

**PERCEPTIONS OF SELF-HELP GROUPS FOR
CHILD SEXUAL ABUSE SURVIVORS:**

**AN EXPLORATORY STUDY AMONGST MENTAL HEALTH
WORKERS**

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of Arts (Clinical Psychology)**

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ABSTRACT

This explorative, qualitative study examines the perceptions of mental health workers about self-help groups with adult survivors of child sexual abuse. Given limited formal mental health services in South Africa, self-help represents one informal alternative which could supplement mental health service provision. The study thus arises from a perspective which values self-help groups and is informed by the urgency of community needs in this area, and takes seriously the idea that it is possible and desirable for mental health care workers to facilitate and foster community support systems. Twenty-two in-depth interviews were conducted with a sample of convenience which included eleven clinical psychologists, five psychiatrists, three social workers and three non-professionals and included interviewees from organizations currently engaged in issues relating to child sexual abuse. A semi-structured interview schedule was used and interviews were audio-taped. Interview responses were systematically analysed and common themes extracted around awareness of self-help, perceived benefits and problems of survivor self-help groups and the role of professionals. Main themes have been illustrated by verbatim transcriptions from audiotaped material. Most participants have had limited exposure to self-help groups. Whilst there was openness towards self-help with survivors, caution was expressed about dangers to clients in survivor groups which are not monitored by formally trained and accredited professionals. Self-help was considered useful mainly as an adjunct to formal services. Limited knowledge of self-help groups is a major determining factor informing professional perceptions. Recommendations for education of professionals are made in order to promote self-help groups and collaborative professional attitudes.

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INTRODUCTION

The mushrooming of self-help groups is one of the most noticeable features of community mental health service delivery in the last decade in Britain, USA, Australia and many other countries (Borkman,1990; Young and Williams,1988). Mental health service provision in South Africa is grossly inadequate for the majority of the population. It is marked by inequitable distribution of services along racial lines and most services are in urban areas and in the private sector (and therefore costly). There is a focus on institutional care at the expense of primary community care and human and financial resources are limited (Freeman,1989). No reliable mental health statistics exist for South Africa, but human resource problems are clear from the estimated public sector ratios of 1 clinical psychologist per 304 000 and 1 psychiatrist per 276 000 of the population, whilst First world ratios are around 1:4000 and 1:14000 respectively (Freeman,1992). Though the ratios for psychiatric nurses (1:5400) and social workers (1:5200) are considerably better, not all work in the mental health field (Freeman,1992).

The problem of child sexual abuse increasingly demands attention in the mental health sphere and the need for services in this area has been highlighted (British Psychological Society Report, 1990). Though there are no reliable South African figures for prevalence of sexual abuse of women, indications are that this might be in line with Western societies where estimates of between 12 and 44% are commonly reported (Levett,1987,1989a). Child abuse and neglect presents 70-90% of the case load of social welfare agencies (Child Abuse Prevention Project Proposal,1992) and it would be fair to suggest that many of these are child sexual abuse cases. Clearly, providing for accessible and affordable care will become a priority for mental health service provision in South Africa. Training more professionals is expensive and takes many years, especially with limited training opportunities at university level. More information is needed on alternative and informal resources which could usefully extend, diversify and complement existing formal mental health services. Self-help groups are now considered one of the principal resources for prevention and treatment of psychological distress (Jacobs and Goodman,1989; Orford,1992), but this trend is not evident in South Africa. However, there are related developments in the primary mental health field. Of relevance here, is the discussion of the value of helpers or counsellors with similar

cultural, socio-economic and linguistic backgrounds to clients, and the recognition of their accessibility to the community, their sensitivity to social and cultural factors and the bridging role they play between professional services and community needs (Dawes and Davids, 1983; Freeman, 1989; Hines, 1973).

This study explores perceptions of mental health workers about self-help groups for adult survivors of child sexual abuse. By focusing on self-help with adult sexual abuse survivors, this study enters a relatively new area. As self-help groups are considered part of the informal helping networks of society, systematic research on self-help groups is in its infancy stage (Borman and Lieber, 1984). Professional literature on self-help groups in general, and particularly about self-help survivor groups, is minimal and South African research non-existent. As such, the study is of an exploratory nature. It draws on professional literature about self-help groups in general, on literature about professional involvement with self-help groups, and on literature about child sexual abuse survivors. Where available, self-help literature, mainly in the form of pamphlets and newsletters from self-help organizations are also consulted. Previous research examining professional attitudes to self-help groups commented on the traditionally cautious relationship between self-help and formal mental health services. In the past there has been a widespread perception that professionalism and self-help are mutually exclusive and, at times, antagonistic (Steinman and Traunstein, 1976). Recent work indicates more favourable attitudes and has encouraged increased professional awareness as well as a more collaborative approach to self-help groups (Borkman, 1990; Chesler, 1989; Madara, 1990; Meissen, Mason and Gleason, 1991).

It is anticipated that many mental health workers in South Africa are likely to have had little contact with, and maintain a cautious approach to self-help groups, as reported in previous research. An important aspect of this study is to explore what encumbers professional attitudes to self-help groups. It was expected that professionals would foresee several problems with self-help groups for child sexual abuse survivors and that they would be reluctant to see such groups operate autonomously. Furthermore, that mental health workers with experience of self-help groups and/or of working with child sexual abuse may be more flexible and open in advocating self-help as a treatment option because of familiarity with the issues. Finally, this study will explore possibilities for collaboration between self-help groups and professionals in the field of child sexual abuse.

Self-help groups

Defining self-help groups

The literature on self-help is diverse and often confusing because of varying use of the term self-help. Self-help groups can be defined very basically as "voluntary associations amongst individuals who share a common problem and who seek to use the group as a means of dealing with that need or problem" (Durman,1976,p.432). The main features are that groups are member-governed and provide mutual support. In the main, self-help groups are financially self-supporting. The most common kinds of problem focus are substance abuse and life stressors. "Dealing" with the problem can include a wide variety of activities such as emotional support, social companionship, ideology and role models, a sense of mastery and control, relevant information and advice, and pressure group activities.

Distinctions are often not recognized between self-help groups, support groups, mutual aid, peer support and group therapy. These terms are often used interchangeably. Chesler(1989) provides some clarity by explaining the distinction in terms of two areas of difference. Firstly, the amount of knowledge authority and leadership required and secondly, the different goals and activities of groups are what distinguishes self-help groups from other groups. In self-help groups (often referred to as mutual-aid groups), having the same problem as others in the group is usually considered adequate knowledge for the group leader, whilst support groups and group therapy require professional training in human services. Leadership in the latter would also have more authority whereas in self-help groups authority is shared. This introduces a further distinction: the "pure" or autonomous versus the "hybrid" self-help group. The former is led solely by members who share the problem and the latter may have professional involvement and support.

Professional leadership is most likely to occur in groups whose aim is counselling or therapy, whereas lay leadership is most likely in self-help groups with support, education and social advocacy as the main activities. Traditional professionally-led group therapy and professionally-led support groups are not considered in this study. The self-help groups concerned are both autonomous and hybrid groups and this study partly aims to determine which option is perceived as more acceptable amongst mental health workers.

Historical background

The origins of self-help groups can be traced back to mutual-aid groups during the Industrial Revolution, when labourers formed mutual aid societies, craft guild systems and later labour unions to cope with the stresses of rapid changes in society. Amongst the economically and politically disadvantaged (working and lower classes), people grouped together for social support and assistance of the old, sick and disabled as there was insufficient help from their government. In the process, group identity, social awareness and political activism was often fostered (Katz and Bender,1976).

Contemporary self-help groups differ in the sense that they focus on health and human services. These groups can be dated back to the 1930's when Alcoholics Anonymous and Recovery were initiated, followed by the organization of parents of sick and mentally handicapped children. The civil and human rights movement in the 1960's and 1970's saw the growth of women's movement groups and specialized groups for various handicapped and stigmatized conditions (eg. stutters, ex-offenders), all fighting against discrimination and prejudice. Specialized self-help groups also developed to support members with diseases (eg. diabetes, arthritis); medical treatment (eg. heart surgery); and life transitions and mental health (eg. bereavement, menopause, depression). Self-help groups have also developed in response to traumatic events such as natural disasters, torture, and sexual assault (Borkman,1990).

The aims of self-help groups vary. With addictions the aim is to achieve and maintain 'sobriety', meaning both abstinence from the undesirable substance and "fundamental change in thinking and acting" (Kurtz,1989,p.98). Usually a Twelve-step program is used for practical and spiritual guidance. Family support, health, disability and life transition groups aim to meet the psycho-social needs of members and to promote emotional and social adjustment. Such groups support and enhance the coping capacities of group members. This is usually achieved through self-disclosure, perceptions of similarity and communication of empathy and acceptance (Medvene,1989).

In 1978, in the U.S.A, the President's Commission on Mental Health recommended consultation between mental health services and community support networks. This culminated in the 1987 Surgeon General's Workshop on Self-help and Public Health, a landmark for formalizing self-help and professional interaction and evidence of the growing acceptance of self-help groups amongst professionals and

the general public. The Surgeon General, C.Everett Koop, made recommendations which stressed the importance of preserving the autonomy of self-help groups and of developing egalitarian relationships between self-help groups and professionals (Borkman,1990). These developments were echoed by the World Health Organization(WHO), in the early 1980's, which was consulting widely in Europe on self-help and health (Newsletter of the International Information Centre on Self-help and Health,1985). Further efforts established self-help clearing houses in the USA which help people find and form self-help groups.

Self-help and mental health services

Relevant literature reveals recognition of the value of self-help groups in mental health care (Borkman,1990; Emerick,1990; Galanter,1988; Gotlieb, 1981; Jacobs and Goodman,1989; Madara,1990; Powell,1989; Steinman and Traunstein,1976). The European and American experiences have shown that self-help groups have been established to help people cope with a great variety of medical, psychological and social problems. Most self-help groups are small, local and quiet, but there are large national networks too. The largest and most well-known of these, Alcoholics Anonymous, is an organization that plays a central role in complementing formal health care of alcoholism. Jacobs and Goodman(1989), two American psychologists attached to the California Self-help Center, advocate closer co-operation between professionals and self-help groups. They argue that professionals have tended to underestimate the number and magnitude of self-help groups because of their quiet nature. The authors venture a rough estimate that in the USA in 1989, as many people used self-help groups in a year as used psychotherapy. It is suggested that self-help groups now rival psychotherapy as a format for personal help and they urge fellow psychologists to consider involvement with self-help groups. Putting their case strongly, they write:

"We will argue that self-help groups are well on their way to becoming a major and legitimate format for delivering mental health care in this country. If we psychologists do not play a significant part in this development, other professionals will, perhaps dropping our national relevance a notch" (Jacobs and Goodman,1989,p.536).

The crux of their argument is that increased social changes creates a need for social support, whilst there are financial and other limitations on the availability of government mental health and social services. This stimulates the search for alternate treatment models.

Others have a more comprehensive view of the move towards self-help in mental health care:

"The increasing professionalization of health care delivery systems, improved client awareness, funding cutbacks and an emphasis on voluntarism have led recipients of health services to turn increasingly to self-help groups" (Yoak and Chesler, 1985, p.427).

Benefits and problems of self-help groups

Self-help groups form part of the informal helping networks of society. They have largely been ignored by researchers and professionals who have confined their interest to captive populations such as are found in hospitals and clinics. Though systematic research on self-help groups is in its formative stages, there is documentation of experiences, observations and surveys which indicate the importance of self-help (Borman and Lieber, 1984). Much of the literature on self-help groups is fairly optimistic about its benefits. Some of these benefits are recognized by professionals and self-helpers alike.

The central value of self-help groups lays in the fact that people find solace, strength support and acceptance from being with others who share a common experience. Social support has the "ability to 'buffer' the impact of psychosocial stress on physical and mental health" (Jacobs and Goodman, 1989, p.538). Acceptance can help members deal positively with feelings of isolation and stigma and is considered vital in making cognitive, emotional and behavioural changes necessary for more effective functioning.

Self-help groups increase accessibility of health and social services on more than one level. Groups can meet the needs for peer support (the 'buddy' system), that formal mental health services cannot adequately address, often at hours when professional staff are not available. Affordability is another major factor that increases accessibility (Madara, 1990).

With sharing a common problem, there is a process of normalizing needs, in contrast to the tendency among professionals to "problemize" personal difficulties (which then require extensive treatment) (Durman, 1976, p.436). The sense of responsibility and community can also facilitate positive change as the locus of control is with members, rather than with professionals. (Madara, 1990).

A key element in self-help is the process of being able to help another person. This becomes a source of feeling socially useful; there is a sense of equality in giving and taking and a feeling of interpersonal competence (Borman and Lieber, 1984).

Knowledge and understanding about the focus problem is increased as members share information, conceptual frameworks and reading material. Self-help groups have identified needs and ways of coping, some of which have been incorporated into the education of professionals (eg. alcoholism) (Comstock and Mohamoud, 1989).

Self-help groups have the potential to act beyond the immediate group and tackle broader social aspects by increasing public awareness of the problem or by acting as a pressure group to affect social policy (Durman, 1976). Social advocacy may also include lending assistance to others outside the group, with similar needs.

From an organisational point of view, self-help groups are known to be adaptable to a wide variety of social and cultural settings and have produced lay helpers in the community who have started other self-help groups. Primary health care projects are increasingly identifying and training such community based helpers or "natural" counsellors in the mental health field. The Mamre Community Health Workers' Project train local people to become lay counsellors for family and community care (Networker, 1992). Similarly, the Eldorado Park Centre for Peace Action Program envisage training local helpers as part of a long-term strategy for community involvement in combatting violence and improving psychological well-being (Seedat, Terre Blance, Butchart and Nell, 1992).

Professional literature often raise questions about the effectiveness of self-help, whether a self-help group can cater to the needs of an often heterogeneous group in terms of age, stage and severity of problems. Could events (eg. distress of one member) be emotionally upsetting rather than supportive? Could the sharing of knowledge perhaps also mean spreading misinformation, perpetuation of myths and raising of false hopes? (Orford, 1992). Some professionals caution that self-help groups may foster inappropriate dependence in members or encourage an anti-professional stance (Chesler, 1989).

Self-help groups have been criticized for being disorganized, unreliable and superficial and for inadequate participation amongst racial minorities and social classes, those with the least access to formal health services (Borkman, 1990).

Over and above this, there are various constraints under which self-help groups operate. Individuals participating need the belief that self-help is appropriate for them. Practical and professional constraints, the lack of support and lack of understanding, can make it very difficult for groups to function effectively.

Although hard evidence for the effectiveness and success of self-help groups is not overwhelming, a large amount of anecdotal data suggests that it is. Some feel that while the success of self-help groups might reflect certain inadequacies inherent in formal health services, they nevertheless have a value of their own. Durman makes this clear when he aptly comments:

"Self-help groups are neither a panacea for the inadequacies of current service delivery nor a frivolous fad with little relevance for meeting the real needs of people" (Durman, 1976, p.442).

Judging from potential benefits, quite clearly, self-help groups have an important role to play in service provision. However, their efficacy also depends on the willingness of professionals to work with and accept the legitimacy of self-help.

Mental health workers and self-help groups

Despite acknowledged benefits, self-help groups exist in an "ambiguous, mixed and often marginal relationship" to mainstream health delivery systems (Borkman, 1990, p.321). Traditionally the relationship with professionals has been an uncomfortable one for both, with professionals tending to shy away from self-help groups.

"Lacking familiarity with the potential of self-help groups to be primary treatment of choice for any number of personal problems, the psychologist sometimes views them as mere inexpensive, naive adjuncts to therapy" (Jacobs and Goodman, 1989, p.536).

The authors humorously describe psychologists' perceptions of self-help groups as "hand-holding, morale boosting, do-no-harm meetings of fellow sufferers" (p.536).

There seem to be contradictory attitudes on the part of professionals toward self-help, some are more positive and others are more cautious of self-help. Advocates of self-help see it as a healthy extension of organized health care rather than as a threat to the professional establishment or a substitute for professional care. They discourage professional resistance to the role of self-help groups.

Looking at the possible barriers to the establishment of a mutually supportive relationship between self-help groups and professionals, authors suggest various reasons. Statements have been made about the superiority of professionals and their territoriality when it comes to intervening with certain problems. There may be an attachment to familiar therapy as the only intervention. Self-help groups may be perceived as too self-sufficient, and perhaps, unwelcoming. Taking a more optimistic view, others suggest that a lack of familiarity with self-help groups distorts viewpoints and that some professionals keep their hands off out of respect for the self-governance of self-help groups (Chesler, 1989).

A study by Chesler (1989) on the "dangers" of self-help groups aims to understand and challenge professional views. The research was part of a larger study on self-help for families of children with cancer. Personal interviews were conducted with 63 professionals who were asked three standard questions:

"1)'Some professionals say that self-help groups can be dangerous: Have you ever heard that stated?' 2)'Have you seen evidence in the local group of such dangers actually occurring?' 3)'What do professionals mean when they talk about the dangers of self-help groups?'" (Chesler, 1989, pp. 308-309).

Results showed a big difference between the number of professionals who had heard about the dangers, and those few who actually experienced them. The author indicates that sample bias may partly account for this considerable difference (respondents were already working with support and self-help groups), but nevertheless feels that the results point towards the importance of "considering that the roots of professionals' beliefs about self-help groups are in their ideology, rather than their experience" (Chesler, 1989, p. 310). Chesler argues that such ideology has an impact on professionals' behaviour towards self-help groups and perhaps on the behaviour of their clients.

In the above study, professional perceptions of problems with self-help, can be broadly summarized as follows. Firstly, dangers to parents/members ("creating emotional problems" for parents was most frequently listed); and secondly, dangers to professionals (challenge to the authority of professionals was top of the list). Professionals seem to view the dangers that self-help groups posed to members, as outweighing by far the dangers they pose to professionals. Members are felt to be endangered because of escalating anger and anxiety, inappropriate use of therapeutic process, fostering the members' dependence and undue pressure to conform to the group ideology as well as spreading medical misinformation. Some typical group dynamics (such as leadership problems) are

often treated as problems exclusive to self-help groups. Another example is where the group may be working on instrumental group tasks which is then considered by professionals as diverting from 'more important' psychological issues (Chesler, 1989).

From a professional perspective, there is also the view that self-help groups hold dangers for the professional establishment. Amongst others, the main perceptions are that group members may develop an anti-professional stance and show resistance to professional services.

Looking at the many perceptions of differences between professionally led groups and self-help groups, Chesler is of the opinion that such comments are "not only invidious, they usually are undertaken without sound comparative data" (Chesler, 1989, p.305). The author suggests that these fears may result from an implicit professional monopoly on mental health care services and assumed expertise. In sketching the history of professionalization, Louw (1988) paints a picture of increasing regulation and control which entrenched specialist expertise and elite status. He points to the moral ambivalence of increased professionalization, with elements of service to society and self advancement living side by side. Self-help, where the client rather than the professional has primary responsibility for care, may be considered a challenge to the traditional professional role.

Turning to positive professional attitudes to self-help, a recent study involving 168 American clinical psychology and social work postgraduate students found that most participants held positive beliefs regarding self-help (Meissen, Mason and Gleason, 1991). Illustrating the direct and indirect influence of beliefs on behaviour towards self-help, the study determined that those who were members of self-help groups had more positive beliefs and significantly greater intention to participate in self-help.

When asked what problems this sample assumed were appropriate and inappropriate for self-help, "addictions" topped the list as appropriate whilst "mental illness" (chronically mentally ill) was considered as inappropriate. "Emotional reactions to life crises" (eg. bereavement and divorce) were considered appropriate, whilst depression (eg. chronic, manic-depressive) was considered an inappropriate focus problem for self-help groups. By way of explanation, the authors suggest that, as mental health professionals in training, the students

believe that approaching serious mental illness requires professional training to succeed. They anticipate though, that mental health self-help groups will continue to grow and make a significant impact on mental health policy (Meissen, Mason and Gleason, 1991, pp.706-711).

Leading on from the above study, the important question for the present study is whether long-past experience of child sexual abuse is an appropriate focus problem for self-help. If self-help is to be investigated as a possible treatment option with large numbers of adult survivors who feel they need assistance, some understanding is required of the perceptions of mental health professionals as to its likely suitability. This will be of importance if supportive relationships are to be developed between professionals and those, one way or another, engaged in self-help options.

Mental health workers and Child Sexual Abuse

In the past few years there has been a rapid growth in the recognition of both the incidence and some of the implications of child sexual abuse. This presents challenges to all the relevant professions and there is acknowledgement child sexual abuse is a complex area of work. The British Psychological Society established a Working Party in 1989 to raise awareness of psychological issues involved with child sexual abuse and to encourage multidisciplinary co-operation and continuing research.

There is some debate on whether there are always identifiable long-term psychological consequences to child sexual abuse and this remains a contentious issue (Browne and Finkelhor, 1986; Levett, 1989a, 1990, 1992; Russell, 1991; Sheldrick, 1991; Travis, 1993). Some literature suggests that psychological sequelae may, in fact, resemble that of a post traumatic stress syndrome (Armsworth, 1989; Edwards and Donaldson, 1989). These effects, many of which relate to stigma (Levett, 1990, 1992), show in different ways and may be delayed until adulthood. Others maintain that many abused children grow up to be able, non-abusive, coping adults who never come to the attention of health or social services, or that certain survivors do not seek treatment from professionals, so consequences are not recognized (British Psychological Society Report, 1990; Levett, 1987, 1990, 1992).

Today it is commonly accepted by professionals that difficulties in forming close relationships, depression, anxiety, feelings of isolation, stigma, hostility and mistrust, poor self-esteem, substance abuse, self-destructive behaviour and sexual maladjustment may occur in a certain section of the sexually abused population (Bass and Davis,1988; Browne and Finkelhor,1986; Deighton and McPeek,1985; Mullen,1990). Many young adult women who were sexually abused as children seek individual or marital counselling, although there are few services for them and many cannot afford professional care (Deighton and McPeek,1985). With rising awareness of child sexual abuse and its possible long-term effects, it can be anticipated that increasing numbers of adult survivors will attribute current problems to these experiences and will come into contact with the mental health system. It is likely that many of these survivors may not need intensive professional intervention, but there may be a need for a form of support and education, and for some, the need to help others with the same problem.

As mentioned in the beginning, the South African mental health system is grossly inadequate and this is coupled with, as is the trend in the Western world, a decrease in state funding. Against this background, it seems unlikely that the formal mental health system could adequately provide services for adult survivors, especially given the variety of these clients' needs. There is a need to explore creative and innovative ways of complementing and diversifying formal services for adult survivors. Self-help groups need consideration because, formally or informally, they have traditionally played a useful role as an adjunct to health and social services.

"In dealing with rising demand and limited resources, mental health centers can at a minimum identify and use self-help groups to meet the expanding mental health needs of their communities without having to expand their budgets" (Madara,1990,p.112).

The use of self-help groups with adult survivors of sexual abuse is addressed by women's organizations in Britain and America. The Incest Survivors Campaign, a London based group, advocates self-help as the preferred intervention and in the mid 1980's advised on how survivors could start a self-help group (Incest Survivors Campaign pamphlet,1984). There has been a rapid growth of literature geared towards supporting and advising survivors of long past sexual abuse, often written by survivors themselves. Most well-known and widely-sold amongst these survivor books, is The Courage to Heal by Bass and Davis (1988). This guide book has a strong self-help component. It is critically described as the "bible of the incest-recovery movement" (Travis,1993,p.1), a point elaborated on later.

Informed by feminist activism, self-help is seen as a way of empowering survivors in a way not possible in a patient-doctor relationship. The view is that it is best to talk to others who had the same experience and the emphasis is on the individual's inner strengths and capability for growth. The self-help principle of "action leads to therapy and therapy leads to action" means that the woman receives strength to heal the abuse in her past through support and she gives strength to the cause of helping others, thus being self-responsible and giving mutual aid (Incest Survivors Campaign pamphlet,1984). In the process, it is said, feelings of worthlessness and isolation can be healed through the contact with other survivors (The Support Centre Against Incest pamphlet,1988).

Underlying this trend of thought are the perceived ideological differences between feminist philosophy and psychology (and by implication professionals) in the field of sexual abuse.

"Psychology has consistently operated as an instrument to police women's reactions to sexual assault - limiting and individualizing what we can learn from such experiences, and obscuring the political implications" (Kitzinger,1992,p.400).

Ironically, the authors of contemporary survivor books have recently elicited similar criticism. Travis(1993) argues that "The Courage to Heal" and other such survivor books are supposedly written from a feminist perspective, but that the authors oversimplify complex issues of trauma, after-effects and memory of long past events. The problem is that after-effects checklists include virtually any problems women may experience. Solutions which are restricted to recognising the abuse and seeking therapy, remain personalized. This point has been consistently argued by Levett(1987,1989b,1990,1992) who cautions against uncritical and oversimplified notions of cause and consequences as these encourage women to ascribe all their life problems to a particular experience or trauma. She points out that this serves to obscure the socio-political factors at play in shaping women's position in society and acts as a social control factor. Travis, coining the phrase "beware of the incest-survivor machine", points to the dangers of 'creating victims', spreading misinformation and expanding the therapy and self-help book market to the exclusion of a broader socio-political and social change perspective. Thus, the discourse of trauma can create a self-fulfilling prophecy and a "victim identity" with no acknowledgement of the resilience of some survivors (Levett,1987).

Nevertheless, there is evidence to support criticism levelled at professional treatment of adult sexual abuse survivors. Exploitation and re-victimization by helping professionals is possible; as is therapists' lack of knowledge about sexual abuse, their denial or inability to be objective, and their possible sexual involvement in the name of treatment are all feasible and are reported by Armsworth(1989). The author also lists interventions that clients found helpful such as validation, empathic understanding, acknowledgement of the clients' needs and the absence of derision. It could be argued that these interventions are within the scope of self-help group activity, though dealing with child sexual abuse in a self-help group could foreseeably have its own set of problems.

The aim of a self-help group for adult survivors would presumably be similar to that of groups for life stressors, that is, supporting and improving the ability to cope with a difficult situation. Aims may be more diffuse and varied from one survivor group to another, but would be commonly achieved by the distinctive kind of help available from a self-help group. The key element is the special bond that form between those who share the same problem, that leads to emotional support. Through self-disclosure, the survivor breaks the silence and isolation associated with sexual abuse and the group offers emotional reassurance and acceptance ("I've been there, too"; "You are not alone"). Individual stories told include what difficulties members have tried to overcome, thus providing role models, hope and motivation to peers. Knowledge about sexual abuse may be increased and advice shared on ways to deal with stigma. Group members may extend their concern to others outside the group and advocate for improved legal system and public awareness and protection by fighting myths and stereotypes (Powell,1989,p.24-29).

It could be argued that Travis'(1993) criticism of therapy and support groups as individualized and therefore limited, equally apply to survivor self-help groups. Group members may have to consider this criticism when establishing goals and decide on the place of social advocacy for their group, as this would be one way of addressing the broader socio-political aspects of child sexual abuse. Another consideration is the view that, for some, disclosing abuse may be pointless, with nothing to gain and possibly something to lose, perhaps inviting stigma (Levett,1987,pp.83-84).

At this point, it is important to distinguish between well-established self-help groups like Alcoholics Anonymous (which has developed a workable perspective

of the problem and its resolution) and fledgling or new groups (Borkman,1989). Of necessity, a survivor group would be a fledgling group because of non-existent guidelines, where members are learning together about the problem and where open-mindedness about experiences and resolutions are required. It is recommended that a survivor self-help group contain a mixture of members at different phases of resolution (from newcomers to veterans), for much of the learning occurs by example. "Fledgling groups that contain only newcomers face extensive problems in learning" (Borkman,1989,p.23).

Jacobs and Goodman(1989), two psychologists, support the idea that for some problems, self-help groups may in fact be regarded as the treatment of choice by client and professional, but it is unclear to what extent this view is shared by other professionals.

Several authors have explored the possibility of an alliance between professional services and self-help groups (Borkman, 1990; Chesler,1989; Emerick,1990; Orford,1992; Toseland and Hacker,1982,1985; Yoak and Chesler,1985). It is argued that there is a place for partnership and that "such coalitions of clients and professionals are vital to ensuring service delivery" (Yoak and Chesler,1985,p.427).

Adequate knowledge about self-help on the part of professionals is considered one of the most important conditions for successful collaboration. The literature highlights the need for education about the workings of self-help which would enable professionals to effectively negotiate their involvement with self-help groups.

A framework for consultation and co-operation could be developed to guard against jeopardizing the autonomy of the self-help group. This, according to Chesler, would be an ongoing process of reshaping traditional professional roles "away from a principal and solo role to a collaborative one" (Chesler,1989,p.322). There are gains for both parties as professionals would benefit in personal and professional growth and knowledge. Self-help groups may be enriched by the resources of professionals. Though agreeing with this, Madara rather skeptically notes that "the first thing professionals have to learn about self-help groups is that there is something to learn" (Madara,1990,p.115). He locates the problem with training programs for professionals where the concept of self-help is not

sufficiently addressed and professionals do not discover the roles they might play in supporting this resource.

Many different roles for professionals have been suggested. These include consultant, organizer, initiator, referral source, group leader, co-facilitator, guest speaker, member or no role at all. There is more support for external roles such as consultant and referral agent which represents indirect participation. Direct participation as facilitator is generally considered less appropriate. The role of initiator (helping to start and organize new groups) is considered by some to be the most productive professional involvement and a large percentage of self-help groups started this way (Madara, 1990).

This study explores the perceptions of mental health workers about self-help and aims to establish whether professionals in the Western Cape would consider survivor self-help groups as a treatment option where groups are not necessarily facilitated and monitored by formally trained and accredited professionals. It also investigates what levels of collaboration with self-help groups are preferred. Based on the literature about professional attitudes to self-help, it is expected that a cautious attitude towards self-help groups will prevail amongst most professionals. A more flexible and positive approach is expected from those with exposure to self-help groups, with experience in working with child sexual abuse and amongst service organizations.

The rationale for this exploratory study arises from the belief in exploring alternative and diverse ways of providing effective mental health care, precisely because of limited and inaccessible resources. The importance of self-help groups in community mental health services, and anticipated increasing demands for services in the field of child sexual abuse, are further motivating factors. As is the argument that self-help might work better with some adult survivors. There is a need to explore the perceptions of mental health workers about adult survivor self-help groups, as this information could contribute to promoting the idea of self-help and developing collaboration between professionals and self-help groups.

METHODOLOGY

Method

From the literature, it became evident that the area under investigation is relatively new and potentially controversial. Therefore, a qualitative method for gathering and analysing data was thought to be appropriate, to allow informants to share their perceptions freely and for various viewpoints to emerge in the process. It was decided that a suitable methodology for the present study would involve in-depth or long interviews as:

"There is an implicit, or explicit sharing and/or negotiation of understanding in the interview situation which is not so central, and often not present, in other research procedures" (Brenner, Brown and Canter eds, 1985, quoted in Cooper, 1989, p.5).

To ensure that the scope of the study remained manageable and the need for some 'direction' of information gathered, the use of a semi-structured interview was considered important. According to McCracken (1988), this ensures that the investigator covers all terrain in the same order for each respondent, arrange data gathered and allows the interviewer to give attention more fully to the informants' testimony. (The process of developing the interview schedule is described under the **Instrument** subsection).

Sample

As this was an exploratory study, twenty-two informants were selected on the basis of proximity, convenience and their involvement with the field of child sexual abuse. All the interviewees were directly involved in mental health service provision and represent a cross-section of professional health workers in hospitals, private practice, and universities; as well as professionals and non-professionals from organizations offering mental health related services to the broader community. A special effort was made to include mental health workers who have experience of, and are currently engaged in the field of child sexual abuse; as well as those with notable clinical experience, though not necessarily with child sexual abuse issues.

The sample consists mainly of professionals (86%; n = 19). Of those, more than half (58%; n = 11) are clinical psychologists. Psychiatrists constituted 26%(n = 5)

of professionals and social workers 16%(n = 3), whilst non-professionals made up 14%(n = 3) of the total sample.

The sample includes four clinical psychologists who are educators of clinical psychology masters students at the three universities in the Western Cape (University of Cape Town, University of the Western Cape and Stellenbosch University). Their participation was considered important because of their role in shaping professional identity and attitudes of students. As relatively permanent staff members they also play a role in maintaining a body of knowledge that is passed on and used by those they teach.

The majority of the sample group are female (64%); this reflects the sex distribution in helping professions. Ages range from 30-59 years for professionals and from 24-38 years for non-professionals. Though there was a wide range of professional experience (3-35 years), most professionals had gained considerable experience in the mental health field with only 4 out of 19 professionals having less than 9 years experience.

To make provision for comparative data, subjects were divided into four groups, based on professions (a clinical psychologist group and a psychiatrist group), on whether they had expertise in dealing with child sexual abuse and a group for service organizations. Each group is provided with a code so as to aid in presenting findings, in identifying quotes and to ensure confidentiality.

The categories are as follows:

Clinical psychologists (CP)

This group consists of 6 clinical psychologists, which includes two private practitioners (CP1 and CP2), one hospital psychologist (CP3), three educators of psychologists (CP4, CP5 and CP6).

Psychiatrists (P)

This group consists of three private practitioners (P1, P2 and P3), one psychiatrist from a government community mental health service (P4), and a hospital psychiatrist (P5).

Specialists (S)

This group includes interviewees with varied backgrounds selected for their known and reported involvement with the prevention and treatment of child sexual abuse.

One subject had no particular expertise in this field, but was categorized with this group because of specializing in community psychology; in the case of two participants, their child abuse focus overlapped with an interest in and work in community psychology. The group consists of four clinical psychologists (S1,S2,S3,S4), one of whom is an educator of psychologists, one a practicing community psychologist and two private practitioners. Two social workers (S5 and S6) and one non-professional from a service organization (S7) complete the group.

Service organizations (SO)

This group consists of four interviewees, of whom two are non-professionals (SO1 and SO2) and of the two professionals, one is a social worker (SO3) and one a consultant clinical psychologist (SO4). What they have in common is that they all work for informal mental health service organizations which offer services to the community at little or no cost. Their participation was considered important for the ideas they could bring from working with a broad clientele, often not served by mainstream mental health services.

Instrument

The instrument was a semi-structured interview schedule in which participants were asked a variety of closed and open-ended questions about self-help groups defined as "Voluntary associations among individuals who share a common need or problem and who seek to use the group as a means of dealing with that need or problem" (Durman,1976,p.432). The main features of these are that they are member governed, for mutual support and around a shared or common problem. This definition was used in determining the level of awareness of self-help groups amongst participants and to provide a baseline definition for all participants.

The construction of a 24 question interview schedule (see **APPENDIX**) was informed by the self-help and professional literature, (see Borkman,1990 and Meissen, Mason and Gleason,1991) and by discussions with two professionals with experience in the field of child sexual abuse. The use of the term "survivor", as opposed to "victim", emerged in the course of these discussions as important for its positive focus on the coping capacities of victims. The term "survivor" is used in this study.

The draft interview schedule was first discussed with a clinical psychologist knowledgeable about survivor self-help groups. Suggestions for developing and

focussing questions were incorporated, after which the interview schedule was piloted on two clinical psychologists. Further refinement of the instrument resulted from their responses and suggestions, and from discussion with a social worker experienced in professionally-led group work with survivors. The interview schedule was finalized after a third pilot interview.

The main topics covered in the interview schedule are discussed below.

Demographic Data

Demographic data on age, sex, profession, number of years experience in the field of mental health as well as the extent of experience with child sexual abuse survivors were elicited.

Awareness of self-help groups

Participants were asked about their understanding of, and involvement with, self-help groups. The aim was to establish the level of their awareness of and exposure to, self-help groups as this was considered a factor possibly influencing further responses in the interview. A 5-point scale ranging from positive to negative was provided and respondents asked to pick one word that best described their attitude to self-help groups.

Self-help and child sexual abuse

In an open ended format, participants were asked for their views on the possible benefits and problems with self-help groups for child sexual abuse survivors, and to rank these in order of importance. Previous research (see Chesler, 1989) determined that professionals' perceptions of the dangers of self-help groups may influence their behaviour, for example, referral. Reasons for referral, or the lack thereof, are explored in the next section.

Role of self-help groups as a treatment option

Ideas about appropriate referral to self-help groups were examined. Participants were asked when and why they would regard self-help as an alternative, complementary or follow-up treatment option to professional intervention.

Role of mental health service in relation to self-help groups

Amongst other questions, this section asked participants to evaluate various roles for professionals in relation to self-help groups and to list three preferred roles. In addition four hypothetical models of intervention were presented and participants were asked to choose which model they would most easily refer to. The aim of

this was to explore how professional mental health workers perceive of themselves co-operating with self-help groups.

At the end of the interview, participants were asked to comment on the form and substance of the interview.

Procedure

Interviewees were approached telephonically to elicit participation in the study. The researcher explained that the study was aimed at getting recommendations from mental health professionals and non-professionals about the provision of mental health services given limited resources. Self-help in specific problem areas was identified as the subject of the study. At this stage it was not specified that child sexual abuse would be the main focus.

The interviews each lasted 45-75 minutes. Anonymity and confidentiality were guaranteed. Responses were noted in detail on the interview schedule, verbatim where possible, and audiotaped.

Completed interview material was carefully and repeatedly read. Thematic categories which appeared repeatedly in the data and which related to themes in the literature were systematically extracted and identified. In the case of all four main categories of information in the interview schedule (see **Instrument**), statements were transcribed under the number of headings and subheadings referring to common themes. These subheadings were not predetermined, but emerged from the material, though guided by the framework of the interview schedule. Some subheadings established initially collapsed as they appeared to overlap frequently. A total of 9 subheadings were identified for the section on Benefits and problems of self-help groups, which represents the largest portion of the material. The remainder of the interview material is presented without subheadings other than those offered by the interview schedule, but the same process of systematically extracting frequent and common responses was adhered to in the reporting of the results. Headings and subheadings representing themes of all the responses in this study were plotted on grids which accounted for every statement made by each participant to determine trends in and amongst the various sample groups. This allowed the researcher to study the data for any clustering or main trends. Main themes are illustrated by quotes transcribed from the audio-taped interviews.

RESULTS AND DISCUSSION

For the purpose of this study, four main categories were selected for discussion, each comprising several aspects and sub-categories. In the first section responses concerning general awareness and attitude to self-help groups are depicted in descriptive statistical terms. From the second section onwards, the researcher is not dealing with quantifiable data, but mainly with common themes. As such, section two deals with the perceived benefits and problems of self-help groups with adult child sexual abuse survivors. Sections three and four report on the role of self-help groups as a treatment option and on preferred professional roles and models of intervention. The last section provides useful miscellaneous comments extracted from the interview material. Selected comments are extracted as illustrations from the broad base of material; where quotes are used, interviewees are identified by code as explained in the **METHODOLOGY** section.

Awareness and attitudes towards self-help groups amongst mental health workers

More than half of the respondents (59%) had a limited (45%) to poor (14%) understanding of self-help groups. There was little awareness of what self-help groups do and difficulty in identifying more than one of the key elements; that self-help groups are: "member-governed", for "mutual support" around a "shared/common problem." (see **Method** for Durman's definition)

The minority of respondents (41%) had a fair (32%) to good (9%) understanding of self-help groups as they identified the three major elements, and generally showed a more in-depth understanding by offering additional information. Only two participants showed an awareness of the political and social advocacy component of self-help groups. On the whole, the specialist group appeared to have a better understanding than any of the other groups as all except one were rated as having fair to good understanding.

When asked to pick one word from a 5 point scale (positive, cautiously positive, unsure, cautiously negative, negative) that best described their general attitude toward self-help groups, again, over half (59%) chose 'cautiously positive'. What respondents seemed to indicate here was a general openness to consider the value of self-help groups, but with many reservations. Twenty-seven percent of the sample endorsed 'positive'. They were mainly, but not exclusively, those with membership of, or close contact with, self-help groups. Two (11%) respondents picked 'cautiously positive' to 'unsure' and one (5,5%) indicated a cautiously

negative attitude. The latter respondent, a professional, works in a fairly mainstream service organization and had recently been unsuccessful in initiating a group for parents of sexually abused children, factors which may account for the negative response.

As could be expected, most respondents (68%) had never been a member of a self-help group, whilst the minority (32%) of the respondents had been a member of one or more self-help groups at some point in their lives. Amongst these were self-help groups for personal growth (encounter groups), women's groups, peer counselling, a self-help group for the families of Alzheimer sufferers and an Incest Survivors group. Those with membership were spread throughout the sample, with three out of seven in the specialist group. All those with self-help group membership, except two, were rated as having fair to good understanding of self-help groups.

Though direct contact was minimal, all respondents (except two) had made a referral to a self-help group in the past. The main referrals were to Alcoholics Anonymous and its related self-help groups (Al-Anon, Al-Ateen). Other referrals mentioned were Share (bereaved parents), parents of schizophrenics, pre-school children, foster children, and mentally handicapped children. Groups for depression, divorce, single parents, drug addicts and sexual abuse survivors, even a group of women who started a sewing club, complete the list of referrals. Some of these groups are run by professionals and so, strictly speaking, they would not classify as self-help groups.

Summarizing, it would seem that most participants had limited understanding of self-help groups, limited membership and a cautiously positive approach to self-help groups. This finding is not surprising as earlier studies have shown that where professionals had direct contact with self-help groups, attitudes were positive; and professionals as members being more positive than those who were non-members (Meissen, Mason and Gleason, 1991). Positive personal beliefs are important and affect intention to collaborate with self-help groups. The sense of caution characterizing the attitude of this sample, is probably due to a lack of exposure to self-help groups as evidenced by low membership. Furthermore, most respondents agreed that they obtained little information about or exposure to self-help groups during their training. The basis for this cautiousness is explored more in the next section on benefits and problems of self-help groups. However, the issue is complicated by the focus on adult survivors of child sexual abuse.

Self-help groups and child sexual abuse survivors

When asked whether participants considered child sexual abuse a suitable focus for self-help groups, all except four felt it was *sometimes*, not always, suitable. The provisos mentioned were mainly that it would depend on the client and/or on the nature and effectiveness of self-help groups.

Benefits of self-help groups for child sexual abuse survivors

Participants' responses to the question about perceived benefits can be categorized as follows (starting with those benefits most frequently cited by participants): peer support, breaking isolation, empowerment, education, social advocacy, and accessibility. Ranking was not pursued as most respondents felt the benefits to be interlinked. For instance, peer support and breaking isolation, listed most frequently, often overlapped. Categories will be amply illustrated by quotes to provide a feel for the exploratory nature of material in this section.

Peer Support and Breaking Isolation

Most participants (82%) highlighted that in self-help groups, peer support is available when members share about the problem, when they identify with each other, and when learning methods to cope. It was expressed that peer support might be helpful because ventilating and sharing guilt, self-blame and anger in a trusting, open and understanding environment can help members to get beyond these feelings and to learn about ways of coping. The social benefit of peer support is most often cited in both professional literature about self-help and by self-helpers themselves. They express the sentiment that peer support is the one benefit professional intervention cannot easily provide. In fact, a study of 18 self-help groups in Canada found that what was rated highest by group members was "sharing communalities" and "meeting others with similar problems" (Borman and Lieber, 1984, p.15).

Participants in this study highlighted the particular significance peer support has for sexual abuse survivors. The majority of respondents (68%) highlighted the importance of breaking the isolation that is associated with being a survivor. It involves combatting alienation and aloneness and breaking the silence and secrecy so often associated with sexual abuse. This factor was particularly emphasised by the specialist group as all, except one in this group, made explicit reference to addressing isolation and secrecy.

The following quote illustrates the importance participants gave to this benefit:

"It breaks the 'It's only me, it's my fault' syndrome... and the whole thing, 'I'm different to other people, I am to blame', so it breaks that kind of isolation" (S6).

This is considered an essential aspect in the healing process in much of the professional literature on treatment as well as in survivor books. It is reported that "silence which surrounds the experience of sexual abuse contributes importantly to the traumatic effects of the experience", particularly because of the stigma attached to the abused (Levett,1989a,p.127). Bass and Davis (1988) highlight why "telling is transformative" and encourage women to share what happened to them as part of the healing process. A community psychologist in the specialist group elaborates:

"Flowing out of that would be a kind of reconceptualizing it... that whole shifting the blame... I think the kind of process of seeing that this has happened to many people" (S1).

A member of an Incest Survivors self-help group describes the experience:

"In sexual abuse, to contradict the isolation is probably the most crucial aspect... people honestly feel they are the only people it ever happened to ..." (S7).

She explained that much of the feelings of contamination and shame could be dealt with by meeting other survivors and that self-esteem then has a chance to develop: "So being part of a self-help group is just so liberating" (S7).

Empowerment

The issue of empowerment was mentioned by 22% of respondents. Adult child sexual abuse survivors are seen to regain a sense of mastery where this has been perceived to have been taken away by their abuser:

"The ability to say, 'now hold on, that wasn't right', uhm, you know, 'that was wrong', that sort of thing. Giving her the right, helping her to see it in perspective, gaining some self-respect... uhm, learning to be assertive, believing in her feelings again, you know, believing in herself" (S04).

A specialist experienced in child sexual abuse self-help groups confirms these perceptions saying "It's a contradiction of the victim role" (S2).

Empowerment through helping others is considered an important therapeutic gain in self-help groups:

"It's also transforming your experience of being victimized into knowledge and experience that can not only help you, but can help others... you know, so it's saying, yah, you were a victim at one stage, but now you're not, you're a survivor" (S2).

Education

Some participants made indirect reference to the beneficial educative aspect of self-help groups. A few (27%) directly addressed this issue, commenting that self-help groups increase awareness about the problem. This happens firstly, through sharing information on the development of symptomology and of the healing process and secondly, through helping to understand how it could have happened without blaming themselves. Dealing with myths and the misconceptions of others about child sexual abuse were regarded as a major educational focus by one specialist:

"... people come with things like 'Does this mean I'm gay?' and 'Does this mean I'm going to abuse my children?'" (S4)

What is being highlighted here is that many survivors are worried about having children, being able to care for them 'properly', and the possibility that their own children may be abused (by themselves or others). Whilst some of these fears may have some basis, it nevertheless highlights the need for education about how self-stigmatization develops in an atmosphere of secrecy and silence and the reasons for how that silence develops. Silence may be protecting the victim from stigma by others, but it, in effect, engenders self-stigmatization whilst safeguarding the perpetrators (Kitzinger, 1992; Levett, 1989a, 1990).

In fact, normalizing the experience is seen as a positive product of this education process:

"In that way, it almost normalizes, you know, the experience. I'm not saying that child sexual abuse is normal, but it makes it almost okay that it happened to you, and you and you..." (S6).

The survivor is able to recognize and gain from similarity in the group and hopefully move away from self-blame to a broader understanding of the problem. Kitzinger (1992), quoting Kelly (1988), highlights the political importance of this

process in commenting that medicalization of sexual abuse has reduced a "social and political issue into a matter of 'diagnosis'" (p.413).

Accessibility

The affordability and accessibility of self-help groups are highlighted as potential benefits by 18% of participants:

" The main advantage is that it doesn't cost; it's an issue in this country. The therapist is not able to see the person for an ideal number of sessions because of cost" (CP1).

One participant could speak about accessibility from experience:

"Yes, there was a commitment to call each other. There was a real feeling that we could do this. It made it very safe and containing to call someone...."

Commenting about the dilemma of limited formal mental health services, she concluded:

"For me, self-help groups are based on common-sense notions. It seems to me a really effective way, especially in a developing country, where there just aren't the kind of individual services for the amount of distressed people there are,... something that surely could be developed" (S7).

Social Advocacy

A small minority (16%; n=3) of participants (two clinical psychologist and one specialist) made mention of social advocacy as an activity and benefit of self-help groups. This involves taking some kind of social action. For example, in educating the broader community, seeking to affect social policy and doing prevention work.

A clinical psychologist explains:

"Many people are motivated to take action that will prevent this from happening again... and maybe they'll be able to share guidelines with each other and even try and sensitize other people on this issue..."

The speaker acknowledges the limitations of individual intervention in this instance, commenting that this was "not so easy to do as an individual, but can be much more effectively done in a group" (CP5).

What is of interest here is that most respondents identified the benefits of sharing and support, which have been described as more therapeutic, but few made

reference to the more educational, social and political components of self-help groups. Most self-help literature acknowledges the therapeutic gains of sharing communality, but also stress the value of socially orientated activities.

Lack of acknowledgement of the broader social benefits (education, social advocacy) for adult survivors may in part be due to the limited understanding of, and exposure to, self-help groups, evidenced by findings in the section on general awareness. Whilst popular feminist literature may give particular importance to the social component of healing, professionals in this sample may merely be reflecting their preferred way of working with individuals, at times to the exclusion of the social needs of these individuals.

Problems of self-help groups with child sexual abuse survivors

Participants were asked in an open-ended format: "What would be the problems of self-help groups for child sexual abuse survivors?" There is a keen awareness of problems in this sample. From responses, the following concerns emerged: the possibility of reinforcing problems; a lack of containment and facilitation, the need for a back-up system and the feeling that child sexual abuse is too complex an issue to be adequately dealt with in self-help groups. Unique responses are dealt with later under *Miscellaneous*. The concerns were often perceived by respondents as being interlinked, and will therefore be presented as general themes. Themes are documented in terms of how often the concern was raised and will start with the problems mentioned most frequently.

Reinforcing problems

From the sample, it is perceived that whilst members of a self-help group have the common purpose of dealing with their problems, issues might not be resolved and may even be reinforced in the group. This view was expressed by a majority (68%) of participants. Different aspects of this problem were focused upon by other participants. A consultant psychologist thought that problems may be dealt with superficially:

"...like anger, I think, can be a collusive kind of thing. That people can all get angry together, but in fact they're not facing the real pain that is underneath the anger or the hurt or the guilt or whatever"
(S04).

This perception that some self-help group members may avoid responsibility, supported by the collusion of fellow members, was echoed by other respondents.

Another concern is that group norms or ideology may interfere with the effectiveness of the group. A community psychologist expresses this difficulty:

"It's like saying that ... uhm, everybody must have the same kind of experience... or experience things in the same way..."

She continues:

"I think very often with self-help groups, and that's the other side of advocacy, is that they become crusaders...uhm, or that certain members of the group become crusaders." (S4)

Emphasising that survivors need different things at different times, a social worker in the specialist group cautioned against such "proselytising". This respondent wondered how much permission there is within self-help groups for issues to be named and for a member's "story to be told in their own words" (S5).

What the above respondents are expressing is partly a concern that the group functioning might be derailed by one dominating member, possibly suffering from a personality disorder, who may insist on their own viewpoint, preventing the group to explore all the issues. Without a skilled facilitator to turn this potentially negative experience into one where diversity is tolerated, such a group will be bound to fail in many respects.

Problem reinforcement may occur when the 'victim' element is given too much emphasis, perhaps creating an 'us and them' mentality. In other words, the idea of common identity can have a negative effect:

"...the other thing I'm thinking of is the whole issue of labelling. Sexual abuse victims are actually seeing themselves as victims and maybe reinforce that victim role in the group..." (S4).

A similar concern about seeking therapy "because of sexual abuse" has been raised in the literature on discourse of trauma. When seeking therapy for childhood sexual abuse, the focus is on a specific instance of victimization when, it is argued, problems could often more usefully be viewed as those of being female in a socio-historical context (Levett,1990,1992; Travis,1993).

One psychiatrist agreed that in-group mentality can be negatively supported, but saw this as a problem common to all groups, not just for self-help groups. Borkman(1989), however, notes that complaining, whining and self-pity may be found, but are usually restricted to early phases of self-help groups.

Lack of containment, facilitation and back-up

Difficulties about containment, facilitation and back-up support were not always directly linked by respondents. These problems were often expressed as part of a general concern about the effective functioning of survivor self-help groups, and when analysed this way, the concern is shared by 82% of respondents. This prompts the question: would the self-help group be able to deal with the "heavy emotions" that may arise?(S3). For example, might not a group member whose emotions are not adequately contained feel abandoned in just such a situation, "thus continuing the vicious cycle of damage" (CP3).

A psychiatrist puts it in a nutshell: "You might open a can of worms that you can't contain" (P5), adding that, in the process the person's defenses could be undermined and this could cause further problems. The concern that the distress of members may affect others negatively, has been raised in the literature. (Orford,1992).

By contrast, another psychiatrist who could foresee no problems with self-help groups, disagrees and expresses his view with amusement:

"I don't think that really holds because otherwise, following it through to the logical conclusion, nobody must express any emotion to anybody except professionals because they can't be contained (Laughter)... I think that applies to any self-help thing. A self-help group is just a structured way of sharing your problem. People can just as easily talk with their friends about it and not be contained ... or whatever" (P2).

Of concern to many was the perceived lack of trained facilitation in self-help groups. The reasons given are: that emotions can be difficult to contain; that facilitators could provide some objectivity, when needed, to protect the group from destructive dynamics or individuals; and that they help to deal with members in crisis. Comstock and Mohamoud(1989) are of the opinion that groups with neither a professional facilitator nor a Twelve-Step program are most likely to encounter difficulties. This is illustrated by the experience of a consultant to a depression self-help group:

"... they were really just going round in circles and pulling themselves down and there was nobody there who was able to put it into perspective for them or reflect back to them..."(SO4).

It is in this context that the need for professional back-up and referral is stressed:

" Well, I think the main problem for me is, you know, that there might not be a back-up system. Maybe within the group someone might have a particularly scary experience" (SO2).

This concern about facilitation is shared by the participant with experience in an Incest Survivor group.

"When people think of self-help, they often think there is no facilitation, or even strong leadership,... to me, I feel that's a need... Any group that I'm a part of, I'd want someone to facilitate the process, whether rotatory or same facilitator, but there must be facilitation of the process" (S7).

"It just means there is one person taking responsibility for monitoring for example, time, checking certain things,... if people are okay, and practical tasks, for example, tea breaks, games,... that make the running of the group effective,... someone thinking for the group" (S7).

Others considered the role of facilitator as more complex, someone who could "monitor, refer and contain" (SO4) and "prepare the groups for what could happen and to coach them through difficult situations" (SO2).

The consultant who related the problem in the depression group, reconsidered the issue for adult survivors:

"With survivors of child sexual abuse, it's something that happened a long time ago, they've gained a sense of control of their lives and to some extent, and although feeling,... very powerful feelings may come up, it's unlikely to be coming up at the same time."

She concluded:

"I suppose there is a self-regulatory thing that goes on in groups too, you know, that somebody in the group is going to take on the role of cautious one or the reasonable one, you know" (SO2).

Here there is some recognition that the severity of long-term effects vary and that many survivors may have reasonable coping capacities, a point of ongoing debate and polarization among academics and clinicians (see Levett,1990,1992; Russell,1991; Travis,1993).

The extent of polarization of views on psychological sequelae is illustrated by this contrasting comment by Comstock and Mohamoud(1989): "Survivors of incest, having been so repeatedly and so traumatically violated, have never had the

opportunity to learn appropriate boundaries and appropriate caretaking behaviours (for themselves and for others)" (p.185). This view of survivors could be considered an overgeneralization. Nevertheless, the concern expressed by these authors, about possible under-and over-involvement of members in a survivors self-help group, is a concern also reflected, though indirectly, in this study.

Child sexual abuse too complex

Few respondents (14%) made explicit reference to the idea that child sexual abuse may be too complex a problem to deal with in a self-help group. Though few directly referred to this, the strong emphasis placed on containment and back-up may reflect that this issue is an underlying concern. A clinical psychologist directly expresses this reservation:

"I'd say, at times, even for trained professionals, it can be quite complicated in a way; guiding themselves through defenses, intrusive memories... and the pathology can be quite severe" (CP5).

One respondent felt that issues of sexuality may be difficult to deal with in a self-help forum. Another felt that some survivors "may need more than just catharsis" and that self-help groups may not be able to provide assistance to those with more complex therapeutic needs.

Miscellaneous points

It was noted that survivors might not seek other appropriate forms of treatment once in a self-help group. The example was given that some survivors may benefit from hypnosis, but will not avail themselves of this treatment once in a self-help group.

Two participants raised an important issue with regard to the idea of single sex survivor groups: "There is a real gap in terms of men and women speaking to each other" (S5). Though group therapy literature is clear about the importance of mixed sex therapists in groups (see Ken Heap, 1988) on the issue of mixed sexes in sexual abuse groups, it is silent. It may be worth for mental health workers and self-help members to start thinking through the benefits and problems of mixed sex survivor groups.

Lastly, there are two unique problems experienced by a community psychologist in his work with self-help groups. Firstly, it is difficult to find peers with self-help

experience who can be leaders and secondly, there are not many professionals who are willing to be involved with self-help groups:

"... finding professionals who are prepared to treat their clients with that level of respect. To not feel threatened by it, I think people are threatened by it... that's the only understanding I can have why they're so reluctant... uhm... a misunderstanding also of the role and usefulness of it" (S2).

In the main, it appears there is a stronger perception of possible problems with adult survivor self-help groups and the arguments are convincingly presented. The common concerns expressed were potential damage to survivors and an inability to meet their needs adequately. This corresponds with Chesler's findings on 'dangers' of self-help groups for parents of children with cancer, where "creating emotional problems" was rated as the main difficulty. Inappropriate expression of emotion, undue pressure to conform to group norms and leadership problems are common dangers perceived by professionals in both studies.

What is striking is the absence of perceived dangers to professionals. Unlike Chesler, concern over dangers that may threaten the role and status of professionals remained unexpressed by participants in this study, except for one or two isolated references. In the main, professionals expressed concern only for the well-being of the client. This is understandable given professional knowledge and ethic of care in mental health and social services.

It is worth considering that the effective care of clients is not the only issue at stake, but also the monopoly of professionals. The traditional position of control and accountability in delivering mental health services may heighten professional awareness of dangers of self-help groups. After all, here the client, rather than the professional has primary responsibility for care and this situation contradicts the framework of formal mental health service delivery.

Heightened awareness of the complexities around sexual abuse could partly account for exaggerated professional concern about dangers to the client. This is possibly also based on the contested assumption, that all survivors are vulnerable and in need of professional care. Acknowledging both the strengths and needs of survivors in a self-help group, an Incest Survivor group member comments that self-help groups are for relatively "healthy" survivors, meaning people with ego strength who have coped reasonably well with their lives. However, the tables are turned when she expressed her concern about professional expertise:

"Do some psychologists even assume that sexual abuse has taken place?... A lot of professionals don't have good gender analysis,... don't have political analysis or good understanding of power relations" (S7).

Ironically, professionals worry about lack of expertise and adequate empathy in self-help groups, when self-helpers have expressed similar complaints about professionals they have sought for treatment. This dilemma of mutual mistrust of expertise is highlighted in the professional literature about self-help, but there is little systematic study of the issue. Of interest is the finding by Torro (1988), that peer-led groups for the mentally ill had more group cohesion, more expressiveness and self-disclosure in comparison to professionally led groups (Meissen, Mason and Gleason, 1991).

Nevertheless, there are potentially real dangers, precisely of the nature described by participants in this study. However, Chesler points out that there is no evidence in the available literature that such dangers are commonplace or, for that matter, that they are more likely to occur in self-help groups than in professional groups.

Role of self-help groups in treatment

Respondents were asked in a closed question format (YES/NO) whether they would consider self-help groups for adult survivors as an alternative, complementary and follow-up option to professional intervention. They were then asked to elaborate on their answers. What follows is a summary of these responses.

Follow-up option

All (100%) of participants said Yes, they would consider the follow-up option. In other words, after some form of professional intervention. This was also the preferred option by the majority (86%) of respondents. The main reasons for their preference were:

- i) consolidation: through ongoing support and contact, survivors can integrate, extend and maintain gains started in professional therapy;
- ii) economical: follow-up self-help groups are a cheaper and more accessible form of tertiary care;
- iii) primary prevention: through social advocacy, education and assistance to other survivors, community awareness and involvement is raised. This is important in preventing child sexual abuse.

Of the three participants who were less than positive about this option, two felt it depended on the needs of the client and the third, that it was only indicated if professional intervention was unsuccessful.

Complementary

The majority (86%) of participants responded positively to considering self-help as complementary to professional intervention, but only one (4,5%) thought it the best option. Support from fellow survivors and taking more responsibility for their own healing were considered important gains here.

Gleason (1988) found that graduate students were of the opinion that self-help would work best in conjunction with therapy. (cited in Meissen, Mason, and Gleason,1991). Material in the present study reveals more ambivalence about this option than both the other options. That this is not an easy or comfortable option for professionals, was highlighted by three participants. One commented: "It can get messy. I don't work in this way" (S5). This may be suggestive of the discomfort professionals feel when the roles and boundaries in treatment become blurred. One of those who expressed discomfort nevertheless regarded complementary self-help as the best option because he felt various needs of the client were being met. Showing awareness of the difficulties of negotiating the role of therapist, he anticipated that the self-help group may be idealized and the therapist devalued. He does however consider it a challenge to professionals, to deal with this conflict without feeling too threatened. Powell(1989) underscores this point, commenting that "individuals could benefit from both knowledge for different aspects of their problem or in different stages of coping with their problem" (p.35).

Alternative treatment

Twenty-seven percent said No, they would not consider self-help groups as an alternative to professional intervention. The main reasons were concern for clients' well being in the absence of professional involvement. For the rest, participants felt it depended on the needs of the individual client, though most had reservations. When the survivor was not too severely affected and support from fellow survivors was considered a priority, the alternative option was sanctioned. Also, the reputation for success and the accessibility of the self-help group are factors that would influence participants' consideration.

These opinions differs from feminist views of self-help as preferred alternative due to issues of communality, power, control, and social advocacy. Except for a few interviewees, there is little acknowledgement of these benefits. Only three (14%), all in the specialist group, acknowledged that self-help may be preferred above professional intervention by some survivors, showing awareness of the importance of decreased pathologizing. The increased educational focus of self-help groups was considered a further gain. Interviewees also highlighted limitations in professional care (lack of peer support, power dynamics, dependence) which may make self-help preferable above professional treatment.

All told, it would seem that professionals, specialists and non-professionals alike, prefer self-help groups as a follow-up treatment option for adult survivors. There was ambivalence about self-help groups as complementary to professional intervention. Self-help as an alternative to professional intervention elicited the most negative responses.

The value of self-help as follow-up is acknowledged in professional literature and by self-helpers. In particular, Madara(1990) and Powell(1989) comment on self-help as a supportive environment to consolidate and extend benefits of treatment, improving long-term care and reducing recidivism. If they succeed, these are important gains but, nevertheless, the virtually unanimous preference for self-help as follow-up in this study, does raise further questions about professional views of self-help. Professional literature illustrates the conflicts and confusions around collaborating with self-help groups (Borkman,1990; Chesler,1989; Durman,1976; Emerick,1990; Yoak and Chesler,1985) but these conflicts are minimized when self-help is confined to providing aftercare service. Presumably, when self-help is confined to follow-up services, professionals do not have to deal with sharing responsibility or knowledge, and their roles are not directly challenged; the professional remains the one with expertise for primary intervention whilst self-help remains only an adjunct to therapy. It is possible that this is rather a self-fulfilling prophecy amongst professionals and serves to confirm the professional perception that self-help groups deal only with superficial aspects of problems and therefore should be limited to aftercare.

The role of mental health workers in relation to self-help groups

Professional Roles

Participants were asked which three roles they would be most comfortable with in relation to self-help groups. This was preceded by a question on the appropriateness of various roles suggested in the literature viz., consultant, leader/co-facilitator, referral agent, guest speaker, researcher, initiator, trainer, no role.

The three most popular choices were:

1. Consultant (68%)
2. Referral Agent (59%)
3. Guest Speaker (46%)

The consultant role was conceived of as dealing with the selection and supervision of the group process. Whilst most participants did not question this, some objected to this view. One participant felt that selection function was not appropriate and another that a consultant needs to be defined more broadly as a resource person.

These findings are in line with Gleason's(1988) finding that 'consultant' and 'speaker' were the most highly rated roles by professionals when dealing with self-help groups (cited in Meissen, Mason and Gleason,1991). Generally, there seems to be less support for internal roles such as facilitator or therapist. In contrast, one study showed a greater support for such internal roles amongst graduate students (Meissen, Mason and Gleason,1991). The authors suggested this may be due to willingness to get involved with self-help groups on a campus where collaboration is encouraged. They also suspected a lack of knowledge amongst students about what self-help groups need from professional involvement as giving rise to a naive "any help is good help" idea.

When looking at the specialist groups ranking indication separately, there are slightly different preferences. They are as follows:

1. Consultant
2. Trainer
3. Initiator

These roles represent a greater level of involvement and reflect an acknowledgement that professional expertise could be useful for self-help groups.

The fact that specialists preferred different roles to the rest of the sample may be due to their greater experience with self-help and/or with the specific problem of sexual abuse. This experience may have increased their awareness of what self-help groups need. One specialist demonstrated a critical awareness of the challenge to traditional mental health structures, urging trained professionals to rethink their roles: "I think it's a mistake in a third world country to think of yourselves as a direct service provider" (S2).

When asked how appropriate it was for professionals to have no role in relation to self-help groups, the predominant response was that there would always be a role for professionals. There was, nevertheless, an understanding that the desired role for professionals would have to be negotiated by the self-help group and the professional. Relevant literature highlights concerns about professional involvement which may not be in the best interest of self-help groups and the fear that the self-help ethos may be lost. Some opinions support that professionals and self-help groups keep distinct boundaries. It is also known that some self-help groups do not want professional involvement. Notwithstanding, one survey of self-help group leaders report 62% in support of professional involvement (Toseland and Hacker, 1982); in another, 70% of self-help group members were reported as being satisfied with professional involvement (Bright, 1990 cited in Meissen, Mason and Gleason, 1991).

Models of Intervention

Participants were given four hypothetical intervention models and asked which ones they would refer to more easily, and why. Each of the models is listed below with a summary of the main objections and preferences.

- i. A child sexual abuse survivor advertises in a local newspaper that she is looking to start a self-help survivors group and invites other survivors to join the self-help group.

All except three respondents felt negative about choosing this option for referral. Their reservation to this option was the lack of information about, and the motivations of the person starting the self-help group. Concerns regarding emotional exploitation, lack of containment, continuity and back-up support also re-emerged. One respondent related a story about someone starting a self-help group in this way and ending up in a mental hospital.

The positive aspects of this choice were highlighted by two respondents who pointed out the importance of the energy and commitment of self-starters, saying that this was the essence of self-help.

- ii. A local women's organization which provides support services to rape victims and battered women, now offers a self-help group for child sexual abuse survivors, led by a lay counsellor.

Most respondents had a mixed reaction to this option, mentioning the positive aspects, but also expressing their concerns. The factors mentioned that would lead them to consider this as referral model were: the lack of advertising; the presence of a lay counsellor who, presumably, would have some experience with the problem; that it is an established organisation which can provide credibility, accountability and continuity as well as a support network. One respondent, from a service organisation similar to the one described, felt that this model was the one she would be most likely to support as she has seen it work.

Concerns were raised about the level of training and of lay counsellors and whether they are survivors themselves; the reputation and success of the women's organisation; its credibility and back-up support. Two participants (one professional, one non-professional) had explicit concerns that this model may not provide the necessary expertise to deal with child sexual abuse issues. Two others felt there is a need for both sexes to be included in this model, in order to initiate collaboration between men and women.

- iii. A Child Sexual Abuse Survivors Centre, run by professionals and offering various modalities of treatment, make available their resources (consultation, supervision, venue etc) for use by self-help groups (as another wing to the existing services they offer).

Most respondents preferred this model of intervention for the combination of professional back-up support and self-help autonomy. It provides for a range of professional involvement (consultation, supervision, training, specialist knowledge) and as a part of a specialist institution, the credibility and accountability of self-help groups would be increased. To illustrate the latter, one respondent noted that a code of conduct is binding on professionals and that this would give them greater accountability. According to one interviewee, there is a strong possibility of such an option becoming a reality in Cape Town in the near future.

The reservations expressed by five respondents concerned the motives of professionals as opposed to the motives of self-starters; the threat to the

autonomy and independence of the self-help group; and the possibility of disrespect and marginalization of self-help in this model.

- iv. Child sexual abuse survivor's group facilitated by a professionally trained counsellor/clinical psychologist.

There was a general willingness to refer to this option, though most respondents were clear that this was not a self-help group. A psychologist felt there is a need for autonomous self-help and professional interventions such as this model, as well as some exchange between the two.

Reservations were expressed about the motivation and expertise of the professional who ran the group. For example, was the professional able to share and join with the group "in a real way". This option was considered too structured and the proximity and the accessibility of the group for survivors, other than white middle-class women, were questioned.

On the whole, professionals seem reluctant to trust self-help groups to operate independently and without guidance and control by professionals. The favouring of hybrid above autonomous self-help groups is evident, both in the preferred professional roles and the preference for models of intervention involving a certain level of professional skill or expertise. Co-option of self-help groups by professionals, though mentioned, was not considered a strong possibility.

As mentioned before, this caution may be due to genuine care for the client, perhaps particularly in the instance of what is considered to be the more complex problem of sexual abuse. It also needs to be considered that caution may be due to professional territoriality and judgement. Which problem they consider are appropriate for professionals and which require other models of intervention. Such exclusivity would seem to be particularly strong when dealing with life threatening problems, but also where sophisticated knowledge is required (as is considered in the case of child sexual abuse). Louw(1988) identifies the tendency by professionals to create specialized pockets of knowledge as a problem, as it does not encourage public decision making. Nevertheless, the complexities and contradictions surrounding the issue of sexual abuse may make it difficult for professionals to share responsibility with clients and this, in effect, reinforces their monopoly of the provision of mental health service.

It could be argued that professionals have a cognitive framework which suggests people must behave in a certain way when they have a problem and when in contact with the mental health care system. Against this background, self-help groups with the added social benefit of reducing professional monopoly, may be considered a challenge and potential threat to professionalism.

Some authors (for example, Chesler,1989) believe professionals create subtle barriers to autonomous groups which may be reflected in exaggerated fears and caution. One study (Ringer et al.,1984, cited in Chesler,1989) discusses fears and perceptions of the dangers of self-help groups for parents of cancer patients. The authors admitted that many of the professionals' fears were based more on "personal anxieties and defences than on rational judgements of what went on in groups and what was good for parents", and that the self-help group members were often more ready to deal with the difficult issues than professionals thought (p.317). Confusions and conflicts in the area of sexual abuse may be adding to professional anxiety and increased concern for client welfare.

Useful comments for professionals and self-help groups

Various participants offered advice and recommendations to address problems raised and to facilitate closer co-operation between professionals and self-help groups. Some of these comments are paraphrased below.

1. Self-help groups need to be time-limited and structured to ensure effective functioning. (S4)
2. There is the need for a self-help group to be attached to some structure or organization for continuity and credibility and because survivors may find it difficult to initiate a group. (CP6)
3. In a self-help group, one needs people who have developed trust and who care about what they are doing and who can allow people to grow at their own pace. (CP4)
4. Self-help groups are usually doing something about problems no one else has approached. They may appear to step on toes in the process, but this might be a case of professionals protecting their own turf. (S1)
5. The history of self-help groups in the South African context is important, in particular the ability to examine self-help groups that failed and the reasons for that failure. There should be some evaluation of the self-help group by their members. (S5)
6. Many people in rural areas, for example, have unrealistic expectations of psychologists. Self-help groups could educate clients with regard to expectations of the help provided by mental health professionals and give members a sense of control of the intervention. (S4)

7. People gravitate towards what meets their needs, whether groups are set up by professionals or not. (P3)
8. Some survivors may need professional help with other problems such as alcohol or drug addiction before being in a self-help group for sexual abuse. (S5)
9. There is still the question of how does one get people to make use of self-help groups for their emotional needs, especially with men. (SO4)
10. Survivors don't "get fixed-up" overnight or in 6 months. The process is initiated in therapy and cemented in self-help groups. (S6)
11. Non-involvement of professionals stifles developments in the area of self-help. Professionals can be useful by offering practical assistance, for example, the provision of a venue to convene a group. (S6)

By way of summary, a social worker facilitating professionally-led groups for adult survivors, pointed out that survivors need different things at different times and calls for a healthy cross-fertilization between self-help groups and professional intervention, rather than proscriptive thinking about these matters. (S5)

CONCLUSION AND RECOMMENDATIONS

Problems in the provision of mental health services, coupled with the urgency and diversity of the needs of adult survivors of child sexual abuse, motivates investigating self-help as a treatment resource. This study explored this issue by focusing on mental health workers' perceptions of self-help for adult survivors.

The participants in this study are not representative of all mental health workers as views may differ given another sample in the same or another geographical area. Nevertheless, as an exploratory study, the trends in this study are meaningful by revealing perceptions of a cross-section of mental health workers and specialists in the field of sexual abuse.

Findings in this study are that most mental health workers in formal services have had little exposure to self-help groups in general and are cautious about such groups. While they display a willingness to consider self-help groups as a treatment option for adult survivors of childhood sexual abuse, this is mainly as follow-up care. Participants held strong views on the potential dangers survivor groups hold for clients, especially those not monitored by formally trained and accredited professionals. They also expressed the concern that the needs of survivors may not be adequately met in self-help groups. Respondents were open to the idea of professional involvement with self-help groups.

Those with experience of self-help and/or sexual abuse treatment showed a more in-depth understanding of the issues at stake and engaged more with the complexities. They displayed a more balanced view of the pros and cons of self-help, and had an understanding of broader social issues calling for change in traditional mental health services. Nevertheless, specialists in the field are not agreed on how to place self-help in relation to professional services for adult survivors.

There are certain trends and omissions in responses which are of interest in this study, both directly in terms of emphasis and, indirectly, lack of emphasis in certain areas. There was a general question in the questionnaire on both benefits and problems of self-help. Though answers tended to list as many pros as cons, the arguments for the negatives of self-help were more convincing. There was also an absence of reference to 'dangers' self-help might hold for professionals (eg. competition, anti-professional stance). This raises several questions. 1. Are self-

help groups really dangerous, or particularly dangerous for sexual abuse survivors? 2. Are the negatives expressed indicative of professional commitment to client care? 3. Could this be professional protectionism (in a monopolized service) or is it that formal professional training makes it difficult to fully consider the value of informal services? 4. Is it that professionals do not have enough information about self-help groups? Or perhaps it is the omission of a pointed enquiry about how professionals saw self-help as affecting their work and status that created this negative trend. It is suggested that these questions be included in a further study.

There was a lack of emphasis on the educational aspect and social advocacy function of self-help groups in this study. Perhaps because respondents focussed predominantly on individualized therapeutic needs (dealing with emotions, containment, etc.) rather than the social needs of adult survivors. Maybe respondents assumed that all survivors are in need of professional-type interventions, therefore they emphasised the potential dangers of the methods of self-help groups. Such an assumption ignores the broader debate about the long-term effects of childhood sexual abuse and the notion of resilience amongst some survivors. It is reasonable to assume that there are many survivors who may not need intensive professional intervention, but who would gain from the peer support, companionship and role models of well-adjusted and coping survivors.

What is clear in this study though, is that the lack of knowledge about self-help groups is a determining factor in informing professional perceptions of self-help groups. This is supported by earlier findings of Borkman,1990, Chesler,1989, Emerick,1990, and Meissen, Mason and Gleason,1991. These studies recommend that professionals be educated about self-help groups. This researcher regards education of professionals about self-help as a priority for it may lead to the increasing availability and accessibility of self-help groups, to the benefit of clients. Professional attitude are bound to affect attitude of clients and the efficacy of self-help groups also depends on professional willingness to collaborate (Borkman,1990; Chesler,1989; Durman,1976; Meissen, Mason and Gleason,1991).

To successfully educate professionals about self-help, the traditional individualized, formal emphasis of present educational models, needs to be re-examined. In South Africa, mental health services are inadequate; there are too few professionals and training is too lengthy and costly. It is vital that the authorities acknowledge the inadequacy of the present service. Training needs to enable professionals to

address this challenge, both in terms of attitude to informal services and to plan, initiate and collaborate with informal services such as self-help groups.

Both didactic and experiential education of the workings of self-help groups is needed, and students must be introduced to such groups in order to familiarize themselves and create an awareness of informal services. Professionals need to know about self-help groups in the community so as to be in a position to offer assistance and referrals. Referral to self-help groups could usefully be viewed as one strategy in a multimodal intervention and not simply as diverting clients away from professional services (Toseland and Hacker, 1982).

There are certain factors to consider for successful collaboration. Education of professionals in their approach to self-help groups should avoid a narrow clinical conception of mental health and illness. They should value the contribution of self-help groups and have some awareness of what is possible in developing a partnership. There should be a de-emphasis of status differentials and a willingness to relate on an equal level with self-helpers. These might be some of the hardest tasks facing professionals as they require changing ideas about treatment and the customary professional role (Orford, 1992).

Professionals need to be aware that they could have a vital role in initiating self-help groups in collaboration with lay helpers. It would be important that a consultation model be negotiated to ensure collaboration and not co-option.

Self-help groups have an important educational focus but may inadvertently perpetuate myths and stereotypes (Orford, 1992) about causation and consequences in sexual abuse. Hence professionals (academics and clinicians) have a responsibility to write relevant, accessible material to counter the oversimplified statements of the more accessible media writers, ideologues etc.

Good leadership and facilitation in self-help groups were regarded as important in the professional literature and as vital by respondents in this study. Professionals have much to offer by imparting knowledge to lay counsellors and facilitators, such as: basic skills in group process development, encouraging flexibility and tolerance of diversity, and sharing of responsibility.

The aim of survivor self-help groups may differ from group to group but would generally center on supporting and enhancing coping skills. A group's usefulness

would seem to lie in dealing with issues where peer support and advice is of primary value. For example, dealing with self-blame and with stigma by self and others; managing disclosures and confrontations; and dealing with concerns of intimacy, sexuality and parenting. Education about myths and social advocacy may be included in these goals.

All told, self-help groups represent only one avenue of investigation for alternative health and social services. This study is initiating enquiry in this field. It hopes to stimulate thinking, promote wider discussion and provoke debate about self-help in general and, in particular, the area of child sexual abuse. It is recommended that specialists in the field of sexual abuse work together - considering the complexities and challenges in service provision, and debate the merits and demerits of self-help. Education and changes in professional perceptions of, and attitudes to, self-help hopefully will generate sharing of knowledge and authority between formal and informal health care services. Additional comments by respondents indicated that participating in this study was educational as it provided an opportunity to think more systematically about self-help. It also raised interest in and awareness of self-help groups for adult survivors.

There is a need to research the differences in perspective of the same health problem among professionals, self-helpers and lay people. In particular, research is needed on the views and expressed needs of adult survivors. These are of crucial importance for future service planning and delivery, especially with regard to the black African population, for whom few services presently exist.

The study proved awkward in the absence of ongoing survivor groups and literature about such groups. Should survivor groups be established in the near future, responses could change for better or worse depending on the perceived functioning of such groups. Adult survivors could usefully have been included in the study, and/or a workshop arranged to consider the findings of this research project. This, however, was beyond the scope and limits of this research. This study could act as a resource for drawing up a questionnaire that could be administered on a larger scale for more cost effective research.

Sexual abuse is a complex and confusing area of study and treatment. Self-help groups are difficult to assess because not enough has been documented (partly because of lack of priority by professional researchers). Though, at first, it may appear that more problems come out of combining self-help and sexual abuse in

this study, the researcher feels it presents a worthwhile challenge in broadening our horizons in the search for new ways forward in mental health services.

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APPENDIX

INTERVIEW SCHEDULE

INTRODUCTION

My name is Natalie Leon. I am working as a Clinical Psychologist at Avalon Treatment Centre and this research is the thesis component of my Masters in Clinical Psychology.

This study is aimed at getting Recommendations from Clinical Psychologists as Professionals and Non-psychologists in Service Organizations about Mental Health Services which could be provided given limited trained services. The focus is Self-help in specific problem areas.

The interview is 60 to 90 minutes long and will be anonymous and confidential. The completed research report will be available in the UCT Library and the interviewer is willing to present the findings to interested forums.

With your permission, I would like to tape the interview as a backup. When I use the term "Professional", I mean "Clinical Psychologist", unless otherwise stated.

DEMOGRAPHIC DATA

I/V No. DATE:

Name:

Gender:

Age:

Where are you working at present?

How long have you worked as a Clinical psychologist / in this field?

Where studies completed and when?

AWARENESS OF SELF-HELP GROUPS

1. What is your understanding / definition of self-help groups?

DEFINITION OF SELF-HELP GROUPS

Researcher offer a definition of Self-help groups.

"Voluntary associations among individuals who share a common need or problem and who seek to use the group as a means of dealing with that need or problem" (Durman, 1976, p.432). Main features are that groups are member-governed; for mutual support; around a shared/common problem. Note examples.

EXPOSURE TO SELF-HELP GROUPS

2. Have you ever been a member of a Self-help group?

3. Do you know someone who has been a member of a Self-help group?

4. Have you ever recommended or referred a client to a Self-help group?

5. Did you obtain any information about Self-help groups during your training as a Clinical Psychologist/ during your work in this organization?
Please elaborate

6. Pick the position on the 5-point scale that best describes your attitude to Self-help groups.

- a) POSITIVE
- b) CAUTIOUSLY POSITIVE
- c) UNSURE
- d) CAUTIOUSLY NEGATIVE
- e) NEGATIVE

I would now like to look at Self-help groups with Adults who are Child Sexual Abuse (CSA) survivors, as the specific focus of the study.

EXPERIENCE WITH CHILD SEXUAL ABUSE

7. Do you regard yourself as having experience in the area of Child sexual abuse?

Please elaborate:

8. Would you regard yourself as having particular expertise in the area?
YES/NO

CHILD SEXUAL ABUSE SURVIVORS AND SELF-HELP GROUPS

9. Is Child sexual abuse a suitable focus for Self-help groups?

YES

SOMETIMES

NO

10. What could be the benefits of Self-help groups for Child sexual abuse survivors?

Please list four and rank where possible:

11. What would be the problems of self-help groups for Child sexual abuse survivors?

Please list four and rank where possible:

12. When would self-help groups be considered harmful (contra-indicated)?

13. Would your answers to the above three questions have been different if you were talking about something other than Child sexual abuse survivors? For example:

a) post-natal depression: YES/NO

If YES, why?

b) diabetes: YES/NO

If YES, why?

ROLE OF SELF-HELP

14. Would you refer to or recommend self-help groups to Child sexual abuse survivors?

YES SOMETIMES NO

For each of the following referral options, how would you decide on the role of the self-help group for a particular client?

15. Alternative to professional group and/or individual intervention:

YES/NO

Explain:

16. Complementary to professional group and/or individual intervention:

YES/NO

Explain:

17. Follow-up option to professional group and/or individual intervention:

YES/NO

Explain:

PROFESSIONALS AND SELF-HELP GROUPS

18. The literature suggest various roles for mental health professionals, in relation to self-help groups. These roles are listed below.

With respect to Self-help groups with Child sexual abuse survivors, please could you rate these roles for Clinical Psychologists.

a) CONSULTANT (re selection/suitability of group members and supervision of group process)

Appropriate:

Always Sometimes Seldom Never

b) LEADER/CO-FACILITATOR

Appropriate:

Always Sometimes Seldom Never

c) REFERRAL AGENT(referring people to Self-help groups)

Appropriate:

Always Sometimes Seldom Never

d) GUEST SPEAKER(source of information)

Appropriate:

Always Sometimes Seldom Never

e) RESEARCHER

Appropriate:

Always Sometimes Seldom Never

f) INITIATOR

Appropriate:

Always Sometimes Seldom Never

g) TRAINER (of for example, group leaders)

Appropriate:

Always Sometimes Seldom Never

h) NO ROLE

Appropriate:

Always Sometimes Seldom Never

19. Which of these roles would you personally feel most comfortable with as a Clinical Psychologist? / as a Non-professional?

- 1.
- 2.
- 3.

20. Do you feel a lack of information about self-help groups has influenced your responses to questions 18 and 19?

YES/NO

MODELS OF SELF-HELP INTERVENTION WITH CHILD SEXUAL ABUSE SURVIVORS

21. Which of the following models would you refer to more easily and why?

i. A Child sexual abuse survivor advertises in a local newspaper that she is looking to start a self-help survivors group and invites other survivors to join the self-help group.

ii. A local women's organization which provides support services to rape victims and battered women, now offer a self-help group for Child sexual abuse survivors. led by a lay counsellors.

iii. A Child sexual abuse Survivors Centre, run by professionals and offering various modalities of treatment, make available their resources (consultation, supervision, venue etc) for use by self-help groups (as another wing to the existing services they offer).

iv. A Child sexual abuse survivor's group facilitated by a professionally trained counsellor/clinical psychologist.

22. Do you feel there is a need, currently, for any of the above options in question 21?

YES/NO

23. Do you think such self-help groups for Child sexual abuse survivors would be a viable option for a range of South African communities. Please elaborate.

24. Pick one of the following to best describe your attitude to Self-help groups with Child sexual abuse survivors;

- a) POSITIVE
- b) CAUTIOUSLY POSITIVE
- c) UNSURE
- d) CAUTIOUSLY NEGATIVE
- e) NEGATIVE

Any comments about the questionnaire:

THANK YOU FOR YOUR PARTICIPATION.

NATALIE LEON