have them. Boundaries mean you can choose. Choice. You can say yes or no to hugs and touch. Ending the group with affirmations was very good. It was better than story or relaxation exercise for me.

6. Yes. Yes. Yes. Because you start to see yourself as important and valuable in a group. Just like you see everyone else and then watching others you start to know if they have rights, you have rights to say "NO".

7. Immensely. I can protect myself with me controlling the zipper and feel good about it. And know I can say something when my boundaries are crossed. The idea of boundaries makes it less difficult. It's not so confusing. Now when I'm feeling alone, guilty or anxious and all those other feelings, I know it's an internal boundary and I can do something about it.

The above data in the women's words indicate that a 12-week group intervention, guided by the principles of survivor therapy, was a positive experience for the seven participants. The results also indicate that the overall goals and group

objectives of the practicum were met. For most women, self-assessments and interpersonal relating improved significantly over the course of the group program. Women acknowledged that being aware of boundaries developed a sense of responsibility in their lives. They became more aware of their invasions in other people's boundaries.

The subjective findings of the women's perspectives indicate an increased understanding of the development of self and its linkage to interpersonal relating. All seven women noted that an understanding of the boundary concept was useful in the building and reparation of internal and external boundaries. This awareness was perceived as a major tool in the comprehension of the feelings of shame, guilt, loss, and anger, and in setting limits in relationships.

The findings of the intervention will be briefly discussed in the following sequence: First, the benefits of a safe group program will be considered, including my role in facilitation. Second, the two main themes, Internal Boundary Development and External Boundary Development will be discussed, and finally, practical implications of the intervention will be summarized.

In reviewing the results of the evaluation, it is evident that a safe setting was a major factor in the positive experiences by the group members. Consistent with the literature and the women's written feedback, one of the most important features of a group program is to ensure the safety of participants. According to Pearlman and Saakvitne (1995), "the work to identify the conditions and prerequisites for safety is the foundation of the group" (p. 242). The two pre-screening sessions with the women

were a significant factor in the development of trust and safety in the early sessions of the program. This appears to support the findings by McEvoy (1990) who states that "conducting screening interviews ... decreases a little of the members' initial nervousness"(p. 65). Additionally, women had the opportunity to locate and assess the group setting prior to the first group session. The post-group individual sessions with each of the women were a positive factor, helping the women deal with feelings about ending. A group for females only was seen as an important safety feature by the women, all of whom had been impacted by the effects of father-daughter incest. According to Cohn (1996), "an all-female group does not pressure women to experience themselves in already established ways" (p. 161). They begin to find and develop fundamental aspects of who they are.

The provision of structure in the form of a Session Guide, group agreements and objectives, and a topics list enhanced safety and security, giving members information about what to expect in each session and throughout the 12 weeks. According to Herman (1992), "the two most important guarantees of safety are the goals, rules, and boundaries...and the support system of the therapist...secure boundaries create a safe arena where the work of recovery can proceed" (Herman, 1992, p. 147).

Consistent with the literature on group work is the role of a positive therapeutic alliance as a contributing factor to the development of boundaries. According to the women's responses, I was able to consistently model and maintain boundaries in the group. Maintaining a sense of direction, starting and ending the group on time and

locking the doors were seen as boundaries and as enhancing safety by the women. In sharing my experience and skills as a group facilitator, I developed rapport with the women and entered their lives. Although a relationship between the group members and myself was based on collaboration, the maintenance and modelling of boundaries demonstrated to the women that there are "no contradictions between power and nurturing in a woman's self-identity...and that self-assertion and caring can coexist" (Bernardez, 1996, p. 246). Being assertive when appropriate and listening to the women's painful disclosures without appearing overwhelmed, appeared to help group members to begin to establish internal and external boundaries. Adopting a "traditional neutral stance often carries with it a distance-making threat that ultimately can be fatal in the therapeutic alliance" (Brody, 1987, p. 170).

Survivor therapy, with its origins in feminist theory and trauma therapy, guided the group intervention. The framework with principles of empowerment, validation, education, an emphasis on strengths, and the restoration of a sense of control over their lives further enhanced the safety of the women. Although the women were affirmed and encouraged to make their own decisions about group involvement, no one was coerced to contribute in the sessions. The decision by the women to decline the planned visit by my advisor to one session was seen as an ability to set a collective boundary. Although this decision came as a surprise to me, I acknowledged it as an appropriate external boundary. Butler and Wintram (1992) note that a "woman's refusal is a mark of assertion and can offer the group a source of discussion and growth" (p. 46). Starhawk (1987) points out the need for groups to have some control

over who comes in. However, had I asked the members at the first session about the advisor's visit the outcome might have been different. Clearly, the group had evolved to the point where individuals were empowered to begin to relate from the self to others. The women noted that they had felt some guilt about the decision, but that they had felt a sense of personal strength in contributing to the decision-making.

The educational component of the model incorporated a mini-presentation and handouts on the session topic. These handouts were viewed as "safety papers" by one of the participants. She said they were a lifeline to the security of the group and were useful in the practice of new skills in between sessions.

The conceptualization of stages provided another dimension of structure and predictability. Although not rigidly adhered to, each stage had a different focus. Stage one (sessions 1-3) focused on introductions and on the review and revision of goals, objectives and agreements. The purpose of stage two (sessions 4-7) was to focus on the development of internal boundaries. Exercises encouraged the expression of grief and loss and the development of self-identity. Stage three, that of external boundary work, focused on present day concerns and on the development of new skills in interpersonal relating. The concept of stages was a guideline only and merely facilitated the group process. Because the women in the group occasionally raised issues of past abuse and present symptoms simultaneously, the distinction between stages two and three was not always clearly defined in the group. The reference to railway tracks (one track symbolic of past issues and one track of present day concerns, with ties in between) clarified the linkage between internal and external boundaries for

the women.

In summary, the safety of the group was largely determined by the provision of structure in the early sessions, a structure that involved careful planning, and input from the group members. The structure and boundaries within the group were a contrast to the lack of structure and boundaries typical of the women's childhood environment. As safety and trust emerged in the group, the structure lessened and evolved into fluidity and flexibility in the second and third stages.

The second theme emerging out of the qualitative findings was the development of self and of internal boundaries. When the child victim accommodated to the wishes and judgements of others, she "gradually shut down the ability to experience her surroundings and her life" (Utain, 1989, p. 14). As she re-experienced the feelings of the child, the survivor connected with self and started the development of internal boundaries.

Techniques and strategies employed in the development of internal boundaries focused on identification and expression of feelings such as loss, shame and guilt, on decision-making, and on changing negative self-blame and shame to positive affirmations. A "personal rights" exercise, although initially not seen as valuable by the women in an earlier session, was discussed again at the last session and described as a useful exercise in reframing negative thinking. McKay (1991) agrees that boundaries can be repaired by "helping individuals own their feelings, identify their needs and wants, and define their personal rights" (p. 9).

Another technique the women reported as being useful in the development of

internal boundaries was a visualization of the childhood home, followed by letter writing to the adult woman from the young child. The exercise was very meaningful for the women and most agreed that going back to connect with the feelings of the girl, although very painful, was a way of beginning to feel the buried self. Utain (1986) describes this trauma work as difficult and long term. She notes that in order to change early distortions, the "survivor must go back to reexperience and complete the early traumas out of which she created decisions about who she is and what is acceptable" (p. 186). Going back and filling the developmental holes was acknowledged as an important part of the process of internal boundary development by the group members. As the women's emotional development grew in group, the gradual process of self-definition occurred, contributing to the formation of external boundaries.

The third theme identified in the women's response to the self-report questionnaires was that of external boundary development or interpersonal relating. The development of external boundaries is a relational process and includes the development of communication skills, conflict management, and taking care of personal possessions such as journals, clothes or letters. Exercises and techniques utilized in the building of external boundaries focused on learning new skills such as self-care behaviours, assertiveness, and setting limits.

According to the women, the conflict resolution exercise (see Appendix W) was an opportunity for them to practice being assertive and to make decisions in ranking the 12 statements. Role-plays in assertive communication were seen as instrumental in change for several women. This change in communication was not, however, always

well received when women risked vulnerability in interpersonal relating outside the group setting.

Another way to inspire the building of external boundaries was to encourage the use of folders for the journals, handouts and collages that the women made. This strategy is consistent with the suggestion of McEvoy (1990) who states that "articles revealing personal information are considered extensions of the person" (p. 73). The folders were usually brought to the sessions, with the women reminding each other to keep them safe at home. As the group members began to make behavioural changes, the process of defining the self and of internal development was enhanced.

Overall, the group intervention was perceived as positive, according to the results. I share that perception. Goals and objectives identified were met. Valuable aspects of the intervention, based on my perceptions and on the findings, were: first, there was a sense of "group" by the participants. The group was more than seven individual women in a setting; a sense of commonality and bonding evolved as the group developed. Second, the group was a safe place where members were able to identify and address issues of self-identity and interpersonal relating. Factors contributing to safety and trust issues were the identification and maintenance of boundaries within the group. The provision of structure, through the utilization of guides and group plans, and individual pre-group meetings with the women were useful in creating a safe environment within which to introduce expressive techniques and exercises.

Several exercises and techniques which were particularly valuable in the group

intervention were the cognitive-behavioural techniques, such as reframing negative thoughts to positive affirmations. The expressive techniques, such as writing a letter to the young girl, were viewed as particularly useful by the women in gaining control over the symptoms of childhood violation. Strategies and tools to help cope with anxiety and intense feelings provided a sense of hope and security when they left the group for their home environment. Overall, the results indicate that generally, awareness of a boundary concept was an empowering concept, and encompassing the women's internal and external realities.

IMPLICATIONS

While several strategies and techniques were employed in the intervention process of internal and external boundary development, it is difficult to separate the effects each exercise had on the intervention as a whole. The various aspects of the exercises, role plays, visualizations, and imagery, are interrelated and connected. However, as the results indicate, many were useful in the process of boundary development.

According to the literature, boundaries are developed in relationships. Intrafamilial child sexual abuse leaves the child with a loss of self. When the child's existence as a separate self is violated, she experiences a world in which she learns to relate from a false self, and is unable to set appropriate boundaries in her interactions with others. The long term effects of child sexual abuse include intra-psychic (negative self-perception, fear, anxiety, helplessness, shame, guilt, anger) and interpersonal

(parenting, revictimization, communication, conflict resolution) difficulties. As boundaries are developed the intra-psychic and interpersonal difficulties are reframed, and the women acquire the skills to protect themselves from revictimization.

Several implications are listed:

a) it is possible for survivors of childhood boundary violation to repair and develop boundaries in adulthood;

b) it is possible for such survivors to increase, to some degree, their level of self-esteem;

c) boundaries betrayed in the context of a relationship can only be rebuilt in connection with others

d) boundary development is an essential component in the healing process from childhood sexual abuse.

e) women survivors are able to put in the effort to change and to make decisions about the development of boundaries.

f) internal and external boundaries may be developed simultaneously, as women develop a sense of self and make behavioural changes.

In summary, boundary problems "arrive from a relative inability to conceive of self without reference to others and the reverse" (Briere, 1996, p. 54). Personal learning benefits and recommendations for future intervention will be outlined in Chapter 6.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

This chapter is a summary of the group experience and of personal learning goals, and concludes with suggestions for further intervention. The primary interventive goal of this practicum was to provide a 12-week group program for women survivors of intra-familial child sexual abuse. The intervention focused on the reparation and development of internal and external boundaries. Seven participants shared in commonality their fears, anxieties and isolation with one another. They developed skills in communication, conflict management and interpersonal relating.

That group work is a beneficial form of intervention is consistent with the literature of social work. Several authors have suggested that there are many specific purposes that are appropriate for growth and treatment groups. The purposes as cited by Wickham (1993) follow:

1. to enhance self-image;
2. to share anxieties and test judgements;
3. to learn to communicate;
4. to learn to relate to others;
5. for catharsis;
6. to resolve the conflict between wish and fear by reducing fear;
7. to externalize suppressed feelings;
8. to improve reality testing;
9. to aid in socialization;
10. to provide a treatment experience that would help the client to develop a sense of identity;
11. to motivate for therapy (p. 29).

The objectives of the group intervention focused on most of the purposes cited (see Appendix M).

While the results of the group intervention indicate the occurrence of change and growth in boundary development, changes occurring within group and in the individual members are "difficult to measure at the best of time" (Wickham, 1993, p. 125). However, according to the findings of this practicum, women did experience benefits such as decreased feelings of stigma, shame and isolation, and an increased understanding of self and interpersonal relating.

The group participants, having been denied the opportunity to develop boundaries during the formative years of childhood, came to group with a limited awareness of the demarcation between self and other. Both self-sense and boundaries had not been cultivated in the family of origin. The women, as young children, had done almost anything to survive, even blame themselves when there was trouble in the family. Because the child needed to survive she could not see anything negative about her parents. Consequently she experienced a gradual shutdown of her sense of self so she could suppress the reality of sexual abuse.

Years after the childhood sexual abuse, the group members recalled the confusion about double messages in the family of origin. They noted how they had been unable to be congruent in their actions and thoughts (what they knew to be true) unless the family allowed it.

When the image the child is expected to present is more important than what she knows to be the truth, the child loses her identity and is unable to develop boundaries. As the literature review indicated, the denial of reality may cause serious long term problems for the survivors.

According to all of the group participants, the long term effects of childhood trauma were latent for many years since childhood. They agreed that it would have been impossible for them to deal effectively with the childhood abuse much before the ages of 26 - 32. While they had not chosen to face the issue today, they had been unable to contain the impact of their trauma. Another point of consensus regards legal proceedings. Although one father had been convicted of child sexual abuse after the offence became known to a counselling agency, not one of the seven women had considered taking their father to court.

Three of the women revealed sexual boundary violations by professionals and expressed shame and stigma about not stopping the abuse. Consistent with the literature, this feeling of powerlessness and helplessness is related to the survivor's self-identity, resulting in difficulties asserting her wishes (Courtois, 1988).

Boundary development is an ongoing process, however its crucial stages are in the developmental years of childhood. When survivors have been denied the opportunity of developing boundaries in childhood, group intervention may be an effective intervention to help fill in the developmental hole.

LEARNING BENEFITS

Personal learning goals of this practicum were to enhance my skills in group work with survivors, and to increase my knowledge of the long term effects of child sexual abuse, of group work, and of the boundary concept, and finally to develop and administer methods of evaluation. In retrospect, I have learned more than I had

anticipated.

Some highlights of my learning have come from the women in the group. Their tenacity and courage, in spite of sometimes overwhelming circumstances, has inspired and taught me much about the impact of child sexual abuse on the adult survivor. Focusing on the women's experience has given me a greater understanding of the ongoing boundary violations in their adult lives. This practicum intervention has also provided a wealth of personal lessons as a group facilitator. The experience has taught me about the importance of maintaining and modelling boundaries as a group facilitator. I learned that the development of rapport and sharing is not a violation of boundaries but a contributing factor to group growth.

Although I had facilitated groups previously, this was the first time I used more than one evaluation measure. While I had some concerns about the possibility of the impact of the evaluations on the women in the group, I learned about the importance of outcome measures and hope to expand my learning in this area. In future group programs I would probably use fewer evaluation measures.

My style of facilitation was more structured in this group than in previous situations. I tended to be more focused and goal-oriented. Perhaps it was because one of my learning objectives was to be more structured and focused in my facilitation. Additionally, I was aware of the session-by-session rating of my facilitation style by the women. Furthermore, this group project was one of the requirements in completing a social work practicum.

I believe I am more comfortable in a less structured, more flexible group environment. Although Yalom (1985) indicates that the most productive group programs are unstructured and freely interacting, survivors may feel safer in a more structured group setting. I believe that survivors, whose childhood environment was a place of insecurity and confusion, need the safety and security of structural boundaries, especially in the early sessions of a group program. While it is important to provide structure in group work, the worker must also attend to the development of skills in balancing structure and flexibility in group work.

Efforts to promote interpersonal relating, through the use of exercises and role-plays, have provided new learning for me. My style had been to focus on insight and on thought processes, assuming that fostering insight had greater promise for change. I believe that the focus on self continues to be useful in behavioural change but that behavioural approaches also provide benefits for the development of self.

Through the review of the literature and my clinical work I have learned that I need to address the effects of trauma work in my life and to care for myself. Working with traumatized individuals exacts an emotional cost. Without self-care and the maintenance of boundaries in my life, my contribution to a journey of hope and healing would not continue.

Finally, the review of the literature has enhanced my understanding of women and boundaries, group intervention with survivors, the impact of child sexual abuse and the importance of boundaries. The creation of a boundary scale contributed further to my learning and understanding of boundary issues and of evaluation. The increase in

skills and knowledge in these areas all point to the achievement of the personal goals for this practicum.

RECOMMENDATIONS

This practicum intervention has generated several suggestions for future intervention. First, it would be beneficial to offer a "pre-group" to those interested in a group program focusing on boundary development. I believe it would be beneficial for the potential members and facilitator if this "pre-group" focused on educational topics, on general issues about the long term effects of child sexual abuse, and on the provision of information regarding the goals and objectives of the group. I would not extend the 12-week group program. Women have difficulty making a commitment to more sessions at the time of commencement. I would, however, offer a second and third 12-week group program to those interested. Furthermore, I would offer a six-week follow-up program to the 12-week group with a focus on specific topics such as parenting, sexuality, spirituality, communication, family of origin, and others as requested. I would explore with women any concerns regarding the tools used in evaluation and share the results with them.

Future intervention and evaluation might focus on the different types of boundaries, for example, rigid, defensive, enmeshed or permeable boundaries. Tools to measure boundaries, such as the one developed in this practicum, need to be developed and refined. The exploration of boundary development from the relational perspective, rather than from the individuation/separation perspective, is an additional

suggestion for further study.

There is a strong need for ongoing training to deal effectively with sexual abuse issues. Professionals receive little preparation to work in the field of sexual abuse. Social work should review educational priorities and expand curricula to include courses on the prevention and treatment of incest and sexual boundary violations. Programs or workshops offering training and awareness of ethical boundaries in the therapist-client relationship should be provided for professionals in clinical work.

Politicians cannot afford to be indifferent to the impact of child abuse. Governments must take responsibility in providing leadership and resources in the provision of available services. The Province of Manitoba should consider changing its policies and procedures (August, 1993) pertaining to the service demands of survivors of incest, and include them in the mental health priority group.

The impact of child abuse is taking a high toll on society. Failure to deal with the plight of its victims can be disastrous to a society. Intervention with survivors rebuilds in them a sense of confidence, hope, and trust as they strengthen and repair boundaries that increase responsibility and autonomy.

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APPENDICES A-Z_2

APPENDIX A

POSTER
GROUP FOR SURVIVORS OF SEXUAL ABUSE

Group counselling will be offered for women survivors of childhood sexual abuse. Potential group members will be screened in late May and early June, 1995. The group will be facilitated by a counsellor experienced in group work and in the area of sexual abuse counselling. The group of 6-8 women will meet for 12 consecutive weeks. Each session will be two hours in duration. There is no fee to be a member of the group. Session themes will include: communication; self-care; feelings of guilt, shame, and loss; conflict resolution; and the development of boundaries.

Those wishing to participate, or those wanting additional information, may contact Lydia Loewen at 453-0357. The sessions will be held at the Women's Health Clinic, 419 Graham Avenue, Winnipeg, MB. I look forward to meeting you.

APPENDIX B

INFORMATION SHEET

This sheet is intended to give you some information about the Women's Survivor Group. My hope is that it will be of some help to you in deciding whether or not to join the group.

The group is for women who have experienced childhood sexual abuse. It will be a place where members will be empowered to take control of their own healing and to move at their own pace. The approach is based on strength, validation and growth. The subjective experience of the women's work is accepted and validated.

The group will be a safe place and is designed to develop boundaries and to promote growth and healing through self-assessment and the development of new skills in the interactive context of the group.

Where:	Women's Health Clinic - 947-1517 419 Graham Avenue, 2nd floor
When:	Wednesday evenings from 6:30 - 8:30 p.m. June 21 - September 13
What:	Topics may include: self-care; feelings of loss, guilt, shame and anger; the inner child; conflict management and communication; boundary development, and relationships.
Facilitator:	Lydia Loewen - 453-0357

APPENDIX C

SUGGESTED QUESTIONS

1. How do you feel about joining a group?
2. Have you had previous individual counselling?
3. What do you hope to get out of the group counselling?
4. Have you ever discussed the abuse with anyone else?
5. Do you have some supports outside the group?
6. Are you able to discuss the abuse with at least one safe person?
7. What was your age at the initial abuse?
8. What was your relationship to the offender?
9. Would you consider the abuse to be a one-time incident/months/years...?
10. What coping strategies have you used?
11. Do you have any questions you'd like to ask?
12. Are you able to make a commitment to attend the group for 12 weeks?

APPENDIX D

BOUNDARY SCALE

NAME: _____ DATE: _____

This instrument is designed to measure what you think your boundaries look like. It is not a test and there are no wrong or right answers. Please rate each statement as carefully and accurately as you can. Beside each item indicate the degree to which it occurs.

		Very much	Pretty much	Just a little	Not at all	Does not apply
1.	I have difficulty making decisions.					
2.	I am able to say no when I want to say no.					
3.	When I am close to others I lose myself.					
4.	When others invade my boundaries I notice it.					
5.	I give as much as I can for the sake of giving.					
6.	I know where I end and others begin.					
7.	I have difficulty ending a telephone conversation when I want to.					
8.	When I disagree with someone I am able to say so.					
9.	I try to please other people even if it means neglecting my own needs.					
10.	I disclose only as much information as I want when others ask me a question.					
11.	I tend to shut people out of my life.					
12.	I have the right to say who touches me and how much.					
13.	I accommodate to the wishes and judgements of others.					
14.	I am able to say no to sexual intimacy.					
15.	When I am asked a question I respond automatically with personal information.					
16.	When other people are hurting I tend to take on their pain.					
17.	When people get close to me I become anxious.					
18.	I feel rejected when my needs are denied.					
19.	I am clear about what I like and what I don't like.					
20.	I take responsibility for the choices I make.					
21.	I feel isolated from other people.					
22.	I have difficulty setting limits for my children.					
23.	When I do set limits I have difficulty enforcing them.					
24.	I sometimes feel like I am the target of other people's comments or thoughts.					
25.	I have a clear sense of my self-identity.					
26.	Other peoples' rights are more important than mine.					
27.	When I initiate things I follow through to completion.					

APPENDIX E

CONTRACT FOR CLOSED GROUP

I _____ agree to participate in a 12 week group for survivors of childhood sexual abuse. Lydia Loewen explained the purpose of the group and informed me that she is a student in the MSW program at the University of Manitoba. I am aware that Lydia Loewen will be submitting a written report to the University and present an oral report to the Masters Committee upon completion of her practicum. I understand that no identifying information will be included in any of the reports or in the discussions with the two committee members and key advisor outside of the group context.

I will keep confidential all information about the women in the group and experiences of members will not be discussed outside the group.

I understand that it is important to attend all sessions (except in the case of emergencies, illness, etc.).

_____ _____

Group Member Facilitator

_____

Date

APPENDIX F

SESSIONS GUIDE

CHECK-IN

HOUSEKEEPING

DEBRIEF LAST SESSION

TOPIC OF THE DAY

(BREAK)

EXERCISE

DISCUSSION

CLOSURE

APPENDIX G

EVALUATION OF SESSION 10

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

1. a) Did the facilitator clearly present / diagram the core self within the context? ☐

   b) Was the diagram helpful in understanding how it may be difficult to act / talk from the core self? ☐

2. a) Did the facilitator clearly present the difference between internal and external boundaries? ☐

   b) Was the presentation helpful in your understanding of the difference between internal and external boundaries? ☐

3. a) Did the facilitator discuss how clear boundaries my be helpful in growth and healing? ☐

   b) Is the group helping you understand how boundaries may be helpful in your growth and healing? ☐

If so, in what ways?

_____

_____

_____

_____

_____

_____

APPENDIX H

Name: _____ Date: _____

SELF CARE PLAN

	SLEEP	NUTRITION	EXERCISE	RELAXATION & MEDITATION
Thursday				
Friday				
Saturday				
Sunday				
Monday				
Tuesday				
Wednesday				

Comments: _____

_____

_____

APPENDIX I

WEEKLY SESSIONS

STAGE ONE - INTRODUCTION TO BOUNDARY CONCEPT

Session 1
Introductions, Objectives, Agreements
"Myths" exercise
Handout "Child Sexual Abuse"
Attendance – 6

Session 2
Boundary concept and self-care
"String" Exercise
Handout "Self-Care Plan" and "Intense Feeling Care"
Attendance – 7

Session 3
Effects of child sexual abuse on boundary development
"Collage" exercise
Handout "Boundary Concept"
Attendance – 7

STAGE TWO - INTERNAL BOUNDARY DEVELOPMENT

Session 4
Themes of loss and remembering
"Letter-writing" exercise
Handout "Loss"
Attendance – 7

Session 5
Themes of shame and guilt
"Cognitive restructuring" exercise
Handout "What is Shame"
Attendance – 7

Session 6
Constructive expression of anger
"Bill of Rights" exercise
Handout "Dealing with Anger"
Attendance – 6

Session 7
Forgiveness and justice
"Justice-Making" exercise
Handout, "Relaxation"
Attendance – 7

STAGE THREE - EXTERNAL BOUNDARY DEVELOPMENT

Session 8	Communication and boundary setting "Role-Play" exercise Handout, "Communication Styles" Attendance – 6
Session 9	Conflict resolution and boundary setting "Decision-Making" exercise Handout "Affirmations" Attendance – 6
Session 10	Revictimization and boundary setting "Who Am I" exercise Handout, "The Core Self" Attendance – 7
Session 11	Family of origin and boundaries "Why Did This Happen" exercise Handout, "Boundaries and the Family" Attendance – 6
Session 12	Ending, Celebration, Affirmations Group and Boundary Evaluations Attendance – 7

APPENDIX J

SELF-CARE FOR INTENSE FEELINGS

Feeling the pain is part of the healing process. When intense feelings overwhelm you, it may be difficult to think. Keep this sample list in a handy place for quick reference.

1. Breathe deeply while counting.
2. Take a warm bath.
3. Listen to music.
4. Hold a soft cushion or teddy bear.
5. Smell perfume or vanilla.
6. Look at a colourful picture.
7. Taste something sweet or sour.
8. Press feet into floor.
9. Exercise / Walk
10. Put feelings into a container with a lid.

APPENDIX K

GROUP AGREEMENTS

1. The group will meet for 12 weeks and will meet for two hours each week.
2. The group will have seven members and one facilitator.
3. The group will meet in the large room on the second floor at the Women's Health Clinic.
4. The group will begin and end on time. (6:30 – 8:30 p.m.)
5. Specific topics related to the development of boundaries will be discussed.
6. The group is for women who have been sexually abused as children within the family setting.
7. Members will keep confidential all information about the women in the group and experiences of members will not be discussed outside the group.
8. The group will be a safe place where members will move at their own pace.
9. There will be an opening and closing exercise each session.
10. There is no fee to be a member of the group.
11. Various methods will be used, for example: drawing, imagery, relaxation, story-telling, collage-making, writing, role-playing, etc.
12. There will be a 10 minute break mid-way through the session.
13. Beverages will be available at all times.
14. Expression of feelings will be encouraged.
15. Articles and books may be "signed out" for return the following session.

APPENDIX L

THE MYTH EXERCISE

MYTHS ABOUT CHILD SEXUAL ABUSE

This true or false handout is to raise awareness of personal beliefs about child sexual abuse and to stimulate discussion and to enhance bonding and commonality in a group. Read each statement, then circle true or false. When finished discuss your response to the statements with the group members.

		TRUE	FALSE
1.	Children provoke sexual abuse by their attention seeking behavior.	T	F
2.	It is very rare for a woman to have been sexually abused as a child.	T	F
3.	Child sexual abuse is usually an isolated incident.	T	F
4.	The most frequent offenders of child sexual abuse are unknown to the child victim.	T	F
5.	The stigma of sexual abuse is placed only on the offender.	T	F
6.	Children lie about sexual abuse.	T	F
7.	The child is usually physically forced into sexual abuse.	T	F
8.	It is easy to heal from child sexual abuse once it is disclosed.	T	F
9.	When confronted with child sexual abuse most offenders will admit the abuse.	T	F
10.	Children believe that the abuser is bad.	T	F

APPENDIX M

GROUP OBJECTIVES

1. To break the isolation and shame by giving members an opportunity to interact with others in a supportive and non-judgemental setting.

2. To express painful memories and feelings such as loss and anger and learn to express them appropriately.

3. To experiment with boundary work and issues of trust and safety within the group context.

4. To learn to say yes when that is appropriate and to learn to say no when that is appropriate.

5. To begin to develop a solid sense of self and begin to trust own judgement.

6. To begin to develop new skills in boundary setting so members will have tools they can use outside the group (self-care behaviours; communication skills, etc.).

7. To learn about child sexual abuse and its related themes: women and boundaries, the effects of child sexual abuse, feelings of guilt, shame, and anger.

8. To begin to take control over actions and to be empowered to move on to a more positive future.

APPENDIX N

MY GOAL

Please state below, in one or two sentences, a specific goal you hope to achieve while a member of the group.

In this group I want to _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NAME: _____

DATE: _____

APPENDIX O

CHILD SEXUAL ABUSE

According to an extensive Canadian study one in two females and one in three males will experience unwanted sexual acts before the age of eighteen. The trauma of child sexual abuse is profound and pervasive. Incest by a trusted family member shatters the child's view of the world as a safe and predictable place. The child is deprived of forming a secure relationship with a loving adult and has difficulty in the development of boundaries and of the self. The development of the self during childhood is essential to the development of boundaries. A sense of self and of boundaries are learned first from the family of origin and later from other people. In order to survive and to form primary attachments to care takers, the child identifies the parents as good and herself as bad. She develops a "false self" if who she is is unacceptable; she wants to belong and not be rejected. Relating from the false self or "people pleasing" self is a substitute for personal boundaries. The long term effects of a loss of self results in difficulties with internal and external boundaries in the life of a survivor. However, the difficulties may disappear after supportive individual and group counselling, suggesting the difficulties were actually admirable survival strategies.

APPENDIX P

BOUNDARY CONCEPT

A boundary is that area which is your own. It is a "line" that marks where I end and you begin. Whether or not we are aware of our boundaries, we all have them. There are invisible (emotional or personal) and physical boundaries. An example of a physical boundary could be a fence, a door, a yellow police tape, or the walls of a room or the skin on your body! An easy way to think of your personal boundaries is as a set of rules you set for yourself – rules about how you allow other people to treat you (and how you treat others). Boundaries are learned first from our family of origin and later from other people. They allow for freedom and security and preserve integrity and dignity. They give us freedom to say no without feeling guilty. We can strengthen boundaries by:

1) increasing awareness of the true self,
   - feeling (not denying) the guilt, sadness, anger, etc.
   - communicating assertively and honestly
   - defining the self; the "who am I"

2) identifying childhood violations,
   - what happened and how did this affect you

3) clean up present boundaries
   - look closely at current relationships; those that need your support (children) and those who are peers and not in a power imbalance. You should feel free to tell peers what you want. Take care of yourself and then if you freely choose to help / support them, do so. Decide what you want and then say what you want. You have the right to make decisions about your life. The goal of boundary development is to be aware of the "I" component and the "we" component <u>without</u> compromising the self.

APPENDIX Q

LOSS

When you first become aware of what you have lost through the child sexual abuse you suffered, you may feel hopeless. You may feel you have been cheated, deceived and robbed of a fulfilling life. They took away your freedom; freedom to come and go without anxiety and fear. They took away your safety; safety of feeling comfortable with other people. They took away your feelings. The pain was too much and so all the feelings had to be buried, including the joy.

While it is true you have been cheated, understanding this fact means there is much hope for you; that you are on the road to recovery. You are now an adult who can care for that vulnerable part of you (the little girl) and begin to express the feelings of sadness and anger (internal boundary development).

As a member of this group you are on a journey of healing and of learning new skills. Healing from the effects of the abuse, and moving steadily to a more positive future is the development of internal and external boundaries.

APPENDIX R

SHAME AND GUILT

Shame is a feeling of being inferior to others. It is internalized as an identity and "makes me feel bad and flawed." Shame comes from blaming the self and leads to low self-worth. It reveals the self inside the person, exposing the self to others. When this self is not okay (or I'm ashamed of who I am) it is difficult to develop boundaries. Shame comes from secrecy and silence in families, and from being abandoned emotionally and/or physically. You can recover from shame by strengthening boundaries, through self-accepting and self-caring affirmations, and by stopping negative thoughts.

Just because you feel shame does not mean you have done anything wrong. Shame comes from others putting it on you. When you have done something wrong you may feel guilt. But guilt is not shame. Guilt is a judgement of behaviour, and shame is an evaluation of yourself. With healthy guilt there is the opportunity to make amends. Shame leaves you feeling there is little you can do.

APPENDIX S

PERSONAL BILL OF RIGHTS

As boundaries are developed, we begin to understand that all human beings have certain rights. When boundaries have been violated in a child's life, the adult survivor may have difficulty believing she has these rights. YOU DO!

1. I have the right to say "no" without feeling guilty.
2. I have a right to joy and peace in my life.
3. I have the right to make decisions.
4. I have the right to make mistakes.
5. I have the right to change my mind.
6. I have a right to give and receive unconditional love.
7. I have a right to feel anger and express it appropriately.
8. I have the right to dignity and respect.
9. I have the right to choose.
10. I have the right to relax and to care for myself.
11. I have the right to feel fear, guilt and shame and then to let go.
12. I have the right to grieve my losses.
13. I have the right to withhold personal information.
14. I have the right to disagree with others and not feel guilty.
15. I have the right to develop and to grow, physically, mentally, emotionally, and spiritually.

APPENDIX T

ANGER

Anger is a basic human emotion. It is one of the most difficult feelings to express. However, when expressed in an appropriate way, anger may be constructive for you and for those around you. If you don't express the anger it may harm yourself or others. Anger is a natural response to childhood sexual abuse. As a child you may have blamed yourself and turned the anger inward to the child or young teen instead of focusing it on the abuser. Anger turned inward can lead to depression, moodiness, shame, illness and self-destructive behaviour.

When anger is expressed in constructive ways, it becomes a valuable resource for positive change and healing. Tips on the expression of anger are listed below:

TIPS ON EXPRESSING ANGER

1. Speak out
2. Find a safe place to scream
3. Write a letter expressing your anger to the offender
4. Punch a pillow
5. Join an exercise club and work out

APPENDIX U

JUSTICE-MAKING

(Adapted from Marie Fortune 1991)

This exercise is valuable in the healing and development of boundaries. An understanding of justice is essential to feeling empowered. Walking through the first six steps, as they relate to a particular situation, assists individual resolution and "letting go".

1.	TRUTH-TELLING	- telling the truth - breaking the silence and being heard
2.	ACKNOWLEDGEMENT	- actively acknowledging the truth (if the perpetrator denies the truth someone else must listen and acknowledge the truth)
3.	COMPASSION	- to suffer with, to reveal suffering (both victim and offender need a separate safe place/person to disclose in)
4.	PROTECTION FOR THE VULNERABLE	- the less powerful must be protected from further harm by the community and the perpetrator
5.	ACCOUNTABILITY	- perpetrator must be held accountable for what he did, (not blamed, but be held responsible) not the survivor
6.	RESTITUTION	- a concrete way of making right what can be made right; ask the "wounded" what she/he needs and cooperate with those needs
7.	VINDICATION	- not revenge but the setting free from bondage, moving towards "letting go" and possible restoration - sometimes reconciliation is possible; sometimes it is impossible (especially when the perpetrator is not open to change and growth)

(This is a valuable exercise in many other situations involving boundary violations, disputes, conflicts, triangulations, etc.)

APPENDIX V

COMMUNICATION STYLE

There are three basic types of communication.

Assertive: speaks in a sure, calm and clear tone of voice. It is expressing how you feel in a direct and honest way. It is expressing yourself in such a way that shows respect for yourself and for those you are speaking with.

"I feel hurt when you say that to me."

Aggressive: usually loud and direct. Can also be soft and manipulative. Feelings are usually honestly expressed. The opinions and wants are honestly stated but at the expense of others. This is standing up for your self in such a way that violates the rights of another person.

"My way is the only way." The goal is to win; to be right.

Passive: (or Non-Assertive) usually tends to speak softly or hesitantly. True feelings and opinions are usually not expressed. Eye contact may be missing and posture conveying a message of submission. It's failing to stand up for oneself in such a way that your rights are easily violated. The goal is to appease.

"Your feelings and opinion are more important than mine."

APPENDIX W

GROUP DECISION-MAKING EXERCISE:

AN EXERCISE IN CONFLICT RESOLUTION

1. Each member is asked to read and carefully consider the following 12 statements.
2. Each participant, without consulting others, should rank the statements from (1) to (12), placing (1) in the blank next to the statement with which you most agree, a (2) next to the statement you agree with the next most, and so on through (12) the statement you disagree with most strongly.
3. After you have completed the individual rankings, the group then must reach one overall ranking from (1) to (12) of the statements. This ranking must be agreeable to all members of the group.

GROUP DECISION-MAKING WORKSHEET

Individual	To Heal From Child Sexual Abuse The Victim Must	Group Consensus
_____	Understand the abuse was not her fault.	_____
_____	Confront the abuser.	_____
_____	Tell someone about the incest.	_____
_____	Grieve the lost childhood.	_____
_____	Forgive herself.	_____
_____	Feel the pain of the little girl.	_____
_____	Feel compassion / love from another person.	_____
_____	Forgive the perpetrator.	_____
_____	Have clear memories of the abuse.	_____
_____	Express the anger.	_____
_____	Acknowledge the abuse.	_____
_____	Find a safe setting to tell the story.	_____

CONFLICT RESOLUTION EXERCISE

A. Suggestion For Group

1. Make sure all members are involved.
2. Do not be defensive (paraphrase others words).
3. State your views gently but assertively.
4. Listen carefully and "hear" what the other is saying.
5. Invite the hidden "below-the-surface" conflict (eg. prod gently).

B. Make an effort to use the sample statements / questions below

1. What are the points we agree on?
2. Are you saying that you...?
3. Could you repeat that?
4. How do you feel about my view?
5. I'd like to understand your point.
6. We haven't heard much from _____ yet.
7. I respect your opinion but I have difficulty changing my view.
8. Maybe I could change #_____ to #_____; your view makes sense to me.
9. Where does everyone stand?

APPENDIX X

AFFIRMATIONS

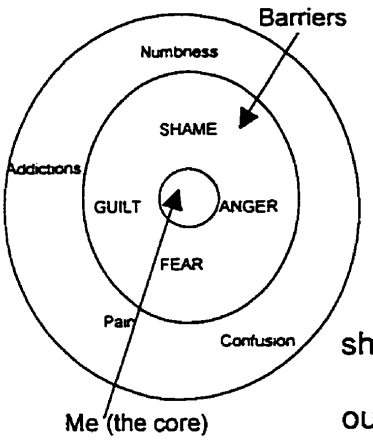
Affirmations are positive statements (thoughts) that can replace negative thoughts. One way of replacing negative thoughts with positive ones is to say out loud new, positive thoughts and statements again and again.

1. I am growing and changing every day.
2. I am a loveable person.
3. I am able to change negative self-talk to positive thoughts.
4. I like who I am.
5. I'm a good driver / listener / mother.
6. I am growing more confident.
7. I have an authentic, true self.
8. I am able to build internal boundaries.
9. I am learning to communicate effectively.
10. I am able to develop external boundaries.

APPENDIX Y

THE CORE SELF

We all have a core self. It is the natural true self that doesn't need to prove anything. If we have been hurt or violated the real self may have gone into hiding but, we still have it deep down. In order to protect the self (to survive) we may have built a wall of fear, anger, shame and guilt (a false or pretend self) so others can't see our core self is hurting. As we begin to heal our core issues, we begin to develop boundaries.



Peeling away the layers of the false self, which are constricting the authentic true self, includes grief work and the development of self-responsibility through experiential, cognitive and behavioural strategies.

EXERCISE

Find your core. Breathe deeply. Loosen up. Feel your centre. Focus within. Relax. Feel your inner life. Allow yourself to go way down inside yourself. Allow your thoughts to let go. Don't hold back. Listen to what you hear. Who are you, separate from others? Write it down or say it. Be spontaneous and share what you want to share.

APPENDIX Z_1

GROUP EVALUATION

Please take a few minutes to complete this evaluation. It is important for the group worker to have some feedback from you in order to improve the group. Your input is deeply valued.

1. What was most helpful about the group? _____

_____

_____

2. What was least helpful about the group? _____

_____

_____

3. Should the group have been longer? Shorter? _____

_____

4. Do you think the number of members in the group was the right number? If not, how many members should be in the group? _____

_____

5. Of all the exercises which one was the most useful to you? Why? _____

_____

6. Which exercise was the least useful to you? Why? _____

_____

7. Do you have any suggestions to help me improve the group? _____

_____

_____

8. Any further comments? _____

_____

APPENDIX Z_2

GROUP BOUNDARY EVALUATION

1. In what ways did the group experience contribute to your understanding of the boundary concept? _____

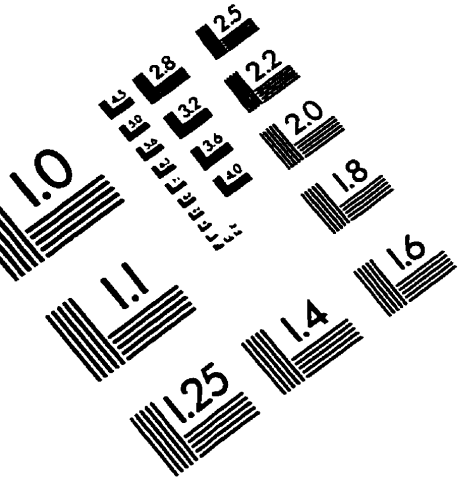
2. Was there enough structure within the group to help you feel safe? Too much? Please comment. _____

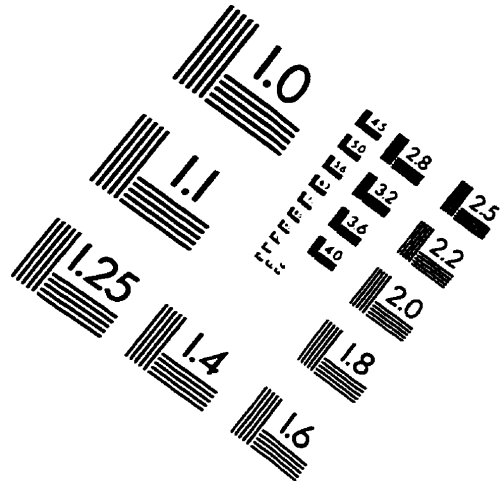
3. What did you see as boundaries in the group? _____

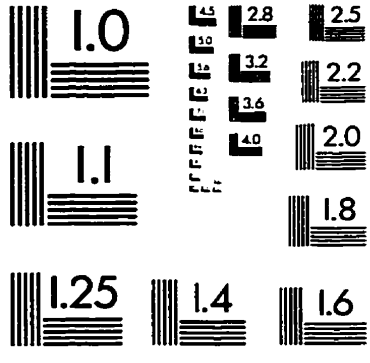
4. How did the experiences in the group contribute to the development of boundaries in your life? _____

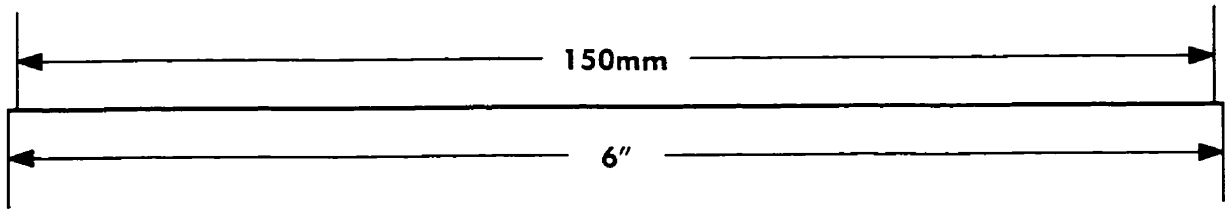
5. In your opinion does the development of boundaries help the healing process in adult survivors? _____

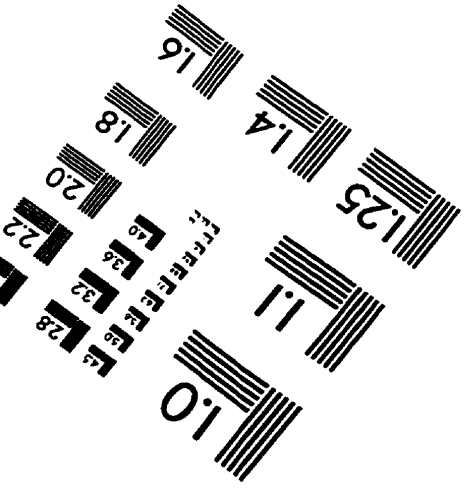
IMAGE EVALUATION
TEST TARGET (QA-3)

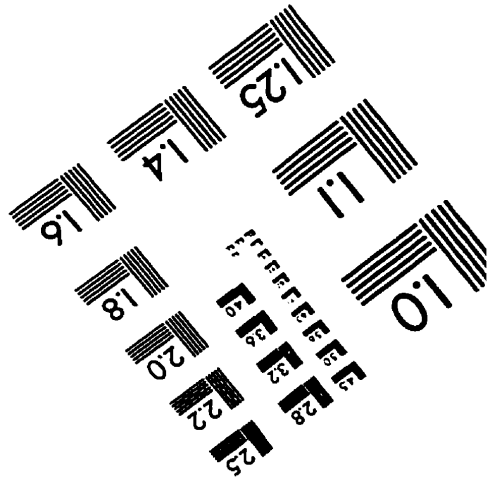












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