STRONG AND SAFE: A HEALTHY RELATIONSHIPS AND EMPOWERMENT GROUP FOR WOMEN WITH DISABILITIES

by

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TABLE OF CONTENTS

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Chapter 1

Introduction

A Statistics Canada survey in 2006, recorded that 14.3% of the population of Canada reported themselves as having a disability (Statistics Canada, 2007). Persons with disabilities are a source of diversity and add further richness to our society. Despite significant advances made in the past couple decades, persons with disabilities face a number of challenges within our society. Poverty, discrimination, and unequal access to community and services remain hurdles for persons with disability living in Canada. Improving access to education, employment, transportation, technology, and healthcare for persons with disabilities are important goals for Canadian communities going forward (Steinstra, 2012).

In terms of mental health, persons with disabilities have higher than average rates of psychiatric disorders than persons without disabilities. Nezu, Nezu, and Gill-Weiss (1992) consider that a number of social and biological factors increase the likelihood of mental health disorders in the general population. Low social support, poor social skills, a sense of learned helplessness, decreased opportunity to learn adaptive coping styles, increased likelihood of central nervous system damage, increased presence of reading and language dysfunction and decreased inhibition in responding to stressful events are all factors that can contribute to psychiatric disorders and are also present for persons with disabilities. In addition, exposure to sexual violence is considered to contribute to psychiatric disorders, the rates of which are much higher for persons with disabilities than the general population (Tomasulo & Razza, 2006).

Women with disabilities make up 15.2% of the female population in Canada, while men with disabilities consist of 13.4% of the population (Statistics Canada, 2007). Women with disabilities report struggling with societal expectations of who they must be both as

women and as persons with disabilities (Lisi, 1993). With a social identity as both women and persons with a disability, many women with disabilities experience discrimination and violence with few services available to support their unique needs. Persons with disabilities are a source of diversity for Canadian communities; however, many barriers remain for persons with disabilities. The challenges faced by women with disabilities can be intensified by their gender and social norms that surround gender.

Purpose and Rationale

In early 2012, the World Health Organization (WHO) declared the organization will give increased attention to the prevention of intimate partner violence and sexual violence to reflect the fact that intimate partner violence is "...significant global health [problem] and human rights [issue]" (World Health Organization, 2012). Rashinda Manjoo (2012), the Special Rapporteur on violence against women for the UN, reported that women with disabilities and interpersonal violence have received attention in recent years as the abuse they incur is unique in cause, consequence and form . The report stated that women with disabilities are 2 times as likely to experience domestic violence as nondisabled women and are likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence. Further, an extensive literature review by Powers et al., (2009) clarified that women with disabilities are more likely to experience physical and sexual violence, increased severity of violence, multiple forms of violence and longer duration of violence than women without disabilities.

In addition to domestic partner violence, it is widely documented that women with disabilities are additionally vulnerable to abuse from caregivers, helpers or other support

people in their lives (Powers et al., 2009). Powers et al. (2009) chose the term interpersonal violence to highlight the relationship based violence women with disabilities experience.

Sordi's (2011) shed some light on the violence experienced by women with disabilities in Canada. In Canada, persons with disabilities are 50- 100% more likely to experience intimate partner violence than persons without disabilities. Further, the rate of intimate partner violence experienced by women with disabilities compared to women without disabilities is rising, from 1.2 times in 1999 to 1.4 in 2004. Women with disabilities were twice as likely to report severe physical violence and 3 times as likely to be forced into sexual activity (Brownridge, 2006). Violence is typically perpetrated by an intimate partner, family member or caregiver (Brownridge, 2006). Violence against women with disabilities is an issue of concern internationally as well as nationally.

In Canada, many service barriers exist for women who are at risk of or are already experiencing interpersonal violence. Rajan's (2011) focus groups with Canadian women with disabilities who had left abusive relationships demonstrated that social services lacked sensitivity to issues faced by women with disabilities. For example, social services were not able to accommodate their physical and cognitive limitations and service delivery did not represent the way in which disability impacts the ability women have to leave an abusive relationship. Issues such as women's shelters without wheelchair access, social services without the ability to provide outreach services and services which could not accommodate unique communication needs were specifically highlighted by Rajan.

In general, the need for mental health services for women with disabilities is higher in the northern and rural context. It has been widely documented that health services are less

accessible in rural communities than urban centers. It is common in Canada that recruitment and retention of professionals is a challenge in smaller rural communities (Barer & Stoddart, 1999). This holds true for Prince George where there are limited experienced, trained helping professionals who specialize in working with persons with disabilities than reside in bigger cities. For example, behavioural interventionists, psychologists and other specialists who may provide the specialized support for persons with disabilities have long waitlists or are only accessible a few times per year as they primarily practice in other communities.

Specific to the issue of interpersonal violence there are similar trends in northern communities throughout Canada. There are few social services that specialize in providing interpersonal violence prevention and intervention services to women with disabilities. For example, local social services in Prince George may provide prevention training for women and include information on how abusive relationships are maintained and support services available locally; however, woman with cognitive disabilities may need training workshops that use concrete examples, and allow more time for questions and interactive activities and provide reading and take home materials that are appropriate for low literacy levels. As another example, social services may provide accommodations to support women who are transitioning out of an abusive relationship but may not be able to accommodate the accessibility and physical care needs of women with physical disabilities.

Further, rural geography impacts women's mental health. A study by Leipert and George (2008) on women's health in rural Ontario demonstrated that women's health is uniquely impacted by rural geography. For example, women in rural locations may experience lower social status, limited resources and isolation, all factors which can contribute to women's poverty, violence against women and mental health issues. Although

there is little research on women with disabilities, interpersonal violence and the rural context, knowledge of the impacts of rural geography on women's health, the decreased accessibility to mental health services in rural communities and the lack of disability sensitive services nationally and locally, indicates that there is a need for mental health services which address interpersonal violence against women with disabilities.

Strong and Safe is a psychoeducational group that focuses on providing women with developmental disabilities, the tools and information necessary to prevent interpersonal violence in their lives. The group is guided by a person-centered theoretical framework. A person-centered psychoeducational group format allows for information sharing with women with disabilities in a way that is accessible and sensitive to the needs of participants. The group focuses on not just prevention but also the recognition of personal strengths and healthy relationship skills to encourage further resiliency. The group is made up of sessions that include didactic instruction as well as interactive activities. In response to a northern context, Strong and Safe fills a clear service gap and allows women with disabilities to have access to mental health services that focus on interpersonal violence prevention in a sensitive manner while allowing valuable mental health professionals to reach a larger number of women at a time.

The issue of violence against women with disabilities provides the rationale for a healthy relationships group for women with developmental disabilities. Nationally and locally, social services struggle to meet the unique and sometimes complex needs of women with disabilities who are at risk of or are experiencing interpersonal violence. My personal location further explains my desire to focus on this particular issue and demographic.

Clarification of Terms

As definitions vary throughout the literature, defining terms used throughout this manual will increase clarity. The term *disability* is broad term used to describe cognitive, physical, and developmental limitations. The term disabilities can describe conditions existing at birth, early onset, traumatic and late onset illnesses, diseases or injuries which result in a loss of functioning. This project focuses primarily on persons with *developmental disabilities* which are defined as disabilities which have occurred during the developmental period of the individual which includes developmental stages spanning from prenatal to late adolescent (American Psychiatric Association, 2013a). Neurodevelopmental disorders include intellectual disability, autism spectrum disorder, learning disorders and neurodevelopmental motor disorders (American Psychiatric Association, 2013a). While physical and mental developmental disabilities include disorders such as cerebral palsy and Down's Syndrome. Care is taken to discern between definitions of disability throughout this project.

Person-centered is another term that occurs throughout this manual. This term is used to describe an approach to therapy founded by Carol Rogers. Rogers (1961) and person-centered therapists place high value on meeting the client where they are at, trying to understand issues from the client's perspective and building a therapeutic relationship that the client can then use to make their own meaningful change. This term is also extended to describe a model of disability support services. A person-centered model of support services strives to understand what the supported individuals want and need to do to achieve their personal goals. Person-centered support services use this information to cocreate appropriate

supportive services for each individual and decrease barriers for the individual to achieve these goals (Care UK, 2010).

Personal Location

My experience working with women with disabilities and my experience working within a northern nonprofit organization which supports individuals with a wide variety of developmental disabilities has contributed to my desire to create a person-centered, inclusive group based on the themes of healthy relationships and self-empowerment

I have spent the last six years working at a local nonprofit organization which provides services to children and adults with developmental disabilities. In my position as a life skills instructor following a person-centered approach, my role is to assist the people I support to achieve skill based goals that will assist them to live more independently. Through my work, I have supported individuals with a large variety of developmental disabilities including comorbid mental health disorders. For example, my organization supports individuals with diagnoses of Fetal Alcohol Spectrum Disorder, Autism Spectrum Disorder, learning disabilities, seizure disorders, cerebral palsy, brain injury, mental health disorders, and many other disabilities that reflect abnormal development. Working with this model of inclusive services, means gaining a general understanding of the diagnosed disability of individuals supported but also necessitates understanding who the person is and what other identity factors are involved. In my experience, working with and understanding other factors in the people's lives tends to be more significant than the disability factor.

A large piece of my work experience has been working with youth and women with disabilities. I have experienced these women as vulnerable to others in their lives, not only due to their disabilities, but also due to other factors such as poverty, past abuse, and low

sense of self-worth. For example, I have worked with young women who are dependent on abusive partners for financial support and held an underlying belief that they are inadequate to take care of themselves. Problem solving for greater financial independence, discovering self-efficacy and understanding were important goals directing our work together. The topic of self-empowerment and safe, healthy relationships is dear to me due to my experiences with these women.

In my own experience of working with women with disabilities in healthy relationships programming, I am aware of my counter-transference around this topic and this population. Feelings such as impatience, frustration and over-sheltering can come up for me. With the example of frustration, I am frustrated at myself for not being able to offer interventions in a more accessible way; frustrated at the person I support for not understanding or making changes in the way that I want them to; feeling pressure from the vulnerability they represent and frustrated that change is critical yet slow. For me, monitoring and understanding my counter-transference will be important throughout Strong and Safe.

Another piece of my identity that contributes to my interest in this topic is my draw to critical feminism. For me, an important lens I use in my work and academics is that of intersectional analysis. Intersectional analysis maintains that gender identity, interests, and opportunity are affected by other identity components such as race, class, culture and power in society (Peterson & Runyan, 2010). It is important to add that although this project is oriented to prevent interpersonal violence by supporting women with disabilities to avoid violence in their lives, it is by no mean taking blame away from perpetrators of interpersonal violence against women with disabilities. Rather, the perspective taken is that society and structures contribute to making women with disabilities vulnerable to interpersonal violence.

It is through understanding these processes and their effects on women that we can provide support for them to be resilient in the face of oppression (Brownridge, 2006). This critical feminist approach has guided my consideration of disability, society and gender throughout this project.

Finally, working, studying for my Counselling MEd degree, and living in Prince George, BC has shaped my approach to this project. As a smaller community, Prince George has a limited capacity for specialized disability services for individuals with specific diagnoses. In my experience, disability support service delivery is often person-centered in approach yet structured in a standard way to support individuals with a large variety of needs. The struggle is finding ways to make universal resources or programs work for each particular client.

I consider that the factors I notice in Prince George, such as a limited number of trained professionals in this area and inclusive person-centred services are also characteristic of rural and remote communities in northern British Columbia. My northern context has encouraged me to design a group that seeks to be inclusive for persons with a variety of disabilities and also to take advantage of a group format as to insure sparse helping professionals in Northern BC are able to reach the most people effectively.

Summary of Chapter 1

Strong and Safe is a person-centered, psychoeducational group that will build empowerment, healthy relationships skills and awareness of interpersonal violence. This chapter briefly described the group Strong and Safe. The terms disability and person-centered were defined to provide clarity to this manual. The high rates of interpersonal violence against women with disabilities and the lack of local services provided rationale for this

project. My personal location provided insight into my reasoning for creating a relationship and empowerment group for women with disabilities, the inclusive model Strong and Safe takes and the choice to pursue this issue within a group format. As well, my personal person-centered and critical feminist lens was described.

Chapter 2

Introduction

The following literature review includes the politics behind the definition of disability, and then the historical background of disability rights. I have reviewed at the way in which persons with disabilities have been accommodated in a variety of groups, with a focus on group organization, techniques and issues that may come up. I also reviewed factors that make women with disabilities more vulnerable to interpersonal violence and describe the complex issue of interpersonal violence against women with disabilities. I then present some recommendations to affect change found within the literature. Finally, I discuss existing interventions for interpersonal violence prevention for both women themselves and organizations with a violence prevention mandate. Individual and group interventions for women with disabilities are discussed. Defining the term disability is an important first step of this literature review.

Defining Disability

The definition of the term disability varies across the literature. According to Gronvik (2009), concepts of disability have been a hurdle within research for decades. Specifically finding definitions that are global and complete while still operational is a daunting task. Across the literature, disability can refer to physical limitations, mental health, cognitive limitations or even chronic illness such as diabetes. To greater understand the term disability; I have reviewed international and national human rights dialogue, provincial social assistance

Each source discussed disability in distinct ways. When used in human rights dialogue and policy, the term disability is broadly defined. The definition of persons with

disabilities used by the Canadian government is also the definition employed by the United Nations is "persons who have long term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others" (Government of Canada, 2013, July 30, para 1; United Nations Enable, 2007, para 1). This definition of disability is beneficial as it is broad and inclusive, highlighting the long term nature of the disability and the effect the disability has on the individual's equal functioning in society.

Interestingly, United Nations Enable (2007) went one step further than defining disability, it also recognizes that the effect disability has on equal functioning may differ depending on culture, position in society and technological adaptive devices. In this sense, other demographic factors are acknowledged as impacting the extent the disability impacts equal functioning in society. This can be considered a social model of disability, where other societal factors are taken in to consideration when looking at disability.

The government of British Columbia, which provides funding for people with disabilities, defines disability as "a severe mental or physical impairment [including a mental disorder], that in the opinion of a medical practitioner is likely to continue for at least two years, impacts and significantly restricts the persons ability to perform daily living activities either continuously or periodically for extended period and as a result of those restriction, the person requires help to perform those activities" (Ministry of Social Development and Social Innovation, June 1, 2010, section 2). The provincial definition focused on time with disability, restrictions imposed by the disability and the person's needs. When funding is involved, it is clear the definition of disability becomes much more specific and thus, operational. Although focusing on mental disability only, the fifth edition of the *American*

Diagnostic and Statistical Manual (DSM-5) is another important source that demonstrates an operationalized term for disability (American Psychiatric Association, 2013a).

The *DSM-5* specifically delineated between a variety of mental disabilities (American Psychiatric Association, 2013a). *DSM-5* provided a medical model approach to disability as it provides context for the diagnosis of disability in individuals. For example, the *DSM-5* clearly established the differences between a variety of disorders such as intellectual disability, communication disorders, autism spectrum disorder, attention-deficit/hyperactivity disorder, specific learning disorders, and motor disorders. Each disorder was described by specific behavioural observations or criteria compared against average or normal developmental behaviours. As a new addition, the *DSM-5* has been described to make diagnostics more inclusive for adults with disabilities, such as adults with autism spectrum disorder (Samuels, June 5, 2013). In addition, efforts have been made to clarify assessments, such as for a diagnosis of intellectual disability, to insure diagnoses and assessments reflect the impact of the deficit on the individuals functioning in everyday life (American Psychiatric Association, 2013b). A clinical diagnosis can be a critical connection to funding and service access for persons with disabilities, in this sense clinical diagnoses of disability remain important pieces of health and social service delivery.

Reflecting on the above definitions, the definition of disability shifts depending on the context within which it is used; as such, there is no standard definition of disability. Gronvik (2009) further typifies and summarizes these categories of definition.

Gronvik's (2009) research looked at the way in which different categories and definitions of disability impact the demographics of persons with disabilities included in studies and thus how disability definitions impact research outcomes. Gronvik identified that

there are three types of definitions commonly used in research. *Functional limitations definition of disability* which consists of a medical consideration of disability or how disability impacts individuals' capacity to complete daily living tasks. *Administrative definitions of disability* consists of administrative criteria which will separate those eligible for disability benefits or social assistance. Finally, *subjective definition of disability* is rarely used, but represents studies where people self-identify as disabled. Gronvik's study revealed that definitions of disability change depending on the purpose of the research study.

This issue of definitions changing relevant to context was demonstrated in the Canadian context by the above analysis of common definitions of disability in international human rights dialogue, Canadian governments, and our medical system. The definition of disability lacks universality and therefore is further defined for the purpose of this project.

Choosing a definition of disability seems to be based on the approach to persons with disabilities. For the purpose of screening measures for group participants, group cohesion and the following literature review, it is important to settle on a operational definition of disability. I chose to focus on persons with developmental disabilities which are long term, permanent disabilities that have mental and/or physical manifestations.

As there is no universal definition of disability, the remainder of my literature review relies on research studies of persons with disabilities that employ a variety of definitions of disability. Efforts are made to note the alternative definitions of disability used throughout this literature review. The historical context of disability rights give important insight into the lack of universality in reference to the definition of disability and the ways in which policy has changed in how it approaches persons with disabilities at a global, national and provincial level.

History of Disability Rights

There are a number of trends within the process of defining "disability" which are consistent throughout the rights movement for people with disabilities. These trends represent societal and attitudinal shifts and represent the way in which the disability rights movement has developed. The following history is presented in terms of the international, national and provincial rights movement for persons with disabilities.

International movement for the rights of persons with disabilities. To consider the history of rights of persons with disabilities, I reviewed the history of the UN and their historic work to make change. I have chosen to focus on the UN because it is an international organization that has representatives from all countries and has a role in creating the mandates and goals of other international organizations like the World Health Organization (WHO) and the World Bank.

The history of international persons with disabilities rights starts in 1948 when the UN adopted the Universal Charter of Human Rights. This was the first international universal statement of rights but did not include persons with disabilities in the Charter explicitly. Therefore, if a person were to claim protection against human rights abuse due to their disability they would have to claim it under a universal rights provision (Stein, 2007). Later, persons with disabilities may also be able to claim protection under conventions that support other protected groups they may belong to, such as children and women.

After WWII, the medical model approach to disability was strong internationally (Stein, 2007). This medical model was oriented towards treatment and rehabilitation of disability and came out of efforts to assist veterans in a post WWII world. These efforts to "fix" people with disabilities resulted in inferior education, community access, and lack of a

voice in managing their own lives (Harpur, 2012). This approach to disability management began to shift in the 1970s to a more social model which focused on how social conditions, not inherent biological limitations, constrain individuals' abilities and thus created a disability category.

This social model of disability grew further when the United Nations declared 1981, the "International Year of the Disabled" and then later stated that the 1980s would be the "International Decade of the Disabled Persons". In 1982, the UN enacted the World Programme of Action Concerning Disabled Persons which not only advocated for preventing and rehabilitating disability but also advocated for equal opportunities for people with disabilities demonstrating the slow shift from medical model to social model within the conceptualization of disability (Stein, 2007; UN Enable, n.d.[b]).

In 2001, Mexico suggested that an Ad Hoc Committee be formed to consider proposals for an international convention to promote and protect the rights of persons with disabilities (UN Enable, n.d.[a]). On December 13th, 2006, the UN adopted the Convention on the Rights of Persons with Disabilities (CRPD) and its optional protocol. By April 3rd 2008, the CRPD received its 20th ratifying country, thereby signifying that the CRPD would now come into force.

The significance of the CRPD for the advancement of the rights of persons with disabilities is well described by Harpur (2012). In fact, he considered the ways in which the CRPD can drive change for disability rights, academia, advocates and government (Harpur, 2012). The existence of the CRPD alone identifies on a global scale that disability is a human rights issue. Harpur discussed the way in which the CRPD has solidified a new paradigm for talking about disability rights as a specific and unique human rights concern and an area of

human rights that is impacted by social determinants. Another contribution of the CRPD is that it has empowered civil society by providing specific steps to be taken in order to progress persons with disabilities' rights in each country. For example, the CRPD provided specific steps on how to enable people with disabilities to exercise their rights to work. By this contribution, CRPD also provided standard criteria for good governance in terms of disability rights. (Harpur, 2012). Finally, through the creation of the CRPD and continuing development and monitoring of CRPD, the CRPD has provided advocates, academia and organizations of persons with disabilities an avenue to voice their needs and wants in terms of meeting human rights.

In 2011, the World Bank and the World Health Organization (WHO) jointly produced *The World Report on Disability.* This report amalgamated research on the prevalence of disability worldwide, looks at worldwide access to health services for people with disabilities, discusses assistive devices and rehabilitation, explores inclusive environments, education and employment prospects for people with disabilities. The report aimed to give an idea of actions, across all levels and sectors that can insure human rights are being met.

The World Report on Disability is a great example of the work that is continuing out of the creation of the CRPD; the focus is now on promoting, monitoring and learning how countries can adhere to the CRPD. This is not only reflected in the publications of international organizations but also in the academic literature.

For example, Crawford, Dinca-Panaitescu, Fougeyrollas, and Rioux, (2013) demonstrated a statistical model to look at employment and persons with disabilities within Canada. Using data from Participation and Activity Limitation Survey completed by Statistics Canada, the authors looked at barriers, enablers, access to a valued situation and

quality of participation experienced by persons with disabilities to assess Canada's adherence to CRPD right to employment. Crawford et al. hoped that this model could potentially be used to look at different aspects of the CRPD and provide a way to monitor ratified countries' adherence to the CRPD.

On a different note, Meekosha and Soldatic (2011) proposed that the CRPD was created and based on voices of affluent countries in the global North. This proposed bias within the CRPD is considered to create difficulties for the CRPD to impact the experience of people with disabilities in the global South, or developing countries. This may negatively affect the way in which the international disability movement could create solidarity across "a global position of structural poverty, violence and isolation" (Meekosha & Soldatic, 2011, p. 1395). They urge for the inclusion of more voices from the global South and greater understanding of the experience of persons with disabilities living in developing countries. Crawford et al. (2013) and Meekosha and Soldatic are just two examples of how research and academics have provided suggestions for further monitoring and implementation of CRPD.

Considering the international rights movement of persons with disabilities, it is clear that the focus on disability as a social construct and human rights issue is a relatively new development. At this time, there is work to be had in creating ways to monitor, develop and advocate for the rights of people with disabilities. The Canadian movement for the rights of persons with disabilities had similarities to the international movement in disability rights.

Canadian movement for the rights of persons with disabilities. There were a number of events that occurred in the late 1970s and 1980s which are considered to have jump started the Canadian disability rights movement (Spinal Cord Injury Ontario, 2003). Still in the "fix-it" approach to disability, a predominant view at that time in society was that

persons with disability were dependent on charity; persons with disabilities were to be spoken for and taken care of (Steinstra, 2012). Although some provinces had their own human rights codes which included disabilities, the Canadian government was still operating by the unconstituted Canadian Bill of Rights which lacked any mention to persons with disabilities (Spinal Cord Injury Ontario, 2003).

In the late seventies, Pierre Trudeau began the process of drafting the first Canadian Charter of Rights and Freedoms, which was a step in repatriating the Canadian Constitution (Spinal Cord Injury Ontario, 2003). When the first draft came out in 1980, there was uproar among people with disabilities in Canada as there was no specific mention of disability within the Charter draft. At the time, few politicians understood the experience of people with disabilities and their need to be protected against discrimination, there was also fear regarding the future financial cost of including disability and the struggles of defining disability in the Charter (Spinal Cord Injury Ontario, 2003) After much lobbying and demonstrating, the 1982 Canadian Charter of Rights and Freedoms, Section 15, contained specific mention of physical or mental disability and made it illegal to discriminate based on disability. Disability rights were now in the national human rights dialogue and people with disabilities now had the ability to use Section 15 to fight in court against discrimination (Spinal Cord Injury Ontario, 2003). Due to the coming together of advocates and the success of the lobbying by persons with disabilities, the Charter would be considered a pivotal event in the disability rights movement in Canada (Spinal Cord Injury Ontario, 2003; Steinstra, 2012).

From this watershed event, persons with disabilities were included a number of other laws, including the Canadian Human Rights Act for federally regulated activities where

persons with disabilities were not only included but the duty to accommodate was also added. This meant that employers had to insure persons with disabilities were not only protected from discrimination but also supported to access employment (Government of Canada, 2013, July 30). This trend of duty to accommodate was continued with the Employment Equity Act (Government of Canada, 2013, July 30).

The disability rights movement in Canada continued on with the social service ministers responsible for services which support persons with disabilities. In 1998, the national social services ministers adopted the document, *In Unison: A Canadian Approach to Disability Issues* to help guide their policies for persons with disabilities. This document was unique as it embodied the social model of disability, which states that disability is a social construct and requires government and society to remove barriers, stigma and work towards greater inclusion (Steinstra, 2012). *In Unison* calls for provincial and federal levels of government to increase disability supports, and increased access to education, work and income assistance (Government of Canada, 2013, July 30).

The Canadian disability rights movement gained strength surrounding the advocacy for the inclusion of disability rights in the Charter. Further work has been done nationally to assure that persons with disabilities receive support, gain equal access to their communities and services and be protected from discrimination. In the 2000s, there was much more development of disability rights in the provincial realm.

British Columbia's movement for the rights of persons with a disability. Disability rights and policies are spread out across both federal and provincial programs. Each province has its own individual support service delivery model which has created disparities across the provinces in terms of access to services for persons with disabilities

(Steinstra, 2012). These disparities exist despite each province modeling their services on the *In Unison* document. Due to the practical role provincial governments have in providing support services, including income assistance, a review of the disability rights movement in British Columbia (B.C.) will focus on supportive programming.

B.C. has come a long way in terms of disability rights. Similar to disability management all over the world, for many years B.C. used medical institutions as their primary support services for persons with disabilities, especially persons with intellectual or developmental disabilities. For example, Woodlands School in Victoria, B.C. was B.C.'s first segregated total residential institution for people with developmental disabilities. Woodlands School remained open from 1804- 1996 when it was closed through public protest (Roman, Brown, Noble, Wainer & Young, 2009). Roman et al. (2009) compared narratives coming out of Woodlands School and others like it to those narratives coming out of residential schools experienced by Canadian Aboriginals and found there were similar themes in terms of the traumatic impact of these institutions. These institutions are an example of how the medical model of disability translated into service in previous years; disability was treated as an ailment in need of treatment.

Although Woodlands School was kept open until 1996, British Columbia announced in 1981 that the three larger residential institutions for adults and children with intellectual disabilities were to be closed down. By 1995, the institutions were closed down with long term residents living in communities with supports such as a small group homes with paid caregivers (Steinstra, 2012).

When looking at the disability rights movement in B.C., we have come a long way in a short time. Since the institutions, British Columbia has focused on maintaining a disability

income support program. Persons with disabilities are eligible for income assistance and other funding for other supports dependent on the severity in which the disability impacts the individual's daily functioning and relevant to their personal needs. This differs from other provincial programs, such as Prince Edward Island, which offers disability support services and income support as separate programs (Steinstra, 2012). Health services are often provided for persons with disabilities by specialized teams. For example, provincial service delivery responded to the influx of deinstitutionalized persons with intellectual disabilities by creating teams which specialized in providing care to persons with intellectual disabilities, for example, Health Services for Community Living and Mental Health Support teams (Friedlander, 2006).

Similar to federal legislation, British Columbia's current human rights legislation, the *Human Rights Code*, outlines disability as a protected ground. Disability is defined broadly and protection from discrimination is provided in terms of employment, services available to the public, publications, tenancy, and membership in occupational associations including unions. In addition, the duty to accommodate is well established in provincial legal system (B.C. Human Rights Coalition, 2002).

B.C. continues to strive towards providing effective services that are in touch with the needs of persons with disabilities. The B.C. government has stated that they hope to make B.C. "the most progressive region for people living with disabilities [in Canada]" (Government of British Columbia, n.d.). The Government of B.C. plans to launch a widespread consultation to better understand issues faced by British Columbians with disabilities on December 3rd, 2013. On January 21st, 2014 a community consultation for the White Paper was held in Prince George, B.C. The resulting report will be called the "White

Paper" which will be presented at a provincial Summit meeting in June of 2014. Barriers, improved accessibility and fiscal commitment will be discussed at this Summit with a variety of governmental, organizational stakeholders and self-advocates (Government of British Columbia, n.d.).

There has been lots of movement in terms of disability rights in British Columbia with the shift from a medical segregation model to a community independence model of disability support services. However, Roman et al. (2009) noted that persons with disabilities have not yet received any apologies or acknowledgment by government officials of the treatment they endured in these institutions. In this sense, although changes have occurred, the history of persons with disabilities in B.C. has not been addressed.

In sum, the disability rights movement internationally, nationally and provincially has demonstrated a shift from a medical, "fix-it" model of disability support to a social model which considers impacts of other social factors on disability. These shifts have occurred through protests, advocacy and consultation. Some challenges remain in terms of problem solving to monitor the rights violations and adherence, providing respectful services and addressing past abuses.

Persons with Disabilities and Group Work

Group theory has influenced the creation of Strong and Safe. In the following section, the therapeutic factors of group, stages of group and psychoeducational group theory are considered. In addition, ideas about cofacilitation are presented. This section also demonstrates the ways in which group work has been used to provide therapeutic support to persons with disabilities. This section explores group organization, techniques, challenges and the therapeutic factors associated with group work for persons with disabilities.

In my experience with preparing this literature review, there are few studies done on group therapy for persons with disabilities, much less person-centered psychoeducational groups. I consider that the limited number of studies reflects the societal attitudes towards persons with disabilities as described previously. For the purpose of understanding group work with persons with disabilities, a variety of studies are reviewed which may not match the specific orientation of Strong and Safe but provide insight into the techniques, challenges and ethical concerns relevant to groups with persons with disabilities. It is important to note that many of the below examples are groups or therapy with persons with intellectual disabilities, and thus will be applicable to group persons with developmental disabilities that impact cognitive functioning.

Stages of group therapy. There are a number of basic stages of group development. These stages are categorized by the progressing levels of trust, safety, and therapeutic work within the group. Although described as progressing stages, each group will progress through these stages in a different way. Groups may not progress through these stages in a linear fashion and may regress, or become stuck in one stage for a period of time. Awareness of these stages can allow group facilitators to adjust the group to meet the needs of group members at each stage. Corey, Corey, and Corey (2010) identified five stages of group development.

First, there is the pregroup stage of a group development. At this stage, the facilitator needs to plan and conceptualize key pieces such as the overview of the group, advertising the group, considering the use of a cofacilitator and creating a common understanding of what this would look like, and what the screening process will look like. Group members will need to learn about the group, understand what it will mean for them to be apart of the group, and

begin thinking of what it is they would like to gain from participating in the group. Members and facilitators will begin the screening process together and perhaps begin an orientation to the group. This first pregroup stage is key to building the foundation of the group.

Second, there is the initial stage of group development. At this stage, the group itself is developing norms, building trust and safety, considering fears about participating in the group and formulating personal goals for their experience in the group. For the facilitator, the major focus of this stage of group is to develop, model and teach norms of the group and support the development of trust by exploring fears, being open to dealing with member concerns and encouraging sharing within the group. For the members, the major focus of this stage is to be open to expressing feelings and thoughts as they pertain to the group, to learn about group process and to be involved in the creation of group norms.

The third stage of group development is the transition stage. The transition stage is characterized by the continued building of trust, testing group members and leader for safety, continued building of interpersonal and communication skills, and the contemplating risk-taking within the group. The transition stage is also marked by conflict as anxiety and defensiveness are acted out within the group. As a facilitator, the key focus is to maintain a safe environment and boundaries when navigating group conflicts, defensiveness and risk-taking by group members. This can be done by encouraging members to understand their own patterns of communicating, modeling healthy communication and group norms and encourage here and now interactions. For this stage, members could try to understand their own resistance while respecting their defences and working through them. Members try to work through conflict, and express themselves around what is going on in the group.

The fourth stage of group development is the working stage. At this stage, trust and cohesion are high amongst group members, communication is direct and behavioural change is accomplished both inside and outside the group. As well, there is greater openness and acceptance to feedback and group members take risks within the group. As a facilitator, it is important to support group cohesion by continuing to model appropriate behaviour like openness to understanding behavioural patterns, supporting members' openness and linking members to one another. As well, encouraging members to begin moving their new skills into life outside of the group is a key piece to this stage of group development. At this stage, members could begin offering feedback to other members, be willing to practice new behaviours in and outside of the group and be open to confrontation and feedback from other group members.

The last stage of group development is the final stage. At this stage, the main focus will be expressing feelings about the ending of the group, practicing new behaviours for the end of the group and deciding what they hope to accomplish after the group. For facilitators, it is important to allow members to express their feelings about the ending of the group, including the meaning it had for them and unfinished business they have with the group. Also, reinforcing change the members have made within the group, and encouraging members to create strategies to help them maintain changes they have made after the group is finished are important facilitation tasks for this stage. For members, it is important to express thoughts and feelings about leaving the group, reflect on the impact of the group and group members in their life, and begin generalizing learning within the group to their everyday life in order to maintain changes after the group is finished.

When considering a group with persons with disabilities, a number of tasks stand out from these stages of group. For persons with disabilities, pregroup activities that allow members to learn about group process and the group itself, including what it could be like to participate in the group are vital to the ongoing process of informed consent. In some instances, more time may need to be taken at this stage with a population of persons with disabilities to insure that members understand what it means to be part of a group despite potential cognitive limitations. Ongoing informed consent is critical to avoid perpetuating historical patterns of oppression.

Self expression can be a challenge for any group member, if we consider the history of discrimination and marginalization against persons with disabilities, the initial stage task of finding a voice and sharing personal thoughts and feelings in the group could be a challenge. In this sense, the importance of building strong group norms that support respect, nonjudgement, safety and self-expression could be critical to the group progressing. In later stages of groups where group members are expected to express their experiences and give feedback to other members, building communication skills and building confidence with self-expression are essential tasks. In addition, discussing existing communication patterns from the perspective of historical marginalization could be helpful.

In the final stages of group, it is important for group members to consider what other support may be needed to achieve their goals for when the group has ended as there is potential for group members with disabilities to rely on others for support with some daily living tasks. As for any group, it would be important to maintain a focus on discussing the end of the group to help prepare members emotionally for the end of group.

As a psychoeducation group, Strong and Safe will likely follow the stages of development. These basic stages of group development guided the selection of the types of activities for each session and can assist the group facilitator to recognize and guide group progression through these developmental stages.

Using a cotherapist. A group can benefit greatly from the use of a cotherapist. Yalom and Leszcz (2005) point out that having two therapists running groups together increases the cognitive and observational range and therefore the intuition and strategies of group leadership. In addition, having a second therapist in the group means that group leaders have more support throughout the process; a second therapist can mean support through debriefing or a support for working through transference and counter-transference in group (Corey et al., 2010). Yalom and Leszcz further suggest that adding a cotherapist can increase the transferential interactions within the group as group therapists are observed to have or begin to demonstrate different roles within the group; for example, the mother and father, or the harmonizer and the provocateur.

Adding a group therapist can be advantageous for practical reasons as well. Group therapists can divide up tasks within the group, such as one therapist can provide support to a particularly distressed group member while the other monitors the group (Corey et al., 2010). In addition, dividing up tasks can mean alternating the role of lead therapist between the two therapists, depending on personal stress, illness or vacation.

A group can sometimes be disadvantaged by a cotherapist if the relationship between the cotherapists is poor. For best success, Yalom and Leszcz (2005) suggest working with a cotherapist that feels comfortable to be with, one who works from a similar theoretical orientation, and one who is open to processing tensions within the cotherapy relationship.

Corey et al. (2010) recommend that the relationship between cotherapist should model ways of coping with interpersonal conflict and direct communication to other group members. Maintaining a good cotherapist relationship can mean making a point of meeting before and after group to prepare and debrief from group and practicing open, nonjudgmental communication (Corey et al., 2010).

Most groups reviewed within this literature review were run with two group leaders (Ghafoori, Ratanasiripong, &Holladay, 2010; Marwood & Hewitt, 2012; Salmon & Abell, 1996; Stoddart, Burke, &Temple, 2002). It seems intuitive for a group with members who have diverse needs to take advantage of a two therapist model of group. A cofacilitator allows extra support to be provided to group members, for example group members with intellectual disabilities who may need more guidance or instruction. In addition, two facilitators may be more likely to be aware of key issues that could come up in the group, such as group members not comprehending educational materials and group members showing signs of dissociating or becoming triggered by content in the sessions. In addition, it would be important to the facilitator have a cofacilitator to debrief interventions, to consider issues of group dynamics, interactions and counter-transference and to hash out and plan around issues that come up within the group. The following provides a further idea of the logistics of group work with persons with disabilities.

Group organization. Group organization is flexible and will often reflect the purpose of the group, member and leader availability and resource restraints. Groups for persons with disabilities presented within the literature had varied group organization. Groups lasted from six sessions to daily ongoing sessions, and ranged from forty five minutes to an hour and a half in length. For example, Salmon and Abell (1996)'s closed group included eight adults

with a moderate learning disability; the group met for an hour once a week for seven weeks. The authors found that the one hour sessions were the limit to which concentration could be held and added that the limit put on the number of group sessions reflected the authors own availability. Alternatively, Mishna et al. (1996) group for adolescents with learning difficulties was formatted into 17, hour and a half weekly sessions. Longhurst et al. (2009) ran their Autism Spectrum Disorder group for sessions that were between 45 minutes to an hour long, five days per week for entire semesters. Marwood and Hewitt (2012)'s CBT anxiety group for persons with disabilities lasted for six sessions. Stoddart, et al. (2002) ran an eight session bereavement group for adults with learning disabilities, for an hour and a half each session. While a CBT based group for adults with intellectual disorders who wanted to improve their mood regulation studied by Ghafoori et al. (2010) ran for eight, one hour and a half session. Almost all groups reviewed maintained a short break midgroup with snacks.

In terms of the demographic of group make up of groups, Mishna (1996) found that including group members of the opposite sex within adolescent groups seemed to raise anxiety levels and preferred to create groups of same sex members. However, most adult based groups were composed of both male and female members with varying ages (Ghafoori et al., 2010; Marwood & Hewitt, 2012; Salmon & Abell, 1996; Stoddart et al., 2002).

In terms of participant selection, Haddock and Jones (2006) noted that most practitioners will develop their own inclusion or exclusion criteria based on the severity of the disability. For example, some practitioners will not work individuals that have no or limited language skills or diagnoses of autism. Salmon and Abell (1996)'s exclusion criteria for their group was when individuals had: behaviours that were likely to disrupt the group on

a regular basis, limited communication difficulties that would prevent participation and an inability to get to the group venue. Selection criteria for other groups was based around type of mental health concern; however most focused on individuals with mild intellectual disability as determined by referral sources.

Psychoeducational group therapy. There are many types of different groups within counselling work. Pyschoeducational groups are often structured, theme oriented and seek to impart information on a particular topic and focus on the development of a specific set of cognitive, behavioural or affective skills (Brabender, Fallon, & Smolar, 2004; Corey et al., 2010). As psychoeducational groups are so specific, the groups will often be comprised of members who have a similar problem or concern.

Psychoeducational groups can hold a variety of therapeutic goals. Education tends to be the primary goal of psychoeducational groups. Secondary therapeutic goals may include sharing and giving feedback, connections between group members, increased self-awareness and the creation of change in group members' lives outside of group (Browne, 2006; Corey et al., 2010).

Groups which address interpersonal violence prevention with women with disabilities could be closely compared to a social skills group. Many social skills training psychoeducational groups are formed to be either preventative or remedial and often have both education and personal issues components (Browne 2006). They often use experiential activities which allow new behaviours and skills to be practiced within the group (Browne, 2006). Role play is an example of an intervention used in social skills groups. Corey et al. (2010) suggested that one of the benefits of psychoeducational groups is that they tend to provide structured training which can be an effective way to combat more severe deficits

amongst group members, like social skill deficits, which could prevent participation in other psychotherapeutic groups. In this theme, Flowers and Booraem (1991) identified that due to the didactic nature, psychoeducational group can bridge members with heterogeneous mental health concerns better in terms of skill development than experiential groups. A study by Cowls and Hale (2005) shed some more light on the benefits of psychoeducational style groups.

In addition to bridging knowledge and skills based gaps between members, psychoeducational groups have a variety of therapeutic benefits. Cowls and Hale (2005) interviewed patients who were participating in psychoeducational groups in an acute inpatient psychiatric setting about their experience in psychoeducational groups. The participants noted that they appreciated the balance of a psychoeducational approach where they disclose emotional issues through interactive activities and then receive tools to apply to the issue. Participants particularly liked experiential activities that reinforced group educational content. It is important to note, participants also reflected on the way in which structured activities created a nonthreatening environment where participants could engage voluntarily in sharing with other group members. In sum, Cowls and Hale demonstrated that psychoeducational groups can provide a non-threatening group environment where group members can gain new tools and share. Browne (2011) reiterated the findings of Cowls and Hale (2005) and states that even with an educational focus, psychoeducational groups will still address many of the therapeutic factors associated with psychotherapy groups. The following provides some indication of how psychoeducational group techniques may be adapted to meet the needs of group members with disabilities.

Techniques that accommodate disability. Group interventions reviewed accommodated disability in a number of different ways from using more active creative techniques to using alternative communication styles to creating a more flexible physical environment.

First, therapists working with adults with intellectual disabilities tended to adapt some of their communication style to the individual's disability. Adaptations included a slower pace, being more concrete around concepts or ideas, simplifying almost everything and providing more support throughout the group (Haddock & Jones, 2006).

The study by Haddock and Jones (2006) acknowledged that acquiescence is an issue experienced by therapists working with clients with intellectual disabilities and requires some focus in terms of client-therapist communication. Therapists usually dealt with this issue by validating all ideas and opinions, using immediacy to have a conversation about the behaviour, and providing multiple choices when asking questions, particularly offering some options that seem ridiculous to insure that there is understanding.

Second, many groups incorporated more creative and active techniques into therapy sessions. Haddock and Jones (2006) discovered that practitioners in general adapted the CBT model for persons with intellectual disabilities to include more creative methods, such as using drawing rather than words, the use of pictures, visual prompts and role play. For journal entries, diary sheets were adapted to allow clients to just tick specific items. Some practitioners incorporated abstract concepts with concrete examples, including more creative ways to demonstrate the abstract like puppets, vignettes, and role plays.

Salmon and Abell (1996) echoed the importance of creative and active adaptations brought up by Haddock and Jones (2006). Salmon and Abell (1996) advocated for more

inclusion of active therapy techniques such as role play, psychodrama, and dramatherapy. They consider more active methods appropriate as these methods engage participation by all members, facilitate self-expression and allow for new and old encounters to be experienced and rehearsed. Some activities used were, role playing social situations that individuals in the group found difficult, exploring anxieties around meeting new people through an experiential meet and greet activity and giving feedback to one another by giving each other stick on labels which were later brought home on paper (Salmon & Abell, 1996).

Tomasulo and Razza (2006) additionally advocated for psychodrama techniques to be used in group therapy with persons with disabilities and suggested an interactive-behavioural model of therapy which included two deviations to standard psychodrama stages of warm up, enactment and sharing. Tomasulo and Razza added a stage that would precede the warm up stage, called orientation. In orientation, members with intellectual disabilities would be given the opportunity to learn the skills necessary for group participation; skills such as listening to other members and back and forth communication. Also, they added a final stage called, the affirmation stage, where members would reflect on what they liked about what the protagonist did in order to reinforce therapeutic behaviours such as self-disclosure and vulnerability. The interactive-behavioural model of group therapy demonstrated a way that intellectual disability, low communication skills can be accommodated in group in an interactive and interpersonal way.

For another example of active and creative interventions, Stoddart et al. (2002) included active techniques in their educational approach to bereavement concerns by including interventions such as field trips to funeral homes, interviews with clergy members,

watching films, and listening to music. These interventions proved to engage individuals and their different learning needs (Stoddart et al., 2002).

Third, techniques used to accommodate the disability focused on taking a directive approach and facilitating interactions within the group. For example, important facilitation tasks in psychodynamic and interpersonal groups include: monitoring discussions to insure group members are following the conversation, insuring group activities are understood by group members, and facilitating interactions for group members to talk to each other and acknowledge each other (Longhurst et al., 2009; Mishna and Muskat, 2004). Just like in a psychodynamic group with persons without disabilities, efforts were made by group leaders to encourage group members to express their needs and understand themselves and their behaviour.

Another way to accommodate disability was to be aware of how the physical environment was affecting therapy and to be responsive to member needs in regards to the physical environment. For example, Longhurst et al. (2009) description of a therapeutic group for youth with Autism Spectrum Disorder highlighted the importance of understanding each member's sensory idiosyncrasies and then adapting the environment to insure members were comfortable. These accommodations could mean temperature regulation, removal of distracting items and even maintaining a standard routine within group (Longhurst et al., 2009). Organizational and environmental flexibility within the session allowed for students to use fidget tools and participate in the group from a variety of positions, including lying down on the ground (Longhurst et al., 2010).

In sum, group work can accommodate persons with disabilities by therapists adjusting their communication style, building in more active and creative interventions, facilitating

more interpersonal communication and creating flexibility within the physical group environment. Even with adaptations there can be some challenges that come out of group work with this population.

Challenges. Challenges may arise in any group experience. A couple of challenges were recognized when doing therapeutic work with persons with disabilities in groups or in individual therapy. Some challenges were associated with understanding what is required to accommodate intellectual disability in group interventions. In some cases, it is difficult to predict the issues that may arise and then problem solve through them. For example, Salmon and Abell (1996) identified some obstacles in using active therapy methods, including that some group members had a difficult time differentiating between what was "acting" and what was real life. In addition, Haddock and Jones (2006) identified a primary obstacle was the client's difficulty in generalizing learning to different settings and then the therapist's subsequent struggle to find ways to bridge learning from sessions to other settings.

Haddock and Jones (2006) highlighted a major ethical concern that came up for therapists included whether or not to include staff members or carers in therapy. Throughout the literature, authors advocated for both the exclusion and inclusion of support workers or carers in group sessions. Some suggested that it was important to respect the individual's autonomy and confidentiality and to therefore exclude carers from the sessions (Haddock and Jones, 2006). Others suggested the importance of including carers to provide assistance to group leaders and to increase the likelihood of success in behaviour change as the presence of carers in session allowed for reinforcement and support at home (Haddock & Jones, 2006; Marwood & Hewitt, 2012; Stoddart et al., 2002).

In sum, challenges that come up around group work with persons with disabilities are trying to predict disability related issues that could come up in session and then problem solving through how these issues can be accommodated. In addition, knowing when and if to include carers or supports can be a challenge.

Therapeutic benefits of group therapy. The therapeutic factors experienced by persons with disabilities in group therapy echoed the therapeutic factors of group listed by Yalom and Lezscz (2005). Yalom and Leszcz defined a number of therapeutic factors which seem to be innate qualities of group psychotherapy experiences. Although each client may experience these factors differently, research and group psychotherapy experience show that these factors are consistent. Yalom and Leszcz highlighted that the instillation of hope, universality, imparting information, encouraging acts of altruism, learning about one's primary family experience, development of social skills, imitative behaviour, sense of belonging or cohesiveness, interpersonal learning catharsis, and existential awareness. Yalom and Leszcz described group therapy as a unique process through which group members can learn about their own interpersonal patterns, feel "normal" and accepted by others, practice new behaviours, connect with others in a healthy way and connect with their own personal value in the group. Significantly, much of the growth within group can be translated to members' lives and relationships outside of group.

Yalom and Lesczc's (2005) therapeutic factors of group are relevant to the therapeutic outcomes of Strong and Safe. Although all factors could be beneficial for group members, factors such as interpersonal learning, imparting information, socialization skills, imitative behaviour, altruism, and group cohesiveness are particularly relevant for the group

demographic of women with developmental disabilities, the overall goals of Strong and Safe and the psychoeducational component of the group.

Yalom and Lesczc (2005) therapeutic factors were recognized as important therapeutic factors for group members with disabilities by a number of different studies. Mishna et al. (1994) and Mishna and Muskat (2004) found that many youth with disabilities had experienced psychosocial losses with their barriers to connect with peers in a social environment. In their studies, the authors found that psychodynamic groups could be used to correct psychosocial losses experienced by adolescents with disabilities. Psychodynamic groups benefited group members as they experienced feelings of acceptance and safety among peers, empathy and caring for others, and a supportive environment through group therapy (Mishna et al., 1994; Mishna, 1996; Mishna & Muskta, 2004). Longhurst et al. (2009) echoed these findings and reflected that youth began to feel less alone and have a sense of belonging. Longhurst et al. noticed changes in group members as they began to be hopeful about learning how to interact with others and developed a sense of self-worth and importance within the group.

Longhurst et al. (2010) and Mishna and Muskat (2004) stressed the importance of allowing group members to connect over their shared experience of having a disability as key to developing feelings of acceptance and belonging. Mishna and Muskat established this aspect by recognizing the commonality of disability in the group within the first session. In this way, a sense of community is built and group members begin to support each other and practice mutual aid (Longhurst et al., 2010; Mishna & Muskat, 2004).

Aside from therapeutic factors of group, there were some studies that demonstrated group may be an effective treatment of a number of mental health and emotional concerns for

persons with learning disabilities (Marwood & Hewitt, 2012; Stoddart et al., 2002). For example, Marwood and Hewitt (2012) demonstrated that a CBT psychoeducational group was effective at treating anxiety in persons with learning disabilities. Stoddart et al.'s (2002) education based support group for adults with intellectual disabilities who were struggling with bereavement concerns showed that after participating in the group, members showed significant improvement in symptoms of depression. Meanwhile, Ghafoori et al.'s (2010) CBT based group for mood regulation for adults with intellectual disabilities found significant decreases in somatisation, interpersonal sensitivity, obsessive compulsivity, depression, anxiety, psychoticism, and global distress. However, no treatment gains were maintained at follow up (Ghafoori et al., 2010).

The above listed therapeutic factors are relevant to the therapeutic outcomes of Strong and Safe. Although all factors could be beneficial for group members, factors such as interpersonal learning, imparting information, socialization skills, imitative behaviour, altruism and group cohesiveness seem particularly relevant for the group demographic of women with developmental disabilities, the overall goals of Strong and Safe and the psychoeducational component of the group.

Persons with disabilities involved in group therapy experience therapeutic factors of group, such as sense of belonging, the instillation of hope and universality. Group work with persons with disabilities has been shown to be effective but may require some adaptations, such as the inclusion of active and creative interventions, increased structure and adjustments to therapist communication style. Although some challenges remain, such as whether or not to include carers in therapy, groups remain a therapeutic and viable option for persons with disabilities. An understanding of the therapeutic factors will allow facilitators to not only

educate potential group members or organizations hoping to run this group on the benefits of group work, but also will allow facilitators to encourage these processes within the group as the group moves through its various stages.

Women with Disabilities and Interpersonal Violence Prevention

This section describes the vulnerabilities and barriers to services and recommendations for interventions that have arisen from consideration of the vulnerabilities of women with disabilities to interpersonal violence. Vulnerabilities to interpersonal violence are closely linked and deeply connected to societal attitudes towards persons with disabilities.

Vulnerabilities and barriers A trend within the academic literature on healthy relationship interventions is to explore the social reasons why women with disabilities are vulnerable to violence. This approach reflects the social model of disability which considers that social dynamics create barriers and challenges for persons with disabilities and are therefore, social dynamics are paramount to understanding the experience of disability (Curry, Hassouneh-Phillips, & Johnston-Silverberg, 2001; Powers et al., 2009). It's important to consider that many of following issues faced by women with disabilities represent risk factors for violence against women with disabilities as well as barriers to seeking assistance.

A literature review by Plummer and Findley (2011) of peer reviewed articles on women with disabilities who have experienced abuse identified the following risk factors or vulnerabilities of women with disabilities. These risk factors include lack of identification of abuse by the victim, service barriers, the role of perpetrators in their life, social isolation (Plummer & Findley, 2012). Curry et al. (2001) added that discrimination and stereotyping faced by women with disabilities also become risk factors for interpersonal violence. In

addition, Hassouneh-Phillips and McNeff (2005) demonstrated that low self-esteem is a risk factor for women with disabilities to experience interpersonal violence. Rajan's (2011) data from focus groups of women with disabilities across Canada who have left abusive relationships confirm many of these risk factors.

Discrimination. Discrimination and negative stereotypes are components of the way in which our society approaches the issue of interpersonal violence and women with disabilities and how women with disabilities perceive themselves. Curry et al. (2001) considered that women with disabilities are devalued within our society and that women with disabilities are typically viewed as asexual and dependent. This societal attitude to women with disabilities means that service providers, caregivers and other persons in these women's lives may not be aware of the risks of interpersonal violence to women with disabilities or be aware of interpersonal violence as it occurs. Curry et al. also highlighted that some abusive actions which target the person's disability may not be considered by support staff to be inappropriate or harmful towards their client. For example, removing the battery from the wheelchair of someone who is dependent on this support could be considered similar to the action of locking someone in a room; however, this restriction may be considered appropriate by caregivers or support persons (Curry et al., 2001). To make matters more difficult, these abusive actions are often not defined as abuse in law (Plummer & Findley, 2011).

Stromsness's (1993) study on how women with disabilities experience sexual abuse uncovered a theme of perceived vulnerability towards crimes due to their disability. A number of women interviewed by Stromsness identified that they felt like 'easy targets' due to their disability, in fact 71% of her participants considered that crime happens a lot to persons with intellectual disabilities. Stromsness's study revealed that women with

disabilities are aware of discrimination and have developed a sense of self-perceived vulnerability due to their status as disabled in society.

Discrimination and societal approaches to women with disabilities are related to many of the subsequent components of the vulnerability of women with disabilities to interpersonal violence. The effects of discrimination on women with disabilities is interwoven in the factors described below.

Lack of identification. Often the first step in stopping an abusive relationship is to recognize that the relationship has become or is abusive. Identifying interpersonal violence can be a challenge for women with disabilities for a number of reasons. When caregivers do not recognize their own abusive behaviour due to forces of discrimination, oppression and marginalization, it is clear that women with disabilities would also not recognize abusive behaviour due to these forces (Baranti & Yuen, 2008). In addition to issues such as low self worth which will be described below, victims often do not know their rights or have the skills to problem solve through the process of identifying and leaving an abusive relationship (Sordi, 2011).

An open letter from Martha Sheldon, who described her experience as a woman with a disability who had been sexually exploited in relationships, brought up another important piece to this dynamic. Sheldon considers that her social and emotional development made it difficult to recognize that she was being taken advantage of in her relationships with men (Sheldon, 1993). Curry et al. (2001) also identified that some women with disabilities who are more concrete in their thinking patterns may lack problem solving skills necessary to identify and then report an abusive interpersonal relationship. As well, they may fear that others would react with disbelief or that they wouldn't be heard as they are a person with a

disability. From this reflection on the barriers to women with disabilities recognizing abuse, it is clear how the lack of disclosure of abuse is one of the major barriers identified by Sordi's (2011) report on interpersonal violence prevention for women with disabilities.

Service barriers. Another key vulnerability to interpersonal violence is that there are a number of systemic barriers to service access. Often, when interpersonal violence is reported, women are met by insensitive front line workers and inaccessible services (Plummer & Findley, 2011; Sordi, 2011). Shelters which are physically inaccessible to women with disabilities, services with no outreach programming, and services with frontline staff who do not have training on how to best support persons with disabilities are some of the barriers women experience when accessing services for women who have experienced violence. Rajan's (2011) focus group participants highlighted that services were also deemed inaccessible as communication and comprehension needs were not accommodated and their unique issues were not understood.

Baranti and Yuen (2008) highlighted that because interpersonal violence for women with disabilities is different than violence against women without disabilities, often abuse screening or assessment instruments used in public services are not sensitive to women with disabilities. In addition, services will rarely provide violence prevention training for women with disabilities. Stromsness (1993) added that even when women do identify the need for counselling assistance, there is a lack of effective therapeutic interventions for women with disabilities that have been abused.

Role of perpetrators and dependency. One of the unique aspects of the interpersonal violence experienced by women with disabilities is that often the perpetrator can be someone they require care from. In this sense, women can be highly dependent on their perpetrator for

their daily care needs. Often, these perpetrators will have continual and frequent access to the women as they hold roles of caregivers or health professionals which can translate to long term and abuse with increasing violence (Plummer & Findley, 2011).

Dependency on a perpetrator for care needs can mean women experiencing violence hold concern about how they will receive daily care outside of the abusive relationship. This is especially true of women of low income status, who may not be able to afford to pay a professional caregiver or additional care support (Brownridge, 2006). As well, there is the risk that an attitude of over compliance and learned helplessness surrounding the disability may have been created over long term exposure to abusive caregiver relationships (Plummer & Findley, 2011). This attitude of learned helplessness can mean that women will not recognize abuse nor report abuse but that they might also see their disability requiring more external support than it really does.

Isolation. Women with disabilities are often be isolated both socially and physically. Due to this isolation, women with disabilities are at greater risk of abuse. For example, a study of women with physical disabilities by Nosek et al. (2006), revealed that participants who were less physically mobile and more socially isolated were more likely to experience abuse. In addition, when a disability limits access to the community like a disability that affects communication or mobility, the woman may be more isolated and therefore, less able to report abuse.

Social isolation plays an important role in an individual's ability to both recognize abuse and report an abusive relationship. A study of safety promoting behaviours of women with disabilities, by Powers et al. (2009), found that just like women without disabilities, women with disabilities would begin the process of leaving an abusive relationship by

reaching out to informal supports like friends. Women with disabilities are at risk of interpersonal violence and the continuation of abusive relationships when they are isolated.

Low-self esteem. Self-esteem contributes to both the ability to identify interpersonal violence as well as the ability to end abusive relationships (Brownridge, 2006). Sordi (2011) acknowledged that an important piece of the social context of interpersonal violence against women with disabilities is the low self-esteem experienced by some women with disabilities. Sordi highlighted that low self-esteem can cause women with disabilities to believe that they deserve the abuse or are responsible for the abuse that they incur and thus self-esteem becomes a barrier in identifying abusive relationships and reporting the abuse. Sordi considered that these messages about self worth are derived from the way in which women with disabilities are undervalued in our society.

Hassouneh-Phillips and McNeff (2005) examined the link between low sexual and body esteem and intimate partner abuse in women with disabilities through a qualitative study. Hassouneh-Phillips and McNeff found that women with more severe physical impairment were more likely to see themselves as sexually inadequate and unattractive, thus, had an increased vulnerability of getting into and staying in abusive relationships. As the women interviewed saw themselves as having low desirability, they were more likely to settle for unsatisfactory relationships with the belief that they would be unable to find another relationship. A key theme was that women had internalized societal messages about their self worth and their value within relationships. For women with disabilities, the dominant societal messages are not of empowerment and autonomy but rather focused on their limitations and their dependency (Curry et al., 2001). In sum, low self-esteem can cause women with disabilities to consider they deserve the violence they experience and that they will not find a

better relationship, thus enter into abusive relationships or prolong their exposure to interpersonal violence by staying in abusive relationships.

Lack of knowledge. Despite numerous studies demonstrating that violence against women with disabilities is widespread, Sordi (2011) stated that violence against women with disabilities is a relatively small area within academia. Baranti and Yuen's (2008) literature review study adds to this statement; the authors suggested that the complex nature of violence against women with disabilities, as an invisible population, is under recognized by the general society. Further, when it comes to looking at interpersonal violence there is a lack of studies which explore "risk factors, incidence, vulnerabilities, experiences of and impact of abuse, and use of and barriers to services" (Baranti & Yuen, 2008, p. 116; Curry et al., 2001). More research is needed to further understand and support women with disabilities through the issue of interpersonal violence; however, societal recognition of this issue remains a barrier.

Adding to this, Smith's (2008) analysis of the frequency of interpersonal violence for women with disabilities strongly recommended that interventions need to be developed that will support women who are at risk of interpersonal violence and in particular, strengthen assessment procedures to identify women who are experiencing interpersonal violence. Lund (2011) further recommended testing the efficacy of existing abuse intervention and prevention programs for women and men with disabilities. The lack of studies done on services used by women with disabilities who have experienced interpersonal violence is reflected in my literature review as there was a strong focus on vulnerabilities and recommendations within the literature and few empirical studies of actual services and programming provided for this issue.

In sum, there are a number of social dynamics which create real barriers for women with disabilities and in turn, make women with disabilities vulnerable to interpersonal violence. In addition to focusing on risk factors and vulnerabilities, the literature also offered some suggestions of programming to deal with these vulnerabilities.

Recommendations. There are a number of recommendations in the literature in terms of how programming for women with disabilities can positively impact interpersonal violence against women with disabilities. This section reflects the themes of empowerment based programming, disability sensitive services, and a call for more research.

Empowerment based programming. There was a theme of recommendations to focus on more empowerment-based programming for women with disabilities to act as a preventative and healing support. Sordi (2011) described a need for services that encourage a healthy and autonomous sense of self, that encourage the creation and maintenance of healthy relationships and provide information to women about their rights and violence against women with disabilities.

Wang and Dovidio's (2011) study on the impact of disability status on individuals with disabilities' autonomy-related thoughts brought them to the conclusion that resiliency in persons with disabilities can be enhanced by promoting social autonomy and looking at other pieces of identity besides disability status. Harrison, Umberson, Lin and Cheng's (2010) grounded theory study which sought to develop a theory on health promoting behaviours for middle-aged women with disabilities came to similar conclusion that self determination and support of positive relationships were key to healthy aging and suggested these be important factors in programming for women with disabilities. Harrison et al. importantly pointed out

that identity factors that are nondisability related, such as sense of self and lifestyle, are critical for health promotion programming.

Rajan's (2011) focus groups of women with disabilities who had experienced interpersonal violence which answered the question "what helped [you] to leave abusive relationships", highlighted the importance of maintaining positive relationships and increasing social connections. Maintaining positive relationships and increasing social connectedness is considered to provide preventative and also assistive benefits to women in abusive relationships.

A final aspect of strengths based programming is the expansion of programming for women with disabilities or violence against women programming to include information that will educate women on interpersonal violence and their rights (Baranti & Yuen, 2008; Sordi, 2011). Education based interventions are considered to act as prevention against interpersonal violence and also give women the information to identify and then leave abusive relationship. In addition, these interventions may include some self-protective skills training like assertive communication or self-defence techniques. Included in these interventions would ideally be information to create a disability sensitive plan of escape from interpersonal violence, including resources and services to turn to. A disability sensitive plan will reflect the specific needs of the individual and be comprehensive in supports they could utilize while they transition out of the relationship (Baranti & Yuen, 2008).

Disability sensitive services. Services need to be accessible for women with disabilities and have disability sensitive focus. Accessibility, according to Baranti and Yuen (2008), means a program will have trained staff, outreach and interpersonal violence

prevention programming, accommodations in terms of services and material, and established program policies towards persons with disabilities.

Disability sensitive services mean that staff are trained and are aware of issues that women with disabilities face and how to accommodate limitations created by their disabilities. Baranti and Yuen (2008) highlighted the importance of designing these services for women with disabilities; for example, insuring that screening instruments are sensitive to women with disabilities and will consider the unique issues faced by women with disabilities who experience interpersonal violence.

Rajan's (2011) focus groups of women with disabilities who have experienced interpersonal violence identified that disability sensitive services need to not only be sensitive to issues faced by women with disabilities but also be equipped to provide trauma informed, low cost, and anti-oppressive based counselling to promote healing. In addition, the focus groups highlighted the need to have services acknowledge the impact of their low income status and thus be equipped to provide financial support when the woman is leaving an abusive relationship.

In sum, the recommendations for programming in the literature highlighted a need to bring greater visibility to the issue of interpersonal violence and women with disabilities (Baranti and Yuen, 2008). Focusing on strengths, identity and building upon empowerment is an important theme. As well, greater accessibility to services and disability sensitivity within services are important to both prevention and assisting women to leave abusive relationships.

These recommendations reflected the unique vulnerability to interpersonal violence and barriers to support women with disabilities face. Discrimination, self-esteem and isolation are just some factors that impact interpersonal violence and women with

disabilities. The following illustrates a number of ways programming has met recommendations.

Existing Violence Prevention Programming

Existing programming which addresses the issue of interpersonal violence and women with disabilities seems to focus on both interventions for women with disabilities and interventions for service providers to encourage domestic violence prevention organizations to become more disability sensitive and accessible.

Interventions for organizations. As many of the barriers and vulnerabilities faced by women with disabilities are systemic in nature, it is helpful to reflect on the way in which support services have become more disability sensitive.

For example, Safe Place (n.d.), is an Austin, Texas based community organization which strives to promote healing and prevention of interpersonal violence against men and women and provides training and consultation for individuals or organizations that wish to learn more about interpersonal violence and persons with disabilities. Some key issues they cover are risk factors and strategies to reduce risks to abuse, safety planning with people with disabilities and dynamics of power in control in abusive relationships involving peoples with disabilities (Safe Place, n.d.). Similar training is available through the Baylor College of Medicine's Centre for Research on Women with Disabilities (Baranti and Yuen, 2008).

Other organizations, such as the Alberta Committee of Citizens with Disabilities, focus on particular service areas. For example, the Safe Haven workshop raises awareness among domestic violence shelter staff and management about the unique situations facing women with disabilities. Safe Haven also provides suggestions on how shelters can appropriately and respectfully support women with disabilities (Alberta Committee of Citizens with

Disabilities, 2009). For some organizations, gaining disability sensitivity means understanding what the needs of women with disabilities are in regards to the specific service that they deliver. For example, The Centre for Research and Education on Violence Against Women and Children, based out of the University of Western Ontario, is developing disability sensitivity in their programming by consulting with women with disabilities to design an outreach strategy for disability communities (Jaffe, Berman, & MacQuarrie, 2011). Other organizations, such as the YWCA of Peterborough Halliburton, assist local organizations in this process by completing audits of violence intervention services and then provide training to increase service accessibility for women with disabilities (Canadian Women's Foundation, 2013).

Increasing physical accessibility, consultation with persons with disabilities, and understanding of disability issues are all important steps for organizations to take in order to prevent interpersonal violence against women with disabilities. With these shifts, women with disabilities may face fewer service barriers and systemic discrimination.

Interventions for women with disabilities. Interventions vary from computer based education to training groups to group psychotherapy. Lund (2011)'s literature review of peer-reviewed studies from 1995 to 2010 revealed that violence related intervention programming for people with disabilities often were psychoeducational and skill based. The majority of programming reviewed focused on abuse identification and prevention. The following will explore interpersonal violence interventions for both individuals and groups.

Individual interventions. The individual interventions for violence prevention vary greatly. Robinson-Whelan et al. (2010) created an online training program for women with disabilities to access from their homes. This training program included vignettes of

interpersonal violence survivors who described their abuse and their survival experiences, identified warning signs of abuse and safety promoting strategies. The vignettes also included affirming messages. The survivors and their stories differed by race, disability, age and type of perpetrators. Robinson-Whelan et al. (2010) found that this mode of training was effective for abuse awareness, especially for women who had been assessed as having low abusive relationships awareness.

Other online resources included the "Dating Violence Awareness" program offered by Vecova, the Centre for Disability Services and Research based in Calgary, Alberta (Vecova, 2012). The Dating Violence Awareness program offered powerpoint presentations, with worksheets that include activities such as role plays and discussions. Topics included were safety, self-protection, healthy sexuality and assertiveness, gender and stereotypes in the media, power and control dynamics and the cycle of violence (Vecova, 2012). Vecova's Dating Violence Awareness program resources were presented in plain language to encourage accessibility and were available for public use on their website.

There were a number of training based individual focused interventions that focused on self-protective behaviours. The sexual abuse prevention models of Egemo-Helm et al. (2007) Lumley et al. (1998) and Miltenberger et al. (1999) were based on the same response and lure resistance intervention model for women with intellectual disabilities. These studies trained participants to recognize abuse and resist lures through behavioural skills, like saying no, avoiding the predatory person and letting someone know. Each time a participant achieved a low score during skills assessment they would receive additional behavioural based training (Egemo-Helm et al., 2007). Each study varied on its inclusion of naturalistic settings in role-plays. For example, Egemo-Helm et al. conducted training and assessments

on the resistance behaviours of women with disabilities in naturalized settings (eg. in the community). In-situ assessments were done by having a person unknown to the participant approach them and proposition them. Egemo-Helm et al. found that that their in-situ training allowed better skills generalization than studies done by Lumley et al. and Miltenberger et al. as three of four participants showed maintenance of the skills learned within the training program. These programs were critiqued for the potential to create psychological distress in the individuals participating (Lund, 2011). There seems to have been no abuse awareness education included in these programs.

Alternatively, Cooke (2003) supported a solutions-focused time limited therapy to assist persons with disabilities who have experienced abuse. Cooke advocated for empowering interventions that encourage the individual to focus on their strengths and positive forces in their life. Cooke suggested interventions like listing positive traits about themselves, listing positive activities they enjoy, learning about self-nurturing rituals, choosing a healing symbol to focus on and participating in a present focused activity were helpful in building strength and resiliency after abuse. Cooke's empowerment approach was similar to that of Khemka (2000) and Khemka, Hickson, and Reynolds' (2005) group interventions.

Group interventions. Group interventions were varied as well, from empowerment focused groups to skills based groups. Most groups reviewed were psychoeducational in some aspect and had a component focused on building self-esteem and self-empowerment.

Khemka (2000) and Khemka et al. (2005) had a different approach to violence prevention programming. These authors considered that there was a cognitive gap in terms of decision making skills around interpersonal relationships between women with disabilities

and women without disabilities. However, they considered that building the decision making skills of women with intellectual disabilities could be an effective way to bridge this gaps and thus increase safety promoting behaviours. The ESCAPE program, developed by Khemka et al. (2005), entailed a number of educational sessions on healthy relationships, how to identify abusive relationships and included interactive activities which focused on the emotional, cognitive and motivational aspects of decision making. Then, group members would participate in support group sessions to connect what they had learned about decision making to issues in their own lives. The program consisted of twelve curriculum sessions and six support group sessions. Through surveys, Khemka et al.'s (2005) found that their group was successful in building knowledge, decision making skills and empowerment in their participants.

This empowerment based group model is similar to Building Bridges Across Barriers. Building Bridges Across Barriers is another program that brings women with disabilities, immigrants, and refugees together with the focus of exploring oppression, building solidarity, and ultimately stopping violence against women (Springtide Resources, 2013). Building Bridges was created by Springtide Resources, an organization supporting the end to violence against women and children based out of Toronto, Ontario. Building Bridges provided leadership training workshops using an antioppression and feminist approach. The program consisted of eight training sessions on topics such as privilege and power, building allies, and resistance and activism (Springtide Resources, n.d.).

Singer's (1996) group for adults with a variety of disabilities who had both experienced abuse and identified as being in need of abuse prevention training was an example of a group with an education and skill based group that focused on empowerment.

Singer's group used techniques such as role plays, discussions and demonstrations to teach group members basic assertiveness skills, and talk about what they liked about themselves to build self-esteem. The group members observed demonstrations by facilitators of good and bad touch and what actions needed to be taken. Finally, group members got to practice their skills in a role play. Post group, Singer found that group members showed improvements in their communication and safety protection skills and their knowledge around healthy and unhealthy relationships.

Finally, Barber, Jenkins, and Jones' (2000) group for women with learning disabilities who have been abused is an example of a person-centred educational group. Barber et al. designed a group with structured educational sessions with supportive and nonconfrontational group discussion. Barber et al. highlighted that group sessions were planned as the group progressed based on group members' personal goals and issues. The topics covered in educational sessions were sexual knowledge and health, assertiveness, self-protection and coping, and relaxation techniques. Discussion, modelling and role plays were used to deliver group content. Barber et al. found that women in their group learned behavioural rules for self-protection and found that self-esteem had increased throughout the group.

Interpersonal violence prevention interventions for women with disabilities were separated into two categories: programs which encourage greater accessibility in mainstream domestic violence and violence prevention services programs specific for women with disabilities. Key ways community based programs can increase their accessibility is by becoming aware of the unique aspects of interpersonal violence and women with disabilities, shift system attitudes to reflect greater respect, have increased physical accessibility of their

programs and understand what persons with disabilities need in their communities. Interpersonal violence prevention interventions for women with disabilities have been provided on both a group and individual basis. Psychoeducational, empowerment and behavioural in focus were all qualities of interpersonal violence prevention interventions for women with disabilities.

Summary of Chapter 2

This literature review reflected on a number of key topics which relate to interpersonal violence and women with disabilities. First, the contested definition of disability was presented and the definition of developmental disability to guide this study was suggested. Second, the evolution of disability rights in Canada and internationally was reviewed and the trend towards a social model of disability was highlighted. Third, group therapy interventions for persons with disabilities were reviewed. Techniques, group organization and potential issues were central elements to this review. Fourth, a greater look at the issue of interpersonal violence for women with disabilities was taken. Barriers and social factors which impact vulnerability to interpersonal violence were considered. Finally, interventions that support women with disabilities in interpersonal violence prevention were highlighted. The following are insights taken from the literature review that inform the group, Strong and Safe.

Implications for Strong and Safe. There were a number of insights revealed through the literature review that are important for group Strong and Safe. A careful consideration of a working definition of disability guided the literature review and will also guide the screening procedures for the group.

The history of the disability rights movement provided important insights into the need for empowerment of persons with disabilities to advocate for their rights and a social model of disability. The history of disability rights also provided insight into the roots of discrimination and societal attitudes towards persons with disabilities.

The review of group interventions for persons with disabilities provided important information in terms of how groups and therapy may be adapted to accommodate developmental disabilities. Suggestions such as the use of psychodrama, role play and field trips informed the choice of activities in Strong and Safe.

The reflection on vulnerabilities of women with disabilities and the unique factors involved in interpersonal violence against women with disabilities provided important insights. First, this reflection provided insight into disability sensitive programming and the social and support needs of women with disabilities who experience interpersonal violence or at risk to experience interpersonal violence. This knowledge informs activities and the content process in group sessions.

Finally, the description of interventions which have already been used in interpersonal violence prevention provided an important understanding of what has already been done with groups on this topic. This information allowed me to consider topics, themes, and activities that could be helpful in the creation of Strong and Safe but also allowed me to reflect on how I want Strong and Safe to be similar and different. For example, in-situ behavioural assessments are not congruent with my theoretical orientation whereas person-centered group work presented by Barber et al. (2000) provided me with a congruent framework for Strong and Safe. The following is a preview of the group, Strong and Safe, as informed by the literature review.

Chapter 3

Introduction

Strong and Safe is a healthy relationships and self-empowerment psychoeducational group. The focus of this group is to respond to the issue of interpersonal violence against women with disabilities. This group will strive to maintain a person-centered integrative orientation and integrate a critical feminist approach to the issue of interpersonal violence and hold a trauma-informed lens to group planning. This section further describes the group Strong and Safe, including its demographic, duration and structure and group goals. A look at ethical concerns that could come up for this group is considered. Finally an overview of the proposed group is provided.

Demographic

Strong and Safe is geared towards women with developmental disabilities. Women must be over the age of nineteen to become group members. The inclusionary criteria for this group is that group members must self-identify as having a developmental disability and live independently or independently with some support through services. Examples of this support could be living independently but with access to life skills appointments, or the limited use of home-care services, for example, weekly assistance with cleaning tasks.

Due to the concern of interpersonal violence from support persons and the goal of personal empowerment, efforts will be made to insure group members are supported adequately by the group leaders so that support persons will not be needed within the group. However, if an individual requires one on one support to participate in the group this accommodation will be granted to allow for accessibility as part of a disability sensitive

service. Information surrounding group process, therapeutic benefits of group and the psychoeducational content of the group will be shared with support persons as requested by group members.

Duration and Structure

Strong and Safe is a closed group structured to run over nine weeks, with two hour long sessions. The first session is an orientation session where group members get a chance to meet, ask questions about the group and express their goals for the group.

Each session contains debriefing and check-in activities to allow group members' issues or concerns to be focused on in the group that day. Feedback is gathered through discussions and check-ins each week to help shape the focus of each session. In addition, group leaders' observations in terms of group safety, impact of certain disabilities on group progress and members' understanding of content may also impact the focus of the sessions. Adaptations to the group format could include the removal of environmental distractions, inclusion of more active techniques or more time spent on certain topics or activities. Additional resources in Appendix T provide openly accessible alternative materials on healthy relationships topics that could be used as additional activities if certain topics covered in group require more attention. Each session will include a fifteen minute break where light refreshments are be provided.

Goals

The goal of Strong and Safe is to increase awareness of abusive relationships and teach women how to identify these relationships. Also, Strong and Safe provides support for women to build skills that will enhance their safety; such as creating healthy relationships,

assertive communication, and safety planning. To support this process, Strong and Safe provides opportunities for women to gain awareness of their personal value, strengths and resources as women with disabilities. Strong and Safe group leaders will present this material in an accessible and disability sensitive manner. Guidelines for disability sensitive services can be found in Appendix S.

In addition, to the general goals of the group, group members are encouraged to have personal goals for their participation in the group. Strong and Safe empowers group members to meet their own relationship and safety based goals in the group through the provision of a variety of resources and activities. These goals will be met through both group process and educational activities. For example, healthy boundaries, assertive communication and concepts such as trust and safety can be taught through participation and experiencing group therapy.

A Person-Centered Integrative Approach

Strong and Safe is a psychoeducational group with a person-centered integrative theoretical approach. This integrative approach has a person-centered theoretical foundation while integrating techniques and tools from a variety of theoretical orientations. To better understand how the integrative theoretical approach works within Strong and Safe, I will briefly describe person-centered therapy within an assimilative integration model and how this is combined with psychoeducational group therapy.

Person-centered therapy. Person-centered therapy was developed by the work of Carl Rogers. Rogers and person-centered therapists placed a high value on understanding the client's subjective experience of life and the healing nature of a therapeutic relationship (Corey, 2009; Thorne & Sanders, 2013). Rogers believed that there are three conditions that

promote growth in any relationship: genuineness, unconditional positive regard and empathic understanding (Rogers, 1989). Additionally, Rogers identified that when he is his most genuine self in session, his presence becomes a healing force for growth (Rogers, 1989).

In person-centered therapy, the therapist's role is not to be an expert but rather to create a trusting therapeutic relationship, strive to understand the client's unique experience and believe in the client's ability to grow (Corey, 2009; Thorne & Sanders, 2013).Through this therapeutic process, the client can connect with their own inner resources and make meaningful changes for themselves. Clients will bring about change in their own ways given their worldview and experiences with the therapeutic relationship supporting this individual growth process (Corey, 2009).

Rogers' person-centered approach to group work followed similar themes as his work with individuals. He considered that every group process will be unique and all groups will naturally develop and move towards healthy behaviours on their own (Rogers, 1970). Rogers considered that holding a specific goal for a group is unnecessary and may affect the natural growth of the group. Instead, Rogers strived to be more of a member within the group than a facilitator, thereby allowing his whole self to participate in the group process (Rogers, 1970). Some tasks Rogers focused on are: building safety within the group, encouraging group members to make the group what they want, using his thoughts and feelings in the here and now, giving honest feedback to group members, making efforts to understand group members subjective worldview, accepting the group development where it is at and accepting individuals within the group where they are at (Rogers, 1970).

Assimilative integration. In an assimilative integrative model, a therapist may integrate a variety of interventions into their practice but maintain foundations in a particular

theoretical system (Corey, 2009). This process of integration will look different for each therapist. The following explanation of the theoretical background of Strong and Safe sheds some light on how person-centered therapy is assimilated with various group interventions within the psychoeducational group model.

Implications for Strong and Safe. The theoretical background of Strong and Safe is person-centered within an assimilative integration model. A theoretical foundation in person-centered therapy means that the group facilitators view each group member as a unique person without focusing on their diagnosed disability. Group facilitators focus on bringing the qualities of genuineness, unconditional positive regard and empathy to the group setting while highlighting group members' own self-efficacy in changing their own lives.

Second, this person-centered approach insures the psychoeducational model of Strong and Safe is flexible to the unique needs of the group members. For example, feedback is gathered from group members throughout the group to assess for safety within the group, the goals of group members within the group and what content they would like more focus on. In this sense, the educational content is structured yet the pacing through this content will be flexible to the needs of the group members and each group will be unique.

Assimilated techniques and interventions were selected using a number of criteria. First, techniques and interventions were considered for their effect on the therapeutic relationship and phase of group development to insure safety and trust are built (Thorne & Sanders, 2013). Second, techniques and interventions were considered for their advancement of the goals of the group: self-empowerment and healthy relationship training. For example, interventions which encourage the client to take stock of personal resources were deemed as helpful integrations to encourage the client to see their inner resources. Third, the

interventions integrated needed to be genuine, feel comfortable to the therapist presenting them and represent the therapists own self and beliefs.

In sum, the person-centered approach allows this group to be inclusive to women who hold a variety of development disability diagnoses yet will allow facilitators to run a psychoeducational group that may meet the unique needs of each group using this manual. Assimilated techniques and intervention were chosen and integrated to advance the group through its goals and group development and reflect the therapist's own self.

Pregroup Screening

Group members participate in a pregroup screening interview. In this session, they meet with group leaders to determine if they meet the criteria for the group, discuss their interest in the group, their expectations of the group and complete an informed consent interview. This meeting allows the group leaders to get an idea of the group dynamics.

After the group member has consented to joining the group, a short interview is completed to clarify the new group member's understanding of themselves and relationships. Questions such as "How do you describe yourself?" and "What is a healthy relationship?" are asked. See Appendix A for the pregroup screening interview guide created to facilitate this entire process. See Appendix B for the consent form created for Strong and Safe.

Evaluations

Evaluations are completed at the beginning, end and throughout the group. A short interview is completed within the pregroup screening interview which addresses what the individual hopes to get out of the group, their understanding of healthy and unhealthy relationships and themselves. This provides a baseline for their individual goals for the group

and provide a baseline for the final evaluation. This interview also serves as an opportunity to urge the group member to begin thinking about their own personal goals for group.

At the end of the group, a short questionnaire is offered for participants to fill out. This questionnaire will include questions surrounding the accommodation of their disability, what they learned in the group, the therapeutic benefits of the group and if their goals were met for the group. This questionnaire uses plain language and image based scaling questions when possible. This questionnaire can be done anonymously.

Alternatively, the questionnaire could be completed along with an interview to gain a deeper understanding of the group member's experience of the group. Within the interview, questions about how they view themselves and their understanding of healthy and unhealthy relationships have been included to shed some light on the changes in their awareness of self and relationships has changed throughout the group. See Appendix C for an example of the questionnaire and interview. Informal evaluations are completed throughout the group in the form of check-ins. As mentioned earlier, check-ins can be used to guide the group progression.

Ethical Considerations

There are a number of ethical issues that could come up in a group such as this one. Issues such as group screening, consent, counter-transference, comorbidity of mental health disorders and disability and trauma-informed practice will be discussed.

Screening of group members. The Canadian Counselling and Psychotherapy Association of Canada (CCPA) (2007) states that "counsellors have the responsibility to screen prospective group members, especially when group goals focus on self-understanding and growth through self-disclosure" (p. 10). In addition, CCPA (2007) states the importance

of informing prospective group members of group member rights, confidentiality in group work, and group techniques used to avoid psychological harm to group members.

Even at a basic level, interpersonal group work could bring up strong feelings that members may find uncomfortable. Psychological harm could come from a number of group dynamics such as scapegoating, group pressure, breaches of confidentiality and aggressive confrontation (Corey, Corey, & Corey, 2010). For the purpose of Strong and Safe, identifying the risks and benefits of participating in the group is important. For this reason, Strong and Safe has incorporated a pregroup screening interview to discuss the risks and benefits of the group process and allow the therapist to assess difficulties that may come up with certain individuals in group. The pregroup screening interview provides an important opportunity to gain consent with the prospective group member to participate in the group.

Consent. When considering working with the population of persons with developmental disabilities, which may include intellectual disabilities, it is important to be aware of issues of informed consent. Ensuring informed consent is received falls under the CCPA (2007) *Code of Ethics*, Section B5: Children and Persons with Diminished Capacity which describes that counsellors must "... conduct an informed consent process with those legally appropriate to give consent when counselling..." and counsellors allow clients with diminished capacity to give consent when they have the capacity to give consent (p. 8). For ethical and advocacy reasons, it is important to insure that group members can consent to participation within the group.

Currently, there are no universal assessments for determining the capacity to give informed consent. An appraisal of British Columbia's consent laws demonstrates that the capacity to provide informed consent is to be evaluated by the health professionals involved

in the individual's care (Ministry of Health and Ministry Responsible for Seniors, 2000; Ministry of Health, Mental health and Addictions, 2007).

Some suggestion on how to insure informed consent is obtained through the literature on research that involves persons with intellectual disabilities. Goldsmith, Skirton and Webb (2008) along with Morton and Cunningham-Williams (2009) found that the capacity of individuals with disabilities to give informed consent can depend on the ability of the researcher to tailor the delivery of relevant information to the abilities and needs of the individual concerned; for example, pictures could be used, text could be read aloud, and advocates and carers could be involved to assist communication. Perry (2004) suggested the use of a written consent form, an easy to read information sheet and that consent information is read verbally to participants.

Arscott, Dagnan and Kroese (1998) advocated for the use of a prestudy questions session after the individual is briefed on the study. After the individual is briefed about key issues such as expected participation in the study, the study topics, as well as potential benefits and risks, a question period will follow to determine understanding and retention of information. Questions may include "Are there any good things about talking to me?" and "What am I asking you to do?"

Efforts will be made in the screening process and throughout the group process of Strong and Safe to insure informed consent is granted by participants. In the screening process, questions, as suggested by Arscott et al. (1998), will be used to insure consent is understood by participants. An example of the consent form used for Strong and Safe is in Appendix B. Throughout the group, consent issues such as confidentiality, benefits and risks of group participation will be discussed as needed.

Confidentiality. Confidentiality is based on the concept that what happens in the room, stays in the room and remains a foundation of the therapeutic relationship and counselling (Pope & Vasquez, 2011). For Strong and Safe, the standard limits of confidentiality are followed. Confidentially may be broken when there is a) risk of harm to self or others, b) risk of harm or neglect of a child, or c) in the case the group leader is subpoenaed by court (Canadian Counselling and Psychotherapy Association, 2007). In the instance that a situation falls outside the limits of confidentiality, confidentiality will be broken with the knowledge of the group member when possible. A number of ethical issues concerning confidentiality may come up in a group of this nature.

First, confidentiality in the group context is reliant on not only the group leaders but also group members. There is often an assumption that everyone in the group is trustworthy yet there is no way to predict how each group member will act in regards to maintaining the confidentiality with others' information. Pope and Vasquez (2011) discuss the concept of trust in group therapy and highlight the importance of letting group members know ahead of time the risks involved with sharing within a group setting as well as how the limits of confidentiality work within a group therapy format. For example, in Strong and Safe, any personal disclosures made to the group leader outside of group will not be shared with the group; however, anything shared with the group leader that pertains to group process and interpersonal relationships within the group, the group leader will work with the group member to figure out how to bring these concerns up in the group. These boundaries are communicated to group members within the first meeting with the group leader. As confidentiality works differently within a group context, it is essential to communicate this to group members and insure risks of sharing within a group are understood.

Second, challenges could come up around navigating the roles of support persons in the lives of group members and their rights to confidentiality. In any therapeutic setting, concerned third parties may demonstrate interest in knowing more about the therapy their loved one is participating in. In Strong and Safe, there is a chance group members will have support worker, family or friend supports that could pursue additional information about the group to enhance support outside of the group, encourage new learning or understand behaviour changes and so on. For some members, having their support persons knowing about the group would be important to their continued success and sharing information with support persons would be considered their right to disability sensitive services. For many agencies and therapists, these requests could be dealt with on a case by case basis by a process of gaining consent from the group member to achieve an understanding and written consent of what could be shared with a specific, named person. When reflecting upon the statistics of interpersonal violence that includes violence perpetrated by carers or support people, there may also be third parties seeking information that pose a threat to the group member. The threat of increased violence complicates the issue of the individual consenting to a release of information.

In terms of sharing information about the group with support persons of group members, this decision would have to be made on a case by case basis. Encouraging and assisting group members to tell their supports about the group could be an empowering process that would align with the group's goals. If the group leader has been asked to share information by the group member, yet feels uncomfortable doing so the group leader would need to express that concern to the group member and problem solve with the group member to come to a mutual agreement which strongly considers the group members safety.

In the instance where the group leader had gained permission to share group information with support persons and feels comfortable to do so there would have to be limits placed on sharing. For example, Strong and Safe group process, content of the group derived from group members could be a breach of confidentiality whereas general group therapy process, therapeutic benefits of group and major topics covered within the psychoeducational component of the group would be appropriate to share. Conversations about the group with support persons should include the group member to align with empowerment and communication goals of the group.

Another concern that could come up is around maintaining confidentiality around the counselling relationship. In the instance of Strong and Safe, this may mean supporting group members to keep their participation in the group private from others in their life. Details such as the location of the group and take-home materials could impact the client's confidentiality of their participation in the group. Monitoring the confidentiality of the counselling relationship, as well as discussing personal safety may be important to the wellbeing of group members.

To reflect these concerns, efforts are taken during the initial meeting with the group member to explain confidentiality and discuss some guidelines around disclosure within the group and sharing their experience of the group with others. In addition, confidentiality is discussed throughout the group itself through both structured activities, such as lessons on boundaries and group norms, and informally, and through informal conversation including modelling and addressing concerns around confidentiality as they come up within the group. Other ethical issues pertaining to safety will be discussed below in considerations of trauma informed practice.

Counter-transference. Counter-transference is an issue that can come in any therapeutic relationship, including therapeutic group experiences. Yalom and Leszcz (2005) describe counter-transference as the reaction therapists have to their clients. Counter-transference can fall into two categories; subjective and objective. Objective counter-transference can be a process where a therapist reflects on the client's "characteristic interpersonal impact on [themselves] or others" (Yalom & Leszcz, 2005, p. 175). Subjective counter-transference is when a therapist's reaction towards her client reflects more on herself, and what she carries into her relationships and interactions. Subjective counter-transference could be repetitive of patterns in the therapist's life or reparative where the therapist attempts to repair damage done in his or her own past (Phillips, 2004). In this sense, counter-transference can be a useful tool in group therapy but also a process that may need to be checked by the therapist.

Some practitioners label persons with disabilities exposed to trauma as difficult clients (Doyle & Mitchell, 2003). Yalom and Leszcs (2005) consider that when a client is considered difficult it is essential to reflect on your counter-transference. This can become challenging in a group context where both individual group members and the group as a whole could trigger counter-transference (Phillips, 2004).

Counter-transference is a very personal experience and will be unique to each therapist's identity and experience. Freeman's (1993) description of transference and counter-transference as they come up for a disabled therapist working with a nondisabled and disabled clients can shed some light on counter-transference issues that come up in the dynamic between persons with a disability and persons without disabilities. Freeman highlighted some of her own counter-transference issues when working with disabled clients

as overestimation of ability, over-sheltering, guilt, anger and over-identification. Freeman acknowledges that many of these counter-transference topics are related to her identity as a woman with a disability. For example, because she has experienced the oppression faced by persons with disabilities Freeman identifies within her self a desire to shelter or protect her clients with disabilities. Reflecting on counter-transference in group, such as what Freeman (1993) demonstrated, will be important throughout this group.

Counter-transference is something that can be used in session, as Jureidini (1988) demonstrated, but it can also be processed to maintain a neutral stance within a therapeutic relationship. Phillips (2004) reflected on the importance of the role of cofacilitators in working through counter-transference.. In addition, maintaining personal counselling and clinical supervision could be important to process counter-transference as it comes up (Yalom & Leszcs, 2005).

In the instance of Strong and Safe, like in any therapy group, it is important to monitor for counter transference. Additionally, seeking supervision or personal counselling to process counter-transference will be important.

As a final note, it is important to recognize the difference between counter-transference and vicarious trauma (Phillips, 2004). Vicarious traumatisation is differentiated from counter-transference by defining vicarious traumatisation as when therapists inner experience is transformed as a result of the relationships with a survivor and their trauma material (McCann & Pearlman, 1990). If vicarious traumatisation seems to become a concern for facilitators, it is an important for a therapist to receive their own therapeutic support to prevent burn-out and psychological distress.

Comorbid disorders. An issue that could come up in this group is that group members could have both developmental disabilities and mental health disorders. Taggart, McMillan and Lawson (2009) looked at the comorbidity of mental health problems, risk factors and resiliency factors among women with intellectual disabilities. The authors highlighted that women with disabilities are more likely to develop mental health problems as a result of physiological functioning and psychosocial risk factors. From a series of semistructured interviews with Irish women who identified as having an intellectual disability, Taggart et al. (2009) identified that that mental health risk factors are being female and having a disability, feeling unlike other women in terms of life stage (eg. not being married or having a child), and experiencing a negative life events such as abuse or assault.

As mentioned previously, research supports that psychoeducational group therapy is effective for homogenous and also heterogeneous mental health disorders (Browne, 2006; Flowers & Booraem, 1991). However, efforts will be made to assist group members to become connected with other mental health services within the community when there seems to be untreated mental health concerns. Mental health concerns, such as post traumatic stress disorder (PTSD), are often under diagnosed and under identified in persons with disabilities due to the way diagnostic criteria are based on persons with standard intellectual functioning (Doyle & Mitchell, 2003). Often, the symptoms of PTSD are misidentified when an individual has limitations in their ability to express or process information and may lead to alternative diagnosis for persons with intellectual disabilities such as anxiety, insomnia, obsessions, and schizophrenia (Doyle & Mitchell, 2003).

In this sense, identifying the need for a referral to other mental health services may require thinking outside of the box. For example, Doyle and Mitchell (2003) highlighted that

insight can be drawn into the presentation of PTSD in individual with learning disabilities from the diagnostic criteria for children and PTSD. Using criteria for children may reflect the individual's ability to process information cognitively and emotionally and therefore their response to trauma (Doyle & Mitchell, 2003). Due to the complexity of comorbid disorders with persons with disabilities it would be ethical to complete referrals for further screening when any indicators of additional mental health concerns arise. In addition, as the group begins to come to a close it would be critical to follow up with any referrals and insure group members are connected with other supportive services to insure group members are supported after the group is over.

When one considers the frequency of interpersonal violence among women with disabilities, it is important to consider the likelihood that these women have already been exposed to interpersonal violence. In this sense, a common comorbid disorder could be PTSD or complex trauma.

Trauma-informed practice. There are a number of concerns that could come up around working with survivors of trauma in a group setting. Strong and Safe content could bring up disclosures of abuse and also trigger symptoms of traumatic stress.

First, the content could bring up disclosures of past or present abuse. In this sense, it would be important to have a plan of action on how to deal with disclosures of abuse within the group setting. Nosek et al. (2001) provided suggestions on how to conduct empirically sound research on abuse and women with disabilities that may give some insight into ethical considerations for dealing with disclosures in an appropriate way. Key points that seem relevant to a group setting are the importance of understanding legal requirements for reporting abusive incidents, providing access to clinical services, installing safety measures

to protect study participants and protect staff from retaliation, and using appropriate validated disability sensitive screening instruments.

The provision of clinical services is touched on above under the topic of referrals out for comorbid mental health disorders. If disclosures did occur within the group setting, it would be important to insure the individual was connected with additional counselling resources. In Prince George, B.C., these resources may include a referral to the Elizabeth Fry Society or the Surpassing our Survival (SOS) Society.

Nosek et al. (2001) expressed the importance of using appropriate validated disability sensitive screening instruments when determining inclusion or exclusion in a study on the basis of if study participants have experienced abuse. For the purpose of this group, abuse specific screening measures are not necessary. However, as mentioned above, disability sensitive assessments will be considered when looking at referring out for further mental health services.

As highlighted by Nosek et al. (2001), it is important to understand the legal requirements for disclosure of abusive incidents. For example, B.C.'s Adult Guardianship Act provides a framework to protect adults with disabilities from abusive or neglectful situations. As adults protected under this act are considered to be unable to seek help on their own, the Act states a duty to report criminal offences on behalf of the person with a disability (Province of British Columbia, 2013). Another key process to be aware could be the reporting process for domestic violence, assault or rape through the justice system. This process would be led by the individual but may require sharing information about the process and taking on a supportive or advocacy role.

When providing support to women who may be experiencing interpersonal violence, providing safety for staff and members would be essential. Standard measures such as inquiring with each participant over preferred or safest contact route, meetings with participants take place in public areas with support from other staff, study materials sent home with participants are considered for content and staff are trained in risk management procedures are suggested by Nosek et al. (2001). For the purpose of Strong and Safe, many of these measures are adopted in the intake procedures to provide safety to group members and staff involved in the group. Of course, when disclosures come up in group settings, it is important to isolate the conversation to protect confidentiality, demonstrate active listening and respond in a nonjudgemental and supportive way.

Second, the content of the workshop could be triggering for women who have a history of interpersonal violence. Lund (2011) identified that studies that employed role play techniques in naturalistic settings for interpersonal violence prevention training were criticised for being psychologically distressing for persons with disabilities. As the topic matter of Strong and Safe deals with interpersonal violence with a vulnerable population, a trauma informed lens is used in the running of group activities.

A trauma-informed lens means that the group will be facilitated with the assumption that every member may have experienced traumatic events in their lives. This lens considers traumatic stress as an explanation for mental health symptoms and also be used to interpret interactions within the group. It is important that knowledge of trauma recovery guides the group facilitation.

Herman's (1997) model for trauma recovery identifies three stages: establishing safety, remembrance and mourning and reconnection. Establishing safety is the primary step

to doing further work towards trauma recovery. As Strong and Safe is a psychoeducational group, the only stage focused on in this group is establishing safety. According to Herman (1997), establishing safety may involve tracking symptoms and adaptive responses, mobilizing natural support systems, and development of a trusting therapeutic alliance.

Ford, Courtois, Steele, van der Hart, & Nijenhuis (2005)'s model for psychotherapy of complex posttraumatic self-dysregulation identified a similar first phase of therapy, alliance formation and stabilization. Like Herman (1997), Ford et al. (2005) identified the importance of the relational context of the process of building safety. Ford et al.'s three stage intervention model focuses its first stage on psychoeducation around traumatic response, self-management techniques and building a working therapeutic alliance which focuses on therapeutic boundaries and clarity of therapeutic focus.

Johnson and Zlotnick (2009) describe a CBT based group used within domestic violence shelters, called Helping to Overcome PTSD through Empowerment (HOPE) and the way in which this group seeks to build safety for group members. HOPE encourages women to identify threats to their physical and emotional safety that are within their control and address these threats. Skills are offered within the group to address these threats, for example the group may work may include building a safety plan or learning skills that will help control the symptoms of PTSD, like grounding techniques.

A trauma-informed lens in Strong and Safe means that symptoms of traumatic stress, such as emotional dysregulation and dissociation, will be monitored within the group. To respond to these symptoms, grounding techniques are integrated into group sessions to provide safety within the group as interpersonal violence and relationship content is delivered. There is a focus on discussing trust and building trust within the group to insure a

strong therapeutic reliance. Further, referrals to individual counselling will be made if symptoms are apparent as further trauma recovery support falls outside of the scope of this group.

Summary of Chapter 3

Strong and Safe has been molded to address a number of ethical issues. Strong and Safe focuses on gaining informed consent throughout the group process, protecting confidentiality of group members, promoting disability rights, encouraging empowerment through a person-centered model and providing education on interpersonal violence.

Chapter 4

This chapter will provide session overviews, goals, objectives, activities and materials needed for each session of the group, Strong and Safe. Each activity has been given an independent page in this manual to allow for easy use. Activities represented on single pages will allow for flexibility in content and lay-out of sessions, so that the user of this manual may adapt group sessions to their group members needs.

Group Orientation

Session	**Group Orientation** (1 hour)
Overview	Nice to Meet You! (15 min.) What is Strong and Safe (10 min.) Test your Knowledge (20 min.) What do we want to learn? (20 min.) Question and Answers (5 min.)
Goal	Provide the opportunity for group members to get to know each other and learn more about the group.
Objectives	**Group will meet each other and practice social skills* **Group leader will begin process of getting to know the group including disability related issues and communication skills of group members* **Group members will learn more about the group and ask questions that have come up since intake* **Group members will take ownership and empowerment by having the opportunity to give input into topics covered in group*

Session	Group Orientation
Activity	**Nice to Meet You!**
Estimated Duration	🕓15 minutes
Materials Needed	☑ Nice to Meet You! Questions (see Appendix D)

1. The group is divided into pairs. Instruct the group that they will have five minutes to learn something about the other group member. Group members may ask for a "Nice to Meet You! Question" if they're not confident starting a conversation with the other person.
2. Each group member will be asked to introduce their partner, including their name and one thing that they learned about the other person.

3.

Session	**Group Orientation**
Activity	**What is Strong and Safe?**
Estimated Duration	10 minutes
Materials Needed	No materials needed.

1. Introduce Strong and Safe. For example,

   "Strong and Safe is a group for women with disabilities. If you are here, that means that you have identified yourself as having some sort of disability. In Strong and Safe we will learn about being in relationships, both romantic and nonromantic relationships (like with our partners, boyfriends, girlfriend and like with our family members, caregivers, etc) and what we can do to keep ourselves healthy, safe and confident in relationships. We are also going to learn about ourselves, including how we act in our relationships and why we deserve a healthy, safe relationship."

2. If using a question box, introduce the question box for this session. Demonstrate writing a question on the slip of paper and put it into the designated box. Let the group know that they may put in a question at any time throughout the group.

Session	Group Orientation
Activity	**Test Your Knowledge!**
Estimated Duration	🕛20 minutes
Materials Needed	☑ Test Your Knowledge cards (see Appendix E) ☑ Flip chart ☑ Markers ☑Categories of "Sense of Self", "Relationships" and "Disability" written on the whiteboard

1. Start off by reading questions from the cards. Encourage Group members to shout out answers to the group leaders questions.
2. Once the activity has been demonstrated, group members can take a more active role, taking turns reading questions and answers off of the cards.
3. Keep track of right answers according to the category (stated on the card) to help understand where group members are.

Session	**Group Orientation**
Activity	**What do we want to learn?**
Estimated Duration	🕛20 minutes
Materials Needed	☑Slips of paper ☑Pens/pencils ☑Box or hat

1. Group members can participate in this activity verbally and/or by writing what they want to learn onto slips of paper and depositing these in a container to be read anonymously.

   This will be an opportunity to gather information about what topics are important to members, individual members' group goals and also allow some time to clarify what participants can expect from the group.

   Questions that could guide this discussion are:

   "What stood out from the Test your Knowledge game? What topics would be helpful to focus on? What do we want to learn more about?"

   "What do you expect to get out of the group? From our first meeting to now, what have you hoped you would get out of the group?"

   "How would we know that we have learned this and/or achieved our goals?"

   "What would we need to learn this and/or achieve our goals?"

   "What is it like being in this group?"

Session	**Group Orientation**
Activity	**Questions and Answers**
Estimated Duration	5 minutes
Materials Needed	☑Slips of paper ☑Pens/pencils ☑Box or hat

1. Group members are given the opportunity to ask questions of the group leader. Questions may be asked verbally and/or written on slips of paper. Additional questions may be gathered from the question box at this time.

Session One

Session	Session One
Overview	Yarn Ball Icebreaker (15 min.) Our Boundaries (25 min.) Break (15 min.) Our Group Norms (25 min.) Grounding Exercise (10 min.) Goodbye Affirmation (10 min.)
Goal	Begin the process of building group cohesion, group norms and learn about boundaries in relationships.
Objectives	**Group members will begin getting to know each other through ice breaker exercise* ** Group members will understand components of respectful communication and consider role of boundaries in healthy relationships* ** Group members will reflect upon their own boundaries within the group in terms of group norms and rules* **Group members will learn about grounding as a tool they can use throughout the group and in their daily lives*

Session	Session One
Activity	**Yarn Ball Icebreaker**
Estimated Duration	🕐 15 minutes
Materials Needed	☑ Ball of yarn

1. With group members standing in a circle, start out by saying a group members name and throwing the ball of yarn to them while still holding onto a piece of the yarn.
2. The group member will then say another group members' name and pass the yarn ball while holding a piece of the yarn. The end result will be a giant web of yarn between all the group members.
3. Draw attention to the interconnectedness within the group as shown by the yarn. For example,

   "As we look around the room, notice how we are all connected by the yarn. A feeling of being connected to each other, just like how the yarn connects us now, can allow us to get to know ourselves better, to feel comfortable, to learn about making friends and how we are in other relationships in our life."
4. Pose questions to the group about how they can connect with others in the group. For example,

   What makes you feel connected or close to other people?

   What makes you feel less close to other people?

   Important topics to cover would be using respectful language, giving each other time when we need it, sharing your thoughts and feelings with the group.

5. The last group member will begin the process of passing the yarn back by wrapping up the yarn ball and tossing it back to the person she received it from. As group members pass the yarn back they each say one word about how they are feeling about today's session.

Session	**Session One**
Activity	**Our Boundaries**
Estimated Duration	🕐 25 minutes
Materials Needed	☑ Flip chart paper ☑ Markers ☑ Magazine cut outs of people to represent different occupations, relationships (eg. doctor, brother and sister, parents, caregiver, etc) ☑ Adhesive putty

Adapted from James Stanfield's *Circles: Intimacy and Relationships* program (James Stanfield: Specialists in K-12 Special Education, n.d.)

1. Encourage group members to line up facing each other. Instruct group members to say *"Stop"* when they begin to feel uncomfortable with closeness of the other group member. Let one line of group members will slowly advance towards the other group members.
2. Highlight how each member could feel where their boundaries were and were able to protect their boundaries in this exercise, by saying *"Stop"*.
3. Group leader polls the group on what boundaries are. Important topics to discuss would be:
    a. Boundaries are rules for interactions with other people
    b. Boundaries can help us feel comfortable with other people, help us stay safe

c. Boundaries can look like many different actions. For example, saying no to spending time with a friend, it could mean telling someone you don't like what they are doing, or choosing to leave a conversation.

d. Boundaries change depending on how you feel, who the person is, and many other factors

4. Group leader will draw out four circles of a descending size within each other on flip chart paper. Explain the circles represent different levels of boundaries. The circles demonstrate Intimate, Friendly, Acquaintance, and Community relationships.
5. Decide together where people with different roles (as represented by magazine cut outs) would fit in these circles. Place these cut outs in the circle as decided by the group.

   There may be some roles that fit in different categories for each group member, for example, caregiver may fall into intimate, friendly or acquaintance circles. The roles that fall into many categories could be important starting points to talk about the qualities of the person or the relationship that allows it to fall in to each category.
6. As a group, discuss behaviours or appropriate interactions for each circle. Important topics to focus on could include physical proximity, what we would tell people in each circle, how people treat us in each circle; how do we feel about ourselves in each circle, etc. In the discussion, highlight how mutual choice is an important part of relationships.

Session	Session One
Activity	**Our Group Norms**
Estimated Duration	🕒 25 minutes
Materials Needed	☑ Flip Chart ☑ Group Norm Statements (See Appendix F)

1. Draw three columns on the flipchart paper, labelled "Okay", "Not Okay", and "Sometimes Okay".
2. Hand out group norm statement strips out to each group member. Group members take turns reading off the group norm off of the piece of paper.
3. As a group, the decision is made to place the group norm statement in the correct column, either "Okay", "Not Okay", or "Sometimes Okay". Adhere each statement to the flipchart. Use examples or scenarios to describe each group norm.
4. Problem solve as a group on how they would like the group to handle when something happens which is "Not Okay" or "Sometimes Okay".

   For example, if we find out that a group member has told people in their lives about something another group member had shared, as a group we will talk about how breaking confidentiality effects all of us. If it happens multiple times, we may talk about the group member leaving the group.
5. Review all of group norms together. Check in to see if a group member feels something has been missed.

6. The flipchart may be kept in the group therapy room as a reminder of the group's commitment to making the group a safe place.

Session	Session One
Activity	Grounding Exercise
Estimated Duration	🕐 10 minutes
Materials Needed	☑ What is Grounding? (see Appendix G)

1. Introduce what grounding exercises and how they are used. For example,

   "Grounding is an activity we can do when we have strong feelings, thoughts or memories we want to control. For example, if I am out for lunch with a friend and I start having strong feelings of nervousness or anxiety that I want to go away, I can use grounding to help. Grounding is a way that we can remind ourselves that we are safe, strong and important. Today we are going to learn one of these activities and practice it together! The more we practice it, the easier it is to use grounding when we are upset."

2. Pick a grounding exercise from the What is Grounding Activity and walk the group through the steps of the grounding exercise while modeling the exercise. Practice the grounding exercise a number of times.
3. Have a short discussion about using grounding in the group sessions. Let the group members know that we will be practicing grounding exercises throughout the group and if they have questions or thoughts about using grounding in the group they should bring it up in the group.
4. Hand out grounding exercises to be practiced at home.

5.

Session	**Session One**
Activity	**Goodbye Affirmation**
Estimated Duration	🕐 10 minutes
Materials Needed	No materials needed.

1. With everyone in a circle, read a positive affirmation. Any positive affirmation could be chosen. For example,

   "I am a beautiful person and do the best I can everyday"

2. Encourage group members to repeat the affirmation as a group.

   Group members could make eye contact with each other or alternatively, place a hand on their chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Two

Session	**Session Two**
Overview	Fears in a Hat (15 min.) Who are We? (30 min.) Break (15 min.) Who are We? Sharing and Discussion (20 min.) Goodbye Affirmation (10 min.)
Goal	Provide opportunities for group members to reflect on who they are, including how they relate to their disability.
Objectives	**Group members will practice using empathy and normalize fears, and talk about trust in the group.* **Group members will reflect on who they are and share pieces of who they are with the group.* **Group members will reflect on their disability and share with the group their experiences of disability to build sense of commonality and empathy within group.*

Session	Session Two
Activity	**Fears in a Hat**
Estimated Duration	🕐 15 minutes
Materials Needed	☑ Hat or box ☑ Pencil ☑ Slips of paper

Adapted from Brandes & Phillips (1995)'s Fear in a Hat Activity.

1. With group members in a circle, hand out slips of paper and pencils/pens.
2. Instruct group members to write down a fear they have about being in the group. Use an example to demonstrate, like *"I am afraid someone will think I am stupid."* Instruct group members to not put any identifying marks on the slips of paper so they will anonymous. Put the fears in the hat or box.
3. Pass the hat or box around the room and each member will pull out a slip of paper and read it aloud to the group. Encourage the group member to enlarge the concept and describe what the person was feeling when they wrote the slip. For example,

   "I am feeling cautious and maybe even embarrassed. I may not want to say much in the group because I am afraid someone will think that I am stupid."

   Encourage other group members to just listen and avoid commenting at this stage.
4. Once all the fears have been read, discuss what we have learned about being in a group and what it is like for other group members to be in the group. Highlight any similarities or differences that came up in the activity.

Session	Session Two
Activity	**Who are We?**
Estimated Duration	🕓 50 minutes
Materials Needed	☑ Who are We? Adjectives (see Appendix H) (cut into strips) ☑ Blank slips of paper ☑ Large pieces of paper for each group member (eg. 8 ½ x 14) ☑ Markers, crayons, pencil crayons ☑ Magazines (can also provide cut out images prior to session to insure time limits are met)

1. Lay adjectives out on a table or hard surface. Have the group look at all the adjectives and pick up adjectives that they have been called before throughout their life. Group members may write down adjectives on spare slips of paper.
2. Let group know that for this activity we are just looking at who they identify themselves as. Encourage group members to put back adjectives that they feel do not suit them. Encourage group members to take their self-identified adjectives with them back to their work space.
3. Hand out large pieces of paper to each group member. Encourage group members to use magazine images or use creative supplies available to create something that

represents who they are. Encourage group members to be quiet during their work time.

4. Prompts may be provided during the poster making. Helpful prompts may be, How would you describe yourself? What is important to you? What is your personality like?

BREAK

(Ask group members to avoid talking about their posters until after the break)

5. After the break, encourage group members to present their poster. Remind group members to only share what they are comfortable with letting the group know.
6. Discuss what came up for group members throughout the activity.

   Encourage group members to reflect what similarities or differences they notice in the group as well as the process of making the posters (choosing adjectives, choosing images, seeing the final product, etc).

   Encourage group members to reflect on disability and how it appears in their poster, if it does appear at all.

Session	Session Two
Activity	**Goodbye Affirmation**
Estimated Duration	🕐 10 minutes
Materials Needed	No materials needed.

1. Encourage group members to pick two or more adjectives, or a statement from their work in the Who are We? Activity and repeat it to the group. Each group member will take turns. For example,

   "I am Jane, I am beautiful and stubborn."

   Group members could make eye contact with each other or alternatively, place a hand on their chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Three

Session	**Session Three**
Overview	Check-In (15 min.) Giving Feedback Role Play (40 min.) Break (15 min.) What I Like About You! (15 min.) Goodbye Affirmation (5 min.)
Goal	*Provide information on feedback and social skills that will enhance their group experience and practice these skills in real relationships within the group.*
Objectives	* *Group members will share how they are feeling about the group to process anxiety and concerns while connecting group members.* **Group members will continue to build social skills for group and relationships outside of group.* **Group members will begin thinking about building healthy relationships in lives outside of group.* * *Group members will have an opportunity to learn about how others experience them and express how they experience others.*

Session	Session Three
Activity	**Check-In**
Estimated Duration	15 minutes
Materials Needed	No materials needed.

1. With group members in a circle, each group member is encouraged sharing how they are feeling about the group in turn.
2. Discuss together has been learned through this exercise. Highlight similarities or differences amongst group members.

Session	**Session Three**
Activity	**Giving Feedback Role Play**
Estimated Duration	🕐 40 minutes
Materials Needed	☑ Giving Feedback Role-Play Scenarios (see Appendix I) (cut into strips) ☑ Flip chart and markers

1. Discuss the concept of direct communication with the group. Focus on the concepts of direct communication being honest, a way to express what you think and feel and can help build relationships.
2. On a flip chart, write the phrase, *"I feel _____when you_____. I want_____"*. Discuss with the group what feelings and actions are. Talk about describing actions objectively and neutrally. Let the group know that we will practice using this phrase to express ourselves.
3. With the help of another group leader, act out a role play from Feedback Role-Plays, see Appendix I.
4. In the first group leader role play, demonstrate indirect communication. Discuss what happened in the role play with the group. Focus on whose needs were met, who expressed themselves and what happened in the relationship.
5. Act out the role play again, demonstrate direct communication this time. Discuss what happened in the role play with the group. Focus on whose needs were met, who expressed themselves and what happened with the relationship.

6. Divide group into partners and hand out role-play scenarios. Let the group members know we are going to be pretending to be other people in the role play.
7. Encourage group members to practice using direct communication with their partner using the example phrase, *"I feel _____ when you_____. I want_____."*
8. Discuss as a group what the role play was like. Some example questions to guide discussion could be:

    What was it like to talk this way?

    What was it like to be talked to in this way?

    Is this a new way of talking to someone for you?

    Is there someone in your life you would like to talk to this way?

    What are some benefits to talk this way to other people?

    What are some risks about talking this way to other people?

    When do we want to speak more directly about what we're thinking and feeling?

    When do we not want to speak more directly about what we're thinking and feeling?

Session	Session Three
Activity	**What I Like About You!**
Estimated Duration	15 minutes
Materials Needed	No materials needed.

Adapted from Silverstone's (1997) activity, Positive feedback- giving and letting in (p. 101).

1. Divide the group into pairs. Encourage group members to take a moment to consider what they like about their partner, based on their experience with their partner in group.
2. Encourage group members to practice using the feedback phrase from the previous activity, Giving Feedback Role Play. If comfortable, group members can practice without the phrase as well. Encourage the receiving partner to listen to the feedback and respond with a simple *"I know. Thank you for noticing."*
3. Encourage group members to remember a couple of things their partner said about them for the next activity.
4. Discuss as a group what this experience was like. Some questions to guide this discussion are:

    What was it like to hear what your partner had to say?

    What was it like to speak to your partner that way?

    What is your relationship like with your partner now?

Session	Session Three
Activity	**Goodbye Affirmation**
Estimated Duration	5 minutes
Materials Needed	No materials needed.

1. Encourage group members to take turns sharing about a positive statement they have taken away from how their partner in the What I Like About You! Activity.

   Encourage group members to phrase the affirmation by completing the sentence, *"Jane sees that I am* _____ *and* _____ *in this group"* to highlight that the idea that feedback is just someone else's' opinion.

   Group members could make eye contact with each other or alternatively, place a hand on their own chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Four

Session	**Session Four**
Overview	Check In (5 min.) What is a Healthy Relationship (20 min.) Break (15 min.) Our Relationship Rights (25 min.) My Support System (20 min.) Goodbye Affirmation (5 min.)
Goal	Discuss components of healthy relationships are and reflect on healthy relationships in our lives.
Objectives	**Group members will continue to build relationships with each other and trust in the group.* ** Group members will learn about components of healthy relationships.* ** Group members will learn about inherent rights in relationships.* ** Group members will reflect on healthy relationships in their own lives and the support provided by these relationships.*

Session	Session Four
Activity	**Check In**
Estimated Duration	5 minutes
Materials Needed	No materials needed.

1. With group members in a circle, each group member is encouraged to share one word to describe how they are doing at the start of group.
2. Discuss how we may need different things from group and group members depending on what we're feeling. Highlight similarities or differences amongst group members.

Session	Session Four
Activity	**What is a Healthy Relationship?**
Estimated Duration	🕒 20 minutes
Materials Needed	☑ Flip chart ☑ Marker

1. Begin a brainstorm session by asking the group *"What makes up a healthy relationship?"* Draw a circle on the flip chart and write down ideas in the circle. Important details to highlight are:
    a. Feelings, behaviours, language that happen in healthy relationships
    b. Description of boundaries in healthy relationships.
2. Ask the group, *"Where do we get ideas about what healthy relationships are?"* Write down ideas that come up around the circle. Important sources to highlight are:
    a. Media (music, movies, books, TV, etc)
    b. Parents or grandparents
    c. Other role models
3. Talk to the group about how both healthy and unhealthy patterns in relationships are delivered through the media, family, and other sources. Discuss with the group how these messages affect us and what we can do about them.

Session	Session Four
Activity	**Our Relationship Rights**
Estimated Duration	🕐 25 minutes
Materials Needed	☑ Relationship Bill of Rights (see Appendix J)

Adapted from Moles (2001), The Relationship Bill of Rights (p. 117).

1. Introduce the Relationship Bill of Rights to the group, see Appendix J. Normalize that every relationship requires these rights and even healthy relationships can work on maintaining both partners' rights.
2. Demonstrate a role play about a relationship right with both group leaders. For example, *"To decide who my friends are and maintain relationships with those friends."*
3. Encourage the group to get into partners and pick a right as a pair.
4. Encourage each group to make a quick role play up about each right and practice their role play together.
5. Encourage each pair to perform their role play to the larger group and share which right they chose.
6. Discuss which rights stand out to group members, including what rights they want to focus on at this time and how relationship rights work to build healthy relationships. Highlight similarities and differences.

Session	Session Four
Activity	**My Support System**
Estimated Duration	🕒 20 minutes
Materials Needed	☑ Large pieces of paper (eg. 8 ½ x 11) ☑ Markers, pens, pencil crayons

Adapted from Moles (2001), My Support Map (p. 3).

1. Ask group members to reflect on which relationships follow what we had talked about in terms of what are healthy relationships and the Relationship Bill of Rights.
2. Instruct group members to draw out their support system and include people that are important to them.
3. Encourage group members to share one relationship with the group and include what about the relationship is healthy and positive in their life.
4. Discuss the activity together and reflect on what is was like to look at positive, supportive relationships in our lives.

Session	Session Four
Activity	**Goodbye Affirmation**
Estimated Duration	5 minutes
Materials Needed	No materials needed.

1. Encourage group members to take turns stating a personalized relationship right from the Relationship Bill of Rights or one that they have thought of on their own. Each member will use the template *"I deserve* _____*"*. For example, *"I deserve to be able to end a relationship."*

   Group members could make eye contact with each other or alternatively, place a hand on their own chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Five

Session	Session Five
Overview	Grounding Exercise (5 min.) What are Unhealthy Relationships? (30 min.) Break (15 min.) Identifying Unhealthy Relationships (20 min.) Group Check In (15 min.) Goodbye Affirmation (5 min.)
Goal	Discuss components of unhealthy relationships while maintaining safety for group members.
Objectives	**Group members will continue building upon their tool box of grounding techniques* ** Group members will learn about components of unhealthy relationships.* ** Group members will practice discerning between healthy and unhealthy relationship behaviours* ** Group members will get the opportunity to share their experience with talking about unhealthy relationships.*

Session	Session Five
Activity	**Grounding Exercise**
Estimated Duration	🕐 5 minutes
Materials Needed	☑ What is Grounding? (see Appendix G)

1. Review the purpose of grounding exercises with the group (see Session One for an example).
2. Pick a grounding exercise from What is Grounding? and walk the group through the steps of the grounding exercise while modeling the exercise. Practice the grounding exercise a number of times.

Session	Session Five
Activity	**What are Unhealthy Relationships**
Estimated Duration	🕓 30 minutes
Materials Needed	☑ Understanding Power & Control Tactics (see Appendix K) ☑ Cycle of Abuse (see Appendix L)

1. Tell the group that if our conversation today brings up thoughts about past or current relationships, group leaders will be available after the group to talk. Encourage group members to think about what they are comfortable with other group members knowing about them. Remind group members to use their grounding skills if needed.

2. Walk through the behaviours presented on the Understanding Power & Control Tactics worksheet. Provide concrete examples of behaviour that fall under each, encourage group members to provide examples as well.

3. Walk through the phases or cycles that unhealthy relationships go through. Highlight how the honeymoon/apology periods encourage people to stay, warning signs and how people who choose to stay can cope in relationships by knowing their relationship cycle.

4. Encourage discussion of the content of the lesson in the group. Some questions to guide the discussion could be:

What was it like to talk about unhealthy relationships today?

What information was new to you? What was already known?

What do you want to learn more about?

How are you feeling about what we learned?

Session	Session Five
Activity	**Relationships Role Play**
Estimated Duration	30 minutes
Materials Needed	☑ Relationships Role Play Scenarios (see Appendix M)

1. Group is instructed to divide into pairs. Hand out role play scenarios from Relationship Role Play Scenarios, see Appendix M. Instruct group members to take a couple moments to practice and decide how they want to finish the role play (each role play will allow an alternate ending).

2. Group members perform their role play for the group.

3. After each role play, the group will have a short discussion and consider the following questions,

   Did we see signs of an unhealthy relationship?

   Did we see signs of a healthy relationship?

   What could the characters have done?

   What did the actors do well?

   What was it like to watch the role play?

   What were your feelings when you saw this role play?

   What skills or support do you think we would need to keep our relationships healthy?

Session	Session Five
Activity	**Group Check In**
Estimated Duration	15 minutes
Materials Needed	No materials needed.

1. Each group member gets an opportunity to speak about their experience in group. Group members are encouraged to listen quietly while each member talks.
2. Introduce the topic of the group ending, allow members to comment on their thoughts on the group ending after three more sessions.
3. Highlight differences and similarities between group members.

Session	Session Five
Activity	**Goodbye Affirmation**
Estimated Duration	🕐 5 minutes
Materials Needed	☑ Relationship Bill of Rights (see Appendix J)

1. Encourage group members to take turns stating a personalized relationship right from the Relationship Bill of Rights combined with something positive about themselves. Group members may use the template: *"I am* _____ *and* _____ *and I deserve* _____*"*. For example, *"I am kind and gentle and I deserve to be able to end a relationship."*

   Group members could make eye contact with each other or alternatively, place a hand on their own chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Six

Session	**Session Six**
Overview	Check-In (5 min.) Unhealthy Relationships and Women with Disabilities (20 min.) Break (15 min.) Safety Planning (30 min.) Self Mandala (15 min.) Goodbye Affirmation (5 min.)
Goal	Discuss components of unhealthy relationships and the maintenance of safety for women with disabilities while maintaining emotional safety for group members.
Objectives	**Group members will learn about rates of interpersonal violence for women with disabilities and the unique issues that may come up* ** Group members will learn about components of safety planning that could be important for women with disabilities* ** Group members will get the opportunity to reflect on their internal strengths*

Session	Session Six
Activity	**Check-In**
Estimated Duration	5 minutes
Materials Needed	No materials needed.

1. Each group member will state how they are feeling going into group today in one word. Group members are encouraged to listen quietly while each member talks.
2. Remind group members about how many sessions are left and allow group members to talk about their feelings about the group ending.
3. Discuss how we may need different things from group and group members depending on what we're feeling. Highlight similarities or differences amongst group members.

Session	Session Six
Activity	**Unhealthy Relationships and Women with Disabilities**
Estimated Duration	🕐 20 minutes
Materials Needed	No materials needed

1. Transition into activity by reviewing components of unhealthy relationships from last week.
2. Share statistics of interpersonal violence for women, and women with disabilities. For example, In Canada,

> *"Half of all women in Canada have experienced at least one incident of physical or sexual violence since the age of 16 (Canadian Women's Foundation, n.d.).*
>
> *On average, every six days a woman in Canada is killed by her intimate partner. In 2011, from the 89 police reported spousal homicides, 76 of the victims (over 85%) were women (Canadian Women's Foundation, n.d.).*
>
> *Women with disabilities are 50- 100% more likely to experience abuse from a partner than women without disabilities. For example, if one in four women experience sexual abuse in their lifetime, approximately 1.5 to two in four women experience sexual abuse in their lifetime* (Sordi, 2011).
>
> *Women with physical disabilities were twice as likely to experience intimate partner violence as women without physical activity limitations* (Sordi, 2011).

Women with disabilities were twice as likely to report severe physical violence (beaten, kicked, bit, hit) and three times more likely to be forced into sexual activity (being threatened, held down, hurt) (Sordi, 2011)."

2. Discuss factors which may make women with disabilities targets of violence. Provide examples of each theme. Frame factors using anti-oppressive lens, highlighting impacts of discrimination and oppression on these factors. Key themes from the literature include,

Discrimination towards persons with disabilities

- Means that violence against women with disabilities may not be recognized and adequate support may not be provided

- Discrimination impacts other factors as well.

Needing care from others (family, friends, paid caregivers, etc)

- Caregivers can with hold medication or assistive devices (eg. taking battery out of electric wheelchair)

Services are not accessible

- Shelters don't provide wheelchair ramps, caregivers, extra support needed to leave abusive relationships

- Services don't provide information which is easy to read and understand or cannot take the time to insure clients understand.

Ignorant mainstream beliefs about persons with disabilities

- Rights of persons with disabilities are not recognized or understood

- Abusers may see women with disabilities as "easy targets"

- *Women with disabilities are considered asexual or not considered to have relationships*

Women with disabilities may be socially isolated

- *Women may have barriers to participating in the community and meeting or connecting with others due to financial or physical barriers. Discrimination may also contribute.*

Lack of awareness of abuse

- *Women with disabilities may not receive the same relationships education as women without disabilities*
- *Discrimination can mean that women don't recognize abusive behaviour because they experience it often and throughout their lives.*
- *Women with disabilities often learn to be "obedient" to others in their lives as a way to cope with having others provide support for their daily needs*

3. Discuss the information given as a group. Questions that could guide this discussion are,

What stood out from the information about women with disabilities and interpersonal violence?

Is this new information to you? Are these facts familiar?

What is needed to decrease the impact of these factors on rates of interpersonal violence?

What role does discrimination play in these factors?

Session	Session Six
Activity	**Safety Planning**
Estimated Duration	🕐 30 minutes
Materials Needed	☑ CROWD Safety Plan Cards (see Appendix N for location of resource) ☑ My Safety Plan (see Appendix N)

1. Introduce safety planning activity and describe its purpose. For example,

   As you already know, violence against women with disabilities is more common than for women without disabilities. For this reason, it is important for us to consider ways that we want to keep ourselves safe if we ever have encountered abusive or unhealthy behaviour in our relationships with others. This activity will help us plan for what to do in the event of an emergency, when we need to get out of a relationship fast. For example, when someone physically hurts you or threatens to hurt you, it is important to have a plan that will help you out of harm's way.

2. Discuss as a group, when using a safety plan may be important. Encourage members to use concrete examples and tie in material from earlier sessions regarding unhealthy relationships.
3. Hand out CROWD Safety Planning Card (see Appendix N). Explain each component of the Safety Planning Card and how this relates to safety planning.

4. Hand out My Safety Plan (see Appendix N). Explain the hand out and encourage members to fill out the worksheet.

   Encourage group members to consider disability related issues such as support persons or caregivers, medication, assistive devices as relevant to the group.

5. Let group know that we will be completing the section, "Services in Prince George, BC that could help me…." in another session.

6. If bringing their safety plans home from the session, encourage group members to consider a safe and private place to keep the safety plan.

   If choosing to leave their safety plans at the agency until after session seven, plans must be kept in a locked secure location to protect confidentiality.

Session	Session Six
Activity	**Self Mandala**
Estimated Duration	🕒 15 minutes
Materials Needed	☑ Self Mandala Work Sheet (see Appendix O) ☑ Markers, pens, or pencils

Adapted from Satir, V., Baneman, J., Gerber, J.(1991), Self-Mandala (p. 274).

1. Introduce Our Internal Resources and describe purpose to group. For example,

   "When we are talking about abusive relationships or unhealthy relationships, especially abusive relationships, it is important for everyone to be aware of the ways we take care of ourselves and the things we do that help us feel good about ourselves. When we are aware of these things we can start to intentionally do them to make ourselves feel better. "

2. Hand out Self Mandala Work Sheet, see Appendix O. Explain the worksheet, encourage the group to think of themselves as made up of many parts, like a puzzle. Explain that each part of them relates to other parts but each piece needs different things to be cared for. When we care for all of our parts, we begin to feel better about ourselves.
3. Encourage the group to write key words or phrases that describes each part of themselves. If they are stuck, group members may ask the group for help to think of ways to describe their parts.
4. Explain that each part of us also needs support and nurturing. If they haven't already, encourage each group member to write how they already nurture or how they think

they could nurture each part of themselves. Allow opportunities for this activity to become a group brainstorm session with group members making suggestions to each other.

5. Debrief the activity in the group. Key questions to reflect on could be:

   What was it like to do this exercise?

   What stood out to you from this activity?

   Are there any parts of yourself that have enough support?

   Are there any parts of yourself that need more support? What do you need from others to be able to give that part of yourself more support?

Session	Session Six
Activity	**Goodbye Affirmation**
Estimated Duration	5 minutes
Materials Needed	No materials needed.

1. Encourage group members to take turns describing an internal resource they have, taken from the Our Internal Resources activity. Group members may use the template: *"I* _____, _____, *and* _____ *and this helps me feel good about myself"*. For example, *"I eat healthy foods, spend time with my friends and talk about my feelings with my mother and this helps me feel good about myself."*

   Group members could make eye contact with each other or alternatively, place a hand on their own chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Seven

Session	**Session Seven** (3 hour extended session)
Overview	Check-In (10 min.) Service Scavenger Hunt (1.5 hours) Break (20 min.) Service Presentation (55 min.) Goodbye Affirmation (10 min.)
Goal	Learn about services within town that can support women who are experiencing unhealthy or abusive relationships and allow the opportunity to practice self-advocacy and self-help skills in a supportive environment.
Objectives	**Group members will become familiar with supportive services around town.* **Group members will learn important self-help skills and practice self-advocacy* ** Group members will build familiarity and confidence in accessing local services* ** Group members will practice assessing for disability sensitive issues*

Session	Session Seven
Activity	Check- In
Estimated Duration	10 minutes
Materials Needed	No materials needed.

1. Each group member will state how they are feeling going into group today in one word. Group members are encouraged to listen quietly while each member talks.
2. Discuss how we may need different things from group and group members depending on what we're feeling. Highlight similarities or differences amongst group members.

Session	Session Seven
Activity	**Service Scavenger Hunt ***
Estimated Duration	🕓 1.5 hours
Materials Needed	☑ Service Interview Questions (see Appendix P) ☑ Referral Services Directory (see Appendix Q) ☑ Consent from local violence prevention services to visit facility and interview service providers ☑ Markers, pens, or pencils

*Depending on chosen service preference, confidentiality concerns or agency policy surrounding transporting clients, this session could be done in-house with representatives of a number of services joining the group for an information session.

1. Describe activity to take place today. If going into the community with other group members, it could be important to discuss how the group members' confidentiality around their participation in the group could be impacted. Insure each member consents to this process before continuing. Ideally, this conversation could occur previously as well when discussing norms around confidentiality.
2. Group is divided by the number of leaders present. Each group will be assigned a local violence prevention agency.
3. Before leaving to the agency itself, encourage group members to take a couple minutes to prepare the "interview" for staff members or representatives. Encourage group members to review questions on Service Interview Questions, see Appendix P, and decide what other questions they would like to ask. Encourage group members to

divide up questions, to insure participation by all members. Remind groups that they will need to prepare a small presentation when they are back in the group.

4. While visiting the agency, encourage group members to ask any questions that come to them and to accept any information/brochures available. Insure information packages/brochures are taken for every group member. Encourage independence in the interview to promote self-advocacy and self-help skills.
5. Return to the group location to meet the other small groups.

Session	**Session Seven**
Activity	**Service Presentation**
Estimated Duration	🕒 55 minutes
Materials Needed	☑ Flip chart ☑ My Safety Plan from Session Six (see Appendix N) ☑ Markers, pens, or pencils

1. Encourage small groups to take a couple moments to prepare for their presentation of the local violence prevention agency they visited.
2. During each presentation, prompt group members to hit specific points such as what services are provided, how to access the service and if there are any disability related issues or concerns they had with the service.
3. Encourage group members fill in their worksheet, My Safety Plan section, "When there is not an emergency, services in Prince George, BC that could help me include…" during the presentation. Group leaders can take notes on the flip chart to assist group members in taking down this information.
4. After the presentations, encourage group members to debrief their experience going to the local violence prevention agencies. The following questions could be used to guide the discussion,

   What stood out for you from today?

   What was it like going to the services you went to today?

What was it like to talk about accessibility and disabilities at the agency you accessed?

What was it like hearing about other services in town?

After today, how have your feelings or thoughts changed about services in town?

What questions still linger after today?

What was it like to having this experience with others in the group?

Session	Session Seven
Activity	**Goodbye Affirmation**
Estimated Duration	15 minutes
Materials Needed	No materials needed

1. Encourage group members to take turns making a statement regarding their rights, which can be either relationship based rights, disability related or more general human rights. Group members may use the template: *"I have the right to _____"* For example, *"I have the right to have my disability accommodated by local services" or "I have the right to have support when I am leaving an unhealthy relationship"*

   Group members could make eye contact with each other or alternatively, place a hand on their own chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level

Session Eight

Session	Session Eight
Overview	Check-In (10 min.) Reflections (30 min.) Break (15 min.) Looking Forward (15 min.) Plan the Final Session (15 min.) Goodbye Affirmation (5 min.)
Goal	Reflect on what has been learned within the group over the past eight sessions and encourage group members to create goals for themselves for after the group.
Objectives	**Group members will have the opportunity to discuss the experience of the group ending and what ending will be like for them.* **Group members will reflect on the psychoeducational component of group and what was learned.* ** Group members will make relationships based goals for themselves outside of group, for when the group is over.* ** Group members will exercise control over the last session to reflect ownership over the group.*

Session	Session Eight
Activity	**Check-In**
Estimated Duration	10 minutes
Materials Needed	No materials needed.

1. Each group member will state how they are feeling going into group today in one word. Group members are encouraged to listen quietly while each member talks.
2. Remind group members about how many sessions are left and allow group members to talk about their feelings about the group ending.
3. Discuss how we may need different things from group and group members depending on what we're feeling. Highlight similarities or differences amongst group members.

Session	**Session Eight**
Activity	**Reflections**
Estimated Duration	🕓 30 minutes
Materials Needed	☑ Flip chart ☑ Markers, pens, or pencils

1. Encourage the group to talk about their experience in the group. Questions to guide this discussion could be,

   What was your favourite activity in the group?

   What was your least favourite activity in the group?

   What did you like most about being in the group?

   What did you like least about being in the group?

   What did you learn about yourself in the group?

   What did you learn about women in the group.

   What did you learn about relationships in the group?

   What did you learn about persons with disabilities in the group?

   What did you learn about being with other people from participating in the group?

   What will you miss about the group?

   What will you not miss about the group?

   What do you wish you did more of in the group?

2. As the discussion continues, encourage group members to express their feelings or thoughts about the group ending.

Session	Session Eight
Activity	**Looking Forward**
Estimated Duration	🕐 15 minutes
Materials Needed	☑ Looking Forward Worksheet (see Appendix R) ☑ Markers, pens, or pencils

1. Encourage the group to consider what they have gotten out of the group, and consider how they may want their lives to be different based on this experience.
2. Hand out the Looking Forward Worksheet. Encourage group members to complete the worksheet using pictures or words, whatever is easiest for them.
3. Encourage group members to review as a group about what their goals are for outside of the group, why these goals are important and what they will need to meet the goals.

Session	Session Eight
Activity	**Plan the Final Session**
Estimated Duration	🕒 15 minutes
Materials Needed	☑ Flip chart ☑ Markers, pens or pencils ☑ Stickers

1. Tell the group that you would like them to help you plan the final session of the group.
2. Encourage group members to come up with their own ideas for the final group session. If necessary, give group members some parameters set by your organization for the final group activity.
3. If stuck, provide some examples of a final group activity. Important themes for group activities would be reflecting on group content, reviewing grounding and self-soothing techniques learned, providing closure to interpersonal relationships and looking towards the future. For example,

   Group Collage *Group members complete a collage based on their experiences in the group, collage can be completed together as a group or sections may be distributed to each group member to complete then pieced together to reveal a larger collage. Collage may be scanned and printed as a poster to be given back to group members to keep.*

Potluck Dinner *Group members are invited to bring their favourite food to share with the group. Alternatively, a theme for the potluck could be chosen by the group, eg. foods for all five senses, comfort foods. Each person could introduce their contribution and then eat together as a social celebratory activity.*

Body Art *Each group member's body is traced on butcher paper. The group member may decorate the outline as they would like and may invite other group members to write notes or draw on their outline. Each group member could take home their body outline.*

Yoga Class *Group members can participate in a yoga class together with emphasis on using breathing or yoga techniques for relaxation and self-soothing.*

Strong and Safe Commercial *Group members could create a commercial based on what they would like to tell future members about the group if they were able to talk to them . Group members could collaboratively plan what they would like have appear in the commercial and then shoot the commercial using video cameras. Usage of the " commercial" and confidentiality would need to be discussed.*

4. If a number of ideas come up and the group is divided, the group can decide on the final activity democratically. One way to do this is via a "dotmocracy".

To complete a "dotmocracy",

a) jot down ideas on the flip chart paper,

b) hand out two stickers to each group member,

c) encourage them to place a sticker beside the final activity/activities that they are most interested in, (group members may choose to place both stickers on one activity, or place a sticker beside their top two activities of choice),

d) the activity with the most stickers is the final activity.

Session	Session Eight
Activity	**Goodbye Affirmation**
Estimated Duration	5 minutes
Materials Needed	No materials needed.

1. Encourage group members to take turns making using their favourite affirmation they have used within the group. Alternatively, group members may use an affirmation that they have made up.

   Group members could make eye contact with each other or alternatively, place a hand on their own chest, head or shoulder to increase sense of connection with the group or themselves depending on their comfort level.

Session Nine

Session	Session Nine
Overview	Check-In (20 min.) Final Activity (30 min.) Break (15 min.) Final Activity (continued) (30 min.) Yarn Ball Check Out (20 min.) Post Group Contact Information (5 min.)
Goal	Reflect on the experience had in the group and complete a final activity which is congruent with the group experience and provides closure.
Objectives	**Group members will have the opportunity to discuss the experience of the group ending and what ending will be like for them.* **Group members will reflect on the psychoeducational component of group and what was learned.* ** Group members will make relationships based goals for themselves outside of group, for when the group is over.* ** Group members will exercise control over the last session to reflect ownership over the group.*

Session	Session Nine
Activity	**Check-In**
Estimated Duration	10 minutes
Materials Needed	No materials needed.

1. Each group member will state how they are feeling going into group today in one word. Group members are encouraged to listen quietly while each member talks.
2. Remind group members that this is the last session and allow group members to talk about their feelings about the group ending.
3. Discuss how we may need different things from group and group members depending on what we're feeling. Highlight similarities or differences amongst group members.

Session	Session Nine
Activity	**Final Activity**
Estimated Duration	🕐 30 minutes (Break) 30 minutes (1 hour total)
Materials Needed	☑ Materials determined in Session Eight

1. Complete final activity as determined in Session Eight
2. If thoughts or feelings come up around the group ending, encourage group members to share these with the group. If necessary, encourage group members to share directly with specific group members as they work through these feelings.

Session	Session Nine
Activity	**Yarn Ball Check Out**
Estimated Duration	🕓 10 minutes
Materials Needed	☑ Ball of yarn

1. Encourage group members to stand in a circle. Demonstrate the activity first by, stating one thing you will remember about the group and throw the ball of yarn to a group member while still holding onto a piece of the yarn.
2. The group member will then state the one thing they will remember about the group then pass while holding a piece of the yarn. The end result will be a giant web of yarn between all the group members and each group member will have shared what they will remember about the group.
3. Start with the last group member to receive yarn, encourage this group member to share one thing that the person who originally passed the yarn to them has given them or something they value about that person and then let go of their yarn and pass the ball back.
4. The next group member will share one thing that the group member who originally passed the yarn to them has given them or something they value about that group member and let go, passing the yarn back to the group member. Continue until the ball of yarn is back in your hands and everyone has shared one thing they value from another group member.
5. Allow time group members to share any thoughts that came up from this activity.

Session	Session Nine
Activity	**Post Group Contact Information**
Estimated Duration	🕐 5 minutes
Materials Needed	☑ Referral Services Directory (see Appendix Q)

1. Let group members know follow-up protocol for your agency and what counselling based services are available if they need further support. Hand out the Referral Sources Directory, see Appendix Q, to group members so they have referral information for further counselling services.

   In addition, it may be important to provide group members with an option for a follow up with a group leader if they have strong feelings around something that was learned or occurred in group.

2. Let group members know about group evaluation questionnaire and interview. Encourage group members to take evaluation home to drop off at a later date or fill it out in the group session. In addition, get names of group members who are interested in taking place in a group evaluation interview at a later date.

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Appendix A

Intake and Screening Interview Instructions: *After the intake form is completed, the therapist and prospective group member will go over the intake questions together. This interview can be done orally or written with discussion over the answers to gain clarity.*

STRONG AND SAFE: INTAKE QUESTIONS

Name: _____

Address:

_____

_____

_____

_____

Phone Number: _____ or _____

Is it safe to leave a message on this phone? Yes □ No □

Who do you live with? (Circle all that apply to you)

Parent Partner Friend Caregiver Child/Children Just Myself

What is your living situation? (Circle one)

I live on my own I live with my family I live with someone who helps me

I live with room-mates I live on my own but have a support worker

If not listed, please describe_____

_____

_____

_____

What is your disability? In your own words.

_____

_____

_____

_____

Who should we call if you need help? (Write their name)

_____

Who are they to you? (Circle one)

Parent Partner Friend Caregiver Child Support Worker

How can I contact them? _____

_____

STRONG AND SAFE: SCREENING INTERVIEW

1. How would you describe yourself?

2. Where did you hear about the group?

3. Have you been in a group before? If so, what was this like?

4. Why do you want to join the group?

5. What do you hope to learn from the group?

6. How do you feel about being in a group?

7. What are unhealthy relationships? What is a healthy relationship?

8. Have you ever shared a story of abuse with someone? Or talked about unhealthy relationships before? If so, what was their reaction? What was it like to talk about it?

_____
_____
_____
_____

9. You consider yourself as having a disability, can you tell me about it? Knowing your disability can help me make sure the group will work for you.
    a. In highschool, what sort of help did you need in class?
    b. Is reading and writing a challenge for you?
    c. What sort of support do you need each day for your disability?

_____
_____
_____
_____
_____
_____
_____
_____
_____

10. Do you have any questions for me about the group?

Complete consent forms if group member is interested in the group and seems appropriate for the group.

Appendix B

Informed Consent Instructions: *The consent form is to be completed orally, with the therapist explaining the importance of individuals expressing any confusion they might have. The client will check each bullet point as they are covered in conversation. Questions such as "Can you tell me what that means?" "Do you have an example of that?" can be a helpful check-in on comprehension throughout this process.*

STRONG AND SAFE: CONSENT FOR GROUP THERAPY

I understand that…..

Strong and Safe is….

- □ A group for women with disabilities
- □ A group to learn about relationships
- □ A group to learn about yourself
- □ A group where you can talk about your life if you want to

Being in Strong and Safe may help me….

- □ Meet and talk with other people
- □ Learn about myself
- □ Learn how to tell other people what I think and feel
- □ Learn about unhealthy relationships
- □ Learn how to get out of unhealthy relationships

Being in Strong and Safe may mean that….

- □ I may have strong feelings in the group, like nervousness, sadness, angers
- □ Some people in my life might have a hard time adjusting to the "new me"
- □ I may learn some of my relationships need to become safer
- □ Other people in the group will know more about me

□ I understand that what is said in Strong and Safe is kept private to the best of everyone's ability.

This means…

- □ I should not share other people's information from the group
- □ I should only share information I am okay with other people knowing
- □ I can trust that my group leader will keep my information private

There are times when my group therapist may need to share my personal information….

- □ If it seems like I might hurt myself
- □ If it seems like I might hurt someone else
- □ If it seems like a child may be hurt
- □ If I have a legal issue and my group therapist needs to go to court

I understand everything that I have checked off on this paper. I give my consent to participate in Strong and Safe.

My Signature: _____Date: _____

Therapist: _____ Date: _____

Appendix C

Final Group Evaluation Instructions: *The group member is to complete the written questionnaire first. Written questionnaires can be completed anonymously at the last group or in individual meetings after the group has been completed. The interview will allow the therapist and group member to have a more in-depth conversation and go over the final evaluation questionnaire and then progress onto interview questions together.*

STRONG AND SAFE: FINAL QUESTIONAIRE

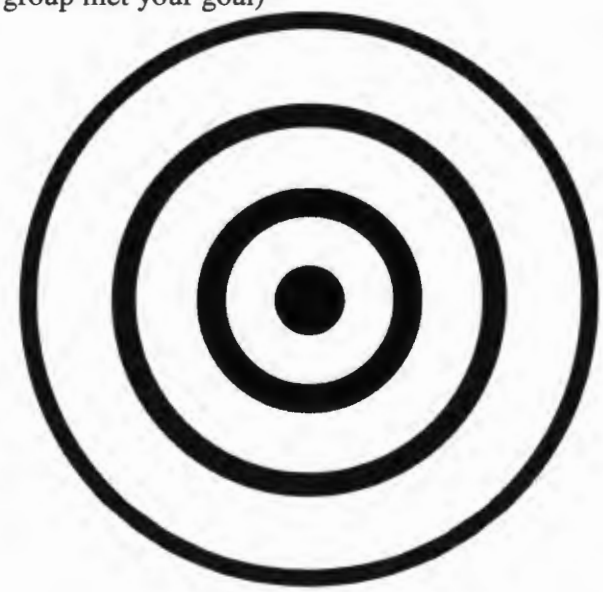
1. **My personal goal for the group was** : (write goal here)_____

_____

_____

_____

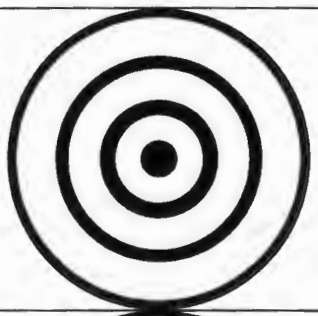
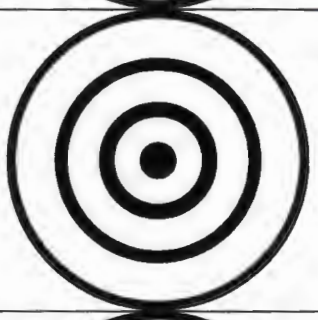
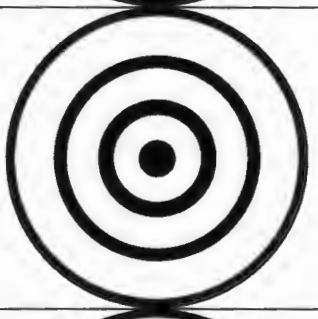
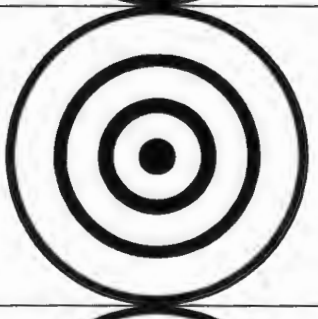
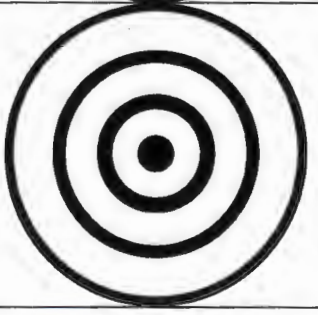
2. **Rate how well Strong and Safe helped you meet your goal** (show on the bull's eye how well the group met your goal)



3. **Throughout Strong and Safe, I….: (circle all that apply)**

"I was part of the group"	"I learned new information"	"Other group members were the same as me"
"I felt hopeful"	"I learned how to work through conflict"	"I helped others in the group"
"I was able to share important things about myself"	" I learned new ways to act from watching others in the group"	" I realized why connecting with others is important to me."
" I learned how I connect with others"		

Rate how well you feel you know the following topics covered in the group....

I learned new things about myself.	
I learned what makes a relationship healthy.	
I learned signs of unhealthy relationships.	
I learned ways I can communicate what I think and feel.	
I learned ways I can stay safe.	

What did you want to know more about?

_____
_____
_____
_____

4. When I think about Strong and Safe, my disability was accommodated…

All my needs were met	Most of my needs were met	My needs were somewhat met	Most of my needs were not met	My needs were not met.

I needed more: _____

_____

I needed less: _____

_____

STRONG AND SAFE: FINAL INTERVIEW

How would you describe yourself?

What did you learn in Strong and Safe?

What are unhealthy relationships? What are healthy relationships?

What was your goal for Strong and Safe?

Did you get what you wanted out of Strong and Safe? What did you want more of, less of?

Did you feel your disability was accommodated in the group? If so, how? If not, what could be done better?

Appendix D

Nice to Meet You! Questions

What is your favourite food?	Where did you go for vacation last summer?	What do you like to do in your spare time?	What is your favourite TV show?
What kind of music do you like?	If you could work any type of job, what would you like to do?	If you could meet one famous person, who would it be?	If you could vacation anywhere in the world, where would you like to go?
If you could be any animal, what kind would you be?	What do you do to relax?	What is your favourite day of the week?	What is your favourite meal of the day?
What type of food do you dislike the most?	What is your favourite season?	What would you do if you only had 24 hours to live?	If you could have any type of super power, what would it be?
Write your own question	Write your own question	Write your own question	Write your own question

Appendix E

Test Your Knowledge!

Categories

Relationships (R)
Sense of Self (SS)
Disability Factors (DF)

Questions:

1. Jealousy is a sign of a healthy relationship. True or False? (R)	2. It is important to be in relationships that make you feel good about yourself. True or False. (R)	3. I can date whomever I like, even if I have a disability. True or False? (DF)	4. I deserve to be treated with respect at all time. True or False? (SS)
5. Women with disabilities still face discrimination. True or False? (DF)	6. Women with disabilities have a harder time leaving unhealthy relationships. True or False. (DF)	7. People can tell immediately when they are in an unhealthy relationship. True or False? (R)	8. If I have decided to be someone's girlfriend, I should have sex with them when they want me to. (R)
9. If I am not nice, people won't like me. True or False? (SS)	10. Women with disabilities have the same rights as women without disabilities. True or False? (DF)	11. Relationships that are unhealthy mean that someone is constantly getting hurt. True or False?(R)	12. If I do something stupid, it is okay for someone to tell me so. True or False? (SS)
Add relationship question	Add disability related question	Add sense of self question	Add relationship question

Answers:

1. False. Jealousy is a sign of an unhealthy relationship (R)
2. True. In a healthy relationships, we will feel good about ourselves. (R)
3. True. Some women stay in unhealthy relationships because they think they won't be able to find anyone else. (DF)
4. True. Everyone deserves to be treated with respect at all times. Be treated with respect may mean someone listens to me, tries to understand what my life is like, and does not do things that will hurt me. (SS)
5. True. Research shows that many women still feel they have been discriminated against due to their disability. Some interviews with women with disabilities have shown that some women feel that some services don't give them what they need, understand their lives or give opportunities for them to share their opinions and experiences. (DF)
6. True. Research shows that women with disabilities may have a harder time leaving unhealthy relationships because of many different reasons, including discrimination (DF)
7. False. Most people may not notice that their relationships have become unhealthy as it happens over time. Some people learn that their relationship is unhealthy from talking to others about it and learning about abuse and unhealthy relationships. Some people may have a feeling that something is wrong. It is different for every relationship. (R)
8. False. Both people should want to have sex before the decision is made to have sex. Even if you are dating someone, it does not mean you have to sex with them when they want, what you think and feel are part of the decision to have sex or not. (SX)
9. False. This is a myth a lot of people believe. Sometimes it is important to speak up against someone, or not spend time with someone, especially if they are not respecting you. (SS)
10. True. (DF)

11. False. Often relationships which are unhealthy will have periods of time where things are going good, where the partner is caring and kind. This can be a reason why people have a difficult time recognizing that it is unhealthy. (R)
12. False. A person may tell you that they don't like what you are doing or may suggest a better way to do something, but they don't get to call you stupid. You are the only one who can decide to take what someone said and change what you're doing. (SS)

Appendix F

Group Norms Statements

Joking about what another person shares.	Telling someone else what another person has shared in the group.
Talking about personal sexual experiences.	Telling someone else about what you learned in the group.
Asking personal questions of other group members.	Not participating in the group.
Gossiping	Keeping personal information to yourself if you are uncomfortable sharing it.
Joining in on discussions.	Sharing personal information about family and friends.
Going off topic.	Skipping sessions.
Add Scenario Here	Becoming angry and leaving the room.
Add Scenario Here	Add Scenario Here

Appendix G

What is grounding?

Grounding is a set of strategies to cope with overwhelming thoughts and feelings. Grounding allows you to focus outward on the external world rather than inward towards self. Grounding can be used effectively for coping with a variety of concerns, like:

Overwhelming emotion (eg. Anger)
Physical pain
Intrusive memories
Anxiety
Craving

You can think of grounding as a "distraction", "centering", "a safe place", "looking outward",or a "healthy detachment".

Why do grounding?

When overwhelmed with negative thoughts or feelings, you need a way to detach so you can gain control and feel safe. For those of us that already detach when we are overwhelmed, grounding can provide a balance between being conscious of reality and being able to tolerate it.

The best part is that grounding can be done any time, anywhere without anyone knowing!

Cognitive Strategies	✍ Play a "Categories" game with yourself. Try to think of "types of dogs," "jazz musicians" , "towns in Northern BC" ✍ Do an age progression. If you have regressed to a younger age (eg. 8 years old), you can slowly work your way back up until you are back to your current age ✍ Describe an everyday activity in great detail. For example, describe the meal that you like to cook (eg. First I peel the potatoes and cut them into quarters....)

Cognitive Strategies ctnd.	ℵ Imagine. Use an image: Glide along on skates away from your pain; change the TV channel to get a better show; think of a wall as a buffer between you and your pain. ℵ Say a safety statement: "My name is _____; I am safe right now. I am in the present, not in the past. ℵ Read something, saying each word to yourself. Or read each letter backward so that you focus on letters and not on the meaning of the words. ℵ Use humour. Think of something funny to jolt yourself out of your mood. ℵ Count to 10 or say the alphabet very s..l..o..w..l..y.
Self-soothing Strategies	ℵ Say kind statements, as if you were talking to a small child- for example "you are a good person going through a hard time. You'll get through this" ℵ Think of favorites. Think of your favorite colour, animal, season, food, time of day… ℵ Picture people you care about (eg. Your children, pets), look at a photograph ℵ Remember the words to an inspiring song, quote, or poem. ℵ Remember a safe place. Describe the place that you find so soothing. ℵ Say a coping statement. Describe a place that you find so soothing. ℵ Say a coping statement: "I can handle this" ℵ Plan a safe treat for yourself, such as a certain desert. ℵ Think of things you are looking forward to in the next week- perhaps time with a friend, going to a movie.

Physical Strategies	☙ Run cool or warm water over your hands. ☙ Grab tightly onto your chair as hard as you can. ☙ Touch various obejects around you: a pen, keys, your clothing, the wall… ☙ Dig your heels into the floor- literally "grounding" them! Notice the tension centered in your heels as you do this. Remind yourself that you are connected to the ground. ☙ Carry a grounding object in your pocket, which you can touch whenever you need to ☙ Jump up and down. ☙ Notice your body: the weight of your body in the chair; wiggle your toes in your socks; the feet of your chair against your back… ☙ Stretch. Roll your head around; extend your fingers… ☙ Clench and relaease your fists. ☙ Walk slowly; notice each footstep, saying "left" or "right" ☙ Eat something, describing the flavors in detail to your self. ☙ Focus on your breathing, notice each inhale and exhale.

Grounding does work, but like any other skill, you need to practice!

Some tips:

- Practice as much as possible, even when you don't need it
- Try grounding for a long period of time (20-30 minutes)
- Notice which methods you like best
- Create your own methods of grounding
- Start grounding early in a negative mood cycle
- Make up index cards
- Have others assist you in grounding
- Prepare in advance
- Think about why grounding works!

Appendix H

Who are We? Adjectives

Beautiful	Friendly	Kind	Loving
Sexy	Strong	Weak	Mean
Ugly	Smart	Stupid	Gentle
Stubborn	Easy-going	Talented	Useless
Important	Plain	Glamorous	Lazy
Level-headed	Emotional	Loud	Quiet
Brave	Wimpy	Silly	Serious

Giving Feedback Role Play Scenarios

Your friend comes up to you and asks if she can spend the night at your house. You don't want her to because you have plans to work on something else on your own this evening. You like hanging out with her but would rather stick to your plans for tonight.
Your parents are often stopping by your place to see if you're doing okay. They don't call or let you know they are coming by. There are times when they come over that you are busy or doing something else and their visits interrupt your day.
If you don't have plans to hang out, your partner only contact you every couple of days. You think that in a relationship it is important to touch base with each other every day. You would like to talk about keeping in touch more often.

Your friend borrows money from you often. In the past, you have asked him a number of times to return the money you loaned him. Most of the time, he asks to pay you back later but does not. At this point, you don't want him to borrow anymore money from you until he pays you back some of the money he owes you.
Your neighbour keeps parking along the road in front of your house. You normally don't mind this. This week, you're having a friend spend the week at your house and they will need to use this parking space. You want to find a way to bring this up to your neighbour.
Your room-mate often eats the food that you buy for groceries each week. You have an arrangement with your room-mate that you both purchase your own groceries. You are noticing that your budget is difficult to meet this month and you want your room-mate to start buying their own groceries.
Your partner continues to tease you about the way you eat, that you are always eating too fast. When he teases you, you joke back and don't show that it bothers you. However, the joking around starts to hurt your feelings.

Your sister asks your other sister, brother and parents to babysit on a weekly basis. You're not sure why your sister has not yet asked you to babysit. You have some extra time in the evenings and would like the chance to babysit as well so you get some time with your niece and nephew.

You hear from another friend that your best friend has been telling people about a private issue you shared with her. Your feelings are hurt that your secrets were not kept.

Your class mate interrupting you often when you start talking. Sometimes you just wait for another chance to speak but other times you just want to keep going with your story. Today you were talking about something really important to you and your class mate interrupted you to talk about something different.

Appendix J

Relationship Bill of Rights.
Adapted from Moles (2001), The Relationship Bill of Rights (p. 117).

Relationship Bill of Rights

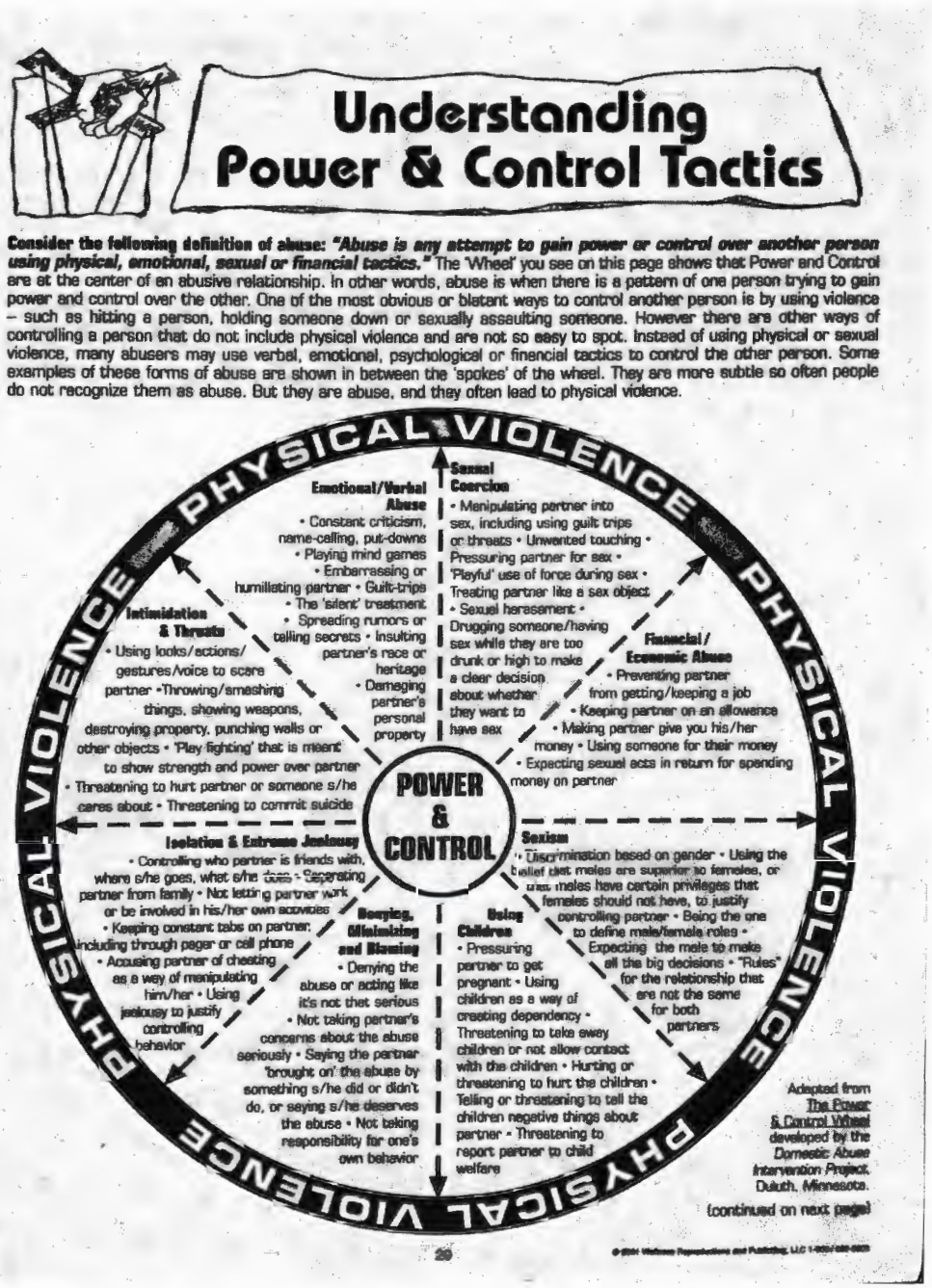
I have the following rights in my relationships with other people. I recognize and respect that other people have the same rights in their relationship with me.

1. To have and express my own feelings and opinions, even if others don't agree with me.
2. To make my own decisions about myself and to have equal power in the relationship.
3. To make my own decisions about my body, including who gets close to my body.
4. To decide who my friends are and maintain relationships with those friends.
5. To participate in activities that do not include my partner or other people in my life.
6. To have privacy.
7. To make mistakes.
8. To control my own money and possessions, or have equal control over money and possessions.
9. To live free from fear, discrimination and abuse.
10. To end a relationship.

Appendix K

Understanding Power & Control Tactics

The Relationship Workbook © Wellness Productions Inc. Melville, NY.
http://www.couragetochange.com/ The Relationship Workbook /(800)440-4003.
Reprinted with permission.



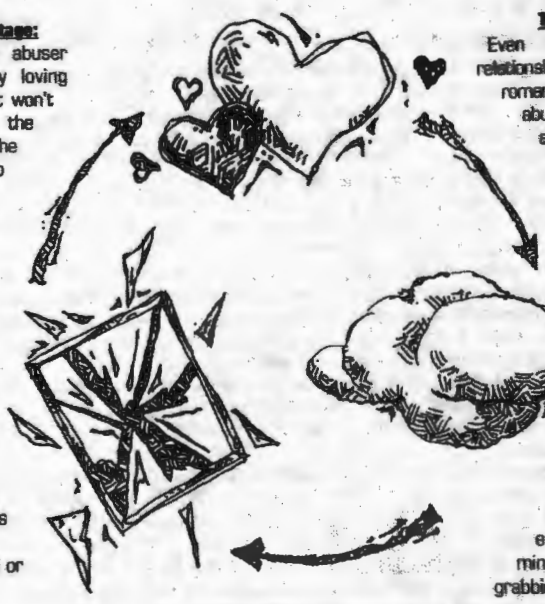
Appendix L

The Cycle of Abuse
The Relationship Workbook © Wellness Productions Inc. Melville, NY.
http://www.couragetochange.com/ The Relationship Workbook /(800)440-4003.
Reprinted with permission.

The Cycle of Abuse

Although not all abusive relationships follow the same pattern, there is a cycle that is similar in many abusive relationships. It looks something like this.

Back to The Honeymoon Stage:
After the 'blow up' the abuser may apologize, be very loving and kind, and promise it won't happen again. Because the abuser is so convincing, the partner will often try to 'forgive and forget.' Unfortunately, the cycle usually repeats itself and the abuse gets worse.



The Honeymoon Stage:
Even the most abusive relationships usually start out romantic and loving. Many abusers act very sweet and kind, express a lot of love and make their partners feel special and cared for.

The Tension Building Stage:
During this phase, tension builds in the relationship. There may be arguments, emotional abuse or minor physical abuse like grabbing or pushing.

The Blow Up Stage:
This is when the abuse is at its worst, and it may include extreme physical or sexual violence.

Have you experienced this cycle in your relationship? If so, briefly write down the behaviors you saw during each of the phases. Or think of a relationship from a movie, book or TV, and write down examples of behaviors you saw at each stage of the relationship.

1. The Honeymoon Stage (beginning of the relationship): _____
_____
2. The Tension Building Stage: _____
_____
3. The Blow Up Stage: _____
_____
4. The Honeymoon Stage (after the blow up): _____
_____

Appendix M

Relationship Role Play Scenarios

Your partner spends a large amount of time on Facebook. You notice that whenever another friend comments on something you write, he will bring it up later in the day and ask about your relationship with the other people. Recently, your partner has asked for your Facebook account password and you gave it to him. You notice that a number of old friends on your Facebook have been deleted since you have given him your password. When you ask your partner, "I've noticed some changes to my friends list, do you know what happened?" your partner becomes angry and says, "What? Are you mad that its not as easy for you to flirt anymore? I knew that you were a cheater!"

You have just moved in with your partner. You have been dating for a long time and both of you felt it was time to take your relationship to the next level and move in together. Ever since your partner moved in though, you have been constantly fighting. Fighting over who cooks, who cleans, when your partner comes home, and so on. When your partner comes home today you tell him that you think you should re-consider living together. He seems angry and shouts, "How could you do this to me! After all I've done for you!"

Your family friend has agreed to give you a hand over the weekend when your parents are out of town. You don't always like having someone check in on you because it can feel like they're judging you but you agree to the arrangement. One day, the family friend drops by your place. They ask you how your day has been and begin walking around the house, as they turn into the kitchen, where a couple days worth of dishes has piled up, they say, "Jeez, I don't know why your mom thinks you could live on your own"

You're out with friends and your partner at the bowling alley. The group decides to get nachos to share and asks if you would like in. Your partner answers for you, "No, she's fine". Your partner then reaches down and pinches your side, just like your partner does at home when he talks about the extra weight you have put on in the last couple years.

Your support worker or caregiver has helped you with your budgeting and banking activities for a long time. Your caregiver no longer involves you in banking activities and changes the topic when you ask about it. You have noticed some mistakes in your budget lately and are suspicious that there is some money missing. When you tell her you'd like to be more involved, "I was hoping to go to the bank with you today. Banking is important to me and I need to be with you." She says, "Maybe next week, I have a lot of other errands to run so it would be easier for me if you just to stay here while I do it. You should be happy I am saving you some work!"

You have been talking with someone online that you had met on a dating website. He has been suggesting you allow him to come over for the last couple nights. You are not comfortable with meeting him for the first time in your home alone but you also don't want him to stop talking to you. You tell him that you're busy and you would rather meet him tomorrow at Tim Hortons. He signs off the chat app you were talking in, only to come back on later and type "You sound like too much of a square. I don't date squares. Lose my contact info."

Your best friend and you have a passionate relationship- it always seems to be a real roller coaster of emotion. When you fight, it can get really heated- often mean things are said and feelings are hurt. However, you always find a way to work things out after you've both cooled off. Last night you had a huge fight, she was so angry that she picked up a plate on the coffee table and threw it at the wall beside you.

You have just started dating someone new. They haven't told you a lot about themselves or their past history. When you were out last weekend, you bumped into an old friend of theirs. On the drive home, your partner told you that they used to date. You start to feel really jealous. You don't want to appear jealous though so you don't ask anymore questions. When your partner goes in to pay for gas, you pick up his phone and scroll through his contacts and notice a contact by the same name as the friend you just met. You start to feel angry and jealous that your partner has the number in their phone, so you delete the contact quickly before your partner comes back to the vehicle.

Appendix N

My Safety Plan

If I think I may be in danger, a couple things I could do to prepare would be:

Make arrangements with **friends or family** to stay with them if needed.

A **bag** packed with important items (see below)

Open a separate **bank account** in my name only.

Redirect pay cheques or social assistance **cheques to your new bank account.**

A **private way to communicate** with others, like owning your own phone, setting up an email or facebook account that no one but you knows the password to.

Safe, support **persons I could call** if I am feeling scared, if I need to leave, or need help leaving are:

Name	Contact Information

I may need to have a bag ready to go if I feel I am in danger so I can leave right away. In this bag, I should have:

- **Money** or credit or debit cards
- Copies of **house keys** and car keys
- Copies of **important documents** like identification cards, birth certificate, driver's license, immigration documents, also,

  _____

  _____

  _____

- **Prescriptions**, like _____

  _____

  _____

- **Medical supplies**, like _____

  _____

  _____

- **Spare assistive equipment**, like _____

  _____

  _____

- **Changes of clothing**
- Small items that will provide **emotional relief**, like_____

  _____

  _____
- _____

  _____
- _____

  _____
- _____

  _____

A **safe, private place for this bag** would be:

_____

_____

_____

It is my right to have my disability accommodated by services I need. **To accommodate my disability, I will need:**

**It could be helpful to think of the other services you have received or have needed in the past, eg. help in school, life skills support, hygiene support, medication assistance etc.*

If I need help getting out, I need to call 911

When there is not an emergency, services in Prince George, BC that could help me include:

Name of Organization	**Contact Information**	**Services**
-example- **Elizabeth Fry Society**	*-example-* 1575 – 5th Avenue Prince George, BC V2L 3L9 **(250) 563-1113** http://pgefry.bc.ca	*-example-* - outreach programming for women, -victim support services, - violence prevention and intervention counselling services, -pregnancy outreach programs, -assistance with court, - employment support *Can self-refer.

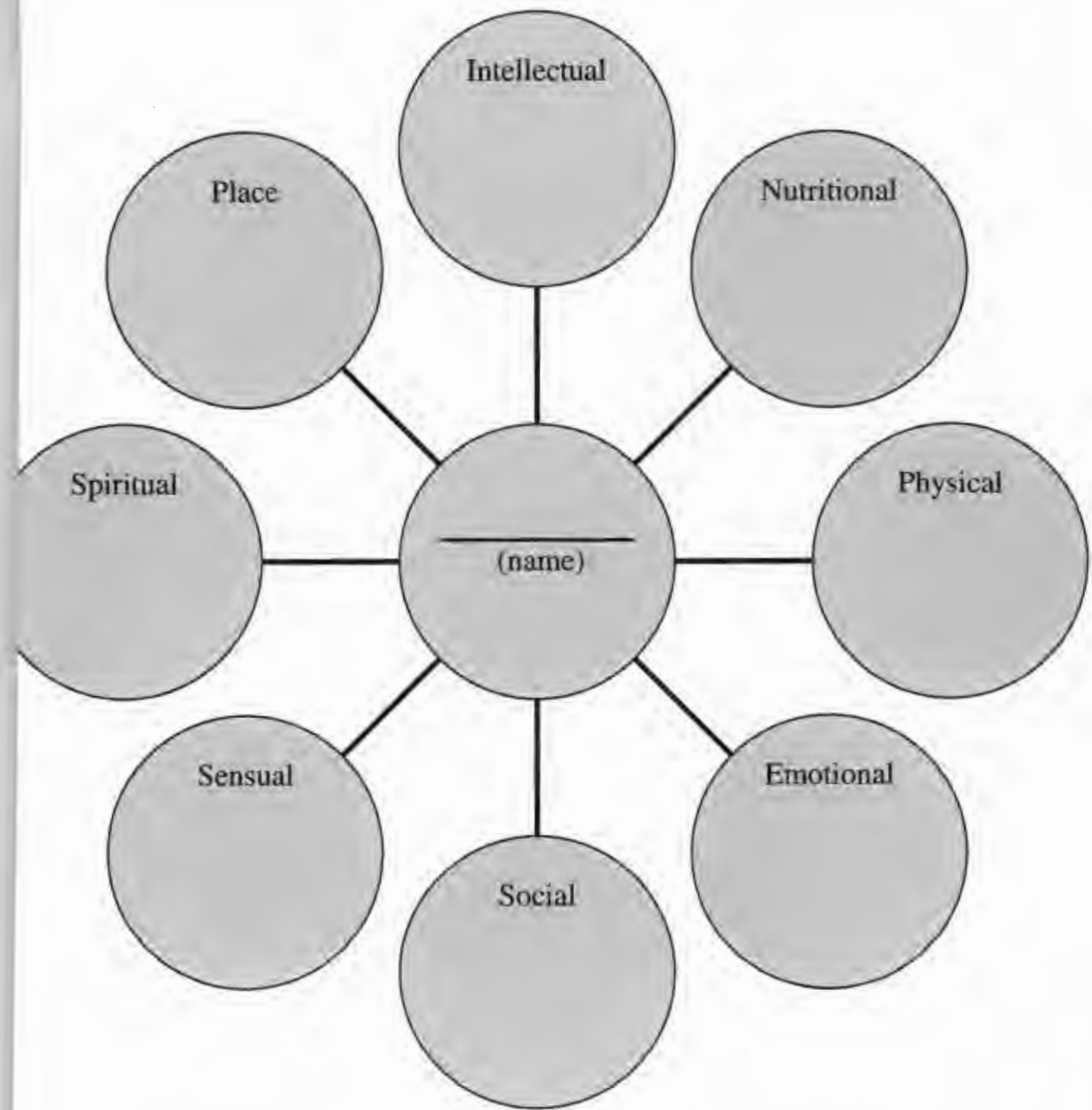
CROWD Safety Planning Cards available from

Centre for Research on Women with Disabilities (CROWD). (2014). CROWD Safety Planning Pocket Card. Retrieved from https://www.bcm.edu/research/centers/research-on-women-with-disabilities/index.cfm?pmid=4578

Appendix O

Self Mandala

Intellectual: Our ability to think, figure out things, make decisions, etc
Nutritional : What we eat or drink that keeps us healthy and feeling strong
Physical: How we keep our bodies and physical health strong
Emotional : How we take care of our emotions, including feeling and managing them
Social : How we interact with others, how we spend time with others
Sensual : What we experience through sight, smell, touch, sound and taste
Spiritual : What we do to find meaning or nourish our soul
Place: What places we build or visit that make us feel good, comfortable, safe


Intellectual
Place
Nutritional
Spiritual
Physical
(name)
Sensual
Emotional
Social

Appendix P

Service Interview Questions

1. What is the name of the organization?

_____

2. What services does this organization offer?

_____

_____

_____

3. Who does the organization provide services for?

_____

_____

_____

4. How can someone access the services? Phone call, referral from a doctor, etc.

_____

_____

_____

5. What is the cost of these services?

_____

_____

6. How does this agency accommodate women with physical disabilities? Intellectual disabilities? Other disabilities?

_____

_____

_____

_____

Appendix Q

Referral Services Directory
Prince George, BC

Counselling Services

Community Response Unit (CRU)- Northern Health 1705 3rd Ave, Prince George, BC V2L 3G7 **Phone: 250-565-2668**	☆*CRU provides brief assessments, short term supportive counselling and crisis intervention. CRU is the access point for Northern Health Mental Health and Addictions services such as the Developmental Disabilities Mental Health (DDMH) (formerly, Dual Diagnosis Mental Health), Community Acute Stabilization Team (CAST) and the Community Outreach and Assertive Services Team (COAST) as well as other Mental Health and Addictions Services. Can self-refer to CRU.*
24-hour Crisis Line Information **250-563-1214** or **1-888-562-1214**	☆*24-hour Crisis Line Information provides crisis support and referral information for services in Prince George, BC.*
24-hour Suicide Support Line **1-800-SUICIDE** or **1-800-784-2433**	☆*24-hour Suicide Support Line provides suicide intervention and emotional support.*
Surpassing Our Survival (SOS) Society www.sossociety.net/ **Phone: 250-564-8302**	☆*SOS provides counselling for women, men, teens and children who are survivors of sexual violence. In addition, SOS provides educational, information and referrals as well as training and presentations on sexual violence. Can self-refer.*
Community Care Centre 1310 3rd Avenue, Prince George, BC **Phone: 250-960-6457**	☆*Low-cost ($10/sesion) confidential counselling provided by supervised graduate students from UNBC's M.Ed. in Counselling program. Can self-refer.*

Counselling Services Cntd.

Native Healing Centre- Prince George Native Friendship Centre 3rd Floor, 1600- 3rd Avenue Prince George, BC V2L 3G6 **Phone 250-564-4324** Email: nhc@pgnfc.com	☆ *Native Healing Centre provides holistic and culturally sensitive counselling services to both Aboriginal and non-Aboriginal people who have survived physical, emotional, sexual or spiritual abuse. Services include one on counselling, addictions counselling, victim services, crisis support as well as access to ceremonies, elders and other cultural facilitators.*

Violence Prevention Services

Elizabeth Fry Society 1575 – 5th Avenue Prince George, BC V2L 3L9 **Phone: 250- 563-1113** **24 hr Crisis and Support Line:** ***1-866-563-1113*** http://pgefry.bc.ca	☆ *Elizabeth Fry Society provides outreach programming for women, victim support services, violence prevention and intervention counselling services, pregnancy outreach programs, assistance with court, and employment support among many other services. Can self-refer.*

Emergency Shelters

Association Advocating for Women and Children (AWAC) **Phone: 250-562-6262** awac@telus.net	☆ *AWAC provides 24 hour emergency shelter for women at risk and their children. Additionally,AWAC provides support, advocacy and referrals.*
Active Support Against Poverty (ASAP) Bridget Moran Place 590 Dominion Street, Prince Geroge, BC V2L 5T4 **Phone: 250-563-5531**	☆ *Provides emergency shelter for anyone over 19 years of age who is homeless or at risk. ASAP Housing Society also provides subsidized apartments for rent to homeless at-risk individuals.*

Advocacy

Coalition of People with Disabilities- BC Advocacy Access- Coalition of People with Disabilities **1-800-663-1278 (toll free)** Hours: Monday-Friday, 8:30-4:30pm	☆*Provides information and advocacy support to individuals with disabilities. Also provides training and workshops on advocacy.*
Prince George Adult Protection Line **Phone: 250-565-7414**	☆*A non-emergency, Northern Health reporting line to report abuse, neglect or self-neglect of an adult who cannot seek support and assistance on their own.*

Low Income Housing

BC Housing 1380- 2nd Avenue Prince George, BC V2L 3B5 **http://www.bchousing.org/** **Phone: 250-562-9251** Email: NorthernRegion@bchousing.org	☆*BC Housing provides subsidized rental housing for persons with low income or with permanent disabilities. Can complete housing application online.*
Amber House- Elizabeth Fry Society 1575 - 5th Avenue Prince George BC V2L 3L9 **Phone: 250-563-1113** **Amber House 24 hour E-mail shelter@pgefry.bc.ca**	☆ *Amber House is a transition home for women and children leaving abusive situations and a housing program for low income persons. Amber House provides crisis counselling, pet facilities, referrals, advocacy and has a wheelchair accessible ramp and facility.*
Elizabeth Fry Society Housing Society 1575 - 5th Avenue Prince George BC V2L 3L9 **Phone: 250-563-1113**	☆ *Elizabeth Fry Society coordinates a Housing Society which provides subsidized rental housing for low income persons and persons with disabilities*

Low Income Housing Ctnd.

Friendship Lodge- Prince George Native Friendship Centre 1656 Queensway Prince George, BC V2L 3GB **Phone: 250-562-3004** Email: jcampbell@pgnfc.com	☆ *Friendship Lodge provides supported rental housing for adults who are homeless or at risk of being homeless. In addition, the Friendship Lodge provides Lifeskills support, group activities, referral, 24/7 staff support, residential support workers and employment readiness services.*

Financial Support

Ministry of Social Development and Social Innovation Prince George Employment & Income Assistance Office 1445 10th Ave Prince George BC V2L 2L2 Phone:1-866-866-0800 Apply for Social Assistance Online **https://www.iaselfserve.gov.bc.ca**	☆ *Provides social assistance for persons with a disability (PWD) to persons with long term, permanent disabilities as well as social assistance to persons fleeing an abusive relationship. Also provides hardship grants and other assistance funding to eligible individuals.*
Student Aid **www.studentaidbc.ca**	☆ *Provides grants to allow students with permanent disabilities access to post secondary education. Includes grants that cover assistive devices, tutors, note takers or other accommodations students may need.*

Support Services for Persons with Disabilities

Community Living British Columbia (CLBC) Suite 207, 1600- 15th Avenue Prince George, BC V2L 3X3 **Phone 250-645-4065** princegeorge@communitylivingbc.ca	☆ *Provides referrals and funding for a variety of support services for persons with developmental disabilities, Fetal Alcohol Spectrum Disorder, and Autism Spectrum Disorder. Can self-refer to local office.*

Support Services for Persons with Disabilities Ctnd.

Brain Injured Group Prince George 1237 4th Ave Prince George, BC V2L 3J7 **Phone: 250-564-2447** info@pgbig.ca	☆ *Case management and group support services for individuals who have suffered a brain injury. Referrals for an intake can come from doctor, nurse, social worker or individual can self-refer.*
Employment Action 1505 Victoria St, Prince George, BC V2L 2L4 http://www.employment-action.bc.ca/ **Phone: 250-564-8044**	☆ *Employment Action provides employment-related services to persons with a variety of disabilities. Services include vocational interest and aptitude tests, resume development, job placement assistance and support and career counselling.*

Transportation

Care Free Society (Prince George HandyDART Services) 2832 Queensway St., Prince George, BC V2L 4M5 **Phone: 250-562-1394**	☆ *Care Free provides door to door transportation services for persons with disabilities. Service includes monthly taxi coupons. Contact information for a medical professional to verify need for door to door service is required on application form.*

Looking Forward....

In this group, I learned...

When this group is over, I want...

I will need to ....

... to make this happen.

Some support I might need along the way is.....

Appendix S

Questionnaire for Disability Sensitive Services

Here are some questions to help consider the accessibility of services for persons with disabilities.

1. Does my service accommodate current support persons if needed by the client?

2. Does my service accommodate the need for supportive persons? Can I assist a client to access a support person?

3. Does my service support the use of assistive devices? (service animals, technology that requires wifi or phone line, electronic scooters, etc)

4. Does my service accommodate low literacy levels? (Image-based resources, non text based information hand out available)

5. Does my service take extra measures to insure consent is given before proceeding with care/services? (Encourage clients to repeat back in their own words, address issue of consent throughout service provision, provide concrete examples of consenting issue, etc)

6. Does my service take extra measures to accommodate intellectual or learning disabilities? (simplify concepts, taking more time to explain, encouraging or allowing space and time for questions, etc)

7. Does my service deal with issues of discrimination appropriately?

8. Does my service abide by the guidelines of the UN Convention on the Rights of Persons with Disabilities?

9. Does my service practice follow a trauma informed model of practice? (Considers physical and emotional safety of clients in all aspects of service provision)

10. Is my service physically accessible?
    a. Smaller offices or meeting rooms will accommodate a wheelchair or scooter?
    b. Automatic doors or option of automated doors?
    c. Ground outside is even, well-maintained and wheelchair accessible?
    d. Ground level entrance with elevators if needed?
    e. Wide doorways and hallways and bathrooms that are wheelchair friendly?
    f. Few obstacles that could impede movement? (eg. open drawers, clutter, etc)

ADDITIONAL RESOURCES

Rights of Persons with Disabilities

B.C. Human Rights Coalition. (2002). Grounds of protection in B.C.: Disability- Physical or Mental. Retrieved from: http://www.bchrcoalition.org/files/GroundsProtection.html

☆ *Description of physical and mental disabilities a protected ground in B.C. Human Rights Law. Includes information on the duty to accommodate, and areas of protection provided in B.C., like employment, service access, tenancy, etc.*

Government of Canada. (2013). *Human rights and disabilities.* Retrieved from: http://www.pch.gc.ca/eng/1354827727788/1354829460923

☆ *Definitions of disability rights in Canada. Legislation and acts which provide protection in Canada. Links to international and provincial/territorial rights.*

Public Guardian and Trustee of British Columbia. (2012). *BC's Adult Guardianship Laws: Supporting self determination for adults in British Columbia.* Retrieved from http://www.trustee.bc.ca/pdfs /Adult%20Guardianship/Protecting_adults_from_abuse_neglect_and_self_neglect_Feb%20%202012_FINAL.pdf

☆ *Describes B.C.'s Adult Guardianship Laws, definition of abuse, neglect and self-neglect and provides some reporting suggestions.*

UN Enable. *The Convention in Brief: General Information.* Retrieved from http://www.un.org/disabilities/default.asp?navid=16&pid=156

☆ *Provides an overview of the Convention on the Rights of Persons with Disabilities including guiding principles and frequently asked questions about the Convention.*

Relationships Programming

Alberta Health Services. (2013). *teachingsexualhealth.ca.* Retrieved from www.teachingsexualhealth.ca

☆ *Free lesson plans for teaching about sexuality, sexual health, relationships and abuse organized by age and ability. Ranges from grades four to twelve with resources for both parents and teachers.*

Liptak, J., Khalsa, K., Leutenberg, E. (2002). *The Self-Esteem Program: Inventories, activities & educational Handouts.* Plainview, NY: Wellness Reproductions & Publishing.

☆ *The Self-Esteem Program includes educational hand-outs, activities and quizzes focusing on topics such as self-esteem, body image, decision making, learned helplessness, personal responsibility, and values exploration.*

Moles, K. (2001). *The relationships workbook: Activities for developing healthy relationships and preventing domestic violence.* Plainview, NY: Wellness Reproductions & Publishing.

☆ *The Relationships Workbook is 153 pages of printable worksheets with instructions for activities or discussions for each of the worksheets. Topics focused on in this workbook include evaluating your relationships, understanding abuse, exploring values, building healthy relationships, and making good decisions. This workbook can be used by both victims and perpetrators of abuse.*

Vecova Centre for Disability Services and Research (Vecova). (2012). *Dating violence awareness.* Retrieved from http://vecova.ca/research/project-websites/dating-violence-awareness/

☆ *Vecova Research Centre for Disability Services and Research is a non-profit research and service agency affiliated with the University of Calgary. Vecova has created and made available online their interactive, adaptable, plain language, six session program for persons with disabilities which focuses on topics like healthy, unhealthy and abusive relationships, stereotypes, gender roles, and power in relationships.*

YWCA of Canberra. (2009). *Relationship Things.* Retrieved from http://www.ywca-canberra.org.au/community_resources/relationship-things

☆ *Relationship Things is a six session program targeting youth which focuses on violence prevention. Relationship Things includes education about self-esteem, role of respect in relationships, communication, safe sex, and violence and sexual assault. Resources are available after entering in information regarding the use of the materials.*

Working with Persons with Disabilities

Alberta Committee of Citizens with Disabilities (2009). *Safe Haven Workshop.* Retrieved from http://www.accd.net/publications/Projects_and_Research/2009_Safe_H aven_Workshop.pdf

☆ *The Safe Haven Workshop developed by the Alberta Committee of Citizens with Disabilities consists of both the facilitator's guide and participant's workbook. The Safe Haven Workshop is geared towards service providers and covers topics such as social conditions which enhance vulnerability of women with disabilities, barriers to support experienced by women with disabilities and a functional needs approach to strategies to assess and meet the needs of women with disabilities.*

Canadian Centre on Disability Studies (1997). *People with Disabilities.* Retrieved from http://dawn.thot.net/disability_guide.html

☆ *Provides in depth information about a variety of disabilities including assistive devices and accommodations. Further, this document provides information on etiquette when interacting with persons with disabilities.*

Center for Research on Women with Disabilities (CROWD). *CROWD Home.* Retrieved from https://www.bcm.edu/research/centers/research-on-women-with-disabilities/index.cfm?PMID=0

☆ *CROWD at Baylor College of Medicine in Houston, Texas, has many online resources focusing on women with disabilities and sexuality, self-esteem, stress management, violence prevention, healthy promotion and access to health care. The CROWD website even contains information on best practices in violence prevention and intervention with women with disabilities.*

University of Northern British Columbia. (2012). *Access Resource Centre's Instructors' Handbook*. Retrieved from http://www.unbc.ca/sites/default/files/assets/access_resource_centre/arc_handbook_oct_2012.pdf

☆ *The Access Resource Centre at UNBC provides support to students with disabilities. Starting on page 16, in "Suggested Instructional Strategies", the Instructor's Handbook describes ways in which a variety of disabilities can be accommodated in university courses. This resource may provide important information regarding the accommodations individuals may require in a psychoeducational group.*

SUGGESTED READING

Atkinson, D., & Williams, F. (Eds.). (1990). *Know me as I am.* London: Hodder and Stoughton.

Banks, M. (2003). *Women with visible and invisible disabilities: Multiple intersections, multiple issues, multiple therapies.* New York, NY: Taylor-Francis.

The Empowered Fe Fes & DIVAS (2011, February 3). Takin back our power [Video file]. Retrieved from http://empoweredfefesanddivas.blogspot.ca/

Beyondmedia Education. (2004). *Beyond disability: The Fe Fe stories* [Video]. Chicago: Author.

Davis, L. (Ed.). (2013). *The disability studies reader* (4th ed.). New York, NY: Taylor-Francis.

Matthews, G. (1990). *Voices from the shadows: Women with disabilities speak out.* Canada: Women`s Press.

Rousso, H. (1993). *Disabled, female, and proud!: Stories of ten women with disabilities.* Santa Barbara, CA: Bergin & Garvey.

Hollomotz, A. (2011). *Learning difficulties and sexual vulnerability: A social approach.* Philadelphia, PA: Jessica Kingsley Publishers.

Mintz, S. (2007). *Unruly bodies: Life writing by women with disabilities.* Chapel Hill, NC: University of North Carolina Press.

Rajan, D. (2011). *Women with disabilities and abuse: Access to supports: report on the pan-Canadian focus groups.* Disabled Women's Network (DAWN) Canada. Canada: Canadian Women's Foundation.

Sordi, A. (2011). *Violence against women with disabilities: Violence prevention review.* Vecova Centre for Disability Services and Research. Canada: Canadian Women's Foundation.

Willmuth, M. & Hocomb, L. (Eds.). (1993). *Women with disabilities: Found voices.* New York, NY: Haworth Press.

Appendix U

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