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Adolescent Family Survivors of Sexual Trauma: Program Development

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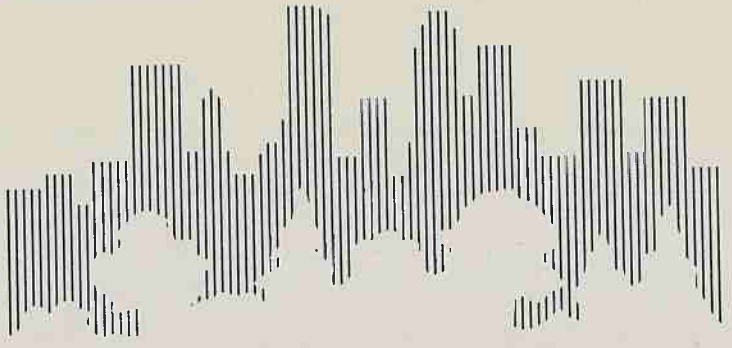

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MASTERS IN SOCIAL WORK THESIS

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Adolescent Family Survivors of Child Sexual Trauma: Program Development

1993

ADOLESCENT FEMALE SURVIVORS OF CHILD SEXUAL TRAUMA:

PROGRAM DEVELOPMENT

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of the Graduate Program of Augsburg College

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ABSTRACT OF THESIS

This thesis will explore theory and propose a program specific to the needs of a particular population of adolescent female survivors of child sexual trauma. This population of adolescent and young adult females are the runaway, throwaway and homeless survivors of child sexual trauma that I have had the opportunity to work with for the past three years as an outreach worker. These survivors have had a history of sexual violence and too little support to enable them to heal from these experiences. This thesis focuses on expanding current outreach services to this population of young women grounded in an exploration of the current literature. The expansion of services involves the development of a comprehensive abuse healing program with group work as the chosen method of treatment. Theory and program development will take place within a framework of feminist theory drawing on empowerment models, personal and professional observations and experiences. The proposed program's structure, goals, and curriculum will attempt to reduce and undo some of the fear, isolation and loneliness that pervades much of the lives of the young survivors in this group. It will offer a nurturing and non stigmatizing environment of care aimed at providing an opportunity for both individual healing and collective group empowerment.

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And last, a very special thank-you to Kimberley Johnson, my friend and lover for staying up with me those nights and for nurturing and caring for me. Without this tending to me and the children, I would not have completed this thesis.

This has truly been a collaborative effort.

DEDICATION

This thesis is respectfully dedicated
to the young female survivors
I have been privileged to work with,
and grow from,
this past few years.

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CHAPTER I

Introduction

A. Overview

Practitioner's Poem
By Nancie Palmer

I honor your act of courage
inviting me to join your journey to freedom
You - who seek to unchain your bondage
from a heritage of fear
To banish the ghosts of oppression
To break the silence which surrounds
your soul.

I am humbled by your presence
exquisite testimony of a will to survive.

In honoring you I bring with me my work
- a knowing search of my own soul
That my ears - once full of raging
sounds from my own battles- now hear
the message in your pain
That my eyes - once blinded from lost self
see your light in the emptiness
of the abyss.

I am strengthened by our humanness
for are we not - all seeking a way
to survive.

Come let us walk together-
In gratitude I join your path
For I will never be the same
You have touched me. (Source unknown)

Chronic sexual abuse of female children is so pervasive in our society that all girls and women have been intimately affected by it, whether or not they have been the direct victim of a sexual attack.

As survivors or sisters, mothers, daughters, lovers/partners, or friends of a survivor, we all must deal with the reality that it is not safe to grow up female in this country. This focus on the reality of the victimization and violence perpetrated against females does not discount the fact that boys and men, too, are the victims of and affected by abuse and violence. Nonetheless, the fact remains that the percentages of reported victims of sexual violence continue to be disproportionately female, and the perpetrators of sexual violence disproportionately male. This affects everyone, diminishing and wounding all of us.

There are two major foci of this thesis. The first pertains to what it is to be female with a history of sexual victimization - the problem. Specifically the problem is outlined with a particular population of adolescent and young adult females in mind. These young women are the runaway, throwaway and homeless survivors of child sexual trauma that I have worked with for three years as a youth outreach worker. They have had a history of sexual violence and too few resources and support to enable them to heal from these experiences. The second part of this thesis focuses on expanding current outreach services to this population of young women grounded in an exploration of the current literature. The expansion of services involves the development of a comprehensive abuse healing treatment program with group work as the chosen

method of treatment based on an integration of practice experience and theoretical literature.

B. Starting Point - A Lived Experience

The ideas and hopes for this thesis, along with the program within it, flow out of my lived experiences. Author and activist Sandra Butler (1992) stated in regard to belief and theory formation, "We know that everything begins with a lived experience. Everything. You can not make sense of your life or the world in which you find yourself, if you do not start with what it has been like to be me" (see reference). Rather than attempt to present this material solely from an objective position, I make available to the reader my own ideas, ideas and biases that are imbedded in what I have learned through my own lived experiences. With the knowledge of my perspective within the context of my experiences, the reader can then agree or disagree with the ideas put forth. Lived experience includes both professional and personal occurrences. My professional training has been in the field of social work. Professional practice and observations have included work within a homeless shelter, battered women's shelters, women's prisons, and most recently at a community health clinic in the role of youth worker. To my professional training and work experiences I bring the realities of what it has been to be a 30- year old white female who has lived her entire life within an urban environment.

I also bring to my work with adolescent and adult women my own history of challenges and healing from a history of chronic sexual abuse, of having three children by the age of twenty-two, and of living on public assistance both as a child and then again as an adult. I bring these personal experiences to my work and to this thesis.

C. The Relationship - Informational Context

Much of the information I bring to this thesis I gained through relationships with female coworkers and with the adolescent and young adult women with whom I worked in the past few years. In this thesis I use a voice-centered relational approach to gathering knowledge accompanied with extensive theoretical literature to support the information found through this approach.

Dr. Annie Rogers (1992) spoke of the voice-centered approach in - "Response to Sexual Abuse: Creativity and Courage". The following is the approach as she describes it:

> This approach includes listening to girls and women as authorities about their own experience, and representing their voices in a written text, rather than replacing their words with interpretations. Listening to girls and women in this way requires us to bring ourselves into relationship with another subjectivity, another voice, a real living presence, a girl or a woman who may or may not recognize herself

> in our descriptions of her. Knowing the power of making psychological interpretations, which includes our power to make ourselves invulnerable by revealing only the lives of others, my colleagues and I have tried to reveal our own lived experience in our work, so that our readers might understand really the basis for our interpretations. A voice centered relational approach to research entails representing the voices of girls and women, including the voices of researchers (see reference).

For the most part, the young women whose voices I speak of are adolescents and young adult women. We talk about and make references to them as "those runaway kids on the street", "the lazy welfare moms", and "the crack - addicted pregnant women." The interactions and the relationships formed with these young women have convinced me both of the enormous needs of this population and the inadequacy of services and programs available to meet and respond to those needs. These relational experiences have shown me how they, as both individuals and as a group, have been neglected by our society, our policy makers and program planners. I have observed this position of neglect move to a position of blaming them when the desperation of their lives becomes too visible for us to ignore. It is at this point policies and laws are made, programs implemented to regulate behavior and, thus the blame is shifted. An example of this blaming is when a young survivor of abuse, in an attempt to numb her pain, uses drugs. Society ignores her if it only harms herself. However, if she's

pregnant, she is reported to authorities. The law is in place to "protect the unborn fetus"; it was not set up to get help to the young woman who has been harmed in the first place. Instead of this approach, we could be much more helpful with our policies and our programs if we would begin examining our many systems which are responsible for the desperation of their lives.

D. The Broader Societal Context

The problems and issues that I will be exploring in this thesis, violence and victimization for example, are broader societal concerns and we as social workers and concerned persons need to be concentrating on effecting change on this level. In addition, while we are attending to these broader societal changes, we need to be planning and implementing programs that are both caring and nurturing to the individuals and groups of women most hurt by childhood abuse and trauma.

With a degree of self-consciousness, I write about a program in terms of its ability to "nurture and care." As a trained professional, I have been taught continuously about the need to be "detached and not overly involved," "setting good boundaries," "being professional with clients," and certainly "alert to transference and countertransference issues." While it is important to acknowledge the need for these concepts and ideas, such as self awareness and boundaries, my relational experiences

with these young women run counter to some training in this area. I have come to believe that further separating from these young women is not the answer. In fact, we cannot be truly helpful in any substantial way without genuinely caring for and joining young women.

Having been honored by a number of young women's willingness to share their life stories with me, anything less then genuine care and an honest relationship would be neglectful. Their lives are filled with damage and pain. The stories are many times horrifying. In the midst of such pain and testimony, a method of care by workers, not often spoken of in academic journals, is what is called for. In addition to a voice centered approach as described by Rogers (1992), a perspective of connection and commonalty with these young women is central to my understanding and work with survivors. Rogers (1992) stated this as the following:

> I do not separate myself from them. Not anymore than I can, nor want to, separate myself from my patients and women friends who are remembering their abuse. We are sisters in a reality so wide spread that sexual abuse in this country can only be called common, ordinary, pervasive. The percentages shift and change as we know more about this horrifying reality. Right now about one third of all girls are molested before they are eighteen years old. One in four women will be raped in adulthood. The sexual abuse of girls and women cuts across all racial and class lines, a sharp indictment of patriarchy (see reference).

It is my hope that the following program will be used in an effort to begin to address some of the fear, isolation and loneliness that has been a pervasive theme in the lives of too many young women.

E. The Work- Environmental Context

For the past three years, I have had the opportunity to work on a team of youth outreach workers at an adolescent health and counseling clinic on the East side of St. Paul, Minnesota. My experience at Face to Face Health and Counseling Service, Inc. has led me to insights. During this time the outreach team focused its efforts on reaching a specific population of young women we thought to be disenfranchised from the mainstream of social services. One assumption we held of this population was that they were lacking vital resources and services such as health care, housing, finances, education and a means to employment. The outreach methods varied depending on the experience, style and preference of the individual outreach worker. Some common methods included "hanging out" at malls and on the streets, in drop-in centers, transporting to appointments, and acting as labor coaches.

The population we were trying to reach was labeled "highest risk". The project operationalized this term to be young pregnant women between the ages 13 - 23 and who were homeless, near homeless, and in an abusive relationship or using illegal drugs.

During this three year time period, we came into contact with hundreds of young women that were experiencing these realities in varying degrees.

We had three primary areas of care to offer: first, a comprehensive prenatal program within a larger adolescent social service agency; second, advocacy in the many social welfare systems they dealt with; and finally, we provided an authentic and supportive relationship.

While building and maintaining relationships we were also attempting to empower clients with information in the following areas: general health and wellness, safer sex and birth control practices, Sexually Transmitted Diseases (S.T.D's), Acquired Immunodeficiency Syndrome (A.I.D.S.), pre and post-natal care, safe housing, chemical health, relationships and parenting issues. At times it was frustrating and confusing as we watched their life situations and choices. For example, we found that these young women consistently were in unsafe situations. For example, many women had repeated episodes of S.T.D.'s. Many involved themselves in relationships that they were "fed up" with but continued to put all their energies into. Experts in the field have labeled these phenomena "learned helplessness" and the behavior "relationship dependent." My experiences and relationships with these young women did not convince me of these labels. Their situations were much more complicated than these labels could explain. I saw young women being quite clear about their wants and

needs. However, they had too few resources and no supportive environment available for them to meet these wants and needs.

Without this supportive environment they had no space to explore themselves in relation to self and others. No safe environment had been provided where healthier choices or more positive behaviors could take place. Following is an examination of the problems that child sexual trauma has caused for the individuals in this group. After fully exploring this issue, with an overview of the current services available to this group, the final product will be a therapeutic program aimed at providing a safe environment where healing from abuse can begin. A healing treatment program that integrates current theoretical literature and practice experience.

CHAPTER II

Female Survivors of Child Sexual Trauma

A. Introduction

Annie Rogers (1992) used the following passage of Virginia Woolf's diary to describe what feelings and sensations a survivor of sexual trauma is left with after abuse:

> Virginia Woolf records in her diary on the first day of March, in 1937: **"I wish I could write out my sensations at this moment. A physical feeling as if I were drumming slightly in the veins: very cold: impotent: terrified. As if I were exposed on a high ledge in full light. Very lonely. Very useless. No atmosphere round me. No words. Very apprehensive. As if something cold and horrible, a roar of laughter, at my expense, were about to happen. I am powerless to ward it off. I have no protection. And this anxiety and nothingness surround me in a vacuum. It affects my thighs chiefly. And I want to burst into tears but have nothing to cry for. Then a great restlessness seizes me, the exposed moments are terrifying. I look at my eyes in the glass and see them positively terrified."**
> When Woolf wrote this passage in her diary, she had not yet written out the memory of Gerald Duckworth molesting her on the ledge of the dining room at Tallandhouse when she was six (See reference).

B. Recognition of Sexual Abuse and Trauma

The last decade has seen a dramatic increase in the recognition and study of female survivors of child sexual abuse (Blake-White & Kline, 1985; Briere, 1989,1991,1992; Courtois, 1979; Drauker, 1989; Finkelhor & Browne, 1985; Harter, Alexander & Neimeyer, 1988; Herman, 1981; Herman, Russel & Trocki 1986; Patten, Gatz, Jones & Thomas, 1989; Sanford, 1987; Silver, Boon & Stones 1983; Vander, B.J. & Neff, 1982; Wyatt, 1985, 1990; Wyatt & Powell, 1988; Hart, Mader, Griffith & de Mendonca, 1989; McCullough Scherman, 1991; Runtz & Briere, 1986).

"Research indicates that molestation usually begins when the child is less than 8 or 9 years old, and is perpetrated by someone in the mid-20s or older who is typically male" (Briere, 1992, p. 4). Sexual abuse can begin in infancy and continue well into adulthood. Young women I have worked with have usually had many different situations of abuse and trauma with more than one perpetrator. John Briere (1992) writes of characteristics which are frequently associated with greater trauma than abuse without such characteristics:

* greater duration and frequency of abuse
* multiple perpetrators
* presence of penetration
* physically forced sexual contact
* abuse at an earlier age
* molestation by a perpetrator substantially older than the victim

* concurrent physical abuse
* abuse involving more bizarre features
* the victim's immediate sense of personal responsibility for the molestation.
* victim feelings of powerlessness, betrayal, and/or stigma at the time of the abuse (p. 6).

C. Prevalence Rates of Female Child Sexual Trauma

Research on the prevalence of child sexual abuse began in 1929 (Wyatt & Peters, 1986). Since that time prevalence rates for survivors of child sexual trauma have varied significantly depending on definition of abuse, population surveyed and research design used. For example Hart, Mader, Griffith, & de Mendonca (1988) studied the prevalence of an abuse history among hospitalized adolescents. They concluded rates were as high as 75%. Sandra Butler (1992) stated that 38% of scientifically studied women qualify as child sexual abuse survivors by the legal definition.

This flood of recognition may be viewed with caution, as history has shown societies to have a strong reluctance to abandon their denial in accepting the reality of child victimization. David Corwin states, "The sexual victimization of children evokes so much denial and repression that even though it surfaced into professional awareness three previous times during the past 130 years it was resuppressed each time by the formidable denial and backlash it illicited" (Wyatt & Powell, p. 251).

For a recent example of this denial and backlash see Schoenewolfs' article entitled "The feminist myth about sexual abuse" (Schoenewolf, 1991).

D. Consequences or Effects of Child Sexual Trauma

A history of sexual victimization has been positively correlated with an array of later life difficulties. "Sexual abuse of children is now recognized as a serious mental health problem, both because it is so widespread and because of increasing evidence of its traumatic effects" (Herman, Russel & Trocki, 1986, p. 293). Certainly effects or consequences of trauma will vary from person to person, but written literature on long term effects of child sexual trauma for survivors lists common issues and fears to most women. They include lower self-esteem and personal power issues, fear of intimacy, trust problems, flashbacks of abuse, memory loss, body image problems, sexuality and sexual problems, self abusive behaviors, chronic body pain, difficulty in parenting, and chronic depression attributed to the sexual abuse (Barnes, 1989; Bass, 1988; Dominelli, 1989; Finkelhor, 1985; Gilligan, 1991; Harter, 1988; Herman, 1986; Miller, 1990; Sanford, 1987; Wyatt, 1988).

E. Accompanying Variables of Barriers and Oppression

Focus on the many layers of oppression and victimization that young women experience must be a major consideration for both theory and program development.

The layers of oppression that continue to prevent these young women from taking ownership over their bodies and their lives are monumental. This abuse may come in many forms, including sexism, racism, heterosexism, and classism.

Gail Wyatt (1990) and others (Brassard, Germain & Hart, 1987; Dore & Damois, 1990; Farber, 1989; Ho, 1992), draw parallels between racism and sexual abuse. Gail Wyatt indicates the need to address both types of abuse:

> Many of the dynamics of racial discrimination and racist thinking parallel the dynamics of child sexual abuse. It is important for clinicians and researchers to first assess the multiple forms of victimization to separate the effects of child sexual abuse from those of other traumatic events. Second, the cumulative impact of these experiences should be assessed. Furthermore, treatment of one form of victimization is less likely to be effective unless all forms are included in the therapeutic intervention (p. 341).

Pharr (1988) and others have written in the area of homophobia regarding shared experiences of oppression and parallels to sexual abuse (Dominelli, 1989; Neison, 1991). For poor and working class females, classism is an equally relevant variable of potential isolation. It is also a form of oppression (Butler & Wintrum, 1992; Rubenstein, 1991; Williamson, Borduin, C.M., & Howe, 1991). Therefore, this group of abused adolescents, although

heterogeneous in some characteristics and demographics, has several shared experiences with oppression in their lives. First, they are oppressed by their gender in a culture that devalues being female (Berzoff, 1989; Dominelli, 1989; Gilligan, 1982, 1991; Herman, 1981; Kiefer, 1990; Mason, 1991; Wyatt & Powell, 1988). Second, they are oppressed by their age in a society that (1) regularly puts down adolescents, (2) limits their rights as minors, and (3) often leaves them dependent on abusive adults to educate and protect them (Dominelli, 1989; Miller, 1981; 1988; Williamson, Borduin, C.M., & Howe, 1991).

Any understanding of abuse and its effects on young females must include these and other societal and community systems of oppression and victimization. It must also include the understanding that the abuse will have an impact on their lives - may impede their quest for healthy development, self actualization, and empowerment.

F. Consequences Specific to Adolescent Survivors

Research literature indicates that an adolescent female survivor of earlier sexual abuse has an increased likelihood of engaging in runaway behavior, experiencing homelessness and having an active involvement in prostitution (Kaliski, Rubinson, Lawrance & Levy, 1990; Pennbridge, MacKenzie & Swofford, 1991; Simons & Whitbeck, 1991; Stiffman, 1989; Yates, Mackenzie, Pennbridge & Swofford, 1991). For this population other possible

consequences have been identified including: an increased risk for Human Immunodeficiency Virus (H.I.V.) and other Sexually Transmitted Diseases (S.T.D.'s) (Cohen, MacKenzie, Yates 1991; Zierler, Feingold, Laufer, Velentgas, Kantrowitz-Gorden & Mayer, 1991), problems with chemical abuse (Dembo, Dertke, la-Voie, Borders, et-al, 1987; Hart, Mader, Griffith & DeMendonca, 1989; Singer, Petchers & Hussey, 1989), and early sexual activity involving intercourse and early pregnancy (Cohen, Mackenzie & Yates, 1991; McCormack, Janus & Burgess, 1986; McCullough & Scherman, 1991; Polit, White & Morton, 1990; Runtz & Briere, 1986; Wyatt, 1988).

My professional observations, working within the outreach team, with adolescent and young adult females who are experiencing and participating in the above areas of homelessness, prostitution, drug use, early unprotected sex, pregnancy and parenting, also support the above findings.

This association of past abuse to later life difficulties requires youth workers to acquire a broad and accurate knowledge base concerning sexual abuse and its possible consequences during adolescence. In addition, the need for prevention, early identification and (age-appropriate) intervention is apparent (Massie & Johnson, 1989; Vermund, Alexander-Rodriquez, Macleod & Kelley, 1990; Zierler et. al., 1991).

CHAPTER III

Current Care and Treatment With Survivors

A. Introduction

Theoretical research has identified the following issues that are difficult for adolescents: normal body changes, developmental tasks of autonomy and independence, decisions involving their sexuality and identity, trust and relationships, safer sex and birth control practices, unplanned pregnancies, and early parenting concerns (Rubenstein, 1991). These issues for adolescents who are also survivors of sexual abuse may be even further exacerbated. Many of these issues are the very ones identified and outlined in literature to be the most challenging for adult female survivors of abuse (Barnes, 1989; Dominelli, 1989; Finkelhor & Browne, 1985; Harter, 1988; Herman, 1986; Sanford, 1987). The adult survivor has more power because of her adult status along with more years to develop coping strategies. Adolescent survivors are facing these adult issues within a backdrop of abuse with (1) little or no identification or awareness of the impact of their sexual abuse and (2) limited or no age appropriate intervention or help available to them.

B. Current Services to this Population

Unfortunately neither current theory nor practice appears to adequately address the very special needs of

this population of throwaway, runaway, and homeless youth (Pennbridge, Mackenzie & Swofford, 1991).

Because of the special needs of this population, Yates et. al. (1991) recommend "clinics use youth centers, mobile screening units, and other nontraditional approaches to providing medical intervention as necessary for prevention and access to services to be made possible to these youth" (p. 548).

For a variety of reasons, accessing a mental health or social service system is extremely intimating, frightening and risky for these young women. Ritter (1989) in his work with a diversity of homeless adolescents (not just sexual abuse survivors) wrote: "It is not easy to reach these youngsters. Many of them have been so damaged and so abused at home and then so incredibly traumatized by their experience on the streets that the damage is so profound it has become almost irreversible" (p. 158). Many of the adolescents with whom I spend time continue to get hurt because of life situations during the course of our relationship. They are in many ways "the walking wounded". They are like Susan, a 16 year old from Florida.

Susan was pregnant, frightened and feeling very alone when she showed up at the health clinic seeking medical care. She had recently left a dangerous home situation with her "boyfriend", a 31 year - old man. She is a throwaway and runaway, like many others who have experienced and lived through trauma without much helpful

assistance from adults. She came to Face To Face Health and Counseling Service, Inc., because she had heard on the streets that the place was "o.k." and that the workers were "cool."

For many of them, working with an identified outreach worker is the first voluntary interaction they have had with a "helping professional." It is also one of the first non- exploitative relationships they have experienced. This opens the client-worker relationship to many issues. Clients repeatedly push boundaries, wanting outreach workers to simultaneously be their best friend, mother, and "do therapy" with them. I believe these boundary challenges are primarily due to the desperateness of their lives. Contributing factors also include their developmental age and stage.

Outreach workers may also feel quite desperate. They may be the sole support the young person has to assistance for food, health care, housing, legal services, etc. Most outreach/street/youth workers carry a pager as part of their jobs and this further complicates these issues because the worker is often repeatedly called upon when a young woman is in crisis. All of the following are common client reasons for paging the worker; she may be in labor and have no one to bring her to the hospital, she may be being battered by a boyfriend, she may need to get her child to the doctors, she may have no where to sleep, or

she may be just too scared to go to sleep because of nightmares.

The line between outreach services and therapeutic services is sometimes difficult to distinguish. What makes the situation even more difficult is that these young women are often very reluctant to go outside of the outreach workers' care or the agency for further services. It is simply too frightening. Providing therapeutic services as an extension of the outreach services for this population is a logical solution to this problem. Clients can choose whether or not to participate in therapeutic services, but it would be readily accessible to them. This would also be a relief to workers to have clinical back-up by decreasing their own stress and feelings of having to be and do everything.

C. Identified Theories

Conceptual framework for both the program theory and program development draws primarily from feminist and empowerment work with survivors of sexual trauma. Research in the areas of feminist theory and therapy with females and survivors places the problem of child sexual abuse and trauma in a societal context. Examining the role of patriarchy and imbalances of power is also critical. (Berzoff, 1989; Dominelli, 1989; Gilligan, Rogers, & Tolman, 1991; Haaken & Schlap; Laidlaw, Malmo & Associates, 1990).

Important work and exploration with empowerment theories, particularly within communities of color have steadily increased over the past few years (Arbetter, 1992; Bowen, 1991; Mc Whirter, 1991; Nelson, 1991; Rothman, 1989; Waller, 1991). A definition of empowerment is "a process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations," (Gutierrez, 1990, p. 149). Eventual empowerment (and further healing from abuse) for these young women may come with a realization and an understanding of how sexual abuse has affected so many other young women and that they are not alone in their isolation (McWhirter, 1991; Nelson, 1991; Silver, 1983). Within this context of collective identification (Gutierrez, 1990; Lee, 1991; Pharr, 1988), similar to recovery from other forms of abuse and oppression, empowerment and healing are possible (Barnes, 1989; Bass, & Davis, 1988).

And finally, within the frameworks of feminist and empowerment theory as a means of individual and collective empowerment, the concepts of self-help groups and resources are vital (Barnes, 1989; Bass & Davis, 1988; Cornell & Olio, 1991; Riordan & Beggs; Zierler et al., 1991). When appropriate these methods will be adjusted for age and developmental stage of participants and incorporated into curriculum.

D. Professional Directions and Assessment Tools

David Finkelhor and Angela Browne in 1985 began the search for ways to view childhood trauma and methods to understanding the impact of the abuse in a framework which included the "traumagenic dynamics": "The experience of sexual abuse can be analyzed in terms of four trauma - causing factors, or what we will call tramagenic dynamics - traumatic sexualization, betrayal, powerlessness, and stigmatization" (p.530). Others have used and outline this framework in their work (Patten, Gatz, Jones, & Thomas, 1989; Wyatt, 1985).

Separate from Finkelhor & Browne, others have developed tools for assessing sexual trauma and impact of harm. The following is a brief list of tools that follow a feminist approach:

Gail Wyatt developed a Sex History Questionnaire which is a 478- item structured interview (Wyatt, 1985; Wyatt & Newcomb, 1990). John Briere developed a Trauma Symptom Checklist-40 that is "reliable and discriminates well between sexually abused and nonabused subjects" (Elliott & Briere, 1992, p. 395), a Child Maltreatment Interview Schedule (Briere, 1992), and a 13-item Dissociation scale (Briere & Runtz, 1990). And finally for screening and assessing adolescents, Cohen, Mackenzie & Yates (1991) recommend HEADSS (Home, Education, Activities, Drug use and abuse, Sexual behavior, Suicidality and depression). "The

HEADSS interview touches on the major areas of adolescent psychosocial stress and, as a clinical instrument, and provides a useful screening profile," (p. 539). All of the previous tools are useful, non - shaming means of collecting information about the young woman. Information that may be useful to know in the healing program.

E. Diagnostic DSM-III-R and the Effect of Labels

Many child sexual abuse survivors receive a diagnosis using DSM-III-R upon entering the mental health system. Feminist writers in the field have challenged professionals both on the over - diagnosing of women and also on the fact that the particular diagnosis available do not adequately fit the symptoms with the labeled condition (Butler, 1992).

Gelinas(1983) outlined the frequently used diagnosis for female survivors as Dysthymia disorder, Borderline Personality Disorder, Latent Schizophrenia, and Bipolar Affective Disorder. In the same article Gelinas(1983) stated that misdiagnosis of women is not uncommon:

> Our experience strongly suggests that many incest victims do show Borderline Personality Disorders, and incest may be a contributing factor to the development of the disorder in women. But many other patients have erroneously received this diagnosis, probably because of impulsive and dissociative elements (p. 237).

Another DSM-III-R diagnosis that is almost always linked to childhood trauma, as stated by Ross et. al. (1990) is Multiple Personality Disorder. "Multiple Personality Disorder is linked to much higher rates of childhood trauma than any other psychiatric disorder; it appears to represent a dissociative strategy for coping with and surviving abuse" (p. 600).

Most recently Post Traumatic Stress Disorder (PTSD) has been added to the list of frequently used diagnosis by practitioners (Patten, 1989; Wyatt, 1988). And still this diagnosis is being received with varying acceptance (Butler, 1992). Saunders and Arnold (1991) question the diagnosis of both Borderline Personality Disorder and Post Traumatic Stress Disorder and suggest a new option called Disorders of Extreme Stress not Otherwise Specified. "Like a personality diagnosis, it captures characteristic and enduring patterns, in this case reflecting the after effects of chronic trauma, but does not require the specific symptoms of the flooding and numbing phases of Post Traumatic Stress Disorder"(p. 12). The DSM-III-R states that the Personality Disorders refer to behaviors or traits that are characteristic of a person's recent or long term functioning (American Psychiatry Association, p. 335).

As with the previous assessment tools and DSM-III-R diagnosis, the labels have the potential to be misused and hurtful to young women. Once labeled, (be it by a parent, teacher, foster parent, practitioner, probation officer, or

doctor) the labels may follow them, carrying with them the power to influence and control their lives. In addition, many of the young women I have worked with have internalized these labels.

Edwall, Hoffmann, and Harrison(1989) wrote, "In short, the pattern seems to be one of internalization: the abused female adolescent appears to be at risk for creating a picture of herself as bad or sick, while normalizing the situation around her" (p. 287). A few of these labels in addition to "bad and sick" are "juvenile delinquent," "resistant and manipulative," "problem children," "learning disabled," "emotional or mentally disturbed," "Borderline," "victim," "liar," "codependent" and "crazy."

Instead of labeling and blaming them for their life situations it is more helpful to reframe these behaviors. One such explanation of these behaviors is put forth by Runtz & Briere (1986); they consider these anti-social or "acting out" behaviors as an expression or means of asking for help. Scholars, such as John Briere, Sandra Butler and Annie Rogers have been effective in demystifying work with survivors, offering practical suggestions while integrating theory and treatment. An example of this demystifying is the use of typical terms and diagnosis given to many female survivors of trauma: codependent and/or Borderline Personality Disorder.

Both Briere and Butler have reframed these phenomena as logical learned responses of neglect and abuse (Briere, 1992; 1991; Butler, 1992).

Any program that hopes to aid in healing, empowering, or in any way helping this population must meet the client where she is, without labeling or patronizing her. This means the program must be developmentally appropriate, financially accessible, and with an ability to provide a physical and emotional setting where she is comfortable. These provide the foundation to her in eliminating the many barriers that she may face everyday just to survival.

The following program will attempt to combine the above theoretical frameworks into a comprehensive healing program for adolescent female survivors, expanding existing outreach services at Face to Face Health and Counseling Services, Inc.

CHAPTER IV

Program Planning and Development

A. Introduction

> **So how do you sit with a shattered soul? Gently, with gracious and deep respect. Patiently, for time stands still for the shattered, and the momentum of healing will be slow at first. With the tender strength that comes from an openness to your own deepest wounding, and to your own deepest healing. Firmly, never wavering in the utmost conviction that evil is powerful, but there is good that is more powerful still. Stay connected to that Goodness with all your being, however it manifests itself to you. Acquaint yourself with the shadows that lie deep within you. And then, open yourself, all that is you, to the Light. Give freely. Take in abundantly. Find your safety, your refuge, and go there as you need. Hear what you can, and be honest about the rest: be honest at all cost. Words won't always come; sometimes there are no words in the face of such tragic evil. But in your willingness to be with them, they will hear you; from soul to soul they will hear that for which there are no words**
> (Steele, 1987, p. 19).

The following sections move into the second part of this thesis. The focus will be on program development, specific to the needs of this group of young adolescent survivors of child sexual abuse and trauma.

B. Overview of Program

The method of ongoing groupwork with extensive outreach services is a logical extension of currently existing services at Face to Face Health and Counseling Service, Inc. The outreach worker is both the link that connects the adolescent survivor to the additional therapeutic services and the vital ongoing support that

assists healing to take place. My practice experience with this population has shown that circumstances of daily living and issues of housing, food, money, transportation, etc., must be addressed before it is possible to attend to further issues of childhood trauma. And further, because of the many layers of oppression facing this population, the need for on-going advocacy and assistance in these basic needs is clear. The role of an outreach worker is critical in these matters. As mentioned earlier, the outreach worker also offers the opportunity of a safe one-to-one relationship with a caring adult.

Group work as the primary avenue of further healing was chosen for a variety of reasons. Group work with peers is a preferred method of therapy for this population. Many of the one-on-one needs provided by an individual therapy model are being met through the relationship with the outreach worker. In fact many young women repeatedly say "the only one they count on is their outreach worker". A group will expand her frame of reference and her experiences of what can be safe by offering her a different type of healing relationship. Individual therapy may not. Group work, if done well, is also more culturally appropriate for individuals from communities of color (Ashby, Gilchrist & Miramontez, 1987; Ho, 1992).

Ho(1992) stated:

> In view of the minority culture's collectivist or groupism orientation, minority children are probably

> more capable of becoming cohesive in a group than White children who come from an individualistic culture... group interaction and group therapy, if properly provided, may have advantages that individual and family therapy do not... The group experience can be less threatening than individual therapy... The minority child in group therapy can choose when to interact (p.178).

Another frequently used method of treatment with abuse survivors is family therapy. In contrast to this the group method is more appropriate with this population. To begin with, many outreach clients and potential participants of this program are estranged from their families. Many escaped family situations as an act of survival, and it may not be safe to reestablish ties at the beginning stages of treatment. Arlene Stiffman (1989) stated: "Our findings point to the possibility that return to the family may mean entrapment in a situation fraught with mental illness, stressful events, and the possibility of abuse"(p. 76).

And finally, an overview of the literature reveals that group work is a highly successful method of treatment (Riordan & Beggs, 1988). For those clients that may benefit from incorporating additional services of individual or family therapy as healing continues, the facilitators will be available for this. It is important to remember that the young woman is in charge of her healing process. If she feels that she is ready to try

something different with her healing, then she should have all possible choices made clear and available to her.

Following is a review of the literature for female survivors of sexual victimization in particular in regards to group work.

C. Group Work- Review of Literature

A review of literature specific to treatment with survivors has shown group work to be an accepted and often favored method of practice (Ashby, Gilchrist & Miramontez, 1987; Briere, 1992; Butler, 1992; Dominelli, 1989; Laidlaw & Malmo, 1990; Massie & Johnson, 1989; McBride & Emerson, 1989; Nelson, 1991; Sirles, Walsma, Lytle-Barnaby & Lander, 1988). As a means of individual healing and collective empowerment, Dominelli (1989) said the use of group work with survivors of sexual trauma is a practice with accepted validity. This method of treatment also takes into consideration both developmental and gender theories of how adolescents and females learn best - from and through their peers (Gilligan & Rogers, 1991; Kaplan & Klein, 1985; Rubenstein, 1991), and in a relational context (Berzoff, 1989, Fedele & Harrington, 1990).

Brown and Dickey state that "philosophy of group experience is feminist in theory" and further, "the purposes are as follows: to facilitate critical reflection, to define and identify abusive behavior, and to encourage

women to name their own experiences, thereby taking back the power that has been taken away"(p. 60).

Fedele and Harrington in their paper: Women's Groups: How Connections Heal outline four "interrelated curative factors in women's therapy groups." They include "validation of one's experience, empowerment to act in relationships, development of self-empathy, and mutuality"(p. 3). Feminist empowerment theory as applied to group participation of survivors is highly effective, as stated by Dominelli (1989):

> ...enabling abused girls and women to come together in groups where they can work collectively on the feeling of isolation, powerlessness and guilt that mark their state whilst abuse is being perpetrated on them. Coming together collectively enables women and children to transform their experience of incest from being a matter of personal distress reflecting personal inadequacy into a social issue indicative of women's plight more generally (p. 302).

Butler and Wintram (1992) argue that the knowledge and wisdom gained in collectivity among women can be and is "a major tool in the process of deconstructing masculinity oppression, and reconstructing an alternative, personally significant reality....No woman, in any circumstances, can achieve this on her own without reference to the experience of others"(p. 2-3). And finally, McBride and Emerson state; "Groups can help to reduce the sense of isolation

and distance that often characterizes the sexual abuse victim's relationships" (p. 26).

Ashby and Gilchrist(1987) cited empirical data that the participation in a group experience for Indian adolescent survivors had a positive affect on the participants lives. Similar to the adolescents in the Ashby and Gilhrist study, the group experience for this population of adolescent survivors may be equally helpful. The experience may enable participants to experience and understand both their feelings and their environment in a way not possible within an individual or a family therapy experience.

C. Practical and Theoretical Planning Considerations

The following are the areas that will be included in program development. These considerations should be discussed and understood between all workers, outreach and group facilitators:

1. Strengths of Survivors

Most important to program planning and development is a philosophy of building on the many strengths survivors possess. This includes honoring and building on the courage that has sustained them in their lives. Building on strengths is both a starting point and ongoing theme in program curriculum. A group with focus discussion on strengths, and in particular positive labels included the following example of young females. All of the members of

an adolescent mother group I facilitated had been, to varying degrees, negatively labeled because they were teenage mothers and on public assistance. The group focus was on leadership and was entitled "Young Women's Leadership Group." During the process of our seven month program the young women began to reject the negative labels given to them from families and society, and they began to accept more positive ones the group offered. In a final evaluation, the members began to identify themselves as "smart women," "young leaders" and "helpers."

2. Societal oppression and victimization experienced

Focus on the many layers of oppression and victimization that young women experience must be a major consideration for both theory framework and program development. As stated earlier, oppression and violence affect all women, but survivors of earlier childhood abuse may be at an even greater risk of repeated victimization because of lifestyles, racial/ethnic background, social class and/or limited choices (Simons & Whitbeck, 1991). Societal and community realities of violence to participants must be put into words and a language that can be understood and integrated into participants' lives.

3. Life Span Developmental Issues and Tasks

Planning and curriculum need to be specific to this age group. Earlier ages and stages that may have been

missed because of abuse and neglect must also be taken into consideration. This group of young females are at varying levels of developmental and maturity levels depending on both their inherent inner resources and the amount of deprivation experienced in their lives. Child sexual trauma affects all areas of a child's development, as stated by Nelson(1991): "Such deprivation inhibits the child from developing and using competencies in ways that result in healthy growth and development" (p. 623). Linda Sanford (1987) also wrote of this, "Children who are chronically abused sometimes remain at this early developmental stage because they did not receive the nurturance and guidance needed to accomplish early developmental tasks. Furthermore, children's psychological resources often become organized around surviving chronic abuse, and little is left over for general development" (p. 2). Certainly, this seems to be true of most of the young women with whom I've worked.

Another example of interrupted developmental tasks is incomplete knowledge regarding sexuality and sexual abuse. Adolescent women may have little or no accurate information on these subjects (Gilgun, 1986), and a history of sexual abuse compounds these issues. This is illustrated in the situation of a young adolescent I will call "Mary", who came to our clinic for pregnancy testing. Mary came in for testing because she had "missed her period." Mary explained that she had been "going with her boyfriend for

about five months and "doing it" with him for the past two months." Upon further discussion, I realized that "doing it" for Mary meant touching her boyfriend until he ejaculated. Mary had never actually had intercourse, or for that matter, taken her clothes off while "doing it." Mary was fourteen years old and did not have basic information regarding sexuality and sexual reproduction. In addition, on Mary's intake form she marked "yes" in the box indicting a history of sexual abuse. Concrete information will be incorporated into group curriculum on these subject areas of sexuality and reproduction.

4. Basic Needs and Survival Issues

For many, the basic needs of food, shelter, love, safety, and health care are lacking. These must be addressed if survivors are expected to participate in any healing or therapeutic experience. A commitment of time, energy and resources will be needed and must be incorporated and prioritized into the program. An example of how a lack of basic needs can affect the ability to access services can be illustrated with a young woman I will call "Nicole". Nicole was a homeless woman that came to the clinic for prenatal care during the middle of her pregnancy, long after she ideally would have begun care. As her outreach worker, we worked together for weeks then months trying to access Medical Assistance, food, clothing and housing for Nicole. During this time, she would

sometimes miss important medical appointments due to challenges in her living situation. Also during this time, Nicole was having reoccurring symptoms of earlier abuse including flashbacks and nightmares. Although counseling was something Nicole thought she needed, with her daily basic survival issues, it was not something she thought she could handle at the time. I respected her decision and supported her in attending to other areas such as stabilizing her housing and attending prenatal appointments and prenatal classes.

5. Understanding of Self and Others

The development of a sense of self for girls and women has been studied in the last decade, showing marked differences in the way that girls and boys sense of themselves develop as a result of gender role socialization in our society (Berzoff, 1989; Kaplan & Klein, 1985; Miller, 1984). These differences in sense of self and of self in relation with others will be taken into consideration for curriculum. Sexual trauma in childhood causes profound shifts in reality and understanding of the self and identity issues. A search for meaning of why abuse happens (Silver, 1983) and the beliefs a child learns about the world and her place within it when she is abused by a trusted adult are also areas of concern (Brassard, Germain & Hart, 1987; Draucker, 1989; Helminiak, 1989; Miller, 1981; 1990; and Vander-May, 1982; Wyatt, 1990).

An example of lacking of a sense of self can be illustrated by how many female adolescents answer a particular question on are intake forms at the clinic. The question asks the young woman about the activities she enjoys. It asks about likes, dislikes, or hobbies. Many answer that they don't know what they like, have no hobbies or like "Jane" said they had never thought about it. Jane, a nineteen year old with two children, said she had never thought about it and in fact no one had ever asked her what she liked.

6. Trust and Power Dynamics

Issues of trust and power dynamics must be considered. The dynamics that occur in the child sexual abuse situation are stated well by Dominelli (1989): "The issue of power as it is expressed in relationship of trust is central to feminists' definition of incest" (p. 297). The trust and power dynamics surrounding abuse have been explored in both academic journals and self-help healing books (Bass & Davis, 1988; Druacker, 1989: Finkelhor & Browne, 1985; Vander-May & Neff, 1982). Fortunately, as stated by Massie & Johnson a healthy group experience can facilitate the beginning of trust building (1988). Program curriculum must also educate and provide additional experiences of trust building.

7. Possible Long Term Effects of Trauma and Victimization

As stated earlier, the possible long term effects of sexual trauma for survivors can be varied and complicated. Some general issues for curriculum and program planning include the following: self-esteem and personal power issues, fear of intimacy or trust problems, flashbacks of abuse, memory loss, body image problems, sexuality and sexual problems, self abusive behaviors, parenting their own children, and chronic depression.

8. Stages of Recovery and Healing

Vital to include in curriculum is the information about healing stages or processes so that participants can make informed choices about involvement in the program. Benefits of this information also include further self understanding and normalizing of the recovery process. As outlined in Bass and Davis's Courage to Heal (1988); the decision to heal, the emergency stage, remembering, believing it happened, breaking silence, understanding, grieving and mourning, anger, etc. are all normal reactions and stages of recovery. One young women, "Toni," has been working on abuse issues for almost two years. Recently she shared with me that she has been "crying for what seemed like months" and she was embarrassed because "she wasn't over it all yet." I again offered her the different stages of healing and pointed out that there is no perfect time frame for healing. She was relieved when I congratulated

her for doing well with her healing process and how far she had come in her healing. I gently reminded her that she has much to grieve.

9. The Role of Denial and Dissociation

Denial and dissociation are areas of current and extensive debate within the field of work with survivors. As stated in the book edited by Wyatt and Powell; "Dissociation offers the appeal to children to buy time in their own generation, in hopes of finding healing acceptance and caring in the next" (1988, p. 56). Behavior and coping mechanisms the survivor has had to adopt to survive the abuse and its aftermath, such as denial and dissociation, are suggested that for some, without a long-term therapeutic relationship, much of the abuses of children will never be uncovered (Blake-White, 1985; Cornell, 1991). Denial serves as a very important protective defense for survivors. The balance between honoring it and confronting it may be a delicate issue at times.

C. Program Design

1. Agency

The following program can be utilized in any social service agency that is committed to providing feminist, wholistic treatment and care to young women.

Commitment by the agency can be shown through both the agency culture and philosophy. In addition to a feminist and empowerment culture and philosophy, the agency must have the resources available to provide wholistic, comprehensive care over an extensive period of time. The agency must be committed to hiring and maintaining a diverse staff reflecting various race, ethnicity and sexual orientation. Without these commitments and resources it is unlikely that a program of this type could be successfully implemented.

2. Staff

The program requires two female social workers to co-lead the group with 6-8 participants in each group. One full time outreach worker is needed for each 12 participants to attend to those needs not directly related to treatment. The staff will ideally include women of color and a lesbian to reflect the wide diversity of young women participants and so that participants are able to identify with women from different cultures. In addition to co-leading the group, the therapists will be available to work individually with participants and their families, whenever participants choose this.

The planning process and the development of a positive relationship between coworkers and with support staff must be an intentional act, one which takes time. Philosophies about program priorities, violence and victimization,

adolescents, gender roles, etc., must be discussed, written and agreed upon before implementation of the work with clients.

The details of the program include meeting places, time, transportation and child care for potential participants; these must be completely taken care of before implementation. It is essential to create a safe and comfortable group space and environment prior to the onset of the program. This is accomplished not only by providing the time allotted to accomplish tasks but also with financial resources and priority given to such tasks.

Because of the painful nature of the work we ask young survivors to assume, we too, as an agency and as workers, must commit to our work by preparing the services and space conducive to healing. Also along these lines, workers must commit to doing their own healing work. The agency must commit to both providing workers time to do this healing work and to close and consistent supervision for workers. So that workers can be as healthy as possible in their work with the young women in the program

Beginning work that shows this clear and visible act of intention and care on our part relays a positive message to potential participants about both our beliefs and their worth.

In addition to the three full-time staff, the availability of support staff (reception and secretarial services) and the cooperation of accompanying programs and

services within an agency help to sustain and support a program of this type.

3. Group Focus

The program will serve females between the ages 17 and 21. It will concentrate in areas specific to recovery from sexual abuse including education in common effects of abuse, feelings of anger and grieving, sharing the secret, and developing boundaries.

Group content and process will also include discussion and education in the following areas: current living situations, developmental tasks and stages of participants, gender socialization and expectations, family of origin issues, choice making, sexuality, self-awareness, body issues, trust and relationships. Each ten week series will also include an outside field trip activity. The group will plan and participate together as a group in an act of political activism, protest or participation of a cultural event such as; participating in a "Take Back the Night March" or going to a Native American storyteller.

The program will attempt to view each participant as a whole person, with a mind, body and spirit. Luepnitz (1988) wrote about the whole person as "a person embodied with both capacities and incapacitates, living within the idioms of gender, culture, race, and class, enhanced and inhibited by unconscious process, making choices in historical time" (p. 22).

4. Group Process

Atmosphere should be casual and comfortable with outside distractions kept to a minimum. Along the lines of Virginia Satir's methods of care (Luepnitz, 1988) unconditional positive regard should be provided participants. Deliberate efforts should be made to reach out to members, help them see themselves in a more positive light, and make verbal participation totally voluntary. Group size should be limited to eight to allow for intimacy and trust to build.

Butler and Wintram (1992) stated in regard to group structure and size; "It follows that for a sense of trust, intimacy and self-revelation to be a hallmark of small women's groups, the only restriction to be made is on the size of the group - approximately eight to twelve people (p. 31)." As stated earlier, the cooperative working relationship between the workers is crucial. It appears that the facilitators relationship is key to the success of this program (Butler & Wintram, 1992).

In an atmosphere of co-leading or "co-working" this process can provide participants with a living example of what working together cooperatively between two adults can entail (Butler & Wintram, 1992). This will involve sharing work, supporting each other, offering different perspectives, styles, and modeling communication and negotiation skills. Individually each leader must also model a variety of independent behaviors. These behaviors

include caring, self-knowledge, understanding of others, ability to set clear limits and boundaries, and an ability to communicate (teach) knowledge in a way that is developmentally and culturally sensitive to this age and subgroup of adolescents.

The outreach worker will facilitate the introduction of the young woman to the two therapists for the information and intake process. This will be a time for the woman to meet the facilitators, get information about the group, and learn about what would be expected in group. If she is interested in further pursuing the group, she will meet a again for a brief time with the facilitators to get the logistics of the program. The decision to join or not is totally up to the young woman. During these meetings, the facilitators should begin to offer choices to the young woman beginning the process of decision making and taking responsibility for her own life.

In the area of abusive and incestuous families, Sue Evans(1988) wrote extensively about the effects of boundary violations. The group experience will be an intentional act of learning and practicing healthy boundaries, allowing members to monitor their time and needs within the group. Each group will be two hours long. Facilitators and members will pay close attention to starting and ending on time. The meeting room will be made available one half hour before each session for getting comfortable and for informal talking.

5. Group Goals

The program will have as a general and primary goal reducing feelings of fear, isolation and loneliness. This primary goal is best accomplished when healing for individual participants and collective empowerment takes place through understanding and identification with one another. Following are goals for the group process:

Group Goals

1. To provide a safe environment conducive to healing from abuse for young women.
2. To provide a positive therapeutic and group experience. To offer and help plant seeds of hope and trust in young women.
3. To assist young women in forming authentic relationships with one another, reducing their feelings of loneliness.
4. To provide an atmosphere where differences will be honored and cherished, with the understanding that diversity and the nurturing of diversity will enrich all of us.
5. To give / knowledge about violence and victimization, beginning the process of unlearning messages about abuse and their role in it, assisting women in critical reflection.
6. To present educational and experiential learning opportunities to young women.
7. To assist women in developing empathy for themselves as survivors, reducing feelings of guilt and shame.
8. To assist women in connecting individual life experience and victimization into a context of broader societal framework, reducing feelings of isolation.

6. Group Guideline/Rules

A sample list of group rules may look something like the following list:

Group Rules

1. Speak for yourself, not for anyone else.
2. Listen to others, give attention to the person speaking.
3. Take charge of yourself, this is your space to ask for what you want and need.
4. No put downs.
5. Respect diversity and each person's uniqueness.
6. We will challenge each other about oppressive or hurtful language, behaviors and ideas.
7. Everyone has the right to:
leave if they need to,
choose what activities they want to participate in,
cry,
laugh,
be who they are-
in short to take care of themselves- while not harming themselves, another, or the group process.

Many survivors report coming from homes where family norms, rules or guidelines were either rigidly authoritarian and/or "always changing so that they never knew what to expect or how to act in an attempt to avoid harm." Group rules that are clear and consistently applied can help participants feel safe. Because of this need to be and feel safe, at the beginning of each series, facilitators will take time to discuss and agree upon group rules with participants.

The rules will be printed on a large cardboard paper and visible during each group.

7. Group Space and Artifacts

Many participants do not have a clean, comfortable, nurturing physical space available to them so for this reason and others the space created is very important. The group space should be large enough to allow for group activities and small enough to allow for a feeling of closeness and comfort. Couches and pillows with carpeting is recommended for comfort. It should be separated enough from the rest of an agency to maximize privacy.

At each session, have a small table on which members may put special items related to their life journey and healing. This can be a poem, a doll, a song, a picture of themselves, a letter, a stone or whatever. If they choose they can take time to explain and describe the object during their group time. This special table will be treated with much care and members will be responsible for setting it up each group meeting. Along with the table, a candle will be used throughout each 10 week session. The candle will be explained to both represent and honor the strength and life force each member has carried in their lives. Facilitators will ask for volunteers at the end of each meeting to be responsible for setting up the table and lighting the candle for the next session.

Also important is to create a space designed as the "time alone-safe place." This will be a place that any member, at any time, can access. This area will be small and against a wall with sides; possibly the back of two bookshelves. It will be a cozy corner, with pillows, stuffed animals and comfort objects to assist young women in learning how to identify their needs for time out, alone time. In this safe space they can begin to monitor their own process of taking in and expressing information and feeling pain. Here they can also begin to develop self soothing techniques.

8. General Group Content

The facilitators will have educational activities prepared for each session; activities will take anywhere from fifteen minutes to one hour, resembling a psycho-educational model of treatment (Nichols & Schwartz, 1991 p. 486). The remaining time will be left to group and individual sharing/talking time. Group sessions should be planned and prepared by facilitators but the process should be flexible enough to change and accommodate the group process if it shifts in another direction allowing members to change and heal. Each 10 week series (four series in one year) will contain at least one session on the following areas: self-care, identifying and normalizing feelings, sexual abuse trauma and its impact on survivors, personal boundaries, and self-awareness. In addition, each session

will end with an all day celebration/marathon session. Members are encouraged to take breaks in between sessions and participate in as many series of sessions as they would like. The structure and schedule of the group will reflect the goals of the overall program. The purpose of the ongoing program that opens and closes for new membership is to be both flexible to young women that may want to try a 10 week series and also to others that may want a more intensive longer option and commitment.

9. Schedule

The following is a possible year long program.

Year- long Program Schedule:

Session I. Defining Self: Exploring, identifying and reclaiming.
Dates: January, 12, 19, 26 & February 2, 9,16, 23 & March 2, 9, 16.
Break: March 23, 30

Session II. Honoring Survival: Acknowledging and understanding trauma and abuse, coping strategies learned, family dynamics and roles.
Dates: April 6, 13, 20, 27 & May 4, 11, 18, 25 & June 1, 8.
Break: June 15, 22, 29.

Session III. Relationships: Ourselves, friends, family, children and partners.
Dates: July 6, 13, 20, 27, & August 3, 10, 17, 21, 29.
Break: September 14, 21, 28.

Session IV. Evaluation of choices and decisions: A look at the many areas of life and self.
Dates: October 5, 12, 19, 26 & November 2, 9, 16, 23, 30 & December 7.
Break: December 14, 21, 28 & January 5.

E. Program Curriculum

The following is an example of possible curriculum for the year long program:

Session #1- Defining Self

1. Introductions and self care
2. Self-awareness
3. Stages of Healing from Abuse and Trauma
4. Feeling Identification
5. Sexual Abuse Trauma
6. Consequences of Abuse
7. Healthy Relationships
8. Telling our Stories
9. Exploring Self
10. Celebration; Affirmations and Appreciation

Session#2 - Honoring Survival

1. Introduction; Ground Rules, Is healing possible?
2. The Decision to Heal
3. Naming our Loses
4. Family Roles
5. Self Inventory
6. Feelings
7. Violence Wheel
8. Dealing with Memories
9. Personal Boundaries
10. Celebration: Affirmations & Appreciation

Session #3 - Relationships

1. Introduction; Ground rules, Is healing possible?
2. Types of Abuse
3. Qualities Valued in a Friendship
4. Friendship
5. How to Make an Apology/ How to say Good-bye
6. Stereotypes/Differences
7. Trust/Intimacy
8. Personal Inventory
9. Spirituality
10. Celebration

Session #4 - Life as a Process

1. Introduction
2. Time line
3. Childhood Memory Inventory
4. Feelings
5. Self- Defense
6. Affirmations
7. Breaking the Cycle
8. History of Relationships
9. Sexuality
10. Celebration

CHAPTER V

Program Evaluation

The evaluation tools and steps are critical components of this type of the program. Two types of evaluation will be used. One, to evaluate the program itself and the other, to evaluate if the primary goal of the program is accomplished. The primary goal of reducing feelings of fear, isolation and loneliness are variables related to relationships and trust which are sometimes hard to measure. It may be difficult to measure if, and in what ways, clients are feeling less afraid or less isolated and lonely except by their own estimation. The method I have chosen will be in the form of two questionnaires given to participants before and after each 10 week series. Both of the questionnaire forms are included in the Appendix of this thesis. In regards to evaluating the primary goal, as stated earlier, questions #2, 10 and 11 are most concerned with measuring participants' feelings and questions # 5, 6, 7, 8 and 9 deal directly with measuring areas of isolation and loneliness.

The purpose of the questionnaire will be to collect information on the effectiveness of the program and to provide ongoing feedback after each series is completed. The questionnaire will allow participants to give their perceptions of both their own emotional state and the program effectiveness.

This is consistent with feminist beliefs that women know what is best for them and should be active leaders in their own healing processes. This type of questionnaire will also serve to give facilitators further ideas and suggestions on how the program is being received and about what kind of impact it is having on the participants' lives. Facilitators can then modify and make necessary changes in the following series so that the approach and program can most fully meet the needs of the young women.

A program of this type is aiming at the crucial beginning steps of the healing process. Many, if not most, of these changes or benefits may not become apparent for months, years or until the lives of the next generation of children are being parented. This next generation may be parented by mothers that are more self aware and better able to nurture and care for them because they have been able to attend to their own care and healing from childhood hurts.

The second part of the evaluation will be in the shape of a formative evaluation. This will attempt to assess what the program actually did and in what ways the facilitators needed to modify or adjust the proposed program during implementation.

Patton (1978) states: "It is important to know whether or not a program is effective after it is properly implemented, but to answer that question it is first necessary to know whether or not the program was indeed

properly implemented" (p. 150). This type of evaluation can be accomplished with the assistance of the workers in what is called a process evaluation. When describing this method Patton writes: "Process evaluations look not only at the formal activities and anticipated outcomes but also investigate informal patterns and unanticipated consequences in full context of program implementation and development" (p. 165). Each worker will keep a log of each group; this will include details about attendance, curriculum, group dynamics, participant responses to group, facilitators role, etc. These logs will then be compared and evaluated by an independent evaluator to assess and report what took place in each of the four series for the entire year.

CHAPTER VI

Areas of Limitations

Theoretical Limitations

Using the feminist theoretical framework in working with this population has limitations. One assumption of the program is that the young survivors are their own best therapists or healers. Although generally applicable, it does not take into consideration developmental and/or physical disabilities that may make this assumption untrue for some. Young women may encounter barriers that will make a program with this theory not helpful. For example, a young women with a development disability may need a program that is more directive or more structured.

In addition, the theories of empowerment and feminism alone do not adequately address the presence of very real and ingrained power imbalances within our culture. A young woman may heal herself from the hurts and shame that the childhood sexual abuse caused, but she still lives within a culture where she is not safe from violence. She may feel empowered enough to know she deserves a better housing situation, partner, education, etc., and still be faced with very limited options and choices because of her gender, class, race or ethnicity. The changes needed for more radical redistribution in power and economic structure are not addressed by the theory written about in this

thesis. A more radical perspective is needed for this type of change looking for fundamental societal transformation.

Program Limitations

There are many variables that need to be attended to in a program of this type. This type of program calls for a commitment of time and resources not usually available to communities or agencies. The recruitment of this population of very high risk adolescent females is slow and difficult because their situations may include homelessness, chemical use, and a strong mistrust of adults and professionals. For example, the outreach for the existing project at Face to Face with this particular population took at least a year before a few young women felt comfortable coming into the agency for services.

Implementation may also be difficult because young women in this group are experiencing a wide range of life issues, some related to past abuse, some not. Empowerment and healing are areas that are difficult to conceptualize and further difficult to implement and evaluate. In trying to involve the many layers of oppression and abuses experienced by young women, the proposed program with the focus on empowerment and healing may be trying to do more then humanly possible in one program. In some instances, young people have been so neglected and damaged that what they may possibly need is a total healing of their core selves. This healing, beginning with nurturing and basic

trust issues is clearly more than one program can accomplish. All people need both environmental and some kind of family support when trying to heal from trauma. One program cannot create all of those things by itself.

As with every program, the potential misuses of the information collected and treatment used are present. An area of concern is that this program could put young females in a place of labeling themselves, and revictimize them by showing that this group of young females are powerless. Because of this, it is important that the name of the group be something affirming and positive.

Evaluation Limitations

The evaluation also falls short of being able to fully grasp the extent that which past abuse and present healing attributed to the program. A more complete history gathered of clients, their symptoms or effects acquired, and more thorough assessment of benefits of the program may more accurately reflect the program's impact and its effectiveness. A comparison group or "no treatment" control group of some kind would strengthen this design. Other limitations include the fact that the respondents must include their names to the questionnaires. They may not answer questions as honestly as possible out of fear that the leaders might get angry with them. And finally, self- evaluations are subject to many influences that may affect findings.

CHAPTER VII

Areas for Further Study

Most research has involved adult women survivors. Little is known about successful intervention and treatment for the group of high risk adolescent and young adult women. As therapy and treatment modalities develop, more needs to be published in this area of treatment with very high risk adolescents about what is successful and helpful with this group. Yates and Associates state that "more focused, small-sample, in-depth interview studies with this population are needed" (p. 548).

Another area of potential study is the role of spirituality or some inner power on the ability to persevere and/or heal. Feminist writers (Brock, 1991 and Mason, 1991) in self-help arenas, are writing on these topics, and still others make connections between self-esteem, sexuality and spirituality (Helminiak, 1989). More needs to be explored in the effects of spirituality on persons with a sexual abuse history. And finally, longitudinal studies of child sexual abuse and the effects and effectiveness of group work with survivors are needed in research.

CHAPTER VIII
Conclusion

I have attempted to develop a framework addressing the needs of a specific population of adolescent females survivors. In it I have stated my lived experiences and relational experiences working with survivors within this population. I have reviewed and explored the theories and proposed a program with the hopes of empowering and assisting these young women. This population has been abused, neglected and labeled by our society for too long. They deserve the time and energy needed from practitioners to explore and develop nontraditional ways of care and treatment.

Adolescent females...

"I don't really like it, but when I say no he does what he wants anyway, so I guess, I'm used to it. I just space out like when I was a kid, I'm really good at that."-
A 15-year old pregnant, adolescent, as she describes sexual relations with her boyfriend.

"I didn't really know that I had them. I don't really notice that part of my body, it's like it's not a part of me or something."-
A 19-year old pregnant mother of two, being treated for an advanced, inflamed outbreak of chlamydia and genital warts.

"I don't trust anyone, I'd rather be living on the streets where I never forget to watch my back. Everyone and anyone will screw you anyway, if they can get away with it."-
A 18-year old homeless, pregnant female, who ran away at 15.

... and survivors of child sexual abuse.

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Sample Pre-Questionnaire

Hello-
The following questions are being asked so that the leaders will have an idea of what type of program may be most helpful to you and the other young women that will be participating in the next few months in the group. Because we believe that you are the person that knows best what kinds of support, care and services you need and what will be most helpful to you (and other young women). We hope you will take some time and think about and answer the following questions. If there is any question that you do not want to answer just leave it blank. Also feel free to ask any questions you may have about this form.

Date: Agency Name:

Name: Age:

1. How did you hear about the group?

2. How do you feel about starting a new group?

3. What are some areas in your life you would like support and help with in this group?

4. What are some positive qualities or strengths you possess that you bring to the group?

5. How many people do you have in your life that you can really count on if you need some support or help? _____
What relationship are they to you? (friend, partner, parent)

6. How many people would you say really know you? _____

7. How many people would you say really care about you? _____

8. How many people do you really care about? _____

9. How hard is it for you to talk to others about what's going on in your life right now? Impossible _____
Very hard _____ Hard, but I can do it _____
Not too hard _____ Easy ____

10. Using the numbers 1 through 10 rate how you feel overall about yourself. 1 means the worst and 10 means the best.
1 2 3 4 5 6 7 8 9 10

11. Please make a list of all the things you do to cope when you have a hard time, when you feel really angry or sad or afraid?

12. Please write anything about the group so far or about yourself that you would like us to know, that may be helpful to you or another young women in the group.

Use the back of this page if you need more space.
Thank-you.

Post-Questionnaire

Hello-
The following questions are being asked so that the leaders will have an idea of what parts of group have been most helpful to you and the other young women. We want this information because we believe that you are the person that knows best what kinds of support, care and services you need and what will be most helpful to you (and other young women). We hope you will take some time and answer the following questions. If there is any question that you do not want to answer just leave it blank. Also feel free to ask any questions you may have about this form.

Date: Agency Name:

Name: Age:

1. How many series of groups have you been a part of?
   1 2 3 4

2. How do you feel about completing this last group?

3. What are some areas in your life or things you feel you received support and help with in this program?

4. What are some positive qualities or strengths you brought to the group and to other group members?

5. How many people do you have in your life that you can really count on if you need some support or help? _____
   What relationship are they to you? (friend, partner, parent)

6. How many people would you say really know you? _____

7. How many people would you say really care about you? _____

8. How many people do you really care about? _____

9. How hard is it for you to talk to others about what's going on in your life right now?
Impossible _____ Very hard _____
Hard, but I can do it _____ Not too hard _____ Easy ____

10. Using the numbers 1 through 10 rate how you feel overall about yourself. 1 means the worst and 10 means the best.
1 2 3 4 5 6 7 8 9 10

11. Please make a list of all the things you do to cope when you have a hard time, like when you feel really angry or sad or afraid?

12. What has been the best part of this group for you?

13. What would you like to see changed about this group?

14. Please write anything down about the group so far or about yourself that you would like us to know that may be helpful to yourself or other young women.

Use the back of this page if you need more space.

Thank-you.