Overview of Domestic Violence Intervention Services, Inc. and Call-Rape (DVIS)

Domestic Violence Intervention Services, Inc. and Call Rape (DVIS) offers a variety of essential services that assist in advocacy and recovery for individuals experiencing trauma as a result of lingering effects of physical, sexual, and emotional violence. Specifically, DVIS offers Peer Counseling and Systems Advocacy (including legal systems advocacy, assistance in job and career, finding necessary referrals, housing, etc.). Cognitive therapy is also offered and is proven effective for trauma survivors as they process through their stories and gain an understanding of their victimization and survivorship.

Review of Relevant Literature

Intimate Partner Violence (IPV) is abuse that transpires between two people (current and former spouses and dating partners) in close relationships, which involves physical abuse, sexual abuse, threats, and/or emotional abuse (Center for Disease Control, 2006). Approximately 3 million women are physically abused by their husband or boyfriend each year. Nearly one-third of American women will experience incidents of IPV from their spouse or dating partner at some point in their lives (Family Violence Prevention Fund, 2008).

Frequently women who experience trauma as a result of IPV experience Post Traumatic Stress Disorder (PTSD). PTSD is “characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma” (American Psychiatric Association [APA], 2000, p. 429). Some of the disturbing symptoms found in individuals with PTSD are: 1) reliving memories of the traumatic experience in images, smells, sounds, and physical sensations; 2) avoidance of reminders of the trauma accompanied with emotional numbing or detachment; and 3) increased arousal, as conveyed by hypervigilance, irritability, memory and concentration problems, sleep disturbances, and an exaggerated startle response (van der Kolk, 2000a). These symptoms are often accompanied with sensorimotor reactions, such as motor impulses, muscular tension, trembling and various other micromovements, and changes in posture, breathing, and heart rate (Ogden & Minton, 2002).

Treatment for trauma victims involves three critical steps: safety, management of anxiety, and emotional processing (van der Kolk, 2000a). The first step, safety, is imperative for trauma victims so they may begin healing. One may begin feeling safe by attaining shelter, food, and other means to get back on their feet (van der Kolk, 2000a). Once trauma victims feel safe, they may begin working through their trauma.

Following safety, an essential step in treating trauma is to manage anxiety. It is important to learn anxiety-management and self-regulation before working through emotions associated with trauma. An anxious person attempting to work through emotions will be unconsciously brought back to their past traumatic experiences, because they have not learned the skills to focus on the
present or the here and now. Focusing on here and now is the threshold into experiencing mindfulness.

**Mindfulness** is a term referring to being aware of one's inner experience (mind and body) and being in the present (Ogden & Minton, 2002). Being mindful allows one to experience emotions and inner body occurrences in the present instead of in their past traumatic experience (Ogden & Minton, 2002). In mind-body treatment, trauma victims learn how to articulate a plan of action that can alter the way they feel if they were to experience distress associated with their past traumatic experiences. For example, when they encounter triggers (i.e., smells, noises, physical sensations), a plan of action may facilitate the capacity to be mindful in their current situation, and disengage their sensorimotor reactions from trauma-based emotional responses, thus taming the associated terror (van der Kolk, 2000b). In other words, in mind-body therapy trauma victims learn to uncouple their body responses from their emotional responses.

**Sensorimotor Psychotherapy** is one therapy that involves mindfulness, which involves mindfully tracking one's physical sensations and impulses while progressing through the body (Ogden & Minton, 2002). Often emotional distress is evoked during this exercise because of the intensity. Therefore, while working through the body individuals are encouraged to disregard emotions and thoughts, until the bodily sensations and impulses are at rest and reach stabilization (Ogden & Minton, 2002). It is essential to disregard emotions and thoughts during this stage of treatment because trauma victims often do not have the necessary skills to process their traumatic experiences without experiencing hypoarousal (dissociation) or hyperarousal (excessive arousal) (van der Kolk, 2000b). Other body work used to manage anxiety may include deep muscle relaxation, control of breathing, role playing, and yoga (van der Kolk, 2000a).

Once the trauma victim has some control over their sensorimotor processing (i.e., motor impulses, muscular tension, trembling and various other micromovements) they may begin working through the emotional aspect of their trauma. By learning how to deal with some of the anxiety associated with their past traumatic experiences they will be able to distance themselves from the traumatic stimuli to make sense of their current occurrences. In order to effectively work through their emotional experiences trauma victims need assistance with finding a language to understand and communicate their experiences. This will enable them to put their past events into perspective and to speak about their past without feeling helpless.

Sigmund Freud postulated that “in order to function properly, people need to be able to define their needs, and to entertain a range of options on how to meet them, without resorting to premature action to make those feelings go away” (cited in van der Kolk, 2000b, p. 140). Freud called this: “thought as experimental action” (van der Kolk, 2000b, p. 140). This is a period where trauma victims are encouraged to articulate their traumatic experiences and what led up to it. This gives them the capacity to “own” what they feel. Having the inability to modulate their distress when attempting to confront their past trauma, may cause feelings of being overwhelmed, powerless, and out of control. Having these feelings may lead them to resort to pathological self-soothing behaviors
(i.e., substance abuse, binge eating, self-injury, clinging to potentially dangerous partners (van der Kolk, 2000b). Having the ability to modulate their distress will allow them to discuss their own contributions, thoughts and fantasies, and their reactions in regards to their traumatic experiences, including how it has affected them and their perceptions. The goal is for the trauma victim to share their trauma experience while realizing there is a beginning, middle, and end. Their story is part of their personal history—belonging to their past, not the present (van der Kolk, 2000a).

**Purpose of Study**

The purpose of this pilot study was to evaluate the effectiveness of a Mind/Body Education Component with trauma survivors in a transitional living facility through DVIS. The goal was to promote healing from the traumatic effects of domestic violence or sexual assault by incorporating self-regulation skills that contain the body. These skills include working with the breath, body awareness techniques, movement, establishing boundaries, learning to track specific sensations, and working to integrate the physiological activation in the body as a result of trauma. The nature of the intervention entailed experiential work combined with educational support to understanding trauma and its impact on our bodies, relationships, and lives. Intervention involved individual and/or group depending on each participant’s needs.

**Study Methodology**

This study employed a time-series, mixed methods design. The participants included 6 women who were clients of DVIS and one woman who was participating in individual counseling for domestic violence at DVIS. The experimental component was a planned 12-week program that occurred at DVIS/Sojourners Inn (Transitional Living/Residential Shelter for Domestic Violence Intervention Services clients). The component included group work to develop skills and co-therapy sessions. The program was designed to be teachable to therapists and advocates, transferable to adult clients, and applicable to multiple programs addressing domestic violence and sexual assault.

**Measures**

*Expectations about Counseling – Brief Form*. This 71-item questionnaire includes 18 scales and has produced four factor scores in Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance (see Appendix for a list of the scales that make up the factors). Questions 67-71 were not included within the 18 scales because they consist of demographic information questions. Participants were asked to indicate what they expect counseling to be like using a 7-point Likert scale (1=Not true; 7=definitely true). Higher average scores for each factor indicated a higher level of expectations (Tinsley, 1982).
**Traumatic Antecedents Questionnaire (TAQ).** The TAQ is a 42-item self-report measure which gathers information about lifetime experiences. The experiences are categorized in 10 domains. The first two domains relate to adaptive functioning and the latter eight domains assess exposure to traumatic or adverse experiences. These domains are measured according to 4 different age periods: birth to 6 years, 7 to 12 years, 13-18 years, and adulthood. For each item on the TAQ, respondents were asked to indicate the degree to which the statement described their experiences within each age period. The scale measured both frequency and intensity levels, depending on the question. Intensity and frequency were scored as a 4-point Likert scale (0=never or not at all; 3=often or very much). They also had the option of choosing “don’t know (DK)” if they were unaware of the experience mentioned in the statement or question. Higher scores on the two adaptive domains represent greater levels of adaptive functioning and higher scores on the 8 domains indicate greater exposure to traumatic or adverse experiences (van der Kolk, 2003b).

**Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM).** The CORE-OM is a 34-item self-report measure that was designed to measure psychological distress and outcome of psychotherapies. The 34 items comprise of four domains: subjective well-being (4 items), symptoms/problems (12 items), life/social functioning (12 items), and risk to self and others (6 items). Items are rated on a Likert-scale (0=Not at all; 4=Most of the time) with a time scale of ‘over the last week.’ By repeating this measure before and after therapy, it enables computation of clinical and/or reliability to reflect on the clinical effectiveness of intervention. Clinical scores are calculated as the mean of all completed items on the form, which are then multiplied by 10, so that clinically meaningful differences are expressed in whole numbers. Overall clinical scores range from 0-40 (Mellor-Clark, 2007).

**Trauma Center PTSD Symptom Scale.** The Trauma Center PTSD Symptom Scale is a 17-item self report measure of how individuals react to upsetting experiences in their life. Questions focused on reactions regarding their experiences of trauma. Participants were instructed to consider the most distressing experience or event that has happened to them while completing the questionnaire. Each question consisted of 3 columns of responses. In the first column, individuals were asked to write Y(Yes) or N(No) to indicate whether they have ever had the reaction. If they had never experienced the reaction they were instructed to leave the second and third columns blank for that question. If they had experienced the reaction they were instructed to fill out the second and third columns. The second column consisted of a four-point Likert-type response scale (0=Not at all; 3=5 or more times per week/very much/almost always) regarding frequency. The third column consisted of a five-point Likert-type response scale (0=Not at all distressing; 4=extremely distressing) regarding severity. Higher overall scores indicate a higher level of PTSD symptomology (van der Kolk, 2003a).

**Rosenberg Self-Esteem Scale (SES).** The SES is a 10-item self-report measure of self-worth and self-acceptance. This scale is scored as a 4-point
Likert scale (1=strongly agree; 4=strongly disagree). Higher scores indicate higher self-esteem and self-acceptance (Rosenberg, 1965).

Group Evaluation Scale (GES). The Group Evaluation Scale is a 7-item measure on individuals' general feelings toward participation in a group, feelings of stability/instability, the ability to express problems in front of the group, and feelings of being understood, autonomous, and responsible. Each question consists of 7 items which measure their feelings or experiences while in group therapy. The total score varies between 7 and 49, with higher scores indicating greater benefit from the group (Hess, 1996).

Body Awareness Scale (BAS). The purpose of this 21-item questionnaire was to determine how individuals relate to their body. It was designed by the researchers for this study. Questions focus on various body experiences from breathing patterns to having a sense of safety. The questions primarily consisted of a 5-point Likert-type response scale. The scale’s description varies from question to question. Higher total scores indicate being more comfortable with one’s body (Johnson & Jacobs, 2007).

Participants

Clients attending DVIS/Sojourners Inn were referred to the 12-week Mind/Body Education Component. DVIS personnel explained to clients that they were under no obligation to participate in the study. Participants who expressed interest were referred to Lynda Jacobs (co-investigator) who explained the program and study and the informed consent sheet. The informed consent sheet explained the nature of the study and that their participation in the study was optional.

Demographic variables indicated the average age of the participants was 41, with a standard deviation of 13.02 years. Of the 6 women who were in transitional living through DVIS, 83% were Caucasian and 17% was African American. Regarding their marital status, 50% were divorced, 33.33% were separated from their significant other, and 16.67% were single. Concerning highest level of education received, 33.33% received their Bachelors, 33.33% attended some college, 16.67% received their high school diploma, and 16.67% obtained their GED. Of the 6 women all were employed. Five of the women had children (n=14). A total of 9 children lived in the transitional facility with their mothers and the other 5 were 16 or older. Of the 6 women, all had received prior treatment for IPV at DVIS ranging from 3 months to 2 years. The duration of treatment they were receiving while participating in the Mind/Body Education ranged from 10 months to 3.5 years. All of the women who participated in this study been diagnosed with PTSD. Regarding levels of depression, 3 of the women had been diagnosed with Mild Depression, 1 with Moderate Depression, and 1 with Severe Depression.

Another woman receiving individual therapy for IPV participated in the 12 Week Mind/Body Educational Component. She had been attending therapy for IPV for approximately 6 months. Analogous to the other women in the study she had been diagnosed with having PTSD and was employed. She was 58 years of age.
age, Caucasian, and had no children. Regarding her highest level of education, she had her High School Diploma.

Data Collection

Data was collected by DVIS personnel and entered into password protected electronic spreadsheet software (MS Access). Data was then presented to the researchers to ensure the confidentiality of participants. Names and other identifying information were not included in the data collection. Participants had access to DVIS therapists/counselors if they felt uncomfortable or experienced negative emotional reactions to survey/interview questions. Identifying information was not required or necessary on survey or interview forms. Codes were used to identify surveys, audio/visual, and interview protocols/transcripts.

Results

The results for each of the dependent variables are described below. As this was a pilot study, the intent was to introduce and evaluate the education component so that it could be further developed and refined for future implementation. As such, there were not enough participants or data to conclusively draw statistical inferences regarding the results. Described below are the trends observed in this small sample of data. Much can be learned from examining these results, but one should keep in mind that they are inconclusive from a statistical standpoint.
**Expectations About Counseling-Brief Form**

Figures 1.1 through 1.7 illustrate individual averages in regards to Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance (see Appendix for a list of the scales that make up the factors). Participants rated their expectations on a 7-point Likert scale (1=Not true; 7=definitely true). Figure 1.8 illustrates group averages in regards to the EAC measure (Tinsley, 1982).

**Figure 1.1**

Expectations About Counseling-Brief Form

![Bar chart showing averages for Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance.](chart)

**Participant 1**

Participant 1 had high expectations concerning the therapist's use of Facilitative Conditions (e.g., acceptance, confrontation, etc) and Personal Commitment (e.g. responsibility). She had an average level of expectancy regarding therapist's Nurturance. P1 did not have high expectations concerning the therapist's Expertise.
Figure 1.2
Expectations About Counseling-Brief Form

Participant 2
Participant 2 had high expectations concerning the therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc) and Personal Commitment (e.g., responsibility). She had an average level of expectancy regarding therapist’s Nurturance. P2 did not have high expectations concerning the therapist’s Expertise.

Figure 1.3
Expectations About Counseling-Brief Form

Participant 3
Participant 3 had high expectations concerning Personal Commitment (e.g., responsibility), therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc), and therapist’s Nurturance. P3 had an average level of expectations regarding Counselor Expertise.
Figure 1.4

Expectations About Counseling-Brief Form

Participant 4

Participant 4 had high expectations concerning the therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc) and Personal Commitment (e.g. responsibility). P4 had an average level of expectancy regarding therapist’s Nurturance and Expertise.

Figure 1.5

Expectations About Counseling-Brief Form

Participant 5

Participant 5 had high expectations concerning Personal Commitment (e.g. responsibility) and the therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc). She had an average level of expectancy regarding therapist’s Nurturance and Expertise.
Figure 1.6

Expectations About Counseling-Brief Form

Participant 6

Participant 6 had high expectations concerning Personal Commitment (e.g., responsibility) and the therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc). She had an average level of expectancy regarding therapist’s Nurturance and Expertise.

Figure 1.7

Expectations About Counseling-Brief Form

Participant 7

Participant 7 had high expectations concerning Personal Commitment (e.g., responsibility) and the therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc). She had an average level of expectancy regarding therapist’s Nurturance and Expertise.
Figure 1.8

Expectations About Counseling-Brief Form

The above graph illustrates group averages regarding their expectations about counseling. Overall averages indicated participants had high expectations regarding therapist’s use of Facilitative Conditions (e.g., acceptance, confrontation, etc) and Personal Commitment (e.g., responsibility). Participants had average expectations regarding Counselor Expertise and Nurturance.
**Traumatic Antecedents Questionnaire (TAQ)**

Figures 2.1 through 2.7 illustrate individual averages of frequency and intensity levels regarding their traumatic experiences that occurred in 4 different age periods: birth to 6 years, 7 to 12 years, 13 to 18 years, and adulthood. The experiences are categorized in 10 domains. The first two domains relate to adaptive functioning and the latter eight domains assess exposure to traumatic or adverse life experiences. Age group scores range from 0 to 3 and total scores range from 0 to 12. The symbol * next to scores indicates there were item(s) that were answered with “DK” for Don’t Know and/or unanswered within the domain (van der Kolk, 2003b).

**Figure 2.1: Traumatic Antecedents Questionnaire (TAQ) Score Report**

<table>
<thead>
<tr>
<th></th>
<th>Childhood</th>
<th>Adulthood</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Young Child</strong> (0-6)</td>
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<td>2.50</td>
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<tr>
<td><strong>School Age</strong> (7-12)</td>
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<td><strong>Adolescent</strong> (13-18)</td>
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<tr>
<td><strong>Total</strong></td>
<td>2.50</td>
<td>0.67</td>
<td>7.67*</td>
</tr>
</tbody>
</table>

**Participant 1**

Regarding overall experiences (total scores), P1 scored high in regards to her adaptive functioning, which means she has experienced high levels of Competence and Safety. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P1 experienced: Separation with moderate frequency and intensity; and Neglect, Secrets, Emotional Abuse, Other Trauma, and Alcohol Abuse with low intensity and frequency. P1 did not report having any experiences with Physical Abuse, Sexual Abuse, or Witnessing.
### Figure 2.2: Traumatic Antecedents Questionnaire (TAQ) Score Report

<table>
<thead>
<tr>
<th></th>
<th>Childhood</th>
<th>Adulthood</th>
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<td>Adolescent (13-18)</td>
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<tr>
<td>1. Competence</td>
<td>1.50</td>
<td>1.50</td>
<td>1.50</td>
</tr>
<tr>
<td>2. Safety</td>
<td>1.00</td>
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<tr>
<td>3. Neglect</td>
<td>1.20</td>
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<td>4. Separation</td>
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<td>5. Secrets</td>
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<td>6. Emotional Abuse</td>
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<td>7. Physical Abuse</td>
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<td>8. Sexual Abuse</td>
<td>0.00</td>
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</tr>
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<td>9. Witnessing</td>
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<tr>
<td>10. Other Trauma</td>
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<tr>
<td>11. Alcohol and Drugs</td>
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</tr>
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</table>

**Participant 2**

Regarding overall experiences (total scores), P2 scored moderate to high in regards to her adaptive functioning, which means she has experienced moderate levels of safety but high levels of competence. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P2 experienced: Secrets with high frequency and intensity; Neglect, Separation, and Emotional Abuse with moderate frequency and intensity; and Physical Abuse, Witnessing, and Other Trauma at relatively low frequency and intensity. P2 did not report having experiences with Sexual Abuse.

### Figure 2.3: Traumatic Antecedents Questionnaire (TAQ) Score Report

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<td>5. Secrets</td>
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<td>6. Emotional Abuse</td>
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</table>

**Participant 3**

Regarding overall experiences (total scores), P3 scored high in regards to her adaptive functioning, which means that she has adapted well in regards to competence and safety. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P1 experienced: Secrets with high frequency and intensity; Neglect and Separation with moderate frequency and intensity; and Emotional Abuse, Physical Abuse, Sexual Abuse, Witnessing, Other Trauma, and Alcohol Abuse with low frequency and intensity.
Participant 4
Regarding overall experiences (total scores), P4 scored low to high in regards to her adaptive functioning, which means that she experienced low levels of safety, but high levels of competence. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P4 experienced: Neglect, Emotional Abuse, and Sexual Abuse with moderate frequency and intensity; and Separation, Physical Abuse, Witnessing, and Other Trauma with low frequency and intensity. P4 did not report having any experiences with Secrets or Alcohol and Drugs.

Participant 5
Regarding overall experiences (total scores), P5 scored high in regards to her adaptive functioning, which means that she has adapted well in regards to competence and safety. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P5 experienced: Alcohol and Drugs with high frequency and intensity; Separation, Secrets, and Witnessing with low levels of frequency and intensity. She did not report having any experiences with Neglect, Emotional Abuse, Physical Abuse, Sexual Abuse, or Other Trauma.
Figure 2.6: Traumatic Antecedents Questionnaire (TAQ) Score Report

<table>
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Participant 6

Regarding overall experiences (total scores), P6 scored low to high in regards to her adaptive functioning, which means that she experienced safety at low levels but adapted well in regards to competence. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P6 experienced: Secrets and Emotional Abuse with high frequency and intensity; Neglect, Separation, and Alcohol and Drugs with moderate frequency and intensity; and Physical Abuse, Witnessing, and Other Trauma with low frequency and intensity. She reports having no experiences with Sexual Abuse.

Figure 2.7: Traumatic Antecedents Questionnaire (TAQ) Score Report

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<td>7. Physical Abuse</td>
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<td>8. Sexual Abuse</td>
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<td>9. Witnessing</td>
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<td>0.50</td>
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<td>10. Other Trauma</td>
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<td>0.50</td>
</tr>
<tr>
<td>11. Alcohol and Drugs</td>
<td>1.50</td>
<td>1.50</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Participant 7

Regarding overall experiences (total scores), P7 scored low to moderate in regards to Adaptive Functioning, which means she has adapted moderately with Competence and has experienced a small amount of Safety. Regarding the latter 8 domains, which include exposure to traumatic or adverse life experiences, P7 experienced: Separation, Secrets, Emotional Abuse, and Alcohol and Drugs with high frequency and intensity; Physical Abuse and Neglect with moderate frequency and intensity; and Sexual Abuse and Witnessing with low frequency and intensity. She reports having no experiences with Other Trauma.
frequency and intensity; and Sexual Abuse, Witnessing, and Other Trauma with low frequency and intensity.

**Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM)**

Figure 3.1 illustrates total scores on the CORE-OM for each participant on 4 occasions. The CORE-OM is a measure of psychological distress and the outcome of psychotherapies. Clinical scores range from 0-40, with higher scores indicating greater psychological distress (Mellor-Clark, 2007).

Figure 3.1

Scores regarding psychological distress inclined for P1, P2, P3, P4, and P7, which indicates at T4 they had more psychological distress than they did at T1. P5 and P6’s scores declined indicating they had less psychological distress at T4 than they did at T1.
Trauma Center PTSD Symptom Scale

Figure 4.1 illustrates total scores on the PTSD scale for each participant on four occasions. This scale measured both frequency and severity in regards to how individuals react to upsetting experiences in their life. Higher scores indicate a higher level of PTSD symptomology (van der Kolk, 2003a).

Figure 4.1

Scores regarding PTSD symptomatology for P1, P2, and P4 inclined, which indicates at T4 they had a higher level of PTSD symptomatology than they did at T1. P3, P5, P6, and P7’s scores declined indicating they had a lower level of PTSD symptomology at T4 than they did at T1.
Rosenberg Self-Esteem Scale (SES)

Figure 5.1 illustrates total scores on the SES for each participant on 4 occasions. The SES is a measure of self-worth and self-acceptance. Higher scores indicate higher self-esteem and self-acceptance. Total scores range from 0-40 (Rosenberg, 1965).

Figure 5.1

Regarding self-esteem and self-acceptance, 6 of the 7 participants’ scores (excluding P4) inclined, indicating they had improvement in regards to self-esteem and self-acceptance. P4’s scores declined, indicating her self-esteem and self-acceptance had decreased.
Group Evaluation Scale (GES)

Figure 6.1 illustrates total scores on the GES for each participant on 4 occasions. The GES is a measure of individuals’ general feelings toward participation in a group, feelings of stability/instability, the ability to express problems in front of the group, and feelings of being understood, autonomous, and responsible. The total score varies between 7 and 49, with higher scores indicating greater benefit from the group (Hess, 1996).

Figure 6.1

Overall, all participants' scores inclined indicating they received greater benefit from the group from the beginning. P6 did not take this measure because she was not part of this group. She received the component individually.
Body Awareness Scale (BAS)

Figure 7.1 illustrates total scores on the BAS for each participant on 4 occasions. The BAS measures how individuals relate to their body. Total scores range from 0 to 82, with higher scores indicating being more comfortable with one's body (Johnson & Jacobs, 2007).

Figure 7.1

Overall, P1, P2, P3, and P4’s scores inclined indicating improvement (being more comfortable with one’s body). P5’s scores declined indicating she was less comfortable with her body at T4 then she was at T1. P6 and P7’s scores inclined indicating improvement.
Exit Interview

Figures 8.1 through 8.8 illustrate participants’ responses to questions regarding their experiences while in group and personal change. The responses have been divided up into common categories.

Figure 8.1

“Describe your experience (in general) while being in the group.”

<table>
<thead>
<tr>
<th>Internal Factors</th>
<th>External Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Therapist allowed for reflection on what happened between meetings and if group incorporated what they had learned.</em></td>
<td><em>Didn't get a lot out of it (ice storm, holidays, too busy).</em></td>
</tr>
<tr>
<td><em>Too much conversation non-related.</em></td>
<td><em>No consistency.</em></td>
</tr>
<tr>
<td><em>Not enough time during sessions to express self.</em></td>
<td><em>Twelve weeks was not long enough.</em></td>
</tr>
<tr>
<td><em>Group didn't end the right way. There were no final words and it ended abruptly. It needed closure.</em></td>
<td><em>Group twice per week for an hour would've been good.</em></td>
</tr>
<tr>
<td><em>We would climax in group and then it would end.</em></td>
<td><em>It would've been beneficial if we would've had at least one more week.</em></td>
</tr>
<tr>
<td></td>
<td><em>Group needed to be extended since we hadn't met for 4 weeks.</em></td>
</tr>
<tr>
<td></td>
<td><em>People came in and out of sessions, couldn't focus.</em></td>
</tr>
<tr>
<td></td>
<td><em>Needed consistency.</em></td>
</tr>
</tbody>
</table>
Figure 8.2

“What was the most valuable moment out of participating in the group?”

Most Valuable Moments

Body Awareness

“I realized how tense my body was.”

“More awareness of body and tension, and where tension comes from.”

“Now able to feel self and pay attention to different areas of my body.”

Body Awareness Techniques

“Now, I pay more attention to my body and take care of it when I see there is a problem.”

“Learned boundary styles, not only my boundaries but others.”

“Learned how to ground self and feel own body.”

“When I’m building up anger and fear, I learned how to breathe and ground self.”

Figure 8.3

“What are your thoughts on filling out the measures?”

Views on Measures

Pros

“They were helpful because our therapist went through all of them with us. We got assistance when needed.”

Cons

“They were too long.”

“Some questions were difficult to answer. I did not know how to answer them correctly.”

“I least liked filling out the measures.”
Figure 8.4

“What was the scariest, most uncomfortable or challenging part of being in therapy?”

- **Challenges**
  - **Touching**
    - “I didn’t like the touching part. I don’t like people to touch me that are not my children.”
  - **Privacy**
    - “Too many interruptions.”
    - “Therapist had to confer with our counselors. I feel things we said while in group should have been left in the room.”
    - “We should have progressed into touching. It should have been broken down a little bit further, like different sessions with different goals.”

Figure 8.5

“Have relationships with others changed? What has contributed?”

- **Changes in Relationships with Others**
  - **Communication**
    - “I’m more talkative and interactive. I’ve gotten more comfortable with people.”
  - **Boundaries**
    - “My boundaries have changed allot. I don’t tolerate as much. I noticed my boundaries are different for family versus strangers.”
    - “I’ve learned how to set boundaries with others. I’ve learned I have a right to boundaries. Others should respect mine, I don’t have to just abide by theirs.”
    - “I now know how to set personal boundaries on self and others. I learned more tolerance.”
  - **Mindfulness**
    - “I’m able to control myself more, by not feeling nauseous and not feeling scared when around others.”
Figure 8.6

“How has your relationship with yourself changed?”

Feelings and Body Awareness
- “I’m more aware of my feelings, myself, and have more intuition.”
- “I have more awareness of tension, body, muscles, and breathing.”
- “I’ve learned when your body is telling you something, you have to deal with it.”

Mindfulness
- “I’ve learned to respond to my body with my mind connected to my body, so I can deal with the issue, not just the physical aspects.”
- “I ask myself, Why are you feeling this? I have to find out why. I have done allot of self-examination.”
- “I now know how our physical body affects our emotional state.”
- “I’ve learned how to ground myself and breath, and know I can survive through it.”

Communication
- “I now know how to calm down and stand up for myself.”
- “I have learned to not worry about others’ feelings too much during confrontation. I am now able to confront others without worrying about their feelings.”

Figure 8.7

“What do you think was the least valuable part of therapy?”

Least Valuable Part of Therapy
- Packets
  - “Filling out the measures.”
- Verbal Aikido
  - “I didn’t get the Verbal Aikido. It’s allowing yourself be a door-mat.”
  - Contrasting statement: “I liked the Verbal Aikido. She put it into a physical. I could see it. That’s what is happening to us physically? I liked how she put it where we could see it.”
Discussion

According to the SES, GES, BAS, and PTSD Symptoms Scale the component appeared to have had a mild to profound impact on these women. All women who participated in the group component, according to the GES, received some benefit. This indicates they benefited greatly in regards to participation in group, having feelings of stability/instability, having the ability to express problems in front of the group, and having feelings of being understood, autonomous, and responsible. According to the SES and BAS, 6 of the 7 women on each measure had an overall increase in their self-esteem and self-acceptance, and an overall increase in feeling comfortable with one’s body. Overall, 4 of the 7 women had a decrease in PTSD symptomatology though, the level of symptomatology increased for 3 of the 7. By reviewing the CORE-OM, psychological distress increased for 4 of the 7 women. The facts are unknown in regards to the cause of increased psychological distress and PTSD symptomatology. However, Mind/Body Education group facilitator Ms. Lynda Jacobs postulates one reason could possibly be attributed to losing an essential component of their support system during their stay at Sojourners. According to Ms. Jacobs, a counselor who the women relied heavily on for support left her position at DVIS during the course of the Mind/Body Education Component. Some other sources for the increase in psychological distress and PTSD symptomatology are discussed below.

There are several key indicators found in the exit interview that the women learned new skills they can now integrate into their own recovery. In regards to body awareness, one woman spoke of how in therapy she first realized how tense her body was. Another stated they were able to feel their body, the tension, and recognize where the tension comes from. Women who participated in this group learned various skills including: grounding themselves; listening to their body; reacting to their body when feeling stressed with mind and body; controlling reactions within the body; awareness of feelings; communication (confrontation and setting boundaries with others); and setting boundaries with self. Overall, the women acknowledged several new skills that they have learned and have implemented into their own lives.

Due to various reasons the component did not reach its potential in its entirety. According to Ms. Jacobs and participants there were several possible reasons as to why the component did not reach its full potential. Time and consistency were two of the main issues that were presented throughout the Mind/Body Education Component as discussed below.

Issues of time

Ms. Jacobs expressed ‘issues of time’ being a concern for this group. According to Ms. Jacobs, “Once the psycho-educational component had been introduced, I desired time for experiential and then process.” Furthermore, she indicates, “There was little time allowed for participants to process the experiential component of sessions, which was a crucial part.” Furthermore, “Due
to a lack of time it was really difficult for the women to really come into their body.” According to Ms. Jacobs, reasons attributed to the cause of the inconsistent outcomes on measures were possibly due to the lack of time in sessions to administer measures. Ms. Jacobs had the women complete the measures outside of group immediately after sessions because in-session time was limited. Possible distractions may have occurred while the measures were being complete. Ms. Jacobs recommends separate sessions or longer session are set up for administering the measures, and to only have measures completed within the group.

Group members also expressed concerns regarding time. According to one group member, “There was not enough time during sessions to express self.” Another group member stated, “We would climax in group and then it would end.” Group members expressed clearly that if individual group sessions were longer, the group was extended in duration, or if there were just more sessions throughout the week, they would have benefited more from the Mind/Body Educational Component.

**Issues of Consistency**

Issues of consistency seemed to prevail for group members and for Ms. Jacobs. Two group members stated, “Group needed more consistency.” Many participants mentioned the group needed less disruption. Throughout the 12 week Mind/Body Educational Component, there were ice storms and holidays that hindered the group’s progress. A month of the mind/body therapy had been missed for these women due to these external circumstances. The month missed occurred between the 11th session and the final session, leaving the administration of final measures and exit interview taking place after a long break. According to Ms. Jacobs, women who missed group due to having other arrangements missed essential pieces of the component that hindered their progress in group. According to one group member, “People came in and out of session therefore; it was difficult for them to focus.” Furthermore, during the group a few participants had left Sojourners, one participant gave birth, and, as stated previously, one of their counselors had left their position at DVIS. All of these circumstances led to inconsistency within the group which hindered group progress and effectiveness. According to Ms. Jacobs, these circumstances possibly led to participants lacking trust and comfort within the group. Trust and feeling comfortable within the group is essential for group members to benefit from its entirety.

**Other Issues**

Confidentiality was another issue expressed by participants and by Ms. Jacobs. Participants expressed, “Things said outside of group needed to stay in the group and that did not happen.” Participants and Ms. Jacobs communicated that people continuously came in and out of group which caused the group to lose a sense of privacy. Another issue was that participants did not do home
practice and homework, possibly due to the nature of their lives. Ms. Jacobs stated, “The only time I had them was when ‘I had them’.” Moreover, since the group took place in a live-in facility, there were often living issues brought up with the women prior to sessions. These issues often established the topic for the evening, since the women had a strong need to discuss these issues in group.

Touch was another area of concern for the women. Touch is a sensitive issue for trauma survivors, particularly with those who have a history of physical and/or sexual violence. Because of their trauma, survivors are often disconnected from their bodies and tend to be rigid in regards to touch. Some trauma survivors go to the other extreme and function without healthy boundaries in regards to contact. A common trauma response to touch is to swing between rigidity and total lack of boundaries.

In this program, touch was introduced in the section on boundaries. The participants ranged in their responses to touch: some did not want to have anything to do with touch, except with their children; and some women were more comfortable with touch. There was only one exercise that used touch with a partner, in the form of offering support to learn grounding through the body (a verbal aikido exercise). One woman chose not to participate because she did not feel comfortable at all with touch. The exercise was demonstrated and discussed. This particular class did not have an opportunity to deeply explore safe and healthy touch, which could have been an entire class itself.

Implications

In the future, it is essential for facilitators, participants, and staff within the agency to ensure that confidentiality and a sense of privacy is established for group members of Mind/Body therapy. For trauma survivors, working through trauma and the body can be a strenuous process and an extremely sensitive area. Therefore, according to Ms. Jacobs, there is a “need for clear boundaries before group begins.” Clear boundaries must be set for all group members and staff within the agency. Moreover, Ms. Jacobs expressed “There is a need for private space and no interruptions.” Therefore, according to Ms. Jacobs, it would be important to eliminate all announcements made by the facility during group unless there is an emergency, to eliminate traffic coming in and out of group sessions, and for facilitators to ensure the group’s purpose stays on track. Ms. Jacobs also mentioned it would be beneficial for the facilitator to attend staffing at least once per month so they may be aware of what is going on with the women. Additionally, Ms. Jacobs expressed “The staff needs to be fully apprised on what the group is and its purpose so it will be supported by the greater whole.”

The women also expressed the biggest challenge for them was ‘touch’. Learning how to be comfortable with touch from oneself and being comfortable with touch from others is essential for recovery for these women. It will be important to be clear with group members the importance of the exercises including touch so they will understand its purpose. It will also be important to integrate the process of touching slowly so it will not overwhelm the women. Due
to the issues of time mentioned, it would be beneficial to extend group sessions to 2 hours, with 8 sessions.
References


Appendix A:
IRB Letter of Approval
August 16, 2007

Chad Johnson
Human Relations - OU Tulsa
4502 E. 41st Street
Tulsa, Ok 74135

RE: Mind/Body Education Component

Dear Dr. Johnson:

On behalf of the Institutional Review Board (IRB), I have reviewed and granted expedited approval of the above-referenced research study. This study meets the criteria for expedited approval category 6, 7. It is my judgment as Chairperson of the IRB that the rights and welfare of individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with the requirements of 45 CFR 46 as amended; and that the research involves no more than minimal risk to participants.

This letter documents approval to conduct the research as described:

IRB Application  Dated: August 15, 2007 Revised
Consent form - Subject  Dated: August 15, 2007 Revised
Letter  Dated: August 15, 2007 Letter of Recommendation Mclaughlin & Mosier
Survey Instrument  Dated: August 14, 2007 DVIS Mind/Body Component Exit Interview
Letter  Dated: August 14, 2007 Letter of Recommendation DVIS
Survey Instrument  Dated: August 14, 2007 Group Evaluation Scale (GES)
Survey Instrument  Dated: August 14, 2007 Trauma Center PTSD Symptom Scale
Survey Instrument  Dated: August 14, 2007 Traumatic Antecedents Questionnaire (TAQ)
Survey Instrument  Dated: August 14, 2007 Body Awareness Scale
Survey Instrument  Dated: August 14, 2007 CORE Outcome Measure Survey
Protocol  Dated: August 14, 2007
Letter  Dated: August 13, 2007 Support Letter DVIS Call RAPE

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form. All study records, including copies of signed consent forms, must be retained for three (3) years after termination of the study.

The approval granted expires on August 15, 2008. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with an IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request an IRB Application for Continuing Review from you approximately two months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB office at (405) 325-8110 or send an email to irb@ou.edu.

Sincerely,

Lynn Devenport, Ph.D.
Chair, Institutional Review Board

OU-Tulsa Center of Applied Research for Non-Profit Organizations
Mind/Body Education Component 2008
Appendix B:
Informed Consent
University of Oklahoma
Institutional Review Board
Informed Consent to Participate in a Research Study

Project Title: Mind/Body Component
Principal Investigator: Chad V. Johnson, Ph.D.
Department: Human Relations

You are being asked to volunteer for this research study. This study is being conducted at DVIS (Sojourners Inn). You were selected as a possible participant because you are a client of DVIS and it is believed you may find this program beneficial to your healing and growth.

Please read this form and ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study
The purpose of this study is:

This study is being conducted to evaluate the effectiveness of a new service that DVIS is considering implementing on a broader scale. The goal is to promote healing from the traumatic effects of domestic violence or sexual assault. It involves individual and/or group interventions depending on each participant’s needs. The nature of the intervention will be explained to you in detail by Lynda, but entails experiential work combined with education to support understanding of trauma and its impact on our bodies, relationships, and lives. For example, you may be asked to mindfully focus on sensations in your body as they relate to current or past experiences. You may also be asked to experiment with different physical movements or positions as a way to access bodily resources and data. Of course, you are free to decide not to participate in the overall study, treatment, or particular techniques or exercises at any time.

Number of Participants
About twelve people will take part in this study.

Procedures
If you agree to be in this study, you will be asked to do the following:

You will be asked to fill out a survey describing your symptoms, treatment experiences, and bodily awareness before, during and after treatment for a total of 4 times. It takes a total of about 30 minutes to complete the surveys. Your responses will remain private and it is important that you complete the surveys as accurately and as honestly as you can. The information you provide from these surveys will be linked to other information (e.g., socio-demographic information) you have provided DVIS during your intake. However, your name, address or other identifying information will not be connected to these surveys. Finally, you will be asked to complete an exit interview with Chad.
Johnson within the first few weeks after completing the intervention. This interview will seek more detail about your experiences with the intervention.

**Length of Participation**
This component is a planned 12-week program.

**This study has the following risks:**
The surveys ask questions of a personal nature regarding your health and well-being. Some of the questions ask about things that you may not like about yourself or that others may not like about you. Answering these questions may make you feel a bit uneasy. No matter how you answer these questions, however, no harm or loss of services will come to you, so please be as honest and as accurate as possible. Your responses will not in any way affect the treatment you are receiving at DVIS. Neither the surveys nor the exit interview will ask you personal details about the painful experiences you have encountered.

**Benefits of being in the study are**
The Mind/Body Component is designed to help you heal and deal better with traumatic experiences and their effects. Filling out the surveys may help you understand yourself better and will allow DVIS and the therapeutic community evaluate new approaches to healing the effects of trauma.

**Confidentiality**
In published reports, there will be no information included that will make it possible to identify you without your permission. Research records will be stored securely and only approved researchers will have access to the records.

There are organizations that may inspect and/or copy your research records for quality assurance and data analysis. These organizations include the OU Institutional Review Board.

**Compensation**
You will not be reimbursed for you time and participation in this study.

**Voluntary Nature of the Study**
Participation in this study is voluntary. If you withdraw or decline participation, you will not be penalized or lose benefits or services unrelated to the study. If you decide to participate, you may decline to answer any question and may choose to withdraw at any time.
Audio Recording of Study Activities
To assist with accurate recording of participant responses, interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. Please select one of the following options.

I consent to audio recording.  ____ Yes  ____ No.

Video Recording of Study Activities
To assist with accurate recording of your responses, interviews may be recorded on a video recording device. You have the right to refuse to allow such recording. Please select one of the following options:

I consent to video recording.  ____ Yes  ____ No.

Contacts and Questions
If you have concerns or complaints about the research, the researcher(s) conducting this study can be contacted at (918) 660-3377 or email: cvjohnson@ou.edu. Contact the researcher(s) if you have questions or if you have experienced a research-related injury.

If you have any questions about your rights as a research participant, concerns, or complaints about the research and wish to talk to someone other than individuals on the research team or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu.

You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.

Statement of Consent
I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

Signature  Date
Appendix C:  
EAC Scales and Factors
Expectations about Counseling-Brief Form

Scales and Factors

The EAC includes 18 scales that are included in the factors: Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance. A total of 66 of the 71 questions consisted of questions related to the scales below. After scores were calculated, they were averaged into their one of the four factors for a final score.

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<thead>
<tr>
<th>Personal Commitment</th>
<th>Facilitative Conditions</th>
<th>Counselor Expertise</th>
<th>Nurturance</th>
</tr>
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<tbody>
<tr>
<td>Responsibility</td>
<td>Acceptance</td>
<td>Directiveness</td>
<td>Acceptance</td>
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<td>Openness</td>
<td>Confrontation</td>
<td>Empathy</td>
<td>Self-Disclosure</td>
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<td>Outcome</td>
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</table>
Appendix D:
Mind/Body Education Component Group Sessions
SESSION #1

Getting Clear

• Go over the orientation meeting

• Body resource to help “get us here”

• Getting clear: Setting our intentions – individually and as a group

• Holding vision and intention together

• Awareness and Mindfulness: discussion and practice

• More on grounding

• Homework

• Assessments
SESSION #2

Understanding Trauma

• Review body resources
  1. Grounding: through the feet, through the back
  2. Breathing

• Review mindfulness and awareness

• Review and refine intentions
  1. Flush out intentions (see attached sheet)

• Discussion about trauma
  1. Understanding causes and symptoms
  2. Checklist of your own symptoms of trauma
  3. Purpose of symptoms

• New body resource: containment with arms

• Homework: Identifying symptoms and how you met them
SESSION #3

Experiencing Our Bodies

- Brief Review and Check-In

- Body Resources for Session #3
  - Breathing
    - Sensations: Learning the Language of the Body

- Experiential work with breathing

- Experiential work with Sensations
  - Mindfulness exercise with sensation
  - Drawing the body

- Homework
  - Continue from last week.
  - 5-minute/day calming check-in using breathing, containment, and ‘coming home’ to your body – however that feels good to you

- Research assessments
SESSION #4
Boundaries: Part 1

- Check In: Awareness and skills used

- Body massage and self touch using mindfulness

- Body resource for Session #4 -- Boundaries: Part 1
  - The ability to say “NO”
  - Verbal Aikido exercise

- Action plan
  - Discovering your ability to say “NO”
SESSION #5
Boundaries: Part 2

• Check In: What skills/resources are working for you?

• Body resource for Session #4 – Boundaries: Part 2
  o Verbal aikido and boundaries
  o Boundary styles and habits
  o Healthy boundaries

• Action plan
  o Identify your boundary style(s) in different situations

**For next session: Bring an issue with boundaries that is happening present time in your life.
SESSION #6

Review

• Brief check-in

• Educational piece about boundaries styles and habits

• Experiential exercise
  o Finding your ground (ground gets lost in trauma; finding ground helps maintain balance)
  o Tracking sensations (sensations get stuck in trauma and are not flowing or fluid)
  o Establishing a boundary (boundaries get lost in trauma; making and sustaining boundaries is key in helping create a sense of safety)

• Action plan (see action plan for session #5)

• Assessments
SESSION #7

Review

• Boundary review and discussion

• Review of intentions

• Feedback and discussion
SESSION # 8
Tracking sensations

• Integrating traumatic experience

• Review mindfulness in Session #1

• Review symptoms of trauma in Session #2

• Review sensations in Session #3

• Body resource: Tracking sensations and feeling the shifts
  o Experiential work with sensations
SESSION #9 & #10
Understanding & integrating traumatic experience

• What happens after a traumatic event

• The traumatized part of the personality
  o Fight
  o Flight
  o Freeze
  o Submit
  o Attach

• Survival responses versus creative responses

• Experiential exercises
SESSION #11
Reenactment

- Progressive relaxation exercise
- Check-in
- Reenactment
- Discussion about how reenactment can and does show up
- Working with awareness throughout the discussion
- Talk about final group meeting
SESSION # 12
Completion

- Mindfulness exercise: connecting with your body

- Closing circle
  - Revisiting intentions
  - Group process and sharing
  - Integrating skills in daily life

- Completion of assessments