Healing the Whole Self: Exploring the Development and Evaluation of a Community-Based, Culturally Competent and Evidence-Informed Group Therapy for Women Survivors of Intimate Partner Violence

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Abstract

Research has demonstrated that mental health interventions for women who have experienced intimate partner violence are lacking. Moreover, mental health interventions are generally not adapted or developed for culturally diverse peoples, and therefore may be ineffective and potentially re-traumatizing. Conceptualizations of health, well-being and illness are often Western and Eurocentric, and may marginalize other ways of knowing. While this is not the case for all diverse individuals who engage in therapy, the research literature has suggested that it may be the case for many. As such, the current project proposed to develop a culturally competent group mental health intervention for women in northwestern Ontario who are surviving the emotional and psychological effects of intimate partner violence. Considering the limited number of such interventions, and the paucity of outcomes research, a scoping review was completed of mental health interventions for women of colour survivors of intimate partner violence (Chapter Two). This also included engaging with community members in Thunder Bay, Ontario to gather information about the needs of this particular population (Chapter Three), and integrating this information with best practices for working with typical psychological/emotional consequences of intimate partner violence, creating the Healing the Whole Self model (Chapter Four and Therapy Manual). After the model was developed, it was implemented and evaluated at a community mental health centre in Thunder Bay, Ontario (Chapters Five and Six), and the model was disseminated at a full-day training workshop (Chapter Seven). This dissertation depicts a process of community-based research initiated to fill a gap in services, ensuring quality and effectiveness of services, and examining other such services to gain a better understanding of culturally-based and –competent practices.

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My conceptualization of intimate partner violence in the context of cultural competence has been supported and guided by my many community partners. This project would have been impossible with them. I am constantly inspired by the tireless ways in which they work to serve and support women, and themselves. The strength, resilience, dedication, and passion that is consistently demonstrated through their work is something to aspire to.

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Community can be defined in so many ways. For me, this project was a true collaborative effort, and while we call it “my” dissertation, it belongs to all those who contributed, and to all those who will continue to shape this work.

Thank you to everyone who has done, is doing, and will do this work.

Preamble

While dissertations in Psychology often do not include personal information, I feel it necessary to make my motivations for this project explicit. I have generally been interested in the area of intimate partner violence. While I cannot pinpoint when exactly this interest came into my awareness, during my first year of my undergraduate degree, I volunteered with a sexual assault crisis line. It was in doing this work that I came to learn about the many difficulties that individuals can face in relation to intimate relationships. This experience is likely strongly linked to my research and clinical interests in the area of intimate partner violence. Immediately after my undergraduate degree, I had the opportunity to work on two different First Nations reserves in Northern Ontario. While I was running literacy camps for youth, I had the opportunity to connect and learn from the youth, and many of the mothers in the communities. Something that became uncomfortably apparent to me were the lack of resources and the matter-of-fact nature with which many individuals discussed experiences of violence. It was with this realization that I began to want to gain a deeper understanding of why this might be, and what I can do about it. For those who know me well, many would call me an idealist. However, it was through my Masters in International Development Studies that I came to understand how my wanting to "fix" things could be quite problematic, and without a critical understanding of my intentions and actions, I would likely cause more harm. It was for the thesis for this degree that I completed a critical content analysis of the intersectional factors related to Aboriginal women's experiences of intimate partner violence. I learned that: 1) it is complicated; 2) there is nothing that I can do as an individual; 3) "changing" this with one sweeping solution was not going to be possible; 4) the way the literature discusses Aboriginal women, communities, and their "problems" often does not account for socio-political factors or pays lip service to these factors, is victim-blaming, and does not address strengths and resilience. I still had the desire to do something, but I learned that I was not going to be an expert on the lives of people who were not myself. As such, it was going to be essential for me to work with the very people I wanted to help.

My original hopes for this dissertation were to better understand the resilience of First Nations women survivors of intimate partner violence. However, this seemed a one-sided exchange, as those who were sharing their knowledge and experiences with me would not necessarily receive anything meaningful in return. Upon further reflection of what would make this exchange more reciprocal, I realized that I was gaining clinical skills that may be helpful to some women, especially considering the lack of resources. This was not intended to be provided to all women who wanted to participate, but to those who would find this kind of help beneficial to their healing. This new desire to provide clinical services as a way of showing gratitude was the last step before the evolution of the Healing the Whole Self group therapy. With Healing the Whole Self, I sought to facilitate the process of a needs assessment to find out what the community has, needs, and what Indigenous women want from service providers, and to attempt to meet their needs, while consulting with them at almost every step. As can be seen through this dissertation, my original intention was not quite realized. I had difficulties partnering with organizations, and the demographics of the individuals with whom I conducted the needs assessment (with an intentional desire to speak with Indigenous women in Thunder Bay) were not the same as those who ended up participating in the Healing the Whole Self program. While this is an unfortunate setback to the project as a whole, the way through which the project was developed allowed it to be honouring of all cultures through culturally-competent approaches, and actively integrated feedback received from clients as much as possible.

The purpose of this preamble is not to demonstrate my authority on this subject, or to suggest that my intentions with this project are free of the role of my privilege within it. However, recognizing my privilege, and my role as outsider, it felt essential for me to make my process and intentions clear.

Chapter One: Introduction

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Chapter One: Introduction

Surviving intimate partner violence can lead to a myriad of health consequences (Campbell, 2002; Lafta, 2008; World Health Organization, 2008). The consequences of physical violence may be more noticeable and may lead to earlier and easier recognition of a woman's experience of abuse; emotional, sexual, psychological and spiritual violence are often more insidious and may continue for years before being acknowledged, by the survivor or anyone else. Regardless of the form of violence, many women may experience negative effects to their mental health as a result of violence and abuse (Campbell, 2002; Dutton et al., 2006; Jordan, Campbell, & Follingstad, 2010; Lafta, 2008). These consequences may be amplified for women who belong to marginalized communities (including women of varying ethnicity, ability, sexual preference, and religious affiliation), as they may experience oppression and victimization in other areas of their lives (Oetzel & Duran, 2004), and these interact in affecting their mental health.

Unfortunately, services are underdeveloped for women survivors of intimate partner violence, and most focus on perpetrator rehabilitation or crisis intervention for the survivor (e.g., shelters; American Psychological Association, 2001; Brosi & Rolling, 2010; Warshaw, Sullivan, & Rivera, 2013). In Canada, while there is funding made available to victims of violence to access psychological services (e.g., Victims Services), services have often been found to be inappropriate for survivors of violence, and emphasize use of the biomedical model (Canadian Women's Health Network, 2009). Moreover, to be able to access funding through the government as a victim of violence, the crime must be reported to the police (Canadian Resource Centre for Victims of Crime, 2016), which may serve as a deterrent from accessing such services. As may be expected, this is even more so the case for women who experience marginalization (Bent-Goodley, 2005; Gondolf & Williams, 2001; Lester-Smith, 2013; Serrata,

2012). It has been argued that this is the case because diverse and marginalized women (including women of colour) are very seldom the focus of intimate partner violence research (Gillum, 2002; Hampton, Gelles, & Harrop, 1989; Serrata, 2012; Thomas, 2000).

Diagnoses of mental illness or extremely high levels of distress may facilitate one's access to mental health services in Canada (Sunderland & Findlay, 2015). A diagnostic label may not fully capture a survivor's experience, as diagnostic labels may be interpreted as reductionistic, and further marginalizing (van Den Tillaart, Kurtz, & Cash, 2009). Some research has demonstrated that repeated exposure to traumatic events (e.g., intimate partner violence, torture) can lead to different clinical presentation than exposure to single event traumatic events (e.g., car crash), and may warrant a different approach to treatment (Herman, 1992). Individuals from diverse and often marginalized communities have argued that the diagnostic system is Eurocentric, and may be oppressive and pathologizing (Fellner, 2014). In an effort to respect the complex effects of intimate partner violence, and how diverse identities and experiences of marginalization may interact with an individual's experiences, interpretation, and reaction to intimate partner violence, diagnostic labels will not be used in this study when describing the effects of violence. Instead, the focus is on each individual's experience of intimate partner violence and her interpretations of the effects of the violence on her.

The aims of this dissertation were a) explore the development, structure and outcomes of interventions developed for culturally-diverse survivors of intimate partner violence; b) to better understand experiences of intimate partner violence among women who experience marginalization, using the specific case of Indigenous women in Thunder Bay, Ontario; c) create and evaluate a culturally competent and evidence-informed intervention to attempt to best

support these women—essentially filling a gap in knowledge and services; and d) disseminate this intervention to community organizations.

Language and Definitions

Intimate Partner Violence. While many studies use the terms *domestic violence*, *spousal abuse*, *wife beating* and *intimate partner violence* interchangeably, the focus of this study is on violence experienced by an intimate partner (i.e., boyfriend/girlfriend, husband/wife, common-law partner) while being in that intimate relationship. Terms such as *domestic violence, spousal abuse* and *wife beating* necessitate a legally bound relationship between the two individuals or a co-habiting relationship. These are not the only conditions in which partner violence can occur (American Psychological Association [APA], 2001), and thus the more all-encompassing term *intimate partner violence* will be used. This term also encompasses the other terms; thus, information about wife beating, spousal abuse and domestic violence (with specific reference to male violence against women) would all be considered intimate partner violence. Data that refer to terms such as "spousal abuse", for example, are still referring to intimate partner violence, however, are only referring to one form of this violence, and do not represent all those experiencing this form of violence.

According to the Centres for Disease Control and Prevention (2009, n.p.), intimate partner violence can include "physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy". Furthermore, they state that intimate partner violence "can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may

not impact the victim to chronic, severe battering" (Centres for Disease Control and Prevention, 2009, n.p.)[1].

The Centres for Disease Control and Prevention (2009) further describe the types of violence that can occur. They describe physical abuse as intentional use of physical force to potentially cause death, disability, injury, or harm. Types of physical violence can include, but are not limited to: biting, slapping, throwing, shoving, pushing, scratching, grabbing, choking, shaking, punching, burning, use of a weapon, and/or use of one's body size, strength and/or weight to control the other individual. Sexual violence can be divided into three categories: 1) the use of physical force to compel someone to engage in a sexual act against his or her will (whether or not the act is actually completed); 2) attempted or completed sexual act in which one of the partners is unable to understand the nature or condition of the act, unable to decline participation, or unable to communicate unwillingness to participate in the act; and 3) abusive sexual contact. Threats of physical or sexual violence can include the use of words, gestures or weapons to communicate the intention of causing death, disability, injury or harm. The last type of violence described is psychological/emotional violence. This can involve trauma to the victim caused by acts, threats of acts, or coercive tactics.

Survivor. Much literature wavers between the uses of the terms "victim" and "survivor" in describing women who have experienced violence. The term "victim" can often suggest that

[1] Many studies use the terms domestic violence when they are referring to partner abuse, but are specifically referring to cohabiting intimate partners (and therefore domestic partners). I will solely use the term intimate partner violence when discussing this type of violence, as well as intimate partner violence occurring in non-cohabiting relationships. Only studies that provide similar definitions of domestic violence as the definition of intimate partner violence provided by the Centres for Disease Control and Prevention (2009) will be used, so as to ensure that it is the same type of violence that is being referred to throughout the study. I chose not to use the term domestic violence as this excludes non-cohabiting partners but also because it can refer to violence occurring in a domestic environment that is not between intimate partners (ex. parent-child violence).

the individual experiencing the violence was passive in the interaction (Brosi & Rolling, 2010). Moreover, many women have expressed that the term "victim" can then become part of their identity, which may be undesirable (Parker & Mahlstedt, 2010). While the intention is not to undermine the experience of violence and the suffering this likely caused, the model of the intervention being discussed is founded on empowerment and healing. Thus, to continue to consider women as victims does not provide the space for them to grow from their experiences—to not always be victims. Moreover, the term "survivor" acknowledges strength and agency in getting through the violence. Even if women are currently in an abusive relationship, daily survival symbolizes one's ability to survive adversity. Thus, the term "survivor" will be used to describe women who have experienced intimate partner violence. This choice in language should not simply be a substitute of one word for another, but should reflect a shift in how women and their experiences are conceptualized.

Diversity and cultural competence. Diversity can be conceptualized in a variety of ways. For the purposes of this research, diversity is about the individual, and her unique dimensions, qualities, and characteristics (Canadian Centre for Diversity and Inclusion, 2015). While ethnicity is often thought to be a determining factor of diversity, it is but one. Thus, throughout this dissertation, diversity will be understood to exist within every individual. Similarly, culture exists within all people, not just those thought to be diverse. This dissertation makes the argument that culturally competent skills must be used with all clients, not just those a clinician determines to be different from herself. The American Psychological Association (2002, p. 11) uses the term "culture-centred" and describes this as a recognition that "all individuals, including themselves, are influenced by different contexts, including the historical, ecological, sociopolitical, and disciplinary", and that training and interventions should

acknowledge these differences. This fits with the researcher's conceptualization of culture and diversity existing in everyone, not just in others. A preferred definition of cultural competence is: A system that acknowledges the importance of and incorporates culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs at all levels of service (Whaley & Davis, 2007, p. 564). While this is discussed in more detail in Chapter Two, self-awareness, cross-cultural awareness, and educating oneself are at the crux of this definition. It is in recognizing one's own culture that one can begin to understand the culture of another, as well as the cross-cultural relationship.

Theoretical Framework

Theory of intersectionality. Theories of intersectionality consider that one's experience is not solely from one lens. Theories of intersectionality emerged from the writings of women of colour and encourage inclusivity of a broader group of women in their analysis of gender and definitions of feminism (Samuels & Ross-Sheriff, 2008). As Samuels and Ross-Sheriff (2008, p. 5) explain, "intersectionality enables us to stretch our thinking about gender and feminism to include the impact of context and to pay attention to interlocking oppressions and privileges across various contexts". Crenshaw (1997) further asserts that individuals are silenced as much when they appear within the margins as when they do not appear at all. Such approaches acknowledge that there is no universal collective experience of "woman", and that continuing to marginalize identities is oppressive and silencing (Crenshaw, 1997; Samuels & Ross-Sheriff, 2008).

One way through which this can be achieved is by taking a social ecological approach to understanding intersectionality. This approach suggests that different levels of interactions take

place to create unique situations; in order to understand the situations, these different levels must be understood. Recognizing that it is rarely one single factor, but many interconnected factors that influence the shape of a problem (Heise, 1998), multilevel theorizing allows a focus to be placed on an understanding of concepts of multiple levels, as well at between the different levels (Oetzel, Ting-Toomey, & Rinderle, 2006). This creates a "rich, layered picture of the phenomenon under study [and fosters] synthesis and synergy, [creating] links and loops where there were none before" (Oetzel et al., 2006, p. 728). Oetzel and Duran (2004) suggest five levels of interaction that influence the conditions and experiences of intimate partner violence. These levels are: *individual*; *interpersonal*; *community*; *institutional/organizational;* and *policy*. Without considering how these layers interact, with an understanding that each woman's experience differs at each level, one's approach to understanding the experience of intimate partner violence is oversimplified.

Through recognition of the multiple layers of influences surrounding the occurrence of intimate partner violence, a more holistic understanding of intimate partner violence can be achieved. It is therefore in looking at all these aspects that a more complete understanding of one's experience of intersectionality can be assessed. Bograd (1999) states that intersectionalities:

> color the meaning and nature of domestic violence, how it is experienced by self and responded to by others, how personal and social consequences are represented, and how and whether escape and safety can be obtained...From this perspective, intersectionality suggests that no dimension, such as gender inequality, is privileged as an explanatory construct for domestic violence, and gender inequality itself is modified by its intersection with other systems of power and oppression. So, for example, while all men

> who batter exercise some form of patriarchal control, men's relationship to patriarchy differ in patterned ways depending on where they are socially located. While all women are vulnerable to battering, a battered woman may judge herself and be judged by others differently if she is white or black, poor or wealthy, a prostitute or a housewife, a citizen or an undocumented immigrant (pp. 276-277).

While exploring intersectionality can offer a multilayered and rich understanding of one's experiences of oppression, approaches of intersectionality can be extremely complex and may miss different experiences of oppression as well (Spelman, 2001). To tokenize and acknowledge forms of oppression without critically understanding how such levels interact with each other to affect an individual is to do injustice to such approaches (Crenshaw, 1997). Moreover, dividing layers of experience into separate categories may suggest that these experiences are not related (Spelman, 2001). However, this is largely dependent on the researcher and how such theories are used. The current project focuses on understanding such oppressions, and integrating them within the healing process. Therefore, it is hoped that the tokenization of the complexity of oppressions will not occur throughout this project.

Evidence-based practice. Evidence-based practice involves the explicit and conscientious use of the best evidence in making decisions related to clients (Spring, 2007). The APA Task Force further defined evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (American Psychological Association, 2005, p. 1).

Spring (2007) outlines a three-legged stool model to allow for better understanding of how evidence-based practice can be conceptualized more practically. She points to the best available research evidence as the first leg of the stool. This involves research that is well-

constructed with outcomes that are well-defined and methods that meet the needs of the question being asked. The next leg is clinical expertise, and this involves the clinician demonstrating characteristics such as warmth and empathy—characteristics that have been demonstrated to make therapy more effective, regardless of theoretical orientation. Clinical expertise is not to be understood as the clinician having the expertise to conduct therapy how she or he sees fit, as this would directly contradict the first leg's focus on using the best available research evidence. However, it is also important for clinicians to work within their realm of expertise, meaning that they should only deliver interventions in areas where they have established competency. Lastly, patient preferences balance out the model as the third leg of the stool. Patient preferences offer space for shared health decision-making, where clients have the opportunity to voice their preferences and needs, and have them met, within the therapeutic model. This also involves clinicians who are more culturally competent, in order to be able to better understand the needs of their clients. As has been demonstrated through research with Indigenous individuals, without a consideration of patient characteristics, and in somewhat blindly administering an intervention to a population, therapy may not be effective and may cause harm (McCabe, 2007). Such findings have been replicated with other groups of diverse individuals, where, at best, the effectiveness of interventions have not been assessed, and, at worst, the use of such interventions may be ineffective or harmful (Gillum, 2002; Hampton et al., 1989; Serrata, 2012; Thomas, 2000). Thus this third leg of the stool is as important as the other two.

The importance of evidence-based practice cannot be stressed enough. With current technologies, methods and knowledge available to adequately inform practice, it is unethical for clinicians to engage in the therapeutic process without being informed of what best therapies are for certain disorders; of how the clinician's therapeutic model, skills and characteristics can

affect therapy; and of how to incorporate the needs and preferences of the client into the therapeutic model. This is the underlying foundation of how the current mental health intervention is to be developed.

Some research has suggested recommendations of how evidence-based practices can be modified to be more relevant to the target population. For example, Hays (2009) provided a framework for providing culturally responsive cognitive behavioural therapy:

1. Assess the person's needs with an emphasis on culturally respectful behaviour
2. Identify culturally related strengths and supports
3. Clarify what part of the problem is primarily environmental (i.e., external to the client) and what part is cognitive (internal), with attention to cultural influences[2]
4. For environmentally-based problems, focus on helping the client to make changes that minimize stressors, increase personal strengths and supports, and build skills for interacting more effectively with the social and physical environment
5. Validate the client's self-reported experiences of oppression
6. Emphasize collaboration over confrontation, with attention to client-therapist differences
7. With cognitive restructuring, question the helpfulness (rather than the validity) of the thought or belief
8. Do not challenge core cultural beliefs
9. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones

[2] This is especially important in working with women who are surviving intimate partner violence, as they may experience cognitively skewed perceptions of reality, but there are external aspects of their lives that are distressing as well. How these two are balanced and discussed is a very sensitive matter and should be approached as such.

10. Develop weekly homework assignments with an emphasis on cultural congruence and client direction

By including such steps, it is hoped that clinicians can be more culturally sensitive, but also appreciate clients' culture as a strength, rather than something that needs to be accommodated for or tolerated.

Other research suggests that culture must be at the centre of the healing process, as it is through the elimination of culture (through colonization and assimilation) that trauma occurs (Archibald, 2006). For example, the Assembly of First Nations (2007) suggests that successful Indigenous health programs should include projects that tend to be tradition- and values-based, interventions that focus on the entire family, and projects that respond to the needs of the community. Moreover, links should be made between spirituality and therapy, there should be an intimate knowledge of the tribal community and a drawing together of traditions, and the community should support healing and recovery.

Community-based research methods. One way through which intersectionality can be integrated with evidence is by using community-based research methods. Community-based research is the co-construction of research, and is thought to strengthen the relations between the community and academia (Jagosh et al., 2012). There is a recognition that mental health is complex, and a single discipline or perspective will likely be insufficient to understanding the needs of others (Schensul et al., 2006). Moreover, such approaches provide opportunity for a variety of perspectives of wellness, healing, and allow for community-derived understandings of the consequences of violence. Roche (2008) explains that this form of research provides a platform to explore and creates opportunities for social action and social change. This can

provide insight into the health and health disparities of disadvantaged or marginalized populations (Roche, 2008).

Israel, Schulz, Parker and Becker (1998, pp. 178-180) outline key principles of community-based participatory research:

1. Recognizes community as a unit of identity.
2. Begins with and builds upon strengths and resources within the community.
3. Facilitates collaborative, equitable partnerships in all phases of the research, involving an empowering and power sharing process.
4. Integrates and creates a balance between knowledge generation and action for mutual benefit of all partners.
5. Promotes co-learning and capacity building among all partners involved.
6. Involves system development through cyclical and iterative process.
7. Emphasis on local relevance of public health, social problems and ecological approaches that address the multiple determinants of disease and well-being.
8. Disseminates findings to all partners and involves all partners in the dissemination process.

McIntyre (2008) demonstrates that following these steps may not always be easy to follow, and what participation and collaboration look like in community-based research should be decided upon by stakeholders.

Purpose and Structure of Dissertation

The current dissertation was developed through an integration of the three theoretical frameworks. More specifically, this project was guided by an understanding of needs and gaps in service, by collaborating with community stakeholders, and by integrating this information with

evidence of best practice within the literature. As there is a limited number of psychological interventions for marginalized women who are surviving the psychological effects of intimate partner violence, a scoping review of such interventions for ethnically diverse women was completed. This scoping review demonstrated the lack of research in the area, as well as some common themes amongst them, including using a community-based approach.

The Healing the Whole Self model is meant to be culturally competent and evidence-informed, and was developed in response to the needs identified within the community of Thunder Bay, Ontario. This needs assessment (Strand, Maurullo, Cutforth, Stoecker, & Donohue, 2003; Tremblay, 2009) was focused on Indigenous women survivors of intimate partner violence, as research has demonstrated that this population's experience of violence is particularly severe and frequent (Government of Canada, 2008; Lane, Bopp, & Bopp, 2003; LaRocque, 1994; Statistics Canada, 2006), and there are a high number of Indigenous peoples living in Thunder Bay (Statistics Canada, 2011). Focusing on a specific group of women allowed for an in-depth exploration of the many factors in their lives that may contribute to their experience of violence, thus facilitating an intersectional approach. The Healing the Whole Self group therapy was then implemented at a community organization in Thunder Bay, and was assessed for outcomes.

In order to ensure multiple methods of and accessible dissemination of the group therapy model (Strand et al., 2003), a training workshop was hosted at Lakehead University, in Thunder Bay. This workshop was intended to train service providers on the model, so that they could use it and/or adapt it for their client populations. This dissemination strategy a) taught community members about the model; b) ensured that the findings from this research were communicated and thus not lost; and c) aimed to build the capacity of the community by teaching about

cultural-competence, trauma, and the new therapeutic strategies. It was hoped that in training service providers, this would indirectly benefit survivors of intimate partner violence who are seeking therapy.

The dissertation includes eight separate chapters, including this introduction and a conclusion, as well as the Healing the Whole Self therapy manual. Chapter Two is a scoping review of culturally-based psychological interventions for working with survivors of intimate partner violence. Chapters Two to Seven include a preamble, a bridging text that helps readers situate the specific chapter within the larger program of research. Chapter Three describes the purpose, method, and findings from the needs assessment conducted with and for Indigenous women living in Thunder Bay. Chapter Four integrates the findings from the needs assessment with best practices for working with trauma. Chapter Five is an evaluation of the Healing the Whole Self manual using a case study approach. Chapter Six describes the quantitative outcomes of the Healing the Whole Self therapy, including change in quality of life, posttraumatic stress, depression, and anxiety symptoms, and stress. Chapter Seven describes the community-based dissemination process of the training workshop and some of its outcomes. Lastly, Chapter Eight, the conclusion, provides final insight and reflection, and contextualizes all of the parts of this project within a broader program of research. The Healing the Whole Self therapy manual illustrates the step-by-step approach to implementing the therapy, so that this program can be run easily. While the therapy is structured similarly to a manualized treatment protocol, it is meant to be used as a guide—the priority should be meeting the needs of one's clients.

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Chapter Two:

Integrating Culture and Evidence: A Scoping Review of Culturally Competent Psychological Interventions for Female Survivors of Intimate Partner Violence

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Preamble

This paper was written to demonstrate interventions developed or adapted for working with diverse/non-Caucasian non-European ethnic populations. For this project, diversity could have been conceptualized in many ways. From the perspective of the theoretical framework of the larger dissertation, the researcher understands all peoples to be diverse, regardless of whether their identities conform to the majority demographics of a specific location and/or community. The researcher chose to use ethnic diversity (i.e., women of colour) because this is often the most visible representation of diversity. This review allows readers to reflect on programs and interventions that were developed for women of colour, including their outcomes.

Abstract

The American Psychological Association has advocated for evidence-based practice, including the consideration of patient characteristics, and have directed clinicians to improve psychological services for women survivors of intimate partner violence. This is especially the case for women of colour, who are more likely to experience severe violence, experience barriers to accessing services, and feel dissatisfied by such services. A scoping review was conducted to better understand culturally competent and/or adapted psychological interventions for women survivors of intimate partner violence. Nine interventions were identified, describing a diversity of intervention models and evaluating a variety of outcomes. This review demonstrates the limited number of interventions with evaluations, some of the common approaches to developing interventions, and how definitions of well-being vary.

Chapter Two:

Integrating Culture and Evidence: A Scoping Review of Psychological Interventions for Women of Colour Survivors of Intimate Partner Violence

Until recently, very little attention had been devoted to women of colour surviving intimate partner violence (Gillum, 2002; Hampton, Gelles, & Harrop, 1989; Serrata, 2012; Thomas, 2000). Psychological interventions for ethnically diverse women who have experienced intimate partner violence are, for the most part, even more limited, and have not proven to be effective in helping treat the emotional and psychological consequences of violence. This is, in part, due to the fact that most psychological interventions, in general, were not developed for ethnically diverse individuals, and therefore may not the most suitable for these populations (Bent-Goodley, 2005; Gondolf & Williams, 2001; Lester-Smith, 2013; Serrata, 2012). Moreover, of the psychological interventions that have been developed for women of colour or ethnically diverse individuals, the minority of these are evidence-based and have been empirically supported (Davis et al., 2009; Gone & Alcántara, 2007). Many interventions related to intimate partner violence focus on rehabilitating the perpetrator of violence, and few focus on the repercussions of violence for the survivor (Brosi & Rolling, 2010). Thus, women are often left to heal from the consequences of violence on their own, with the often limited resources that they have.

Intimate Partner Violence

According to the Centres for Disease Control and Prevention (2009, n.p.), intimate partner violence can include "physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy". Furthermore, they state that intimate partner violence "can

vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering" (Centres for Disease Control and Prevention, 2009, n.p.).

Psychological consequences of intimate partner violence. Exposure to intimate partner violence has been associated with elevated levels of posttraumatic stress disorder; depression; anxiety; feelings of shame and guilt; phobias and panic disorders; poor self-esteem; alcohol and drug misuse; and suicidal behaviour and self-harm (Campbell, 2002; Dutton et al., 2006; Jones, Hughes, & Unterstaller, 2001; Jordan, Campbell, & Follingstad, 2010; Lafta, 2008; World Health Organization, 2008). However, most of this research has been conducted with culturally homogeneous populations (Gillum, 2002; Hampton, Gelles, & Harrop, 1989; Serrata, 2012; Thomas, 2000), and research has demonstrated that the effects of exposure to violence may be unique for diverse populations (Gillum, 2008; Puchala, Paul, Kennedy, & Mehl-Madrona, 2010; Serrata, 2012). This may especially be the case when specific populations are mistrustful of mainstream services and police, or have had difficulties or negative experiences accessing services (Bent-Goodley, 2005). Moreover, efforts to fit diverse individuals into Western models of psychopathology may be oppressive (Fellner, 2014).

Cultural Competence and Psychological Interventions for Women of Colour

The American Psychological Association (2005) has asserted that patient preferences must be considered in the implementation of evidence-based practice. Patient preferences offer space for shared health decision-making, and involves a consideration of client characteristics—including cultural diversity. There are several different definitions for cultural competence, including:

a) The ability to obtain positive clinical outcomes in cross-cultural interactions (Lo & Fung, 2003).
b) Possession of cultural knowledge and skills of a specific culture, in order to deliver effective interventions to members of that culture (Sue, 1998, p. 441).
c) A system that acknowledges the importance of and incorporates culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs at all levels of service (Whaley & Davis, 2007, p. 564).

The American Psychological Association (2002, p. 11) uses the term "culture-centred" and describes this as a recognition that "all individuals, including themselves, are influenced by different contexts, including the historical, ecological, sociopolitical, and disciplinary", and that training and interventions should acknowledge these differences. Within this acknowledgment may also include addressing issues of social justice and responsibility (American Psychological Association, 2002). Despite the various definitions, essential to cultural competence seems to be the recognition of individuals' identities in shaping their experience of life, and how clinicians must be aware of this intersectionality, as well as having self-awareness of their own biases. In addition, while having specific information about a client's culture may be helpful to improving outcomes, of more importance may be the navigation of cultural differences to allow for non-oppressive, relevant, and meaningful therapeutic strategies.

Some research has demonstrated experiences of anxiety amongst service providers working with racialized women, leading to culture blindness and/or assumptions about what women want and need (Burman, Smailes, & Chantler, 2004). Bent-Goodley (2005) asserts that understanding historical context, including enslavement and colonization, is essential to being

able to assist women of colour survivors of intimate partner violence. Despite conflicting findings about the variance of rates of violence between racialized and non-racialized groups (Bonomi, Anderson, Cannon, Slesnick, & Rodriguez, 2009; Brownridge, 2008; Collins et al., 1999; Kowanko et al., 2009), how women are affected by violence and how they access resources are tied to their intersecting identities (Kelly & Pich, 2014; Oetzel & Duran, 2004; Nicolaidis et al., 2012). Therefore, regardless of the rate of intimate partner violence, the experience of violence, including stigma, ability to access resources, and other life factors, is shaped by an individual's cultural identity.

Gillum (2008, p. 923) summarized literature on components of culturally appropriate interventions, and suggested that they must:

a) Be developed in collaboration with the target population and relevant stakeholders;
b) Use language that is familiar to the target population;
c) Use channels of dissemination that will successfully reach the target population;
d) Include representative staff;
e) Be conducted in an environment that is comfortable for clients;
f) Incorporate cultural values, norms, expectations and attitudes of target group into the intervention.

What remains unclear is whether interventions need to include culturally-specific practices (i.e., use of cultural practices, prayer, language), or be culturally competent (i.e., be aware of oppression, history, barriers, unique circumstances) in order to be effective (Sue, Zane, Hall, & Berger, 2009).

Aims and Scope of Present Study

There have been calls for interventions developed specifically to support women surviving intimate partner violence (American Psychological Association, 2001), and for interventions designed to be culturally competent and evidence-based (American Psychological Association, 2003; 2005). Sue and colleagues (2009) explain that in most definitions of cultural competence, favourable outcomes (i.e., symptom reduction or improvements in well-being) are not a requirement because of the challenges in measuring outcomes in a culturally relevant way. As such, the following scoping review aimed to explore interventions developed for women of colour survivors of intimate partner violence. This review sought to:

a) understand the theoretical underpinnings of these interventions;
b) whether specific cultural practices were included;
c) how culture was integrated;
d) what outcomes were assessed; and
e) whether such interventions were deemed effective.

This is the first study known to the research team to address this gap. Moreover, because of the lack of studies in this area, and the limited quantitative outcomes, the goal of the research is to examine the extent, range and nature of research in this area, as well as to identify patterns and gaps within the literature (Arksey & O'Malley, 2005).

Scoping studies have been used to "map rapidly the key concepts underpinning a research area" and "the types of evidence available" (Mays, Roberts, Popay, 2001, p. 194). They are often the method of choice when an area of study is new or limited, and seek to understand and explore all relevant literature, regardless of study design (Arksey & O'Malley, 2005). Thus, as oppose to answering a specific research question, as would be the case with a systematic review,

the goal is to scan the literature in order to understand it within the context of the aforementioned aims.

Methods

Scoping Review

There have been a variety of ways through which scoping reviews have been conducted (Arksey & O'Malley, 2005). Thus, Arksey and O'Malley (2005) outlined steps to be included in the process of completing a scoping review. They suggest these steps include:

1) Identify the research question.
2) Identify relevant studies.
3) Undergo study selection.
4) Chart the data.
5) Collate, summarize, and report results.

They include an optional sixth step of consulting with stakeholders (including clinicians, service consumers, organizations, etc.) in order to ensure that the review adequately captures the literature and what occurs within the field.

This model has been criticized for being too broad (e.g., Levac, Coloquhoun, & O'Brien, 2010). For example, other researchers have asserted that the purpose of the research must be clear in addition to having a broad research question (Levac et al., 2010). Moreover, the consultation step, which Arksey and O'Malley (2005) consider optional, has been asserted to be a requirement for the value that it can bring to the research process (Levac et al., 2010). These alternate perspectives have been considered as this scoping review was completed, and integrated as possible and appropriate. However, the model provided by Arksey and O'Malley (2005) remains as the foundation of the method employed for this study.

Searching the Literature

Potential interventions were identified primarily through methodical searches of relevant electronic databases, including PsycINFO, Google Scholar, and the National Online Resource Center on Violence Against Women (NORCVAW). In addition to these searches, less formal web searches were completed to find organization/agency-based models and evaluations of models used with women of colour. Organizations that were listed within the literature were contacted in order to request evaluations of models. Lastly, references lists of selected papers were checked in order to identify any intervention models that may have been missed.

Identifying Intervention Models to Include

Inclusion criteria included:

a) The intervention had to be developed or adapted to be culturally-informed/competent (i.e., to meet the needs of a specific group).

b) The paper had to include an evaluative component (but this did not have to include quantitative data, and there was no minimum sample size). Outcomes measured had to be broadly related to health and well-being.

c) The intervention had to be developed to increase the health and well-being of women (i.e., interventions developed to increase capacity as parents or solely to reduce domestic violence were not included).

d) The intervention had to be described in enough detail to be able to meet the scope of the project (or the information had to be available elsewhere). When it was not, information was requested of the author/agency, and only included if provided.

Because of the broad nature of the criteria for inclusion, inclusion could often not be determined by the title of the article, or sometimes even the abstract. As such, several papers were read in full before determining whether they met inclusion criteria.

The research team did not want to differentiate between quantitative and qualitative evaluative outcomes, as both have merits depending on research questions and sample size. As such, both were included and were treated as equally as possible in the review process.

The search was completed in April 2015. Search terms included *cultur* AND (treatment OR intervention) AND (domestic violence OR intimate partner violence)*, and were entered into PsycINFO and Google. Considering that many evaluative studies of interventions for the psychological consequences of intimate partner violence include small sample size and may be published through community organizations, it was essential to look to the grey literature to attempt to capture some of these as well, which is why Google was used. The Google search identified 47, 600, 600 results, of which the first 120 (or 10 "pages") were used in the process. Through a search on the NORCVAW, the "Assessment and Evaluation", "Intervention and Services", and "Understudied Populations" sections were searched to identify potential studies. See Figure 1 for a description of the document selection process. This scoping review included 12 articles retrieved through PsycINFO, two papers from NORCVAW, and one website from the Google search, for a total of 15 documents representing nine interventions.

Each intervention was carefully studied for process of development, theoretical framework, content and goals, effectiveness, and whether it included culturally-specific components. Of especially helpful information was the ways in which the program was developed, how culture was integrated, and whether the programs were found to be effective as increasing well-being and/or decreasing symptom presentation and distress.

Results

For specific details about the interventions, see Tables 1 and 2. All interventions were designed to meet the needs of specific ethnic groups (e.g., Latinas), and some were even more specific (e.g., suicidal African American women). Almost all interventions included community-based methods in the development and/or evaluation process. One study (Kim & Kim, 2001) did not specify the relationship between the researchers and the organizations at which the intervention was implemented. Outcomes measured varied from severity of psychopathology (including posttraumatic stress, depression, and anxiety), to psychological and personality constructs (including suicidality, self-efficacy, leadership, and self-esteem), to assessments of problematic behaviours (such as drug/substance use, and violence).

All interventions demonstrated improvement in some areas related to health and well-being. Three interventions included comparison groups (Kaslow et al., 2010; Kim & Kim, 2001; Puchala et al., 2010; Taha et al., 2014) which were variations of treatment as usual groups. For example, in Kim and Kim (2001)'s intervention with Korean women, treatment as usual consisted of no psychological supports for women living in a shelter. For the intervention that included consultation with an Elder (Puchala et al., 2010), treatment as usual was not including the Elder (which was patient preference). For the Grady Nia Project (Davis et al., 2009; Kaslow et al., 2010; Taha et al., 2014), treatment as usual included standard psychiatric and medical care, including free weekly suicide and intimate partner violence support groups. For some of the interventions, while there were some favourable outcomes, all of the intended outcomes were not always met (e.g., Kaslow et al., 2010; Kelly & Pich, 2014; Kim & Kim, 2001; Nicolaidis et al., 2012; Serrata, 2012; Taha et al., 2014). Of the seven evaluations that asked about treatment suitability and preference (Davis et al., 2009; Fuchsel & Hysjulien, 2013; Kelly & Pich, 2014;

Kowano et al., 2009; Lester-Smith, 2012; 2013; Nicolaidis et al., 2012; Sanchez, 2013; Serrata, 2013; Simon Fraser University, 2012), all reported that clients enjoyed the intervention. For all interventions, this was asked through the process of seeking feedback, and clients reported appreciating the cultural components, and felt that they were feeling better than when they had initially begun the intervention.

Discussion

As predicted, there is a shortage of culturally-developed/adapted interventions for women surviving intimate partner violence, as can be seen by the nine interventions that were identified. Effectiveness was determined through both quantitative and qualitative measures of well-being. For some interventions (e.g., Warriors Against Violence Society), client reports of satisfaction and change were sufficient for researchers to determine effectiveness, whereas with others (e.g., Grady Nia Project), client satisfaction was coupled with more structured evaluative approaches. This variation speaks to diversity in understandings of well-being (Schimmack, Radhakrishnan, Oishi, Dzokoto, & Ahadi, 2002), emphasis put on psychometrically-supported psychological measures of well-being versus people's personal accounts of well-being (Karasz & Singelis, 2009), and the complexity of completing evaluation research within community-based organizations (Kegeles, Rebchook, & Tebbetts, 2005).

While several of the studies employed community-based approaches, it is difficult to ascertain whether using this method for the development of the intervention led to better engagement or improved outcomes amongst clients. However, the frequency with which this approach was used suggests that it is thought to be an effective way of meeting the needs of a population. The community-based and collaborative approaches used by most of the interventions speak to the need to consult with community stakeholders before developing or

evaluating interventions for women. This approach is especially important because of the hesitance of many women of colour to use "mainstream" services, due to histories of oppression and deception (Williams & Becker, 1994), and because of disappointing, invalidating or distressing interactions with such services (Burman et al., 2004). At the same time, women may want access to mainstream services, and assumptions should not be made about the need to culturally adapt interventions for specific populations (Oetzel & Duran, 2004). Because of this complexity, it is may be that program developers conduct thorough needs assessments, include survivors as key stakeholders and consultants throughout intervention development, and continuously seek feedback.

While some of the interventions include culturally-specific practices (such as the Warriors Against Violence Society), others were built on a culturally congruent foundation for their target populations. For example, Fuchsel and Hysjulien (2013) discuss how concepts such as *familism* and *machismo* were essential to the development of the intervention, and discussions with women came back to these concepts. They explain that having these cultural components allowed clients to know that someone understood them, and that this process helped clients develop trust. However, there were no explicit cultural practices included in the intervention. Similarly, the Grady Nia intervention was developed with an understanding of Afrocentric theory, and was guided by the theory of triadic influence, which suggests that human behaviour is caused by intrapersonal factors, social and situational factors, and cultural and environmental factors (Davis et al., 2009). Again, while there were no specific cultural practices, the intervention itself was developed in consideration of culture, and included African proverbs and focused of Black feminism/womanism. Depending on the target demographic, such approaches

may be more helpful for clients than no specific cultural inclusions or culturally-specific practices—this is dependent on the client's needs.

Integrating specific practices (such as smudging, drumming, tribal dance, and prayer) may not be relevant for all clients, and may incite feelings of guilt and shame. Such inclusions may also be perceived as tokenisms (Archibald, 2006), may further other-ing through assumptions of homogeneity amongst diverse peoples, and thus contribute to marginalization through the denial of intersectional identities (Crenshaw, 1997). For example, the term *African American* is used to represent 33.9 million people in the United States, and is often determined based on the colour of an individual's skin. There is often an assumption that Black individuals have some sort of connection to Africa; however, there are 54 different countries in Africa and two thousand different spoken languages (UPenn Collaborative on Community Integration, n.d.). In addition to African diversity, many individuals who identify as Black may trace their ancestry back to the Caribbean or another geographic area. Thus, including African American practices would likely be meaningless, ignorant, marginalizing and oppressive to the diversity of individuals who are often assigned to this group. On the other hand, some women found that being able to identify with other survivors of intimate partner violence was more important than ethnic similarity (Kelly & Pich, 2014). Kelly and Pich (2014, p. 912) explain that "being an IPV survivor was the basis for cultural group identity" and that "women's sense of commonality was derived from their experiences of IPV".

While explicit practices may not be appropriate for some clients, there are often similar experiences that marginalized peoples may have, including those of health disparities, difficulties accessing services, differential treatment when accessing services, systemic discrimination, racism and oppression, and frustrations through the acculturation process. These experiences

may create mistrust in mainstream services, and thus culturally-specific services may increase trust in service providers and interventions (Nicolaidis et al., 2012). Moreover, there may be culturally-specific frameworks that resonate amongst peoples, such as the Medicine Wheel for Indigenous peoples in North America (Loiselle & McKenzie, 2006). Thus, it is possible to integrate culturally-specific themes into an intervention, while recognizing the diversity that exists within the culture. Alternatively, some clients may appreciate culturally-specific strategies, and this may be supportive to their healing. Thus, this is not to negate the inclusion of such strategies, but to offer clients choice in service, and the expression and inclusion of culture within this. The importance of collaboration and flexibility in approach to intervention are essential to this process (Sue et al., 2009).

Using a community-based approach, completing a needs assessment, and including stakeholders in every part of a program's development, implementation, and evaluation may be one way through which "culture" can be captured without reducing it to practices. Recognizing that culture is influenced by different contexts, including the historical, ecological, sociopolitical, and disciplinary (American Psychological Association, 2002), and not just one's ethnic background or race, as is commonly understood (Ballard, 2002). Moreover, individuals often identify with several different cultural groups, and it can be undermining for anyone else (e.g., service provider, professional, or researcher) to determine which part of that individual's identity is most salient for her. As such, the finding by Kelly and Pich (2014) may speak to an important argument about allowing women to define which identities may be most important in a given setting. Community-based approaches are one way to naturally allow this process to take place.

Quality of studies were not assessed, as this may undermine different ways of knowledge generation, and well-being. However, one study (Kaslow et al., 2010) used a randomized

approach, with participants being assigned to treatment as usual or the studies intervention. While randomized control trials are often thought to be the "gold standard", this may not be the case for many circumstances (Grossman & Mackenzie, 2005), and in the absence of other adequate service to serve as "treatment as usual", such an approach may be unethical. Moreover, in the case of services for intimate partner violence, randomization may undermine client agency, which could reproduce the lack of control which many women have experienced in their violent relationships. Similarly, many cultural approaches are often compared to Western approaches (Fellner, 2014), and thus quality would need to be defined in culturally appropriate ways before such analyses could be included in systematic reviews of culturally-competent/-adapted interventions.

Conclusions

This scoping review sought to explore culturally developed or adapted interventions for working with survivors of intimate partner violence. Nine interventions were found and discussed within 15 sources (including academic literature, community program evaluation reports, newsletters and websites). This demonstrates the paucity of such interventions, and the need to better support survivors of intimate partner violence, especially those who belong to marginalized groups.

Recommendations

The outcomes of the nine interventions suggest that 1) clients enjoy, appreciate and are more likely to trust culturally competent psychological interventions; 2) many of such interventions offer promising, if not positive, outcomes; and 3) more research is needed. While many of the interventions were successful at decreasing distress and symptom severity, some of the evaluations did not assess for symptom severity, or for behavioural change in a consistent

manner. While there may not need to be a consistent way of measuring and comparing cross-cultural research, there should be intention in how outcomes will be measured, and these should occur in clinically, theoretically and culturally relevant ways. One way through which this may be achieved is by discussing mechanisms of change. For example, by examining whether a client has acquired and is successfully using a certain skill that was taught to her, and how this skill may be contributing to her well-being. Such an approach would allow for flexibility in definitions of well-being and health, yet would allow for direct discussion about the role of the intervention in supporting healing.

Regardless of measurable outcomes, client satisfaction was noteworthy throughout those evaluations that sought to incorporate such information. This is clinically relevant because of the barriers to service and lack of satisfaction that many marginalized peoples experience when accessing services (Burman et al., 2004; Williams & Becker, 1994). Moreover, interventions that do not consider culture have reportedly been less effective or harmful towards individuals (McCabe, 2007). Thus, assessing client satisfaction and trust may be necessary steps toward the determination of a gold standard for culturally competent and evidence based practice.

Moreover, while the question around whether culturally-competent versus culturally-specific therapeutic approaches remains unanswered, perhaps this continues to be the case because this is dependent on the target population's needs. Using a community-based approach to determine the needs of a population may help determine how culture can best be integrated for a population, while continuing to recognize that there will be diversity within this as well.

Limitations

As with any review or research, it is likely that evaluations with non-significant or negative outcomes may have not been published (Rosenthal, 1979). This may especially be the

case due to the community-based research methods used in this kind of research, where the researchers may have vested interests in the outcomes. It is also likely that many more culturally developed and/or adapted interventions that have been evaluated exist, but have not been published in scholarly journals. While the researcher made efforts to seek out non-scholarly publications and to contact organizations that may have culturally competent interventions for women survivors of intimate partner violence, it is unlikely that the 15 sources included in this review are exhaustive. Using a wider variety of search databases and sending follow-up emails to organizations may have also assisted in accessing a larger number of evaluated interventions.

While a systematic approach was used to determine study eligibility, having a second reviewer would have been helpful in ensuring that studies were not missed, that exclusion criteria were applied consistently, and would have increased capacity for finding additional interventions with evaluations. Having multiple reviewers has also been encouraged within the literature (Levac et al., 2010). This process would have potentially led to better objectivity and inter-rater reliability. Having said this, the process of selecting and including articles was followed as systematically as the researcher found possible.

With the limited number of interventions and the diversity of measured outcomes, it was also difficult and meaningless to make broad statements about the efficacy and effectiveness of such interventions. Thus, while some of the studies included in this review measured quantitative and/or qualitative outcomes, it is unclear how these may have affected the well-being of the women who participated. Moreover, this review did not seek to compare the effectiveness of culturally developed or adapted models to more mainstream interventions. As such, statements about which approaches may be more effective for clients could not be made. However, considering what literature suggests about marginalized groups and mainstream services, it is

possible that the interventions discussed in this review are more likely to support the healing of the women who attended.

The American Psychological Association has asserted the necessity to consider client characteristics in evidence-based practice, to offer culturally competent services, and for better interventions to be developed for survivors of intimate partner violence (American Psychological Association, 2001; 2002; 2005). This scoping review offered an initial exploration of some interventions that are aiming to offer high quality psychological support to a group of women whose well-being is often neglected. More efforts should be made to collaborate with community organizations to support these types of evaluations, and to support the development of such interventions.

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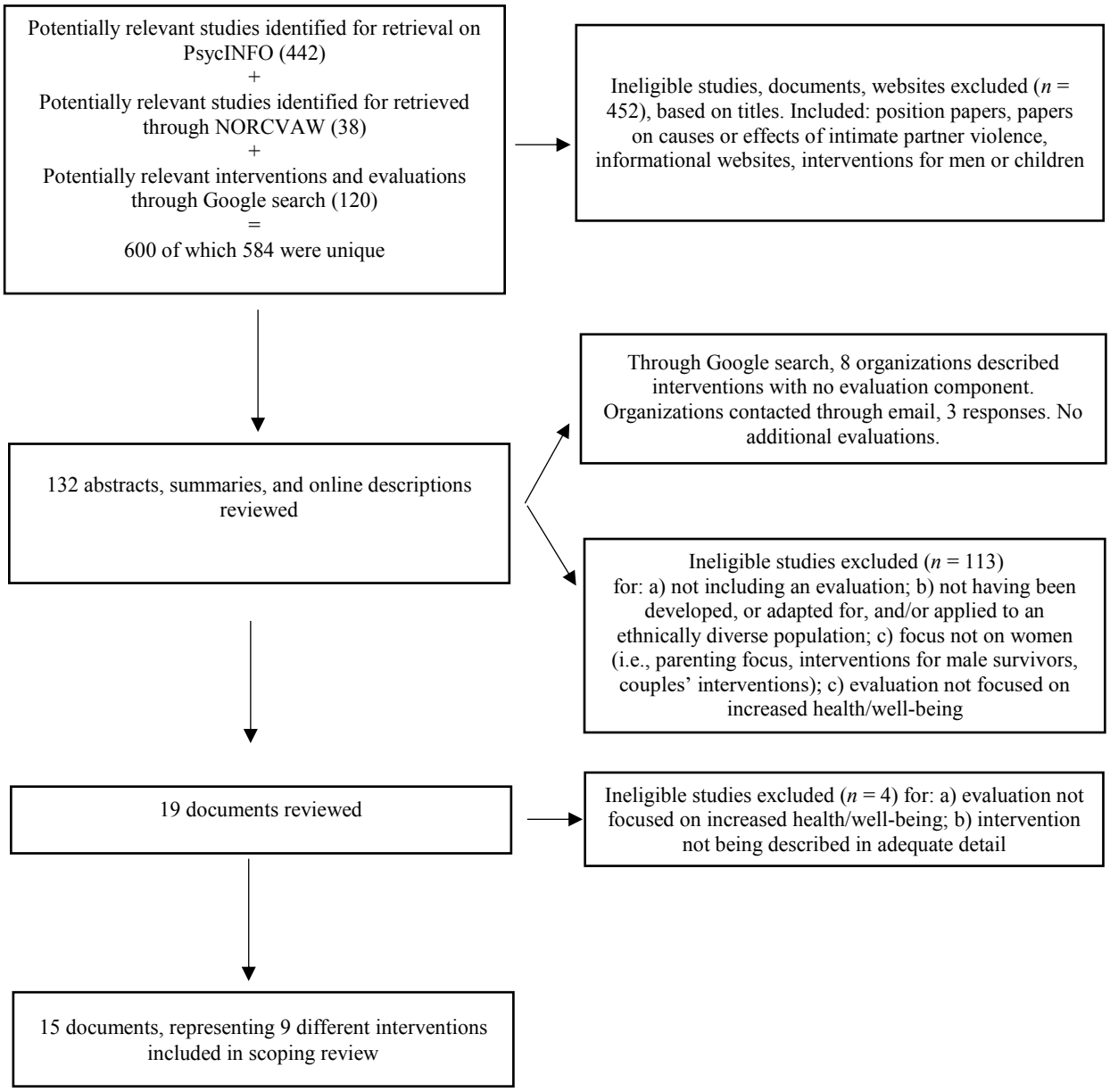

Figure 1. Process of selecting documents for scoping review. Arrows going downward depict the process of narrowing down the articles, whereas arrows going sideways depict how exclusion criteria were applied.

Table 1
Summary of Intervention Characteristics

	CB strategies	Quantitative outcomes	Positive quantitative outcomes	Qualitative outcomes	Positive qualitative outcomes	Treatment preference	Manualized protocol	Culturally-specific strategies	Culturally-informed	Asked for client feedback	Control group
Marrs Fuchsel & Hysjulien	X			X	X	X	X		X	X	
Kelly & Pich	X	X	X	X	X	X	X			X	
Nicolaidis et al.	X	X	X	X	X	X			X	X	
Lester-Smith	X			X	X	X		X	X	X	
Kowanko et al	X			X	X	X	NR	NR	X	X	
Serrata	X	X	X	X	X	X	X		X	X	
Kim & Kim		X	X			NR	X				X
Puchala et al		X	X			NR		X	X		X
Davis et al	NR	X	X	NR	NR	X	X	X	X		X

NR = not rated

Table 2

Descriptive Details of Intervention Characteristics

Program	Description	Outcomes
Marrs Fuchsel & Hysjulien, 2013 – Domestic Violence Intervention Model	-A culturally-specific model originally developed for immigrant Mexican women (participants were not all immigrants or Mexican, but were all Spanish speaking) -Used an empowerment framework -Intended to develop a) sense of self; b) education about healthy relationships and dating, including information about domestic violence; c) self-care/regulation strategies (including relaxation, self-reflection, etc.) -2 hours/week; 11 weeks **Goals:** -Increase awareness about healthy relationships and domestic violence -Increase self-esteem -Empower women to seek help and support -Increase decision-making ability regarding current relationships **Culture and Collaboration:** -Used culturally-based themes (such as *familism* and *machismo*) to inform content -Offered in Spanish -Model informed by in-depth interviews with immigrant Mexican survivors (i.e., needs assessment)	-Increase in domestic violence- and healthy relationship-related knowledge -Increase in subjective well-being, happiness, personal growth -Felt supported by group members -Better knowledge about accessing resources -Found cultural components helpful and empowering **Method:** -Qualitative questions

Kelly & Pich, 2014	-Model originally developed for immigrant Latina women (participants were not all immigrants) -Foundation in Acceptance and Commitment Therapy -Included psychoeducation about PTSD -Intended to a) improve relationship with self, children, and others; b) develop sleep hygiene; c) mindful eating strategies; d) relaxation and exercise; e) faith and family -90 minutes/week; 6-10 weeks -Continued to adapt model based on feedback **Goals:** -Decrease PTSD and depressive symptoms -Increase health-related quality of life; self-efficacy; perceived social support **Culture and Collaboration:** -Ran intervention with ethnically homogenous and diverse groups to assess differences -Offered groups in Spanish and English -Model informed by in-depth interviews with service providers and immigrant Latina survivors (i.e., needs assessment)	-Decreased PTSD and depressive symptoms depressive -Significant increase in health-related quality of life; self-efficacy; and perceived social support -Mindfulness found to be most helpful strategy -Having a translator was helpful for those who needed it **Method:** -Qualitative feedback -Quantitative measure of outcomes
Nicolaidis et al., 2012 – The Interconnections Project	-Model developed for low-income depressed African American women -Included aspects of Motivational Interviewing and Cognitive-Behavioural Therapy -Meant to help women navigate services, rather than develop new service -Used a Health Advocate for one-on-one support, workshops, and case management	-Decrease in severity of depressive symptoms -Change in views about depression, including depression self-efficacy, attitudes toward treatment, and self-management of symptoms

	-Health Advocate explored a) self-care strategies; b) education about depressive symptoms; c) relationship topics; d) goal-setting; e) parenting; and f) case management topics (i.e., housing, safety, and legal services) -Topics covered by Health Advocate were client-directed **Goals:** -Assess intervention feasibility and acceptability -Decrease depressive symptoms, and change attitudes toward depression and treatment -Increase self-efficacy and self-esteem -Increase use of self-management strategies and healthcare utilization **Culture and Collaboration:** -Program housed in a culturally-specific community-based domestic violence drop-in centre -Engaged in a needs assessment with target population -Community-university partnership	-No change in perceptions about antidepressant use -No behavioural change in seeking care for depression -Increase in used of counselling, but little change in attitude toward counselling -Appreciated African-American focus and community setting -Felt able to trust information and strategies **Method:** -Quantitative and qualitative measure of outcomes
Lester-Smith, 2012; 2013; Simon Fraser University, 2012 – Warriors Against Violence Society (WAVS)	-Program developed for Indigenous men and women in British Columbia, Canada -Largely based on storytelling -Includes information about a) identity; b) culture; c) history; d) why violence may occur -Use of Anger Wheel to facilitate education about violence -Includes groups for both men and women, and for each group separately **Goals:** -Prevent and heal from domestic violence	-Allowed for re-connection -Supported meaning-making of traumatic experiences -Contributed to healing -Participants trusted and reported benefitting from the WAVS program **Method:** -Qualitative feedback

	Culture and Collaboration: -Based on Indigenous ways of knowing and approaches to healing -Elders guide the process and provide teachings -Storytelling understood as within Indigenous knowledge system, and to contribute to healing	
Kowanko et al., 2009 Kowanko & Power, 2008 – Family and Community Healing Program	-Program developed for Indigenous women and families in Adelaide, Australia -Consists of several different programs, including structured groups, health promotion programs, access to individual counselling, crisis support when/if needed, and informal peer support -Empowerment based -Emphasis on balance as it contributes to health and well-being **Goals:** -Group activities meant to a) build confidence and self-esteem; b) teach conflict-resolution strategies; c) increase awareness of positive relationships; d) increase healthy lifestyle activities; e) education about violence and safety planning; f) build pre-vocational and employment skills **Culture and Collaboration:** -Used participatory action-oriented methodology -Involved past participants in the program to contribute unique experiences and knowledge, help engage participants, and facilitate interviews -Takes holistic approach to health and well-being	-Increased awareness of effects of violence on self and others -Decreased self-blame -Increased self-worth **Method:** Qualitative feedback
Sanchez, 2013; Serrata, 2012 – Lideres	-Originally developed to address experiences of domestic violence within Latinas, but evolved to be a leadership training -Trains Latinas to be leaders by teaching public speaking skills -Intends to engage community members in meaningful conversation about domestic violence -Focused on empowerment and peer leadership -4-week, 4 hours/week course	-Increased knowledge about leadership, and leadership competency -Increase in knowledge about resources for intimate partner violence

	Goals: -Meant to a) empower; b) increase knowledge about domestic violence; c) engage community; d) increase sense of community **Culture and Collaboration:** -Taps into "natural leadership skills of Latinas" -Program emphasizes culture of collaboration -Run through Caminar Latino; provides culturally-centred services to entire family affected by intimate partner violence -Topic covered by lideres are community-generated	-No change in sense of leadership efficacy -High baseline of sense of community, information about intimate partner violence and empowerment within agency -Reported increase in sense of leadership; motivation to continue in skill development; desire to give back to community (through interview) **Method:** -Quantitative outcomes -Qualitative outcomes and feedback
Kim & Kim, 2001	-Based on Robert's Seven-Step Crisis Intervention model -Includes components of problem-solving, adaptive and constructive coping skills, and empowerment -Aspects of trauma, emotion regulation and processing, education about domestic violence, stress management skills, and action planning -Intervention implemented with Korean women staying in shelters -8 sessions; 90 minutes/session **Goals:** -Decrease depressive and anxiety symptoms -Increase self-esteem **Culture and Collaboration:** -Recognition of limited resources for women in Korea who experience intimate partner violence -Underutilization of formal health services for this population, thus integration with social and life skill services may be a more culturally acceptable way of providing services	-Decreases in trait anxiety -No change in self-esteem -Decrease in depressive symptoms, but not more than control group **Method:** -Quantitative outcomes -Had an experimental control group

Puchala et al., 2010	-Service offered to Aboriginal peoples referred to a psychiatrist for domestic violence consultation -Saskatchewan, Canada -Invited a traditional Elder in conventional psychiatric care -Elder offered compassion and kindness; prayer; listening to client's story; perpetrator was often invited -Talking Circle-type discussions **Goal:** -Reduce domestic violence **Culture and Collaboration:** -Elders and Talking Circle format both Indigenous methods of healing -Integration of Western and Indigenous forms of healing	-"Dramatic" reduction in rates of domestic violence -Decrease in symptoms or symptom-related distress (as measured through My Medical Outcomes Profile-2) -Largest changes in drug use, reports of violence, sleep difficulties, and sadness **Method:** -Quantitative outcomes -Comparison with people who refused Elder consultation
Taha et al., 2014; Kaslow et al., 2010; Davis et al., 2009 – Grady Nia Project	-Program developed for African-American women who are low income and suicidal -Includes a) information about domestic violence; b) suicide safety planning; c) reducing interpersonal risk factors and enhancing interpersonal protective factors; d) reducing social risk factors and enhancing social protective factors; e) reducing cultural/environmental risk factors and enhancing cultural/environmental protective factors -Based on theories of Triadic Influence and Transtheoretical Stages of Change -2 hours/week; 10 weeks **Goal:** -Provide access to health care -Increase connectedness -Enhance social skills -Reduce residual effects of trauma -Find new sense of purpose -Feel empowered -Commit to living	-Decrease in depressive symptoms and distress -Decrease in suicide attempt -Exposure to violence did not increase suicidal ideation -Increases in self-esteem -No group differences in suicidal ideation or posttraumatic stress symptoms -Benefits persisted for women who were less ready to change -High levels of satisfaction with intervention **Methods:** -Quantitative outcomes -Qualitative feedback -Control group (treatment as usual)

	Culture and Collaboration: -Recognition of limited accessibility and negative experiences in using services as barriers for African-American women -Incorporates constructs of Afrocentric theory and is guided by Black feminism/womanism -Use of African proverbs; attends to African American heroines and role models; emphasizes culturally relevant coping strategies -Attempts to overcome negative stereotypes and establish healthy images of strong African American females -Collaborates with culturally meaningful community agencies

Chapter Three

Understanding the Needs of Indigenous Women in Thunder Bay Surviving the Effects of Intimate Partner Violence

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Preamble

This paper illustrates the findings from the needs assessment done with and for Indigenous women living in Thunder Bay, Ontario. Indigenous women were selected as the focus for the needs assessment, and originally for this project, because they are largely represented in Thunder Bay (Statistics Canada, 2011), experience high levels of discrimination and oppressions within Thunder Bay (Canadian Broadcasting Corporation, 2013), and have reported high levels of frequency and severity of intimate partner violence (Brownridge, 2008; Lane, Bopp, & Bopp, 2003; LaRocque, 1994). This assessment was used to inform the Healing the Whole Self model. The scoping review, and especially the finding of the importance of using community-based approaches were used to inform the Healing the Whole Self model as well.

Abstract

Rates of intimate partner violence for Indigenous women living in Canada are higher than national averages. Experiences of violence within these populations have been reported to be more frequent and severe. Indigenous women's voices have often been excluded from literature on the effects of intimate partner violence. Thus, this study sought to better understand the needs of Indigenous women in Thunder Bay, Ontario surviving the effects of intimate partner violence. Nineteen women, including survivors and service providers were interviewed to learn about pressing needs, conceptualizations of health, and the effects of violence. Results demonstrated that Indigenous women have a variety of concerns, and that many concerns relate back to experiences of oppression and systemic discrimination. In order to best support women, it is important to approach work with them in a non-judgmental, person-centred and non-assuming way; however, being knowledgeable about the history of colonization and how racism may affect their lives is helpful.

Chapter Three:

Understanding the Needs of Indigenous Women in Thunder Bay Surviving the Effects of Intimate Partner Violence

According to the Centres for Disease Control and Prevention (2009), intimate partner violence can include physical, sexual, or psychological harm by a current or former partner or spouse, and can vary in both frequency and severity. Thus, the definition of intimate partner violence and how it is enacted is varied and diverse.

Psychological consequences of intimate partner violence. There are several complex psychological effects of intimate partner violence. More specifically, intimate partner violence has been associated with elevated levels of depression (Campbell, 2002; Dutton et al., 2006; Jordan, Campbell, Follingstad, 2010; Lafta, 2008; World Health Organization, 2008), anxiety (Campbell, 2002; Lafta, 2008; Jordan et al., 2010; World Health Organization, 2008), posttraumatic stress (Dutton et al., 2006; Jones, Hughes, & Unterstaller, 2001), feelings of shame and guilt (Lafta, 2008), phobias and panic disorders (Campbell, 2002; Lafta, 2008; World Health Organization, 2008), poor self-esteem (Jordan et al., 2010; Lafta, 2008), alcohol and drug misuse (Campbell, 2002; Dutton et al., 2006; Jordan et al., 2010; Lafta, 2008; World Health Organization, 2008), and suicidal behaviour and self-harm (Campbell, 2002; Dutton et al., 2006; Jordan et al., 2010; Lafta, 2008; World Health Organization, 2008).

Intimate Partner Violence and Indigenous Women

The perspectives of women of colour are often excluded from the literature on intimate partner violence, social factors that contribute to gender-based violence, and the effects of violence (Wotherspoon & Satzewich, 2000). Early research on gender-based violence made an assumption that women's experiences of oppression and gender-based violence were similar.

However, through dialogues with women of colour and other diverse peoples, it has been learned that this is not the case (Bograd, 1999), and that personal history plays a large role in how people understand, internalize, and react to violence (Oetzel & Duran, 2004). Without an understanding of how people's identities intersect to create their experiences and understandings of violence, research may continue to be created from a silencing and oppressive lens of understanding. Indigenous women have argued that their voices are lacking in feminist research, and that the needs and concerns of Indigenous women may vary from those of other women whose voices are more often represented within feminist literature (Monture-Okanee, 1992; Ouellette, 2005; Wotherspoon & Satzewich, 2000).

Indigenous peoples in Canada have experienced and continue to experience systemic oppression and discrimination. Through the processes of colonization, being prohibited from practicing cultural and spiritual practices, having families separated, being geographically relocated and isolated, being presented as helpless within the media, amongst many other forms of violence, Indigenous peoples in Canada have a long history of trauma (Oliver, 2010). The racism that is enacted against Indigenous peoples in Canada often becomes internalized (Archibald, 2006). Thus, feelings of hopelessness, loss of identity, disconnection, and low self-worth are commonly reported amongst Indigenous peoples in Canada (Anderson, 2000)—this is directly related to a history of discrimination, oppression and systemic violence.

The Native Women's Association of Canada (Canadian Council on Social Development and Native Women's Association of Canada, 1991, p. 25) has asserted that "it is an exception rather than the rule to know of an Aboriginal woman who has not experienced some form of family violence throughout her life". Rates of violence against Indigenous women range from 25 to 100 percent, depending on the methodological approach taken (Brownridge, 2003). The

Ontario Native Women's Association (1989) suggested that eighty percent of a sample of 104 women living in Northwestern Ontario had experienced some form of family violence. Furthermore, in a study of Indigenous women in Manitoba and Saskatchewan, the majority of participants reported that family violence was their most important health concern, despite the numerous other health concerns that exist within these communities (Centres of Excellence for Women's Health, 2002). Experiences of intimate partner violence against Indigenous women have been reported to be more severe and frequent than non-Indigenous Canadians (Alani, 2010; Lane, Bopp, & Bopp, 2003; McGillivray & Comaskey, 1999; Statistics Canada, 2006).

In considering that the causes and effects of intimate partner violence may be unique for Indigenous women (Oetzel & Duran, 2004), and that they are necessarily tied to systemic violence and the effects of colonization (Brownridge, 2008), it is important to understand their experiences separately from mainstream literature. Moreover, it has been argued that in order to best support marginalized women, an adequate and critical understanding of their needs must be achieved, and support must be offered collaboratively (Oetzel & Duran, 2004). Thus, the purpose of this study was to gain a better understanding of the needs of Indigenous women living in Thunder Bay, Ontario within the context of intimate partner violence.

Indigenous Peoples in Thunder Bay

Thunder Bay is located in northwestern Ontario, and is approximately 924 kilometers northwest of Toronto, and 599 kilometers southeast of Winnipeg. According to Statistics Canada, in 2011, Thunder Bay had a population of 119, 145 individuals, of which 9.8 percent (11, 670) had an Indigenous identity. Of those who identified with an Indigenous identity, 76.9 percent (8, 980) identified as First Nations, 21.0 percent (2, 445) identified as Métis, and 0.2 percent (20) identified at Inuit. The rest of the Indigenous population identified with another

Indigenous identity or several Indigenous identities. The First Nations peoples living in Thunder Bay are predominantly Ojibwe, Cree, and Oji-Cree (Statistics Canada, 2011).

Methods

Participants

Participants were recruited through community agencies that serve Indigenous women or women who have experienced violence in Thunder Bay, and included service providers and survivors of violence. The researcher conducted seven individual interviews (five of which were audio recorded), one interview with two individuals (which was audio recorded), and participated in one group conversation with ten women (which was not audio recorded). Thus, information was gathered from a total of 19 women for this project. Seven of the women interviewed were service providers; four of them had also experienced some form of intimate partner violence. As such, 15 women with experiences of intimate partner violence were interviewed for this study. Information about ethnicity was not posed throughout the interviews and group conversations. This information was not sought out as it did not seem appropriate to legitimize some people's experiences of intimate partner violence or consider some perspectives as more valid. By not asking about ethnicity, all voices and experiences were valued. Having said this, the group conversation and most of the interviews took place within Indigenous agencies. Of the 19 women represented in the study, 11 self-identified as Indigenous.

Procedure

The researcher contacted individuals at agencies within Thunder Bay that work primarily with Indigenous individuals and/or women surviving the effects of intimate partner violence. These individuals were invited to participate in a focus group or interview. In addition, these individuals were requested to share this invitation with clients and other staff at their

organization. Once participants were identified, a meeting was scheduled and the process of informed consent was communicated. Because of the sensitive nature of the subject matter, audio recording of the interview was presented as optional. If the interview was not audio recorded, the researcher made notes immediately after the interview, and these notes were used to ensure data saturation as opposed to being used within the data analysis process.

Interview questions for both survivors of violence and service providers (see Table 3) focused on understanding the unique presentation and needs for Indigenous survivors of violence. For service providers, the first set of questions was asked, and if the service provider disclosed being Indigenous and having a history of intimate partner violence, and was willing to discuss her experiences, both sets of questions were posed.

Audio recordings were transcribed by a research assistant and then checked by the researcher. Transcripts were analyzed by the researcher and two research assistants (the research team). Using the process of thematic analysis (Braun & Clarke, 2006), each individual of the research team analyzed the data separately, identifying emerging themes. Themes were identified through the grouping of common responses, and then connecting these common responses to one another. For example, several participants discussed the importance of family, while others shared that friends were important for their healing. Thus, both of these would be included under the sub-theme of “social support”, and perhaps under a broader theme of “self-care”. Once the research team had completed this process, the team met to discuss findings and collaboratively decide upon themes.

Throughout the project, consultation and guidance for this project was sought from an Anishinaabe (First Nations) Elder. This included speaking with the Elder about the intentions of

the community needs assessment, its methods, and how this could possibly be used in the future. Her feedback was actively incorporated into the various steps of the project.

Results

Many service providers had experienced intimate partner violence. As such, questions related to experiences of violence and healing were posed to service providers. Because of the overlap of experiences and breadth of knowledge among participants, interviews from both groups were collapsed and analyzed together. The bolded headings (example, Effects of Intimate Partner Violence) indicate the question that was being answered. The next level, for example "emotional effects", represents a theme, while the italicized words (for example, "emotional responses") represent sub-themes.

Effects of Intimate Partner Violence

In terms of the effects of intimate partner violence, many of the difficulties and stressors that women reported experiencing may not directly be caused by their experiences of intimate partner violence. While symptoms of trauma and changes in mood may be more closely related to intimate partner violence, many of the women reported experiencing other traumas throughout their lives. Moreover, the barriers that many women who have experienced intimate partner violence, including psychological/emotional and structural/systemic barriers, were likely present before their experiences of intimate partner violence. All of these factors intersect with each other to represent a woman's situation. Thus, while there are identified themes within this section, these are not meant to be considered independent of each other.

Emotional effects. All participants discussed *emotional responses*, including isolation and loneliness, with some reporting social withdrawal and loneliness especially if their partner was/is their main source of support and community. Moreover, some shared feeling unable to

connect with others, and difficulty trusting others and jealousy. Most women discussed experiences of sadness, anger, hopelessness, loss, guilt, shame, and regret. In terms of *how one's emotions relate to the self*, several women expressed disliking one's self, not feeling comfortable in one's own body, feeling loss of one's identity, and mistrusting one's own emotions and judgment.

Physical effects. Some women reported *consequences of violence*, including experiences of stress, chronic illness, and lack of sleep and nutrition. As a direct result of the violence, several women commonly reported *injuries* such as broken limbs, being stabbed, having one's hair pulled, head injuries, and black eyes.

Reasons for staying. Most participants shared some reasons for staying with their abusive partner, although this question was not asked of them. Some women responded that there were *limited options*, including how there was often nowhere to go to escape the violence, especially if they were living in an isolated community; there was fear of being re-victimized; being financially dependent on their partner; and having a lack of resources. There were responses that related *to positive attachment to one's partner*, including beliefs that one's partner was a "good" person, wanting to be fair to one's partner, and still loving and caring for one's partner. A desire to keep the *family* intact, beliefs about separation and the importance of family togetherness, and beliefs related to the role of a wife/mother were discussed. There were also statements referring to the *normalization of violence*, including that some women had experienced or witnessed abuse as children and/or adolescents. Lastly, concerns around *systems interference* such as police involvement and children's aid were also raised.

Effects on family and community. Some women shared that families may be *resistant* to the woman leaving her partner, often because of pressure to maintain family ideals and

because family members fear the violent partner. All of the women reported that violence has *long term effects*, including leading to broken homes, a history of abuse and trauma, and a lack of education around parenting.

Other Factors that Affect Health

Factors that negatively affect health. All of the women reported that *historical/lifetime traumas*, *loss of identity*, and one's *life circumstances* negatively affect one's health. More specifically, within the discussion of *historical/lifetime traumas*, some women discussed the effects of residential school and the foster care system, and prior experiences of family/domestic violence. In terms of *loss of identity*, all the women discussed how feeling detached from one's culture caused them to feel disconnected from their community, creating a feeling of loss of identity, and this was also the case for those who were disconnected from their family of origin. In the discussion of *life circumstances*, housing, poverty, lack of accessibility to services, mental and physical illness, involvement with the Justice system/having a criminal record, and racism were all raised as negatively affecting a woman's health. The breadth of responses provided was suggestive of a conceptualization of health that considers a wide number of determinants and may reflect holistic understandings of wellness.

Coping strategies. Most women shared strategies that were helpful for them (*adaptive coping*) and that had negative consequences (*maladaptive coping*), noting that some strategies were helpful for short-term coping, but less helpful for long-term coping and well-being. Many women discussed the importance of family and friends in helping deal with their trauma. One woman discussed investing herself in work and school. Participants talked about conscious efforts to engage in self-care strategies and to have good self-awareness about their emotions and needs. In terms of *maladaptive coping*, some women discussed the use of drugs, alcohol, and

"partying", and risky sexual behaviour as a means of regulating their emotions. A few participants talked about neglecting their self-care and socially withdrawing. Without commenting on the helpfulness of these strategies, some women shared reacting in and initiating violence against their partners.

Meanings of Health and Healing

Definitions of wellness included feeling happy and being in a "good place", feeling confident with one's decisions, finding balance, feeling empowered and in control, and not wanting to change oneself for others. In terms of *how healing can be achieved*, it was emphasized several times that this process takes much time and is something to strive for. Primarily, participants discussed the importance of self-care as a means of being healthy. This meant taking care of all of one's self (including physically, emotionally, mentally and spiritually), talking to one's self, and celebrating one's self. Moreover, some women talked about the importance of self-awareness, of letting go of the pain and hurt, and how learning about one's identity and community may be a first step to this process. One participant discussed the importance of not conceptualizing the healing process from the perspective of being "damaged" and becoming "whole", but rather how all individuals are in need of healing to some extent—thus, the need to heal does not make them a "victim" or less "whole". Some participants talked about the importance of taking time to heal and finding stability in one's life. Women talked about the importance of education. More specifically, some women felt that women need to learn about their cultural identity and history, the signs of abuse and healthy relationships, and the importance of re-educating one's self about one's own needs, feelings and how to be self-aware. From a more practical perspective, many women stated that better knowledge about one's options and access to resources would facilitate their healing process.

Several women identified some methods through which they can identify if they are *unhealthy*. Such characteristics included being immersed in one's own issues to the point where one cannot see outside of her own situation, when one is repeating cycles, and when one's grief is affecting one's health. It was explained that when these unhealthy behaviours occur, it is because one has not dealt with her trauma.

Most Pressing Needs

In the discussion of women's most pressing needs, there were a variety of responses. The first set of responses was related to *accessing services*. More specifically, there was discussion about how services need to be accessible for women (e.g., offering child care, transportation), and that there needs to be better information about which services women can access. Participants described the need for a safe space for themselves. Similar to having a safe space, many women shared that in seeking services, it was important that the environment be non-judgmental, respectful of their decisions to stay/leave their partner, and understanding of colonization, the history of Indigenous peoples in Canada, and the systemic discrimination that Indigenous peoples experience.

In terms of the *needs that women present with*, women often present with concerns about anger and grief/loss. Moreover, many women reported feeling a lack of sense of balance and having difficulties trusting others. From a more logistical perspective, women reported needing housing and struggling with poverty, having challenges with their diet/nutrition, and having trouble navigating Ontario Works and Ontario Disability Support Program (and other similar social assistance programs). Women reported needing time to relax and time for themselves.

There was also some discussion around *societal needs*. These included seeing stronger Chiefs and band councils within communities so that there could be better support for women.

Participants stressed the importance of more funding, and permanent funding (as opposed to pilot project-funding) so that women do not have to continue to change service providers and programs. Some advocated that men be held more accountable for their actions, including a movement to remove men out of the house and community (instead of the woman having to leave), and having more solutions and healing opportunities for men. Almost all participants shared a desire to have a restructuring of services to be more collaborative and communicative between agencies.

Some participants shared that *cultural needs* will vary by woman, and thus assumptions should not be made about what women need. More specifically, in their work with Indigenous women and in terms of their own healing journeys, some women appreciated having a cultural/spiritual component (such as consultation with an Elder, drumming, attending sweat lodge ceremonies), whereas others felt uncomfortable participating in such practices. In addition, participants shared that when encouraged to participate in ceremony, they sometimes felt conflicted, felt their choice was being undermined, and found this to be an unfavourable experience. Thus, the need was to respect a woman's choice of how she connects with and practices her culture.

Discussion

While the Results offered a direct representation of what the participants shared throughout the interviews, the Discussion offers a connection between these responses and the wider literature. In triangulating these information sets, meaning can be made and Indigenous women's experiences in Thunder Bay can be situated and contextualized within other (Indigenous and non-Indigenous) women's experiences. In engaging in this process, readers should be mindful about the process of connection and meaning-making, and the subjectivity

involved in this process—the researcher is making these connections, and are meant to be perceived as reflections based on the findings of the study, not as the underlying meaning or what participants meant to say.

In terms of impacts of and experiences of intimate partner violence, as the literature suggests, violence against Indigenous women can often be more severe and frequent than their non-Indigenous counterparts (Government of Canada, 2008; LaRocque, 1994; Statistics Canada 2006a). It seems as though the isolation that many women feel makes it more difficult for them to leave, and that community supports are not always established, creating a high-risk situation. For example, one woman stated "*...often there is nowhere else. So for a woman trying to flee, often in some of the smaller communities there's a housing crisis to begin with. There is no safe place to go. There's no means to get away*". Moreover, there seems to be an added layer of lethality due to that isolation. For example, one woman explained "*...the idea of lethality of intimate partner violence on a woman, and specifically First Nations women. When you're talking about women in more remote First Nations communities, you're talking about…every family has access to firearms and bowie knives and all those different things that isn't the same quite in an urban setting.*" Thus, experiences of violence may be more physically and emotionally injurious for women.

Moreover, while being abused by one's partner can have serious negative repercussions for one's well-being (Alani, 2013), many Indigenous individuals have endured many traumas in their lives (Chansonneuve, 2005) for which healing can take a long time. This was also something that resonated several times throughout the interviews. One service provider explained

> *…one thing that stood out for me really was the multiple traumas that people had experienced in their lives that was completely outside of my own experience in my culture, and so, we just need to remember that, right? It's not just that they're in a bad relationship, or that they had a sexual assault. Many of them are abused as children, physically, emotionally, sexually, many of them have had multiple relationships, multiple assaults, addictions, and loss…*

Some women explained that even though they had not directly experienced some of the traumas, their families had, and thus they were impacted by these traumas regardless. One woman stated:

> *I was born in the 1970s, so at that time there was a lot of umm…It wasn't the 60s but it was the last of the 60s scoop. So kids being apprehended by child welfare, residential schools were still up and running in that area. So me and my siblings went into care from there and I was placed in foster care…I was adopted when I was about 4 and separated from my family so I lost all roots to my culture and identity and stuff like that…The bad thing was that back in the day, when children's aid was involved, they didn't keep great records. Like my adoptive parents never knew my last name. They didn't know I was Native. They didn't know, you know, they didn't know all this stuff. So, I had to find out for myself.*

This seems to be the experience for many Indigenous individuals (Chansonneuve, 2005). The negative impacts of this disconnection from one's family and cultural identity was also repeated several times throughout the interviews. Separation from one's primary caregiver when young can lead to many socio-emotional development challenges, behavioural difficulties, and elevated aggression (Howard, Martin, Berlin, & Brooks-Gunn, 2011).

There was some discussion about the repetition of cycles within one's life in the interviews, and specifically that healing and being healthy meant no longer repeating such cycles. However, it seemed for many women, a cycle of violence was present within their lives. This may have been through experiencing/witnessing violence in their homes as children, within the foster care system, in past intimate relationships, or engaging in abusive or neglectful behaviours with their own children. Unfortunately, having an awareness of these cycles does not stop individuals from repeating them (Lane, Bopp, & Bopp, 2003). One woman explained

> *...during our relationship we talked about our parents, how abusive they were of each other, and how his dad used to fight with his mom too, and how he used to, when he was younger, try to stop his dad from fighting his mom. And he said he never wanted to be that way. And I believed him, right? I believed he would never be that kind of man.*

While these cycles of violence and trauma can repeat themselves, they can also stop; however, this takes hard work. Another woman described her awareness of these cycles in her own life when she stated

> *I also repeated the cycle. So not only was I exposed to a broken family and addiction and you name it. I repeated that myself. So I lost my daughter, I went through the addictions, I went through treatment, I did all this stuff so then it became the same system. And I broke that cycle with me and my kids.*

Many women in the interviews also asserted that re-claiming their identity was a first step to the healing process. This may have been through the process of connecting with one's family of origin, learning about one's history, connecting with other Indigenous individuals and organizations, or practicing one's cultural traditions. Some service providers expressed their surprise at learning how little some women knew about their histories, about their culture, and

about what their people had been through. One woman raised an important question when she shared

> *...but people really got a sense of* 'I get it, I get what happened to our people, I get why the struggles are there'. *And how do you, at that moment, empower them to get out of that victim role, or that* 'this is who we are'...

She went on to explain that this process of understanding one's own identity and how it relates to one's history and culture was more important than the practices that people often associate with tradition.

One's connection to their culture has been demonstrated to be a protective factor throughout the literature (McIvor, Napoleon, & Dickie, 2009), and thus many assert the importance of connecting to one's culture to facilitate the process of healing (Archibald, 2006; Chansonneuve, 2005). However, throughout the interviews, a consistent theme was the need to respect one's choice to practice traditional cultural ceremonies (e.g., sweat lodges). While this may seem like contradictory information, it is essential to be aware that culture is "a system of shared beliefs, values, customs, behaviors, and artifacts that the members of a society use to cope with their world and with one another, and that are transmitted from generation to generation through learning" (Bates & Plog, 1976, p. 7). Thus, while some may romanticize the thought of individuals learning and re-connecting with their heritage, this is not the only way in which cultural integration can be achieved. Instead, culture should not simply be thought of in terms of "traditional" or "historic" conceptualizations—culture is dynamic. As such, connecting with one's culture will mean different things to different people. Regardless of how culture is practiced, lived or internalized, it is thought to facilitate healing (Archibald, 2006). Moreover,

the practice of "traditional" may not be the best option for some women, and others may reject it. For example, one service provider explained:

> *...the reason I brought up drumming is we drum in this room. And so the women's bedrooms are upstairs, and some women are—just loved, like they just—they can't get enough of it right? They talk about the power and the strength of going to sleep listening to the traditional drums and the singing. And other women just want out, like* 'get me out of here while they're doing this', 'when are you going to be done'. *It depends on where they're at.*

Many of the women interviewed expressed the importance of letting individuals guide the process and allowing them to make as many decisions as possible throughout the therapeutic process. Trying to force or pressure women to practice certain traditions or engage with a culture that they may not feel is their own may be oppressive and re-traumatizing. Moreover, there is much diversity within the ways individuals practice their culture, traditions and spirituality, regardless of Indigenous identity, that prescribing specific practices would likely not do justice to the many ways in which culture and tradition can serve as protective factors.

Respect for the wishes of women and non-judgment must also apply to a woman's decision to stay with her partner, and this also was repeated several times throughout the interviews. Women have a variety of reasons to stay in their relationship with their partner, and these can range from fear to love to family expectations. As some of the women explained, no one can understand someone's situation better than the individual experiencing it. As such, service providers must work with women "*where they are at*".

Despite the difficulties and challenges that many women experience in their lives, one pattern that emanated from all of the interviews was the strength that women have, especially in

overcoming or working through difficulties. This is something that has largely been neglected from the literature, as most literature seems to focus on the negative experiences that Indigenous women survive. Some literature discusses family and culture as protective factors (Archibald, 2006), and while protective factors may be effective and helping women cope with their traumas, one cannot ignore the strength that one must have in order to endure the difficulties that women face. One woman explained that in her work with women she likes to

> *...sit and talk about how poor we were, and joke about stuff that they don't take as a joke from somebody else. You know, like just the reality of* 'holy man, we've been through so much hell', *you have to laugh through some of the stuff...*

Women are strong and survive the effects of trauma, life difficulties and everyday responsibilities. While this strength may help them maintain a certain level of well-being in their lives, many women also have an ideal of what they would like their lives to be. For many participants, being healthy and healed meant having self-awareness, being confident and trusting one's self, and not trying to change one's self for someone else. For one woman, she explained that the healing process was never-ending. She stated

> *...I don't know if you're completely healed. I'm always* (pause)*, we're always re-traumatized, we're always impacted. I think you really have to take care of yourself and not lose focus of who you are. That's what keeps me well today... I don't think it ever stops. I don't think it ever changes. I learn every day. I'm experiencing something different every day, so to say I'm 100% healed, I don't believe that.*

Summary and Conclusion

Through this research, it is clear that many Indigenous women living in Thunder Bay understand the effects of violence as existing outside of psychopathological contextualization

(e.g., not using terms such as depression and posttraumatic stress). This fits within broader literature that suggests that Western conceptualizations of psychopathology can be oppressive and silencing of Indigenous holistic understandings of health and well-being (Fellner, 2014). Moreover, as described by many of the participants, and found within literature (Fellner, 2014), health includes balance of all the different parts of the self, and is aspirational in nature. It is important to recognize that experiences of intimate partner violence and other factors that affect well-being are closely tied to the direct and indirect effects of colonization, and systemic racism and discrimination (Archibald, 2006). Thus, a clear understanding of how systems affect women's health and well-being is essential for a comprehensive case conceptualization.

At the same time, it is essential to remember that as much as women can be victims of violence (intimate partner and systemic), they are also survivors—they overcome, they are strong, and they work to take care of themselves. Thus, their experiences and their coping strategies should be validated, regardless of how "adaptive" they are. One way through which this can be communicated is by acknowledging that clients are doing the best that they can in a given situation, even when their strategies may have been unhelpful. By recognizing this, the shame, frustration and negative self-talk can be separated from the overall experience in order to better understand a client's decision making process. Another way that validation can be achieved is through the acknowledgment of one's emotions as appropriate. Many clients have difficulty recognizing and experiencing their emotions, and may react to them in unhelpful ways. By letting a client know that her emotions are valid (i.e., "you feel what you feel"), she can move from questioning whether she should be feeling and toward why she is feeling that way, and how she can better cope with that emotion (Linehan, 1993). It is through validating women's coping strategies while demonstrating new, and potentially more helpful strategies, that women can

begin to heal in a non-oppressive, empowering, and person-centred manner (Gone & Alacantara, 2007; Sue, 2003; Sue, Zane, Hall, & Berger, 2009). Through validation, women can be reminded of their strengths, their abilities to know and take care of themselves, and to re-gain trust in themselves—all of which may have been eliminated through experiences of intimate partner and systemic violence.

This project had several limitations. Primarily, the sample of women who participated in audio-recorded interviews was all service providers. Many of these women identified as Indigenous, and many were survivors of violence. However, it is possible that service providers carry a perspective that is different than Indigenous survivors of violence who are not working in this field. Moreover, it is possible that the sample of women who participated are further along in their healing journey, as this is likely necessary to be working in the field—as such, perspectives may have been conceptualized and expressed differently than those of women not working in the field. Another limitation is that while it was hoped that the process of engaging in this research would itself be empowering, this was not verified. As such, it is possible that the benefits of participating in this research were quite limited for participants. Almost all participants maintained contact with the researcher, and were amenable to providing feedback on this and other related projects, suggesting support and investment in the project. However, this was not directly assessed.

As social workers and other helping professionals continue to work with Indigenous women who are surviving the effects of intimate partner violence, it is essential for them to consider the complex and multifaceted ways that violence and oppression are experienced. Moreover, goals for health and well-being should be defined by the client, and may be holistic and defined outside Western concepts of illness.

Culture is an important part of all people's lives; however, the definition, practices and connections to culture will vary. This is true regardless of an individual's ethnicity. Thus, service providers should provide support and space for a woman to define and practice her culture in ways that are relevant to her. It is clear through this study that how women are affected by violence impacts their entire lives, but that the way through which this occurs will vary. While reconnection to one's culture may be an essential step in her healing process (Archibald, 2006), it may not be a woman's priority—housing, navigating the Justice System, or keeping herself safe may be more important. Each woman should be the one to define her needs, priorities, and how she connects and would like to re-connect with her culture. Working with one's clients in an open-minded, flexible, collaborative, and non-judgmental manner may be essential for healing, regardless of presenting concerns, immediate needs, or culture.

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Table 3

Questions Posed to Indigenous Women Survivors of Intimate Partner Violence and Service Providers

Questions for Survivors of Violence	Questions for Service Providers
What does it mean to be healthy? - How do you feel spiritually, mentally, physically and emotionally when you are healthy? - What does it mean to be a healthy Anishinaabek woman? - How do you know when you are unhealthy?	What are some of the impacts of intimate partner violence on a woman? - Do you think that intimate partner violence impacts First Nations women differently that non-First Nations women? If so, how? - How does intimate partner violence against First Nations women affect the women involved? - How does the violence affect the family and community?
What are the impacts of intimate partner violence on your life? - How does the violence affect your spiritual, mental, physical and emotional health? - What are the impacts on your relationships, your family, your community, and society? - When experiencing violence, what do you need from your relationships, your family, your community and society to feel well?	What are some strategies you use to help support and heal First Nations women from the violence they experience? - Are the strategies used with First Nations women different from strategies used with non-First Nations women? - Which strategies have you found to be most effective with this population?
Partner violence is often not the only thing that affects a woman's mental, physical, spiritual and emotional health. What are some other factors that affect your health (or, in other words, what are some other things that you feel you need to be healed from)?	What do you think are the most pressing needs of First Nations women who have experienced intimate partner violence?
What are some ways in which you cope with the violence and other traumas? - Are these strategies helpful? - Are these strategies healthy? If they are not, why do you choose to use them?	Do you attempt to integrate cultural and traditional practices into services? - If so, how have you/has your organization done this? - Do you feel that the strategies that you've used been effective? - How have you selected what practices to integrate?

- What are some useful strategies you could use? If these are not the strategies of choice, why not? - What strengths to do you draw on within yourself, your family, and your community to go on and to cope with the violence?	- What are some of the benefits of integrating cultural practices? - What are some of the shortcomings of attempting to do this?
What does healing mean to you? - If you felt healed, how would your life be different? - How would your spiritual, mental, emotional and physical well-being be different? - How would your relationships be different? - What do you need to heal? o What can services and people offer to you to help with the process of healing? o What in the past has hindered the healing process?	

List of Appendices for Chapter Three

Chapter Four:

Developing a Culturally Competent and Evidence-Informed Therapy Model for Women Surviving Intimate Partner Violence: The Case of Healing the Whole Self

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Preamble

This chapter is an illustration of how the Healing the Whole Self model was developed. It integrated findings from the needs assessment (Chapter Three) with information about best and evidence based practices found within the literature. It is written as a step-by-step model for how to approach the development of a culturally competent and evidence-informed therapy model, using the Healing the Whole Self model as an example.

Readers may notice a shift in focus from Indigenous women to all women who may experience marginalization. This shift occurs for several reasons:

a) At the time of implementation and evaluation of Healing the Whole Self, very few Indigenous women had enrolled in the program. This made it difficult and inappropriate to draw conclusions about the outcomes of the therapy as they relate to Indigenous women.

b) Based on the needs assessment (Chapter Three), it became apparent that not all Indigenous women, as would be the case for women from other communities, connect and identify with their Indigeneity in the same way. It was therefore decided that there would be nothing "Indigenous" about the Healing the Whole Self model, as this would allow participants to self-define their identities. In this way, the conceptual frameworks, practices and values that are most relevant to them, regardless of ethnicity, could be incorporated into the model for themselves The Medicine Wheel was used as a framework for the model, but many cultures consider health in broader terms than just the absence of illness, and include social and mental wellness within definitions of health (Dodge, Daly, Huyton, & Sanders, 2012; World Health Organization, 1948).

c) While women of differing identities have varying experiences of interaction with the world, research has demonstrated that perhaps more than culture, women identify with other women with experiences of intimate partner violence (Kelly & Pich, 2014). This research suggests that the common experience of violence may be more relevant for some women than shared cultural background. At the same time, experiencing marginalization is often a large component of how one interacts with the world, and may influence the way individuals can and do access services (Oetzel & Duran, 2004; Williams & Becker, 1994). Therefore, it is possible that a non-culturally-specific intervention for marginalized women may be a favourable alternative that respects diversity within culture.

It is possible that some women prefer a culturally-specific approach to treatment; however, this is not the approach taken by Healing the Whole Self. Instead, Healing the Whole Self makes space for all cultural identities and all women with the recognition of the importance of shared experience, while acknowledging diversity within this shared experience. If clinicians choose to use this model, it will be essential for them to complete the needs assessment in their own communities, as there may be different needs, and women may prefer a different (e.g., culturally-specific) approach. Regardless of the approach selected, the clients should determine how culture is integrated into the intervention.

Abstract

Objective: Psychological interventions dealing with the effects of intimate partner violence must be approached uniquely and sensitively. Most interventions are developed from a Western model of health and well-being, and may further oppress marginalized individuals. Considering these gaps in services, the high rates of intimate partner violence amongst marginalized peoples, and the potential harms of not offering appropriate services, an evidence-informed and culturally competent psychological intervention for minority and/or marginalized women surviving the effects of intimate partner violence was developed: Healing the Whole Self. Method: The researcher developed the Healing the Whole Self model by a) engaging in a needs assessment with key stakeholders, using the specific example of Indigenous women living in Thunder Bay, Ontario; b) reviewing the literature of evidence-based practices; c) developing the Healing the Whole Self model; d) seeking feedback. Results: The Healing the Whole Self model offers an integration of Dialectical Behaviour Therapy skills and the Tri-Phasic Model approach to trauma with culturally-relevant practices, and focuses on a holistic understanding of health and well-being. The model was generally positively regarded by key stakeholders and, through initial outcome evaluation, has demonstrated positive effects for clients. Conclusion: Interventions must be both evidence-based and culturally competent. This cannot be done without consultation, and flexibility of manualized treatments. The Healing the Whole Self model offers an example of how a psychological intervention can be developed to meet the needs of those accessing the service in an empowering and relevant way.

Chapter Four:

Developing a Culturally Competent and Evidence-Informed Therapy Model for Women Surviving Intimate Partner Violence: The Case of Healing the Whole Self

Violence against women affects women internationally (World Health Organization, 2008); however, research has demonstrated that women who identify within minority groups are at an elevated risk of experiencing more severe violence and increased consequences of violence, including injury, mortality and negative psychological effects (Lee, Thompson, & Mechanic, 2002). How women of minority groups are affected by violence may vary due to experiences of racism, a lack of cross-cultural dialogue related to experiences of violence, literature that assumes that gender is the primary factor affecting violence against women cross-culturally, and a lack of interventions that consider the unique and intersectional factors that may create the experiences for women of minority groups (Kasturirangan, Krishnan, & Riger, 2004). Thus, there has been a call to consider these unique factors, specifically within the context of intimate partner violence (Kasturirangan et al., 2004). The purpose of this paper is to consider these unique factors, and include them in the development of a culturally competent and evidence-informed group therapy for women survivors of intimate partner violence.

In community-based research, there is a recognition that each community is unique, and thus needs assessments should be community specific (Strand, Maurullo, Cutforth, Stoecker, & Donohue, 2003). The group therapy model described in this paper was developed in Thunder Bay, Ontario, where there is a large First Nations and Métis population (Statistics Canada, 2011). The Healing the Whole Self model (see Therapy Manual) was thus created assessing the unique needs of Indigenous women survivors of intimate partner violence in Thunder Bay. However, as

will be demonstrated, some of these needs largely overlap with those of other marginalized women survivors of intimate partner violence.

The Present Study

The field of clinical psychology aims to promote evidence-based practices (American Psychological Association, 2005, p. 1), which offer an integration of the "best available research" with "clinical expertise" and within the context of "patient characteristics, culture and preferences". It is in considering these three factors that clinicians can ensure best and effective practice, and minimize harm to clients. Thus, it is with the three factors of evidence-based practice that the current project was developed.

The present study sought to:

1) Integrate the best available research with clinical expertise, all within the context of client characteristics, culture and preferences to create an evidence-informed and culturally competent group therapy for women who are surviving the effects of intimate partner violence (Healing the Whole Self).
2) Provide a model for how clinicians/researchers can attempt to develop/modify psychological interventions for unique and diverse populations.

Methods

Several steps are necessary for the development of a culturally competent and evidence-informed group therapy for women surviving the effects of intimate partner violence.

1) Needs assessment with key stakeholders.
2) Review of literature of evidence-based practices in the context of needs expressed through Step One, and common psychological effects of exposure to intimate partner violence.

3) Development of the therapy.
4) Feedback, evaluation and next steps.

For the purpose of organization and clarity, each step will be explained in detail under the Results/Discussion section.

Results/Discussion

Step One: Need Assessment

A needs assessment includes an evaluation of the strengths, resources and needs of a community (Strand et al., 2003). This is important because each community is unique, what each community can do for itself will differ, and the supports a community may need in order to fill gaps in resources will vary (Strand et al., 2003). The needs assessment can include a community profile, which is a detailed description of the community, including its history and its current situations (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011). Speaking with key stakeholders is an essential part of the needs assessment (Kagan et al., 2011; Strand et al., 2003). These stakeholders can include individuals that are meant to benefit or consume a service that is being developed, as well as anyone that would be affected by a change (Kagan et al., 2011).

In the case of the development of a group therapy model for a community, a community profile could consist of history about a specific population, relationships and power dynamics in the community, and information about availability and accessibility of services. In terms of key stakeholders, this can include survivors of violence, service providers who work with this population, individuals in leadership and advocacy positions working with this population, and anyone else who may be important for the development of the intervention.

The case of Healing the Whole Self. A full description of this needs assessment can be found elsewhere (Chapter Three). The purpose of this step was to gain an in-depth

understanding of patient characteristics, preferences and culture. As the Indigenous population is one of the most visible and marginalized populations in Thunder Bay, Ontario, the needs assessment was conducted specifically with this population (Canadian Broadcasting Corporation, 2013; Statistics Canada, 2011).

Community profile. Rates of intimate partner violence, severity of experiences of violence, and psychological consequences of violence have all been reported to be elevated for Indigenous women living in Canada (Brownridge, 2008; Canadian Centre for Justice Statistics, 2001; Government of Canada, 2008; LaRocque, 1994; Lee et al., 2002). Moreover, Indigenous peoples living in Canada have experienced a history of trauma and violence through the Indian Act and colonization, the child welfare system, and residential schools (Archibald, 2006). This violence and oppression continues to exist in many Indigenous populations through government policies (National Collaborating Centre for Aboriginal Health, 2014), high numbers of missing and murdered women (Amnesty International, 2014), the reserve system (Musto, 1990), and the over-representation of Indigenous children in the child welfare system (Trocmé, Knoke, & Blackstock, 2004) and of Indigenous individuals in the criminal Justice system (La Prairie, 2002). Thus, there are several factors that likely contribute to the experience of trauma and overall psychological health and well-being for Indigenous women surviving the effects of intimate partner violence. Moreover, the intersection of all of these factors create a potentially unique experience for this population (Alani, 2013).

Considering the many oppressions and experiences of systemic violence that Indigenous peoples have experienced and continue to experience, it has been argued that psychological interventions must be adapted to the population of discussion (Archibald, 2006; Gone & Alcántara, 2007; Hays, 2009; McCabe, 2007). Current mental health models are understood and

situated within a predominantly Eurocentric Western paradigm, and because of this, they are often managed with mental health programs and interventions that may not recognize, value or meet the needs of Indigenous peoples (Vukic, Gregory, Martin-Misener, & Etowa, 2011). This is especially the case when such programs ignore cultural, historical, and social-political contexts. Some research has argued that even the current Western conceptualization of mental illness is oppressive and stigmatizing, as it does not recognize or allow for other ways of feeling, experiencing and being (Fellner, 2014).

With current conceptualizations of mental illness, individuals will continue to internalize messages of the deficits that they have. This not only can represent experiences of oppression, but can be re-traumatizing[3]. According to Baskin (2007, p.2), "The many traumas that Aboriginal peoples have faced has created a spiral of effects that stem from unresolved guilt, disenfranchised grief and internalized self hatred which is the legacy of colonization". Baskin (2007) goes on to explain that these traumas have created a collective response that cannot be adequately captured by one's personal trauma narrative. Indigenous peoples are considered "other" and with this comes the pathologizing of cultural practices and beliefs, something that has been done historically and continues to occur (Allan & Smylie, 2015). While in Western conceptualizations mental illness is understood as an individual phenomenon, within the context of Indigenous peoples and their collective experiences, the traumas are not individual, nor are the traumatic responses (Baskin, 2007). This is not to say that all individuals will emotionally process and respond to traumas in the same ways, but that continuing to conceptualize

[3] Through the process of colonization, many indigenous individuals were taught that their practices and beliefs were wrong and uncivilized, creating unresolved guilt, disenfranchised grief, and internalized self-hatred (Baskin, 2007). In pathologizing people's behaviours and feelings, this again is a process of telling people that the way in which they cope and exist is wrong and maladaptive, thus recreating a system of colonization and potentially re-traumatizing individuals.

Indigenous peoples' health and well-being outside of their historic context is ineffective and oppressive (Fellner, 2014). It has been suggested that any kind of *mental illness* that is experienced by Indigenous peoples can be represented holistically with the Medicine Wheel, which demonstrates how the healthy self requires balance of the mind, spirit, emotion and the physical self (Fellner, 2014).

Information from key stakeholders. Questions were posed to service providers and survivors of violence in Thunder Bay, Ontario, with a focus on the experiences of Indigenous women (Chapter Three). Many women experience complex concerns, including frequent crises, poverty, mental illness/mental health concerns, involvement with the Justice System, poverty, and child welfare. Historic/lifetime traumas, including family disconnection, effects of residential schools, prior experiences of family/domestic violence, involvement with child protection, and loss of culture were all contributing factors to the experiences of many Indigenous women. There are effects of violence on community and family, including fragmented family, community mistrust, and the cycle of violence—many participants shared that the effects on the community also affected their well-being. Emotional effects of violence reported through interviews included **a**nger/aggression, grief/loss, fear, sadness, anxiety, guilt, shame, loss of hope, emotional volatility, feeling lost (related to identity), emptiness, feeling like a failure, regret, jealousy, nightmares, and self-dislike. Social concerns included need for stable and safe housing, poverty, racism, lack of accessibility to services, concerns with the Justice System, food insecurity, difficulties finding time to relax/engage in self-care, feeling disconnected from one's community, and difficulty navigating social systems (such as the welfare, disability and employment systems).

Effective therapeutic strategies (see Appendix I) when working with this population included psychoeducation related to healthy relationships/recognizing signs of abuse, conflict resolution, understanding what we can and cannot control (i.e., radical acceptance), recognizing the impact of one's actions on others, setting "good" boundaries, developing "skills" to "cope", emotional regulation, learning about one's own needs, recognizing one's options (for services). Therapeutic processes (related to therapeutic alliance) that were found to be effective included treating women equally, supporting women and their decisions, strengths-based approaches, validating traumatic experiences, identifying and trying to satisfy basic needs, building trust, making sure that what is being offered is tailored to the individual, a non-judgmental approach, active listening, caring, honouring different belief systems, giving the opportunity for silence, and offering services for longer than the typical eight to 12 sessions.

In terms of cultural considerations in therapy, an important finding was that practices and beliefs are extremely diverse, even within the same ethnic group—as such, it was essential to not make assumptions or have exercises that are meant to resonate culturally with everyone. Having said this, participants also expressed the importance of being knowledgeable about colonization, the history of Indigenous peoples in Canada, and current struggles that some Indigenous peoples may be experiencing from a cultural framework. In terms of more specific strategies, the importance of letting participants guide the process, recognizing the value of oral traditions, and helping women connect with culturally-specific services (through referrals) may be helpful.

Conclusions. Many of the expressed concerns and needs of Indigenous women discussed in this needs assessment overlap with what many survivors of intimate partner violence experience; others are unique to having a marginalized identity (e.g., racism, barriers to accessing resources, systemic discrimination; Kasturirangan et al., 2004), while some are unique

to Indigenous women living in Thunder Bay (e.g., effects of colonization and availability of resources). The importance of recognizing the many different parts of self, balancing and addressing these parts, and providing a safe space and exercises for the whole self to grow and develop was highlighted. Many individuals of non-European and/or Western backgrounds express the importance of conceptualizing health and well-being as more than simply the absence of symptoms (Dodge, Daly, Huyton, & Sanders, 2012; World Health Organization, 1948). Moreover, experiencing mistrust and dissatisfaction with services, police, and the Justice System is quite common amongst marginalized populations (Bent-Goodley, 2005). The potential isolation, difficulties with safety planning, and cultural practices used for healing are potentially unique to Indigenous women living in Thunder Bay. The history of oppression through colonization is unique, but the effects of the process likely overlaps with colonized populations globally (Marker, 2003). Moreover, with discourses of multiculturalism in Canada, individuals who are considered other (e.g., visible minority groups) continue to experience marginalization (Schick & St. Denis, 2005). This demonstrates that there are many overlapping needs amongst marginalized and/or minority women who are surviving the psychological and emotional effects of intimate partner violence. There are also needs that may be specific to particular groups, keeping in mind that one's cultural identity does not imply similar needs or life experiences.

Step Two: Literature Review of Evidence-Based Practices

In order to balance patient characteristics, preferences and culture with the best available therapeutic strategies for the psychological consequences of exposure to trauma, a literature review including empirically-based and/or community-endorsed practices should be completed. This review would ideally integrate information from the literature regarding effects of intimate

partner violence (e.g., symptoms of posttraumatic stress disorder) with information from the needs assessment. Below is an outline of how this was done for Healing the Whole Self.

The case of Healing the Whole Self. For Healing the Whole Self, a literature review was conducted to gain a better understanding of the psychological/emotional effects of intimate partner violence, and best practices for working with trauma and the presenting concerns outlined in the needs assessment.

Psychological consequences of exposure to intimate partner violence. Intimate partner violence has been associated with several mental health concerns (Chapter Two, Chapter Three). These concerns include depression, anxiety, posttraumatic stress disorder, self-harm and suicidality, poor self-esteem, eating and sleep disorders, and alcohol and drug abuse (Chapter Three, Campbell, 2002; Lafta, 2008; World Health Organization, 2008). Grief, loss, shame, guilt, anger and aggression are also common experiences (Chapter Three, Kearney, 2001). Moreover, through the Needs Assessment (Chapter Three), many women expressed difficulties trusting themselves and others, understanding their emotions, and feeling a loss of identity. Thus, it seems that there are several emotional concerns with which women may present. Moreover, due to the many potential traumas that marginalized women have experienced, working through trauma would likely be an important need to address.

Considering the varied concerns of Indigenous women survivors of intimate partner violence, a therapeutic strategy that would be able to address these concerns in a broad way (to meet the varied needs of the group), yet specifically enough to be relevant to each member of the group would be essential.

There are several empirically-supported therapies for the concerns listed above, including for working with posttraumatic stress, depression and anxiety. However, the American

Psychological Association (2001) has stressed that current therapeutic interventions that relate to the psychological effects of intimate partner violence are likely inadequate. Moreover, while prolonged exposure is a common and empirically-supported treatment for trauma, several researchers (Herman, 1992; Warshaw, Sullivan, & Rivera, 2013) have suggested such strategies may not be effective if trauma responses (such as heightened or exaggerated response) are appropriate for ongoing danger, and assumptions should not be made about passive responses/avoidance, as these may be intentional. Baskin (2007) and Herman (1992) also suggest that when there are a number of traumatic experiences (as is often the case in both intimate partner violence, and the histories and life experiences of marginalized peoples), then prolonged exposure may not suffice to reduce posttraumatic stress responses.

Cognitive behavioural strategies. Several adaptations of cognitive behavioural therapy for trauma have been made for survivors of intimate partner violence (Crespo & Arinero, 2010; Johnson, Zlotnick, & Perez, 2011; Kim & Kim, 2001; Kubany, 2003; 2004). These interventions have excluded prolonged exposure, but have included psychoeducation about posttraumatic stress, stress management, exposure (through talking about trauma, homework, and watching movies about domestic violence), problem-solving skills for independent living, and anger management, amongst other things. They also aimed to address self-esteem and trauma-related guilt. These models were effective at reducing symptoms of posttraumatic stress and depression, with one decreasing the likelihood of experiencing abuse at six months (Crespo & Arinero, 2010; Johnson et al., 2011; Kim & Kim, 2001; Kubany, 2003; 2004). For example, Kubany et al (2004) found that 87 and 83 percent of the women who completed treatment no longer met criteria for posttraumatic stress disorder and depression, respectively. The models ranged from eight to 12 sessions. Crespo and Arinero's (2010) model had similar success, with symptoms of

posttraumatic stress, depression, and anxiety virtually disappeared after treatment, and participants were better able to express their anger. While these adaptations offered promising solutions, they were quite focused on trauma related to intimate partner violence, posttraumatic stress as the main presenting problem, and were quite brief in nature.

Emotion focused strategies. Emotion focused strategies may be helpful for women who express concerns with recognizing, understanding and coping with their emotions, as this therapy teaches individuals how to have better awareness of their emotions, and to control and experience them simultaneously (Greenberg, 2004). Emotion focused therapy for trauma works with past traumatic experiences, and utilizes a positive/healthy attachment figure to facilitate this process (Paivio & Pascual-Leone, 2010). Such an approach may not be appropriate if women are still in their violent relationships, if their violent (ex)partner is their primary attachment figure, and/or if they cannot identify a positive/healthy attachment figure (as might be the case considering family and community fragmentation that may occur in marginalized and/or minority peoples; Harris & Miller, 2006; Paletta, 2015; Ross, 2009). Moreover, it has been suggested that emotion focused strategies may not be the most effective for survivors of intimate partner violence (Clements & Sawhney, 2000), as processing the traumatic events may be too emotionally distressing (Greenberg & Pascual-Leone, 2006). No studies were found that have implemented an emotion-focused therapy approach to survivors of intimate partner violence, and while it has been used with couples, its use in contraindicated for use with on-going violent relationships (International Centre for Excellence in Emotionally Focused Therapy, 2007).

Dialectical behaviour therapy. Dialectical behaviour therapy is a cognitive behavioural therapy, developed primarily to treat borderline personality disorder. The therapy offers four modules: mindfulness, emotional regulation, interpersonal effectiveness and distress tolerance.

Clients should feel as though there is no judgment from clinicians or group members, however; this does not mean that clients are not accountable for their behaviours—clients should expect to be questioned by therapists, this process encourages clients to do their best and to be thinking about their decisions and behaviours (Linehan, 1993a;b). While, to date, there is very limited published research on the efficacy of the application of dialectical behaviour therapy for post-traumatic stress, or for use with survivors of intimate partner violence, it has been theorized to be effective (Landes, 2013; Wagner, Rizvi, & Harned, 2007). It has started to be applied to individuals with post-traumatic stress and borderline personality disorder with promising results in managing trauma symptoms (Bohus, Dyer, Priebe, Kruguer, & Kleindienst, 2013; Harned & Linehan, 2008).

Iverson and colleagues (2009) adapted the dialectical behaviour skills group for women who have experienced domestic abuse. They created a 12-week program, and focused on skills training while offering telephone coaching as necessary. A total of 31 women (all but one of whom were Caucasian) completed the group intervention, and statistically significant decreases in depression symptoms (as measured by the Beck Depression Inventory-II), hopelessness (as measured by the Beck Hopelessness Scale), social adjustment (as measured by the Social Adjustment Scale – Self-Report), and overall distress (as measured by the Symptom Checklist-90-R) were found, with moderate to large effect sizes.

Tri-phasic model for complex posttraumatic stress disorder. Complex posttraumatic stress has been theorized to occur after repeated exposure to violence, including violence that occurs in childhood, and that feels inescapable (such as in torture, prolonged combat, intimate partner violence, and childhood abuse; Herman, 1992). The tri-phasic model has been asserted to be the most appropriate for the symptom cluster for complex posttraumatic stress (Courtois,

Ford, & Cloitre, 2009; Herman, 1992; Luxenberg, Spinazzola, Hidalgo, Hunt, & van der Kolk, 2001; van der Kolk, 2001). Stage one of this treatment involves stabilizing the client, building therapeutic alliance, helping her to better understand situations, people and environments that cause her distress, and developing trust and boundaries (Herman, 1992). This stage is essential before the processing of one's experiences of trauma can begin, because without a sense of safety and stability, it is likely inappropriate to begin processing trauma. The goal of the second stage of treatment is to have the client incorporate the traumas into her memory as a coherent narrative, where the traumatic events become part of the person's narrative, rather than the focus of it. Moreover, the client should learn to cope with the traumatic memories in less affect-intense ways. In the last phase of treatment, the client aims to integrate back into her environment by rebuilding relationships, identifying desirable occupations, and reconnecting with other aspects of her life that were once important and meaningful. It is in this stage that the client has an opportunity to have a fresh start to her life since the trauma, establishing new goals and purpose. Once this stage is complete, the client should feel prepared to carry on with her life, without the trauma impacting her the way it had prior to the commencement of therapy (Herman, 1992). This model has been argued to be more effective when a survivor's mission, an exercise in investing one's time in a meaningful activity (an opportunity to do something for one's self/one's community), is included (Herman, 1992; Luxenberg et al., 2001). The tri-phasic model is often included within different therapeutic modalities, and is an approach to working with trauma rather than a set of strategies belonging to a therapeutic orientation.

A***pproaches to culturally competent interventions.*** Individuals of diverse backgrounds may not benefit from psychotherapy to the same extent as individuals of Western and/or European backgrounds (Fellner, 2014; Gillum, 2008, McCabe, 2007). As such, the American

Psychological Association (2005) asserted that patient preferences, including cultural beliefs and values, must be a part of evidence-based practice, and that practitioners should aim to be culturally competent (American Psychological Association, 2003). This includes a) developing interventions collaboratively with the target population and relevant stakeholders; b) using language that is familiar to clients; c) including representative staff; d) the intervention occurring in an environment that is comfortable for clients; and e) incorporating cultural values, norms, expectations, and attitudes of the clients (Gillum 2008). It should consider potential oppressions, barriers and unique circumstances of the client group (Sue, Zane, Hill, & Berger, 2009).

There is a lack of research on the quality and outcomes of interventions developed for women of colour survivors of intimate partner violence (Chapter Two). A scoping review (Chapter Two) demonstrated the importance of working with the community to establish what might be best for those seeking out the service, thus using community-based collaborative models (e.g., Kelly & Pich, 2014). Some extrapolated important cultural values and developed interventions based on these values (e.g., Davis et al., 2009). Several interventions were developed based on presenting psychopathology (e.g., Nicolaidis et al., 2012), while others were grounded in healing and well-being (e.g., Lester- Smith, 2013). One study applied an already existing intervention to a Korean population (Kim & Kim, 2001); however, this was the only study found through the scoping review to use this approach. Across all interventions, outcomes measured varied, methods of evaluation were inconsistent, and thus, the quality of interventions remain incomparable. Thus, there is not yet a best practice in terms of approach to intervention development, theoretical model, or aspects of culture to be included. Moreover, what the focus of intervention should be, how this should be measured, and ways that feedback ought to be

included are undefined. What was clear was that researchers are working, often with community, to establish effective interventions for survivors of violence.

Integration and discussion. There are several aspects to many of these psychological interventions that may be beneficial for marginalized women surviving intimate partner violence. The cognitive behavioural interventions offer some essential strategies for intervention (including psychoeducation, stress management, and indirect exposure), while the emotion focused therapies offer helpful theoretical understandings of why emotional processing may be helpful for this population. While some emotion-focused strategies may be helpful (such as learning emotion regulation), it has actually been reported to be harmful for working with individuals who are still in their violent relationships. Dialectical behaviour therapy offers strategies that may be helpful, including those related to mindfulness and awareness of one's self and surroundings, emotional crisis management (through distress tolerance), an opportunity to recognize, understand and cope with one's emotions (through emotional regulation), and strategies for having more positive relationships. The structure of the tri-phasic model offers a helpful foundation for how an intervention working with trauma should be built, and has been integrated into many therapeutic modalities. Moreover, complex posttraumatic stress symptoms (including difficulties with affect and impulse regulation, alterations in attention or consciousness, in self-perception, in systems of meaning, and somatization; Luxenberg et al., 2001) overlap with psychological consequences of intimate partner violence, including those found from the Needs Assessment (Chapter Three) and from within the literature. Several researchers have included some aspects of cultural competence guidelines into their interventions; however, it remains unclear how such inclusions have benefitted clients.

Regardless, the importance of cultural competence and ways that this can be achieved have been highlighted throughout the literature (Gillum, 2008; Sue et al., 2009).

Step Three: Development of the Intervention

With the information obtained in the initial steps, the therapy model is likely ready to be developed. Emphasis should be placed on addressing the concerns outlined in the needs assessment, and assumptions about what women are experiencing based on research should be considered critically before being integrated within the intervention. There must be an emphasis on the cultural competence skills of the clinician. These include a recognition of the importance of culture, attempts to appropriately integrate culture into interventions, vigilance toward the dynamics that may result from cross-cultural similarity and difference, and attempts to meet the culturally unique needs of one's clients (Whaley & Davis, 2007). The program should be offered tentatively as opposed to as a manualized treatment, with regular opportunities for feedback within the group. Clients should be invited to offer their own strategies, and the therapist should inquire as to whether the skills and content of the group resonate with people's values and belief systems. Moreover, therapists should aim to educate themselves about the experiences and histories of the peoples in their community (especially their client groups). Integrating relevant and appropriate teachings (e.g., Seven Grandfather Teachings) into the therapy model may be especially helpful for clients. All therapists should make an effort to be non-judgemental, to not pressure women to leave their violent relationships, to work with women on concerns related to child welfare, drugs/alcohol, and risk of harm to self or others. Lastly, this therapy model should be made as accessible as possible (through the offering of bus passes/subsidized transportation, child care, food, and by having a flexible attendance policy). Below is an outline of components of Healing the Whole Self as an example of how this could be done.

The case of Healing the Whole Self. The Healing the Whole Self model is a 20-session group program, with several individual "check-in" sessions as well.

Group sessions. Group content focuses on Dialectical Behaviour Therapy skills, including mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness, and should be structured in this order. Every session should begin with a check-in (an opportunity for clients to share something about their week), a mindfulness exercise, and a Sharing Exercise. The Sharing Exercise provides a platform for each client to share something from her culture, tradition, or upbringing, in a way that resonates with her (this may be through drumming, singing, beading, telling a story, sharing art, etc.). By using the Sharing Exercise approach, each client gets to define what parts of her identity are important to her, gets to choose how to connect with parts of her identity, and is offered an opportunity to take a leadership/facilitation role. Content of the group intervention includes psychoeducation about intimate partner violence and the effects of violence (after basic distress tolerance skills have been taught), and an opportunity to develop a survivor's mission (should clients desire to do so) or work on anything that clients would like. These sessions may be used to collaboratively develop a way of supporting their own healing or the healing of others, to review skills, or to explore other concerns that had not been addressed through the group content. This approach is in line with empowerment approaches, which have been found to be healing (Donaldson, 2005), particularly for marginalized populations (Serrata, 2012).

If clients choose, each group may also begin or end with a ceremony or practice (e.g., a smudge, an Indigenous purification ceremony that uses the four sacred medicines, sage, sweet grass, cedar and tobacco, and is meant to purify the mind, body and spirit; Little River Band of Ottawa Indians, 2014). Should this be something that clients want, the therapist should

encourage clients to lead this ceremony. Caution should be used so that the therapist does not communicate mastery of a cultural group to which she does not belong.

Individual sessions. Individual sessions are intended to build rapport, address initial needs (e.g., housing, food access), and for safety planning, risk assessment, and evaluation of progress and goals. Individual sessions take place prior to the commencement of group, at the termination of group, and every five sessions in between. These sessions are meant to be brief sessions (approximately twenty minutes), and can take place over the phone. The individual appointment after session twenty marks the last meeting, and should be used to offer closure for the client, should address any lasting concerns, and to provide referrals as necessary.

Life history journal. Exposure will take place through a *life history journal*. It is with this journal that clients can document their life story, including traumas they may have experienced throughout (and before) their lives. This journal should be approached in an order that makes sense for the client (e.g., chronological), and include any important life events (regardless of trauma-relatedness), how they were feeling at the time, and what they learned from the event/experience. While most journals are structured to be dominated by writing, it is understood that this may not be the client's preference. As such, each client is invited to use writing, drawing or oral history in order to communicate her life history. If possible, a journal, sketch book or audio recorder should be provided to each woman, based on her selected medium of engaging in this process.

Before the journal is assigned, the therapist should ensure that the client has some basic relaxation and self-soothing skills, which would have been taught by this time. All clients will be made aware of this part of the therapy, and because it does not focus on one trauma in particular, nor does it force women to think about something they are not already in awareness

of, it is hoped that this process will not cause intolerable distress. A client's preparedness for engaging in this process should be her decision.

Discussion. The Healing the Whole Self model offers different components, including skills for understanding one's self, one's emotions, developing effective relationships, learning helpful coping strategies; psychoeducation about violence, the impacts of trauma on people generally; and providing a platform for clients to explore how trauma has affected them personally. Moreover, in being tentative in its approach, it allows for flexibility and for the strategies to be adapted to clients' values and belief systems, thus including culture in a way that is defined by the clients. Moreover, clients have an opportunity to share their cultural practices in an authentic and empowering way. Child care, bus passes, and snacks were always made available in order to increase accessibility.

Step Four: Feedback, Evaluation, and Next Steps

There has been a lack of empirically-supported culturally adapted or developed interventions for minority and/or marginalized individuals (Chapter Two; Gone & Alcántara, 2007). In order to ensure best and evidence-based practice, evaluation of outcomes is a necessary component of an intervention. Evaluation should comprise of primarily qualitative and collaboratively developed outcomes—these are important in order to not further oppress marginalized individuals who may not adhere to a Western and colonial understanding of well-being (Fellner, 2014). However, this evaluation can be supplemented by standardized quantitative measures of health and well-being, with an understanding that these measures have likely not been psychometrically assessed with culturally and/or diverse peoples in Canada. Moreover, feedback and suggestions should be sought from clients throughout, and especially at the end of, the therapy in order to continue with the collaborative nature of the group

intervention. This can occur through obtaining informal or formal feedback from clients, and stakeholders and partners developed during and after the needs assessment. Actively obtaining and recording feedback is important to understanding client needs and how the intervention may be most effective for clients.

The case of Healing the Whole Self. This model was developed through community collaboration; thus, seeking feedback from community stakeholders was an essential step. This was done informally with many of the participants who engaged in the Needs Assessment (Chapter Three) process with the researcher. This included sharing drafts of the Therapy Manual, meeting with individuals to share progress of the project, and consulting with a Frist Nations Elder throughout the development and implementation of the intervention. Most feedback was positive, and stakeholders expressed the importance of this work and for women to be able to access this treatment model. Two participants suggested holding a community-wide training for service providers in Thunder Bay, Ontario, believing that organizations should incorporate this as a part of their programming. The researcher had an opportunity to do this. Approximately fifty individuals attended, and feedback about the therapy model and its applicability across settings was positive and optimistic (see Chapter Seven).

Some stakeholders shared that the twenty-session structure may not be adequate to work through the extensive traumas that many women have experienced. However, one of the stakeholders expressed concern that a twenty-week commitment may be too long and that the length of the program may affect enrolment rate. Some stakeholders also emphasized the importance of more traditional approaches to healing, and that traditional approaches needed to be the emphasis of the healing journey. While the researcher does not disagree with this, there is also recognition that the needs of women will vary, and that the Healing the Whole Self model

offers an adaptation of Western approaches to well-being that may resonate with some Indigenous women.

The research team conducted a pilot study implementing and evaluating the Healing the Whole Self model using quantitative measures for depression, anxiety, stress (Depression Anxiety Stress Scale; Lovibond & Lovibond, 1995), posttraumatic stress disorder (Post Traumatic Stress Disorder Checklist – Civilian Version; Weathers, Litz, Huska, & Keane, 1994), and quality of life (World Health Organization Quality of Life Assessment – Short Version; World Health Organization, 1997), in conjunction with semi-structured interviews about well-being, presenting concerns, and progress throughout the program. Considering the potential harm of conceptualizing health and well-being solely from within a Western framework (McCabe, 2007), quantitative measures should be used with caution. Preliminary findings suggest that clients experienced the therapy model positively and felt they benefitted from it (Chapter Five). Moreover, quality of life significantly increased, and depression, anxiety and stress significantly decreased after participating in the Healing the Whole Self group therapy (Chapter Six). While this is the approach used by the research team, other research teams and/or clinicians may use measures and strategies that are more relevant for their client group's needs.

Conclusions and Recommendations

There is a clear and potentially harmful gap in services for marginalized women who are surviving the emotional and psychological consequences of intimate partner violence. Using the steps outlined in this paper to develop a therapy allows community members to be stakeholders, is designed with a specific community's needs, and can be adapted to meet the needs of diverse marginalized groups. Culture, regardless of its definition, is an important part of an individual's identity. How this is practiced must be determined by the clients. This provides choice to the

client and recognizes the various ways with which people connect with and practice their cultures. The Healing the Whole Self group was one example of how these steps have been applied with positive outcomes.

Some research has suggested that it is crucial for marginalized peoples to engage in cultural practices, and that these will be most helpful for their healing journey (Archibald, 2006; Chansonneuve, 2005; Gillum, 2008). This model offers opportunities to engage in culturally relevant practices in a way that is empowering and meaningful for clients, without assumptions of what these practices may be. The needs assessment process should help clinicians determine how culture can best be incorporated for their target client group. With this in mind, the approach selected will likely not be applicable or helpful for all individuals. Potential clients should be informed of exactly what the model includes prior to the commencement of the therapeutic process.

Researchers and clinicians should consistently engage in needs assessments of clients prior to applying an intervention, in order to ensure that the strategies are relevant for the population. Moreover, feedback and evaluation are an essential part of the process of developing evidence-informed and culturally competent therapy models. Outcome measures for evaluation should consider actual presenting concerns of clients as opposed to stereotypical concerns (i.e., the psychological effects of trauma may be expressed in different ways amongst different groups, thus a measure of posttraumatic stress disorder may not necessarily be relevant). In the selection of outcome measures, researchers/clinicians should also consider whether the measures have been psychometrically evaluated and supported for the specific group with whom the measure is being used. If it is not, the implications of including such measures should be evaluated critically.

The steps outlined in this paper, with the Healing the Whole Self model being an example of how they can be applied, suggest a method of developing a therapeutic intervention that may be adapted and implemented with different groups, as well as one way through which a culturally competent and evidence-informed psychological interventions can be developed. Considering the emergence of this model, researchers and clinicians are encouraged to modify and offer constructive criticism in the effort of establishing best practice. The American Psychological Association (2005) has advocated for the use of evidence-based practices, and including client characteristics and preferences is an essential part of this process. Thus, as future interventions are developed, cultural integration must be a part of this process—the steps outlined in this paper may be one way through which this can be approached.

Concluding Thoughts

There has been a lack of culturally competent and evidence-informed psychological interventions for marginalized peoples (Gone & Alcántara, 2007; Vukic et al., 2011), and it has been argued that interventions that do not consider culture may be less effective or harmful (Fellner, 2014; McCabe, 2007). Moreover, the American Psychological Association (2001) has asserted that current interventions for working with survivors of intimate partner violence may be inadequate and that more work is needed in this area. The approach outlined in this paper included engaging in a community Needs Assessment, contextualizing needs within the broader literature of evidence-based practice, and seeking feedback from community stakeholders. Evaluation and continued feedback are necessary before an intervention should be considered best practice or used widely, in order to ensure efficacy and effectiveness. In order to meet the requirements of evidence-based practice set out by the American Psychological Association (2005), it is essential to understand client characteristics, preferences, and culture, and to

integrate these with clinical expertise and empirically-supported treatments. Following a model similar to that used for the Healing the Whole Self program offers one approach to achieving evidence-based practice, while ensuring cultural integration.

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Chapter Five:

Healing the Whole Self: Evaluating a Culturally Competent and Evidence-Informed Group Therapy for Women Survivors of Intimate Partner Violence

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Preamble

This chapter describes the evaluation of Healing the Whole Self within a community organization in Thunder Bay, Ontario. The findings are based on qualitative responses to pre- and post-intervention interviews. Change was determined by how the participants described change, discussed life circumstances that were different from pre- to post-intervention, and how they had integrated aspects of the intervention into their everyday lives.

Abstract

Objectives: This study sought to evaluate client therapeutic change after participating in Healing the Whole Self, a 20-session group therapy developed for women survivors of intimate partner violence. Healing the Whole Self was developed using a community-based and culturally competent framework. It includes Dialectical Behaviour Therapy skills, is trauma-informed (using the Tri-Phasic Model as a foundation) and has aspects of empowerment strategies.

Method: The group was implemented twice, with a total of nine women completing the program. Clients varied in ethnic background, and ages ranged from 28 to 57. Data were analyzed using information from pre- and post-intervention interviews, using a single-case design.

Results: Findings demonstrate that seven of the women experienced change that could be attributed to the therapy model, whereas the other two enjoyed the therapy and reported benefitting; however, how they benefitted remained unclear to both them and the researchers.

Conclusions: The Healing the Whole Self model may be a useful way for working with women survivors of intimate partner violence.

Chapter Five:

Healing the Whole Self: Evaluating a Culturally Competent and Evidence-Informed Group Therapy for Women Survivors of Intimate Partner Violence

Most psychological interventions related to intimate partner violence have been developed for perpetrators of violence, with very few addressing the psychological needs of the survivors (Brosi & Rolling, 2010). Research (American Psychological Association, 2001; Herman, 1992) has also demonstrated how the experience of intimate partner violence can result in unique psychological consequences, including variations from expected trauma symptoms. Thus, the American Psychological Association (2001) has asserted that better supports and interventions need to be developed to support survivors of intimate partner violence's emotional and psychological needs. Furthermore, most psychological interventions that have been developed to address mental health needs in general have been developed from and for Western and Eurocentric (i.e., White) populations, and may overlook the unique needs of diverse groups (Vukic, Gregory, Martin-Misener, & Etowa, 2011). Such Eurocentric Western conceptualizations of health, well-being and healing may deny other ways of knowing, and may further oppress, silence, and contribute to illness (Fellner, 2014; McCabe, 2007). Within the context of intimate partner violence, how women of minority groups are affected by violence may vary due to experiences of racism, a lack of cross-cultural dialogue related to experiences of violence, literature that assumes that gender is the primary factor affecting violence against women cross-culturally, and a lack of interventions that consider the unique and intersectional factors that may create unique experiences for women of minority groups (Kasturirangan, Krishnan, & Riger, 2004). Thus, there has been a call to consider these unique factors, specifically within the context of intimate partner violence (Kasturirangan et al., 2004).

Healing the Whole Self

The Healing the Whole Self model is a group therapy that was developed using community-based methods, with the purpose of being culturally competent, empowering, and healing. The model was developed by speaking with survivors of violence and their service providers, and situating what was shared about their experiences within the literature on evidence-based practices. In doing this, the research team was able to better inform the "patient characteristics, culture and preferences" aspect of evidence-based practice (American Psychological Association, 2005, p. 1).

The content included in the model is structured around Herman's (1992) tri-phasic model for working with trauma. It includes ensuring safety and stability, processing the trauma and incorporating it into one's life narrative, and lastly integrating back into one's environment. Thus, the therapy spends the initial two sessions individually, allowing for safety planning, risk assessments, addressing immediate needs, and developing therapeutic alliance. To allow for the processing of one's traumatic experience, a Life History Journal is introduced as an opportunity for the client to write about major (or minor) life events, including traumatic experiences, and to describe the effect of such events on her life, and what she has learned from and how she has grown since these events. The reintegration aspect of the model is completed nearing the end of the therapy, and clients have the opportunity to come together to do something that they believe will help them move forward. This is similar to what Herman (1992) calls the survivor mission, and such approaches have been described as therapeutic and empowering (Donaldson, 2005). Offering space for collaboration and client-directed processes may also be appropriate for working cross-culturally and with oppressed individuals (Campbell & Campbell, 1996; Mills, 1996; Spong & Waters, 2015), as it does not make the assumption that the service provider

knows best. There are two sessions dedicated to psychoeducation related to trauma and domestic violence. Most other sessions involve the teaching of Dialectical Behaviour Therapy skills (Linehan, 1993). Each session begins with a Sharing Exercise (a cultural sharing led by one client) with clients taking turns every session, and with a mindfulness exercise. For a more detailed explanation of the development and structure of the Healing the Whole Self model, see Chapter Four and the Therapy Manual.

Purpose of Study

The purpose of the current study was to evaluate outcomes related to the Healing the Whole Self model. Considering the lack of culturally competent interventions that are evidence based and empirically supported (Whaley & Davis, 2007) it was essential to evaluate the outcomes related to this model. However, in order to maintain a lens of cultural appropriateness, it was decided that outcomes would best be measured according to the presenting concerns as described by clients and the change in these self-reported concerns, and how participants connected this change to aspects of the therapy. This relates to challenges in the use of empirically validated and psychometrically supported assessment measures cross-culturally (Mushquash & Bova, 2007). As such, change was measured using single-case approaches, examining change from pre- to post-intervention, and whether aspects of the therapy (i.e., Dialectical Behaviour Therapy skills, information about trauma, etc.) was related to this change.

Methods

Participants

Participants included nine women living in Thunder Bay, Ontario who were surviving the effects of intimate partner violence. Four of these women were still in a relationship and/or co-habiting with their abusive partners, with two of the four no longer being emotionally or

romantically involved with her partner, and another reporting no longer being abused by her partner. At the beginning of the therapy, two of the participants were living with their partners; however, by the end of the program, one of the two women had successfully moved into her own home. Most of the women were unemployed or underemployed (n = 6), and one participant was on disability. Of the women no longer in a relationship with their partner (n = 6), five were involved with the court system or were trying to negotiate assets and/or alimony with their ex-partner. Participants ranged in age from 28 to 57 (M = 48.88). Many of the women had involvement with the Justice system.

Procedure

Recruitment. The researcher collaborated with a counselling centre in Thunder Bay, Ontario, and this is where the groups were run. Potential clients were contacted by the researcher from the centre's waitlist and "Violence against Women" list (these women receive services free of charge from the agency). Clients were asked if they were interested in attending a group therapy for women who have experienced violence or difficulties in their intimate relationships. They were also told that the emphasis of this program would be on the self (and not the relationship with one's (ex)partner). The group was described as being twenty sessions, with each session lasting two hours. Potential participants were then invited to an intake session where they could learn more about the program, and tell the researcher about their goals and interests in attending.

Intake. Upon first meeting, the group, including content and structure, was explained to clients. The evaluation component was also explained. Participants were told that they did not have to participate in the evaluation component in order to participate in the group therapy, and two separate informed consent processes were involved, one for clinical services and the other

for research. All clients chose to participate in the evaluation component. Once this occurred, an intake interview was conducted and audio recorded. Interview questions included presenting concerns, goals, an opportunity for participants to share their story, and their definition of healing and wellness. Participants were informed that they would be compensated fifty dollars for participating in the research aspect of the group, with twenty dollars awarded after the intake, ten dollars half way through, and another twenty dollars upon completion of the group and the post-intervention interview.

The groups. Two separate groups were run separately. Data from both groups were collapsed and analyzed together; however, demographics and process varied slightly between groups.

Group one. The first group included ten women, from which two women dropped out within the first three sessions. One woman attended sporadically (she was often out of town for three weeks, and missed four additional sessions because of illness and weather) and thus her data was not included in the evaluation. The rest of the women attended between 16 and 20 of the sessions. Thus, there was an attrition rate of twenty percent. All but one participant was no longer romantically involved with their partners, and only one partner was living with her partner (however, by the end of the group, she had moved into her own home). This group was run weekly, and was co-facilitated. The primary facilitator was the researcher, who has a Masters in Clinical Psychology, was doing a PhD in Clinical Psychology, developed the group content, and was being supervised by a registered clinical psychologist in Ontario. The co-facilitator had been working at the agency for 2.5 years, has a Master of Counselling, and had been trained by the researcher in the group content and structure.

Group two. The second group initially included six women; however, two of the women never attended any of the group sessions—they only attended the intake session. Thus, four women started attending the group. One woman stopped attending after the third session, and another after the sixth session. The woman who stopped attending after the sixth session contacted the researcher and let her know why she could no longer attend. From those who attended the group therapy, there was an attrition rate of fifty percent. Both women who remained in the group were still in a relationship/co-habiting with their partners, although one of the women was not romantically involved. The group was facilitated by the researcher, and sessions were run twice a week.

Data and Data Analysis

Data included information from a pre-intervention interview during the intake sessions, and a post-intervention interview that took place after the twentieth session. All but one of the pre-intervention interviews were completed by the researcher (one intake was completed by the co-facilitator). All post-intervention interviews were completed by the researcher. Questions in the pre-intervention interview related to the client's demographic information; presenting problem; immediate concerns and needs, including physical, emotional, mental, and spiritual concerns; current social supports; substance and alcohol use; current obstacles; coping strategies; goals; and the client's perception of her wellness. Questions in the post-intervention interview related to whether and how the client's well-being has changed; perceptions of goal attainment or change; changes in perception and attainment of wellness; client's self-perceived strengths; what the client has learned about herself; aspects of the therapy that were helpful or unhelpful; and other feedback.

All interviews were audio recorded, with the participants' consent, and were transcribed and stripped of identifying information. Transcription was completed by someone independent of the research project, and transcripts were checked by the researcher. Each set of pre- and post-intervention interviews were analyzed as a pair. Thus, data analysis occurred using a single-case design. This approach was chosen as it emphasizes the importance of diversity in cross-cultural research, as opposed to the aggregation of data that occurs in intersubject research designs (Hilliard, 1993). Moreover, in psychotherapy process research, it is essential to explore the active ingredients of the therapy and how they result in change for the client. A single-case design allows for this (Hilliard, 1993), as the focus shifts from process or efficacy individually, to "identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change over the entire course of therapy" (Greenberg, 1986, p. 4).

The researcher adapted the method of hermeneutic single-case efficacy design (Elliot, 2002) in order to assess change. More specifically, Elliot (2002, p. 18) outlines that data need to be analyzed to see whether change occurred; establish whether direct evidence linking therapy to client change is present and replicated; analyze the evidence for non-therapy explanations; and come to an overall conclusion about the likelihood that therapy was a key influence on client change. This was achieved by recruiting a research assistant and educating her about the Healing the Whole Self model (she read the therapy manual, learned about Dialectical Behaviour Therapy, and attended a workshop teaching community members about the Healing the Whole Self model). Both the research assistant and the researcher then manually analyzed the interview sets. Each interview set was analyzed looking for change in symptom presentation and concerns, overall well-being, and narrative used by the participant related to aspects of therapy that were helpful. For example, a participant may have explicitly talked about using mindfulness strategies

or may have alluded to mindfulness practices helping her with her sleep difficulties. Both researchers engaged in the analysis process separately, and, based on the information about change and integration of therapy content into their everyday lives, decided whether change could confidently be attributed to aspects of the therapy. After they had engaged in this process individually, they came together to discuss their findings and come to consensus.

Results

Nine interview sets were analyzed. After the research team members individually analyzed the interview sets and decided on whether change could confidently be attributed to aspects of the therapy, they discussed their findings. Decisions about therapeutic change were consistent between both parties, leading to 100 percent interrater reliability. In order to illustrate and emphasize the importance of individual change, each participant and her therapeutic outcomes will be discussed separately.

Individual Change

Of the nine interview sets, the researchers determined that seven of the participants experienced change that was directly related to what they had learned from the Healing the Whole Self group therapy. Change is organized as being related to Dialectical Behaviour Therapy skills modules (mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance), building a life worth living, and an understanding of intimate partner violence, trauma, and their own trauma healing. Below is an illustration of change experienced by clients. The clients (names have been changed to protect client/participant anonymity) are as follows: Willow, Sandra, Alanna, Sherry, Sky, Tanis, Carol-Anne, Janet, and Amber. Janet and Amber were the two members of the second group.

Willow. Willow is a 28 year-old First Nations woman. She attended eighteen of the twenty sessions and was pregnant throughout this time. During intake, Willow explained that she was actively using cocaine and that she wanted to stop. She also had been homeless for several months and had moved into her mother's home upon learning that she was pregnant. During therapy, it appeared that Willow was often not attentive, and seemed to be falling asleep regularly.

In terms of therapeutic change, it was unclear whether Willow benefitted from the components of therapy. She shared that she feels "better" after attending group, but could not articulate how or why. In terms of *emotion regulation*, she shared that she recognized that her painful experiences and the emotions associated with these experiences would pass. She also was better able to validate her emotions. She shared, "I used to bottle everything up all the time. But, you know, I'm close to my mom so I can tell her basically everything." In terms of *interpersonal effectiveness*, Willow shared that she was better able to assess her relationship with her boyfriend, and recognize what parts she did not think were good for her. She explained that she felt more comfortable addressing her needs, as well as her concerns and frustrations about him with him. She had been relying on her mother for social support more proactively. She stated that she appreciated learning about different ways of communicating effectively (e.g., DEAR MAN exercise; Linehan, 1993). In terms of *distress tolerance* skills, she shared that she was attempting to keep herself busy and to distract more often when in distress. She reported that she was trying to sleep less (during intake, she explained that she spent most of her time sleeping, and that this was a coping strategy for her). In terms of *building a life worth living*, Willow shared that she would like to stop abusing substances, would like to go back to school, and was actively looking for housing. She would like to re-gain custody of her three children.

While Willow shared that she enjoyed coming to group every week, it remains unclear whether the therapy itself was beneficial for her. She explained, "…that's why I enjoy coming here. Because it was like, for me.", whereas everything else was for her children or in response to crisis. She framed this as an investment in herself. However, Willow could not articulate if she had learned anything new about herself, including new strengths. Moreover, while she did explain that she had made some changes, it was not clear whether these changes were already being implemented before the start of the therapy, whether she initiated change due to what she had learned or through encouragement from her mother, and whether she had the intention of implementing what she had learned.

Sandra. Sandra is a 53 year-old Caucasian woman who attended all twenty group therapy sessions. During intake, Sandra was still mourning the death of her ex-partner, despite them having been separated for several years. She had difficulties asserting herself with her family and in the workplace, felt many of her interpersonal relationships were unfulfilling, and was often tearful and frustrated with her current situation.

In terms of therapeutic change, analysis of Sandra's interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. In terms of *mindfulness*, she shared that she had become more self-aware, was finding it easier to balance her thoughts and emotions, and that she was able to "pause and assess before feeling overwhelmed". In terms of *emotion regulation*, she shared that she had been validating her emotional experience; was now recognizing what could lead to emotional vulnerability (for her, this related to taking her medication regularly amongst other things); had learned about the temporariness of emotions and that they would eventually pass or decrease in intensity; she described being less emotionally reactive and impulsive; and shared

that she was "reclaiming her hurt" and feeling less shame related to her emotions (especially anger). Related to *interpersonal effectiveness*, Sandra reported that she was learning that she had the right to have her needs met, while understanding that people may not always be able to or want to meet them; she also explained that she no longer consistently took responsibility for conflict (what she called "absorbing") and could acknowledge other people's role in the situation; she began re-evaluating her interpersonal relationships in order to determine which ones in which she wanted to invest her time and energy; and, related to her relationships, she had begun trying to understand other people's perspectives and motivations, which decreased the frequency at which she took things personally. With respect to *distress tolerance*, she shared that she was trying to engage in a better sleep routine and other practices to maintain wellness and decrease emotional reactivity; she explained that she was taking steps to be more physically active; she was engaging in self-soothing exercises (for example taking baths while eating strawberries); and found that she was able to better cope with distressing situations by using the skills she had learned. In terms of moving forward, we looked at *building a life worth living*, as a separate unit of analysis. Sandra shared that she was proactively setting goals for herself; attempting to recognize her needs and attempting to communicate them to others; setting better boundaries in her social and family relationships; and had applied for a promotion, therefore better realizing her potential.

Alanna. Alanna is a 50 year-old Caucasian woman who attended all twenty group therapy sessions. During intake, Alanna was still living with her ex-partner, and was looking to find her own housing. She presented as timid and did not speak frequently. She was having difficulty coming to terms with her "failed" relationship, and took responsibility for it. Alanna

also described having difficulty controlling her emotions, which would lead to frequent crying and occasional binge eating.

In terms of therapeutic change, analysis of Alanna's interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. Related to *mindfulness*, Alanna shared that she had been attempting to use the mindfulness exercises she had learned with some success; and had gained the ability to hold off on acting on something immediately if waiting would lead to better outcomes (i.e., impulse control and finding one's Wise Mind). In terms of *emotion regulation*, Alanna reported understanding that emotions will pass, and that her feelings of loneliness and failure will likely decrease in intensity as she accustoms to her current situation; she shared that she is able to validate her emotional experiences, and that she is actively experiencing and regulating her emotions, leading to fewer occurrences of binge eating and tearfulness. Alanna reported changes related to *interpersonal effectiveness*, including advocating her needs more to others; being more assertive; and feeling more comfortable calling upon social support. Related to this was her *understanding of intimate partner violence*, where she shared that she had more of an understanding of how the abuse affected her. She explained, "…it's like you do realize, how, like I said, how much you were, um, like emotionally abused and how much you were financially abused, and all the other ways, and it does help you understand a little bit better. And I guess in a way it makes you okay with your decision [to end the relationship]." While feeling guilty for (emotionally) leaving her ex-partner was something that Alanna still struggled with, she felt much more comfortable with her decision by the end of the therapy. She shared that she had been engaging in *distress tolerance* practices, including self-soothing, deep breathing, and practicing radical acceptance. Alanna was *building a life worth living* by actively recognizing her strengths;

feeling more optimistic and in control, especially in the face of challenges and adversity; she had moved out of her ex-partner's home; she was able to focus more on herself than on her ex-partner; she felt "confident that [she] can take care of [her]self"; and had moved from a narrative focused on crisis and survival to trying to move forward, with a recognition that this is a process, with some days feeling like "it's one step forward, ten steps back".

Sherry. Sherry is a 57 year-old Finnish woman who attended 17 group therapy sessions. During intake, Sherry shared that she felt quite well and that she had dealt with her trauma. While she did not feel the need to be attending, she shared that perhaps she could help others through her journey. However, throughout the intake, it became evident to both her and the researcher that Sherry still experienced high levels of anger and was irritable, and that she was still quite emotionally reactive in response to her trauma.

In terms of therapeutic change, analysis of Sherry's interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. In terms of *mindfulness*, Sherry's ability to focus on the interview questions noticeably improved from pre- to post-intervention; her focus was something she had recognized as a change within herself as well; she shared that she would also find moments to practice mindfulness (e.g., when watching a fire); her ability to be in the moment had improved (e.g., when driving). Sherry also shared engaging in the use of Wise Mind by being able to withhold immediate gratification to analyze outcomes (e.g., not eating a second serving of food, or being able to giveaway some of her belongings to decrease the clutter of her living space); by understanding that even though she cannot do everything she would like immediately, she can plan for when it would be more appropriate; being able to balance what she needs versus what she wants; and realizing that there is "more than one way to get somewhere". In terms of *emotion*

regulation, she described being less emotionally reactive, including decreased anger, hostility, irritability, and increased patience. In relation to *interpersonal effectiveness*, Sherry shared that she is better to able to walk away from conflict without saying something that she will regret; she has better quality social interactions; she is better able to understand what she wants from her friends; she was finding new ways to connect with friends (e.g., through playing games on the Internet); and by recognizing that different relationships serve different purposes, and that it may be unrealistic to expect one person to meet all of one's needs. Sherry practiced *distress tolerance*, by distracting, and learning which strategies were effective in specific circumstances; deep breathing and self-soothing strategies were also helpful for her. In terms of *understanding trauma and intimate partner violence* and *building a life worth living*, Sherry seemed to be enacting her survivor's mission by trying to help other women, and reported that she has been able to focus on others' need more recently; seemed to more easily engage in radical acceptance through letting go of fair versus unfair binaries; and reported that her traumas and her ex-partner were taking up less of her emotional energy. Sherry shared that there were parts of her relationship that were positive, and did not seem to have as polarized of a view of her relationship. She explained that she wanted more for herself than survival, and shared some of the strengths she had learned about herself, including her potential to excel. She explained, "…So there's a possibility now that I've actually shrugged off the harnesses that have been holding me back, which isn't what I intended, but that's the way life goes so I'm trying to make it work and realizing that I don't have to just make it work. It can be everything I ever wanted." Sherry was going through efforts to improve her life by actively cleaning and de-cluttering her home, going to a sleep clinic to get help with her sleep, and was coming to terms with her physical limitations.

Sky. Sky is a 50 year-old Cree and Polish woman who attended 16 group therapy sessions. During intake, Sky was still quite upset about the betrayal of her ex-partner, and was actively dealing with her divorce. She was working hard to be independent and to be financially stable, but felt as though she was lacking control in her life.

In terms of therapeutic change, analysis of Sky's interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. In terms of *mindfulness*, Sky shared that she was trying to live in the present moment and working on letting go of her thoughts and emotions; was making efforts to slow down and assess a situation before making a decision; and was integrating mindfulness practices into her everyday life. Sky felt her *emotion regulation* had improved, and she demonstrated this through a recognition of what affects her mood and emotional well-being; she shared that she experienced fewer "bad days", where she would spend much of the day crying; practiced self-validation, especially with respect to her emotional experiences; and gained an understanding of how her emotional state can skew her perception of a situation. In terms of *interpersonal effectiveness,* she was becoming more aware of the expectations she had set out for herself and that others may not have the same expectations of themselves—in recognizing this, she was able to feel less disappointed in people. Sky shared that she had come to understand what she was worth in her relationships, and how to expect what she deserves from others; recognized how others' actions can affect her well-being; and was practicing her assertiveness skills. With respect to *distress tolerance,* Sky found that journaling was helpful in coping with stressful situations; recognized that when in distress, she is more likely to make impulsive decisions, and began to implement mindfulness strategies to decrease the frequency of such decisions; engaged in self-talk to help support her through difficult situations; and sought to be

kinder and more empathetic with herself. Sky shared that through the group, she was better able to *understand the effects of trauma and intimate partner violence*, and found the conversations that occurred in the group to be validating. She expressed that prior to the group, she was not convinced that her relationship was abusive or particularly bad, but through the discussions and hearing what other group participants had to say, she was able to better understand her experience and distress; and was able to identify characteristics of a healthy relationship, and by the end of the group, she shared that she was currently involved in such a relationship. Sky was *building a life worth living* by engaging in radical acceptance about what had happened to her with her ex-partner, and about her current struggles with the police, her divorce attorney, her financial situation; she was actively finding ways to make sense of her experience, and to engage in self-growth having gone through everything she did; she served as a leader and role model within the group, which contributed to her well-being; and reported feeling much better than prior to having started attending the group. She explained, "I'm happier than I've ever been in my life. And I thought I was happier before…I was just getting through…Now I feel like I'm living."

Tanis. Tanis is an Irish Canadian woman who attended 15 group therapy sessions. Tanis did not indicate her age, but she was known to be between 45 and 50 years old at the time of therapy. During intake, she explained that she did not feel the need to be there. However, she was friends with Sky, and Sky encouraged her to attend. Tanis shared that for as long as she could remember, she had shut off her emotions and worked solely through logic, because this seemed to be easier. She expressed having difficulty asking for help from people, and generally did not consider her own wants and needs; she explained that she often worked to meet the needs of others, instead of her own.

In terms of therapeutic change, analysis of Tanis' interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. In terms of *mindfulness*, she explained that she was working hard to better acknowledge and consider her emotions in order to find Wise Mind; was making efforts to be more in the moment; had been actively learning about mindfulness practices in her own time because she felt they were relevant to her; reported better concentration and focus; and felt that mindfulness was the "root of everything" and that improving skills in this area would help her in all aspects of her life. With respect to *emotion regulation*, Tanis began acknowledging and considering emotion, and was trying to find a balance, without being overwhelmed by them. This included recognizing that she has emotions (which she was somewhat unsure about during intake); giving herself permission to feel and express her emotions, to herself and to others; moving from avoidance of distress to exploring it; and was able to articulate that emotional experiences are temporary. Tanis experienced changes related to *interpersonal effectiveness*, including being able to successfully speak with her ex-partner about needing more financial support from him (something she did not think was a possibility prior to her participation in the therapy); she was able to finalize her divorce; felt she had gained skills to communicate more effectively; actively increased her social interactions, and became more selective with how and with whom she spent her time; was attempting to be more assertive and communicate her wants, needs, and emotions to others; and gained some self-awareness of how she can affect others. In terms of *distress tolerance*, Tanis shared that planning and organizing herself helped her feel more in control, thus decreasing the likelihood of feeling overwhelmed; and had begun making efforts to take care of her health, through her food choices and increasing her physical activity. In terms of Tanis' journey of *understanding trauma and intimate partner violence*, she felt that she

was able to learn about her own abusive situation, and grieve her trauma and the loss of her relationship. She also found it helpful to support other women through their healing journey. Tanis was *building a life worth living* by making efforts to be more organized; her level of motivation had increased, allowing her to be more proactive in achieving what she wants in life; having more satisfying relationships; and making decisions based on her own wants and needs. She expressed, "I thought I was feeling like myself before…Now that I've come out, I'm just a different person, I think, in the fact that I thought I was myself, I let some of the things in, but now I'm going to be a better self, because I'm choosing better…".

Carol-Anne. Carol-Anne is a 54 year-old German woman who attended 18 out of the twenty group sessions. Throughout the intake, Carol-Anne presented as angry and frustrated at the injustice she had experienced. She disclosed that her ex-husband had wrongfully accused her of assault, and she had to spend a night in prison, lived in shelters for some time, and was still actively dealing with divorce lawyers when the therapy started.

In terms of therapeutic change, analysis of Carol-Anne's interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. In terms of *mindfulness*, she shared that this was new to her but was attempting to use the strategies taught in group, and found that they were helping her cope with distress, and that she found them helpful. More specifically, she explained that she was now able to stop and think before reacting, and was able to evaluate potential outcomes before making a decision. With respect to *emotion regulation*, Carol-Anne shared that she felt more in control of her emotions, and had a better understanding of how her past traumas may have been affecting her current outlook. In terms of *interpersonal effectiveness*, Carol-Anne shared that she was learning to be more assertive and advocate for her own needs, which she described as "being

a me person"; realized that she had been emotionally "unloading" on anyone that she would interact with, and this was negatively impacting her relationships; had a better understanding of how her past relationship was affecting her ability to connect with other people; and started to feel comfortable developing romantic relationships. In terms of *distress tolerance*, Carol-Anne explained that she felt she had transitioned from "panic to coping", and felt that she was able to cope better with the frustrations of her life. She engaged in efforts to change her perspective or find alternative ways of understanding. Carol-Anne sought to radically accept the injustices that occurred to her, but was still having some difficult with this. Carol-Anne was attempting to *build a life worth living* by more regularly taking her medications, finding employment, and making more decisions for herself.

Janet. Janet is a 48 year old Caucasian woman. Janet attended nineteen of the twenty Healing the Whole Self group sessions. During the intake, Janet was particularly distressed and disclosed her difficulties with her current partner. She described him as a "narcissist" and a "sociopath". She shared that she is kind to him and would do anything for him; however, she felt that she could not seem to get him to reciprocate. She described a tumultuous relationship in which she was still actively involved. While Janet had goals related to increasing physical activity, having more satisfying relationships outside of her intimate relationship, processing past traumas, and organizing the clutter in her home, it appeared that Janet was quite focused on her current relationship and the injustices she was experiencing. Janet attended group but would often get distracted by her experiences of abuse with her partner, and did not seem able to engage in the content because of this. It seemed that because of her focus on her partner and his difficulties, she could not focus on her own healing. During the post-intervention interview, Janet described many of the skills that were taught in the group, but did not seem to have a good

understanding of these skills or how they could be applied to her life. Moreover, despite having knowledge about the skills, she continued to be in crisis regularly, and her narrative at the post-intervention interview was quite similar to that in the pre-intervention interview. Despite some change, including making more efforts to take space in conflict, journaling to help cope with emotions, and experiencing positive mood more frequently, it does not seem as though the Healing the Whole Self model contributed to significant therapeutic change for Janet.

Amber. Amber is a 51 year-old Finnish woman who attended eighteen group therapy sessions. During intake, Amber shared that she was still living with her partner, but that she was no longer emotionally or romantically involved with him. She had the intention of moving out, but was not ready to take steps to do this. Amber disclosed that she had recently been in jail and was currently on probation for assaulting her daughter by pulling her hair. Throughout the interview, it was evident that Amber had some difficulty regulating her emotions, was easily angered, and resented her partner and children for her current situation.

In terms of therapeutic change, analysis of Amber's interview set indicated that she had experienced change that could confidently be attributed to her participation in the Healing the Whole Self group therapy. In terms of *mindfulness*, Amber reported that the skills she had learned were extremely helpful for her. She expressed using mindfulness in everyday life, and that this had helped her focus and concentrate (e.g., when reading). She was making efforts to be more in the moment, and to slow things down and think before acting, especially in distressing situations. In terms of *emotion regulation*, she was making efforts to be less impulsive and seemed to be experiencing success with this; and she found herself being able to be more patient with everyday annoyances that would have caused her to feel angry before (e.g., long lineups at the grocery store). Amber was using her *interpersonal effectiveness* skills to be more assertive

with her partner and children, and to communicate her needs better, as opposed to reacting angrily when her needs were not being met; being more aware of how specific interactions can affect the quality of her relationships; and she recognized the importance of working on these skills. Amber practiced *distress tolerance* by engaging in enjoyable activities and self-soothing; attempting to be more optimistic and reframe situations; and engaging in radical acceptance. Lastly, Amber was attempting to *build a life worth living* by incorporating and building mastery; setting goals for herself (e.g., employment); working to feel positive more often; and working toward self-improvement by going for walks, enrolling in an anger management program, and making efforts to lose weight. Amber was able to recognize her "inner strength", and shared, "I feel like I've moved to existence, to wanting to exist, and move forward and…yeah. I want to get out of bed and accomplish what I need to do, and pursue wants and needs, I guess."

Summary of Change

Through an analysis of the outcomes of these nine women, it appears that Sandra, Alanna, Sherry, Sky, Tanis, Carol-Anne, and Amber experienced change that could confidently be attributed to the Healing the Whole Self model. Their change overlapped with content covered within the group therapy, and could often reference specific strategies in the therapy and how they contributed to healing. With Willow and Janet, it was less clear whether they experienced change that was due to the Healing the Whole Self model. While they reported positive effects from attending, it is possible that treatment as usual (i.e., another form of group counselling or peer support) would have had the same effect.

In terms of mechanisms of change, the Dialectical Behaviour Therapy skills seemed to be crucial to the change that the participants experienced. For some of the women, the discussions about trauma and intimate partner violence were also important to their healing process. Most

women enjoyed the Wellness Wheel exercises, and appreciated the collaborative nature of the group structure. Both of these were important to the culturally competent approach to the group; however, how this affected mechanisms of change remains unclear through the data. No participants used the Life History Journal as it was meant to be used, although some did use it to reflect or write positive messages for themselves. As such, it is unclear how this aspect of the model would have contributed to healing.

Discussion

Through their participation in the Healing the Whole Self group therapy, analysis of change through pre- and post-intervention interviews demonstrated that seven of the nine women who attended the group benefitted from their attendance. Moreover, these findings illustrate that the change experienced was likely due to the content in the model, and not solely therapeutic alliance (Castonguay, Constantino, & Holtforth, 2006). Participants were able to talk about the strategies learned in therapy, either informally referring to them, or more explicitly connecting strategies and exercises to change.

Therapeutic Model

Mindfulness and the way in which it was weaved into the entire therapy seemed to be an effective strategy. Sky explained

> At the beginning when you were doing it I was like… okay, I got it. I got the concept early on... And so when you were teaching it, it was like, okay, okay, I've got it, I've got it. But it's the practice, right? So once I got it, and then a few weeks later I started applying it, and a few weeks later started thinking about it more, and you're still teaching it and practicing it, and then I got it even more, and it made sense as to why you're going

> over it every day…It is like practice, it's like a muscle that you have to keep working over and over.

Other participants explained how they had actively sought to learn more about mindfulness on their own time, recognizing its effectiveness.

Many of the participants presented with difficulties regulating their emotions; some felt their emotions were overwhelming or out of control, while others were disconnected from them. It was important to validate each participant's emotions, as well as their strategies for regulating their emotions. This allowed clients to feel more comfortable exploring and connecting with their emotions, without feeling shameful for using a strategy that may not (or may no longer) be effective for them. Research has demonstrated that emotion dysregulation may contribute to occurrences of intimate partner violence (McNulty & Hellmuth, 2008), and intimate partner violence can lead to difficulties regulating emotions, as can be seen through increases in psychological distress (Jordan, Campbell, & Follingstad, 2010; Lafta, 2008). As such, teaching emotion regulation is a core part of the therapy model, and may serve as intervention and protective factor. These skills were related to improvements in emotional control and awareness, trusting one's emotions, willingness to experience one's emotions, recognizing the temporary nature of emotions, and a decrease in impulsivity.

Interpersonal effectiveness is directly related to consequences of intimate partner violence. Many women who experience violence have been socially isolated and have lost their financial independence, furthering their isolation and reliance on their violent partner (Abraham; 2000; Crandall, Senturia, Sullivan, & Shiu-Thornton, 2005). Through the therapy, many women shared feeling more capable in recognizing their "wants and needs", and vocalizing these needs to others. They also learned that vocalizing needs will not always result in having one's needs

met, and that this can come with disappointment. At the same time, they learned about effective communication strategies, and assertiveness. For example, in the context of her work as a consultant, Tanis shared,

> …but I've started to cut people off now and I'm not going to bother calling them, I put them in a different file and now the ball is in their court…but I do have some people that I have to put in that situation, and I have to get it done. So it's almost like, I'm not afraid to say to people, you know, okay, this is where I'm at, but I think maybe I just put it off too long, do you know what I mean?...Because really, if you're spending all that time on people that are not helping you earn a living you're wasting your time.

Learning about in what kind of relationships the participants want to invest their time is especially helpful for developing adequate social support, and for preventing future unhealthy relationships.

Distress tolerance skills are important for crisis situations, and decreasing the likelihood of crisis through maintaining well-being (Linehan, 1993). Clients found that the strategies learned here were helpful on a regular basis. Many found the benefit of integrating mindfulness with their distress tolerance strategies, as it was when engaging in these strategies mindfully that the benefits could be experienced. The participants also began to recognize what kinds of things made them emotionally vulnerable (e.g., inadequate sleep, forgetting to take one's medication, and the anxiety of having to deal with divorce attorneys), and different strategies they could use to keep themselves well on those days. They were able to recognize how emotional vulnerability could skew their perception of a situation. A Wellness Wheel exercise was used to facilitate the development of a self-care plan, and many clients really enjoyed this process, and shared that they were actively incorporating self-care into their lives.

The Power and Control Wheel (Domestic Abuse Intervention Project, n.d.) and discussions about the impacts of trauma on each client's physical, spiritual, emotional and psychological well-being were used to facilitate psychoeducation about intimate partner violence and trauma. Through these conversations, many of the clients gained a better understanding of how the violence they experienced affected them, and were able to recognize their strength, courage, and coping strategies in response to the violence. Validation of coping strategies (regardless of whether such strategies were adaptive) was emphasized, and clients were reminded that they were "doing the best [they could]" regularly. Part of the healing from trauma was to document and reflect on life situations in the Life History Journals. These were optional but encouraged, and most clients did not use the Journals as they were meant to be used. This may be reflective of the lack of engagement with this aspect of the therapy, unclear instructions, or clients engaging in avoidance. Because of the lack of use of the Life History Journals, its benefits are unclear.

Empowerment was used as a therapeutic strategy (Donaldson, 2005), and was structured into the therapy by allotting several weeks to clients collaborating to make change. Group one chose to engage in this process by creating Vision Boards, a collage-based goal setting exercise. This was a client-initiated activity, and almost all of the clients found this to be helpful to their healing journey. Sandra shared that this was the first time she had ever set goals for herself, whereas Sherry explained that she could notice her progress through the goals she was setting for herself. Alanna explained that she did not like the exercise because she did not know what she wanted for herself at that point. She elaborated,

> but it was hard for me because right now I don't know what I want, like… some… like I don't know if I want a house. I don't know if I want to travel, other than going to see my

> son. So it was really hard for me because… that's why when I seen that pursuit of happiness, that was the only thing I put on there, because that's where I feel I'm at. And when I find something that makes me happy I'll know that was there. But to say "I want a man," "I want a house," "I want money"… I don't know if those things would make me happy, if that makes sense. You know, like, I had a house, I had a man, I had money, sort of, do you know what I mean? But it didn't make me happy…so that was hard for me.

Many of the participants were quite removed from their relationships, whereas Alanna had left her ex-partner's home during the course of the therapy. This may contribute to her difficulty in thinking about what she wants for herself other than "happiness" and "peace". While in this specific case, Alanna did not feel connection with the activity, the therapy was facilitated in a way that encouraged feedback and collaboration. In using this approach, if a client communicated that a specific strategy or exercise was not relevant for her, there could be modifications or a discussion about why this might be. This allowed the clients to gain a better understanding of the skills and their rationale, allowed them to contribute to the content of the group, and allowed the researcher to gain insight into the experiences of the clients and how the skills may apply to them. The Vision Board was an interesting illustration of how varied experiences of goal-setting can be, both within and outside of the context of a violent intimate relationship. While Sandra had never set goals, Alanna was having difficulty doing this given her current life circumstances. For others, their goals had shifted since having started the therapy—this demonstrates how one's emotional and psychological transformations can shift one's directions and goals. Having a collaborative and client-directed approach can provide an opportunity for clients to initiate and communicate these transformations.

The second group used these sessions to talk about ways that they would like to create change. They discussed a peer-support group for women, and the importance of self-care and touch as part of healing. The clients decided that this was something they would continue to develop once the group was over.

Building a life worth living was one of the main ways through which healing was assessed. According to Herman (1992), the last phase of trauma healing includes moving forward, re-integrating into life, and a decreased focus on the trauma narrative. The seven clients who experienced therapeutic change seemed to be building a life worth living by setting goals, taking care of their health, investing in themselves, and recognizing their self-worth. Many also shared that while they thought they felt well or were trying to revert to how they felt before their traumas, after their experiences in the group, they felt better than they possibly could have, or felt like a new version of themselves.

Therapeutic Alliance and Cultural Competence

Individuals of diverse backgrounds may not benefit from psychotherapy to the same extent as individuals of Western and/or European backgrounds (Fellner, 2014; Gillum, 2008, McCabe, 2007), leading to an emphasis on patient preference (including culture and values), as well as clinical expertise (Sue, Zane, Hall, & Berger, 2009) in order to offer evidence-based practice (American Psychological Association, 2003). Because Healing the Whole Self was developed to be culturally competent, but was not intended for a specific "target population" (Gillum, 2008, p. 923), the ways in which these factors were included differed from traditional culturally-appropriate interventions.

The intervention takes a non-judgmental and validating approach to understanding clients' situations; this allowed for a celebration of choice, recognition of ability to overcome,

and gave power to the client to be a leader in her healing journey. Such an approach also ensured that the facilitator was not forcing her values and expectations of wellness on to the clients. Literature has referred to the importance of celebrating strengths (Smith, 2006; White, 2002), and of using an empowerment-based approach to therapy (Donaldson, 2005). When combined, clients have the opportunity to see that good things can happen, and that they can be the reason for and direct these good things. In the context of intimate partner violence, where so many women experience guilt, shame, blame, and internalize the psychological and emotional aspects of abuse (Street & Arias, 2001), having an opportunity to engage in this process can in itself be transformative.

This non-judgmental, validating and encouraging approach to therapy allowed for several realities to exist, thus contributing to cultural sensitivity. Moreover, through the development of the Healing the Whole Self model, it was expressed that this approach is essential to working with diverse groups (Chapter Three). This may have contributed to the perceived high levels of therapeutic alliance that existed between the facilitator and the clients. While there was no formal measure of therapeutic alliance, many of the clients shared their experiences and appreciation for the facilitator. For example, Tanis shared that during some parts of the therapy, she felt that the only reason she was coming was to interact with the facilitator (although she later conceded that this may have been an avoidance strategy of hers). Janet shared, "…the way you present things, um… I really like your style. I really like your style. I like that you're female-affirmative, but you're not, you know, one of those female-affirmative, angry-appearing, male-bashing persons. Um… I like that in general you just create this air that's so… feels very accepting and respectful." Creating this environment was intentional, and participants shared that they felt safe and respected connecting with the facilitator and with each other in group. Sandra

described coming to group as her “little island of sanity”, and some participants shared their concerns about the group ending. The bond that was created between the participants and the facilitator, and between participants is reflective of therapeutic alliance, and the way through which this was developed was meant to allow space for diversity. There is debate within the literature about the role of therapeutic alliance in cultural competence (Sue et al., 2009). While the author is not suggesting that therapeutic alliance is sufficient for cultural competence, the alliance likely facilitated engagement in the therapeutic process, and may have been due to her culturally competent clinical skills.

There were also more specific ways that culture was integrated into the therapy. For example, the Healing the Whole Self model, in the specific community at which it was offered, included smudging (a First Nations ceremony) in which clients were invited to participate. This ceremony was led by one of the First Nations clients in the group. Moreover, within the first half of each session, a client was invited to lead a Sharing Exercise, a specific cultural practice of hers. Clients were generally excited, albeit initially apprehensive, about this Exercise. Sharing ranged from one woman bringing her ceremonial drum, another bringing beading, one bringing art, while another shared a picture of her daughters. Some literature emphasizes the importance of culturally-specific strategies (Archibald, 2006; McCabe, 2007). In a group that is multicultural and culturally-inclusive, this may be one method of being able to include specific strategies.

Thus, if using Gillum’s (2008) components of culturally appropriate intervention, as listed above, the approach used by Healing the Whole Self would meet these criteria, although perhaps not as Gillum intended. More specifically, a) the model was developed collaboratively with the target population; b) there was space for clients to use their own language or culturally-specific terms; c) the target population was multicultural, and therefore staff were representative

of this diversity; d) the intervention was offered in a neutral but warm setting. In addition, the researcher provided snacks and warm beverages each session, which were reported to have made the environment more welcoming; e) there were opportunities for clients to share feedback, their cultural views on specific issues and strategies, and for culturally-specific sharing. An all-inclusive and less stringent approach to conceptualizing culture would provide an opportunity for all clients to be treated as unique and diverse. Such an approach should be combined with culturally-specific strategies when appropriate. The appropriateness of such culturally-specific strategies would need to be determined with therapy clients collaboratively, and should be optional. Moreover, while a multicultural lens may be taken, clinicians should still make an effort to be educated about histories of peoples, as well as specific barriers that people may experience because of their marginalized identities.

Limitations and Recommendations

There are several limitations to this project that should be addressed in future research. The first is related to the term diversity. This program was developed to meet a need of culturally competent and evidence-informed psychological interventions for women survivors of intimate partner violence. The researcher conceptualized diversity as being about the individual, and her unique dimensions, qualities, and characteristics (Canadian Centre for Diversity and Inclusion, 2015). As such, it was not necessary to have ethnically diverse individuals in order to have diversity, nor was this diversity necessary to assess the effectiveness of the program as culturally competent. However, there are unique circumstances that marginalized women of visible diversity may experience (including racism, difficulty accessing services, systemic discrimination) that differs from the experience of other women (Kasturirangan et al., 2004). While there were several women in the group who would identify as diverse (due to ethnicity,

ability, immigrant status, and mother tongue), and the researcher would identify all of the women as diverse, the participants were not a stereotypical representation of diversity. As such, future research should seek to include a more diverse group of women (including more ethnic and visible diversity). This may not always be possible, as was the case with this research, due to partnerships with community organizations. However, in order to draw stronger conclusions about the cultural competence of a program, inclusion of multiple diversities is important.

Similarly, it should be noted that most participants were over the age of 45 and were at similar phases in their healing journey. While it is unclear why this may have occurred, it is possible that the community organization with whom the researcher partnered may attract older clients. Regardless of the reason, there were unique circumstances that many of the participants could identify with (including not having young children to care for, experiencing changes in ability, having to care for parents, and menopause). The participants, for the most part, had been separated from their partners for some time (with some women having been separated for over three years, and many for over a year). As such, many of the participants were ready to focus on themselves and their own healing journey, as opposed to actively coping with the traumatic responses from their abusive experiences. All but two of the women in Group One were fairly removed from their ex-partners, with one (Alanna) having little to no contact and one still being in the relationship (Willow), whereas the women in Group Two were more involved with their partners (with Janet still being actively involved with her partner, and Carol-Anne still living with her husband). This division occurred randomly, as recruitment processes were the same for both groups, but likely led to different group dynamics and an increased ability for group participants to be able to relate to one another. Group cohesion may have been different if participants had a more varied age range or were at different phases of their healing journey, and

this may have affected outcomes. Partnering with several community organizations with different approaches to service provision may allow for a wider range of clients.

The researcher was the primary facilitator for both groups, and completed the pre-intervention (in all but one case) and post-intervention interview process with the participants. All participants knew about the research process, and that the process was a part of the researcher's education requirements. As such, it is possible that the participants sought to highlight their positive evaluations of the group, and to undervalue their criticisms. While this may have been the case, the evaluation process and the questions in the interviews sought to better understand cognitive, behavioural and emotional change. Thus, whether the participants liked the group played little value in the determination of whether they benefitted. It is possible that some of the participants exaggerated some of the change they experienced; however, because of the length of time between the pre- and post-intervention (ten to twenty weeks, depending on the group), and the structure of the questions, it is unlikely that clients remembered how they described their concerns in the initial interview. Moreover, change was determined not only based on described change, but how this change was related to therapy content. Thus, it is unlikely that the measure of change based on the research team's evaluations of the pre- and post-interviews was reflective of participants' exaggerations of the benefits they experienced. Future research may benefit from having an external evaluator, or by having non-researcher facilitators conduct the evaluation and/or run the group.

A more conceptual reflection includes the benefits of a culturally-specific versus culturally competent intervention (Sue et al., 2009). Culturally-specific interventions include language and practices that may be affiliated with a specific group, whereas culturally competent interventions acknowledge the diversity and unique circumstances that individuals may

experience, and seek to be inclusive and anti-oppressive in nature (Sue et al., 2009). There have been arguments for both approaches, with some suggesting that (re)connection to one's culture may in itself be a healing process and, as such, interventions with cultural groups must include culturally-specific practices (Archibald, 2006; McCabe, 2007). However, others suggest that this may not be necessary, and that many individuals want access to mainstream services and are not looking for anything "cultural" (Gillum, 2008). In the development of the Healing the Whole Self model, some stakeholders (including survivors and service providers) shared that they wanted to be treated as people, without assumptions of what is best for them, and that if they wanted culturally-specific services, they were comfortable seeking those elsewhere—essentially, they wanted psychotherapy and this is why they were seeking out psychotherapy. It seems that more important than culturally-specific or –informed is that clients feel they have choice in the kind of service they are utilizing. While engaging in the Healing the Whole Self program with culturally-specific groups may allow for more opportunities for clients to connect on several levels, and this may contribute to healing, it is important to consider that "culture is only one relevant factor in providing effective mental health treatment" and "other aspects of clients may be more influential" (Sue et al., 2009, p. 2).

Conclusion

Healing the Whole Self may be an appropriate therapeutic intervention for working with women survivors of intimate partner violence. Considering the shortage of appropriate interventions for this target population (American Psychological Association, 2001; Brosi & Rolling, 2010), and how many of these interventions are not culturally competent, this model may present as a promising practice and good alternative (or addition) to other services being offered. Intimate partner violence can have many emotional and psychological consequences,

and women need to be supported past the stage of crisis. Future research should seek to further assess the effectiveness and efficacy of the Healing the Whole Self program, keeping in mind that wellness should be culturally-defined.

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Chapter Six:

Healing the Whole Self: A Pilot Study Evaluation of a Culturally Competent and Evidence-Informed Group Therapy for Women Survivors of Intimate Partner Violence

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Preamble

This paper demonstrates the outcomes from the quantitative component of the implementation of Healing the Whole Self. This paper is framed as a pilot study because of the small sample size and because of its initial implementation. In qualitative research, such as in Chapter Five, smaller sample sizes are acceptable; however, the analyses in this chapter should be considered as preliminary and tentative. Having said this, considering the therapy model's stage of development, the inclusion of this data in the evaluation is important to provide a full picture of the outcomes of its implementation.

Abstract

There is a paucity of literature evaluating culturally competent psychological interventions for women survivors of intimate partner violence. Healing the Whole Self is a group therapy developed for culturally diverse women who are surviving the psychological and emotional consequences of intimate partner violence. This study was an initial evaluation of this intervention. Participants (n = 9) completed the World Health Organization Quality of Life Short version, the Depression, Anxiety, Stress Scales, and the Posttraumatic Stress Disorder Checklist-Civilian version pre- and post-intervention. Results demonstrate a statistically significant improvement in quality of life, and depression, stress, anxiety symptoms. Analyses of clinically significant change demonstrate promising results. These findings suggest the Healing the Whole Self model may be an effective model to use with this population.

Chapter Six:

Healing the Whole Self: A Pilot Study Evaluation of a Culturally Competent and Evidence-Informed Group Therapy for Women Survivors of Intimate Partner Violence

There is a lack of culturally competent and evidence-informed group therapies for women surviving the psychological and emotional consequences of intimate partner violence (Chapter Two). Much literature has suggested that this is a gap in the literature and in actual service provision, and thus clinicians are often left with little guidance on how to work with these populations. The American Psychological Association (2001) has asserted that current psychological interventions for working with trauma are likely inadequate for working with survivors of intimate partner violence. The needs of marginalized women survivors (i.e., women of colour, with different abilities, etc.) may be unique (Chapter Two and Three; Bent-Goodley, 2005; Gillum, 2008). The purpose of this study was to evaluate the quantitative outcomes of Healing the Whole Self, a culturally competent and evidence-informed group therapy developed for women survivors of intimate partner violence. More specifically, the Healing the Whole Self model's outcomes were evaluated using measures of depression, anxiety, stress, quality of life, and posttraumatic stress.

Healing the Whole Self was developed using community-based methods, and is aimed to be a culturally competent and evidence-informed group therapy (Chapter Four). The model was developed by conducting a needs assessment (Chapter Three), and these community-specific needs were integrated with evidence-based practices (Chapter Four), to develop Healing the Whole Self (see Therapy Manual). The therapy includes twenty mostly group sessions, Dialectical Behaviour Therapy skills, psychoeducation about intimate partner violence and

trauma, trauma processing exercises, and opportunities for collaboration amongst clients (Chapter Four; Healing the Whole Self Therapy Manual).

Methods

Participants

Participants were recruited through a community agency's waitlist and its "Violence against Women" client list. Fourteen women enrolled in both the group and the evaluation process (no clients declined participation in the evaluation); however, four clients stopped attending within the first four sessions (all reportedly due to life circumstances). One additional woman was enrolled throughout the program but her attendance was sporadic, and her data was not included in the analyses. The rest of the participants (n = 9) attended between sixteen and twenty groups. Participants ranged in age from 28 to 57 (M = 48.88).

Procedure

Participants were invited to an initial intake session during which they learned about the therapy structure and process, established goals, and completed the three questionnaires. At the completion of the group, after twenty sessions, participants attended an end of therapy individual session. During this session, referral information was given, feedback was sought, and questionnaires were completed.

Measures

The World Health Organization Quality of Life Assessment – Short Form (WHOQOL-BREF; World Health Organization, 1997). The WHOQOL-BREF is considered a cross-culturally sensitive measure of quality of life (World Health Organization, 1997), and has four main domains, including physical, psychological, social and environmental (Skevington, Lofty, & O'Connell, 2004). The test contains 26 self-administered items, and responses are

recorded using a 5-point Likert type scale. Psychometrics support the use of this measure, including a test-rest reliability averaging .75 (World Health Organization, 1997), and an average internal consistency (i.e., Cronbach's alpha) of .78 (ranging from .68 to .82 across the four domains; Skevington et al., 2004). This measure was used to assess overall quality of life and global functioning of those participating in the intervention, as a means of providing global outcome comparisons.

The Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995). The DASS measure underlying traits of depression, anxiety and stress, with a recognition that these factors are often interconnected (Brown, Chorpita, Korotitsch, & Barlow, 1997). It is a 42-item instrument that asks about symptoms "over the past week", and is measured on a 3-point scale. Psychometric findings support the use of this measure, including a test-rest reliability averaging .77 and an average internal consistency (i.e., Cronbach's alpha) of .93 (ranging from .89 to .96 across the three scales) within a clinical sample (Brown et al., 1997; Lovibond & Lovibond, 1995).

The Post Traumatic Stress Disorders Checklist (PCL; Weathers, Litz, Huska, & Keane, 1994). The PCL is a 17-item self-report measure for assessing symptom presentation and severity of posttraumatic stress. The scale takes approximately five minutes to complete, and has been validated with several populations and forms of trauma, including veterans, individuals who have experienced motor vehicle accidents, sexual assault victims, women who use substances, and more (Harrington & Newman, 2007; Ruggiero, Ben, Scotti, & Rabalais, 2003; Weathers et al., 1994). Psychometric findings support the use of this measure, including a test-rest reliability averaging .88 and internal consistency (i.e., Cronbach's alpha) of .87 (Ruggiero et al., 2003; Weathers et al., 1994).

Results

Data were analyzed using paired samples *t*-tests in order to assess mean differences between pre and post-intervention scores across all three measures. In addition, clinical significance was measured in order to better understand the effects of the Healing the Whole Self group therapy on each client. Table 2 illustrates the means, standard deviations, and mean differences before and after the intervention.

WHOQOL-BREF. A paired samples *t*-test was conducted using the WHOQOL-BREF measures and was found to be significant, $t(8) = -3.28$, $p<.05$. This indicates that there was a statistically significant increase in self-reported quality of life after participating in the intervention.

DASS. A paired samples *t*-test was conducted using the DASS measures, and was found to be significant, $t(8) = 2.78$, $p<.05$. This indicates that there was a statistically significant decrease in self-reported depression, anxiety, and stress after participating in the intervention. The stress subscale indicated a significant improvement in symptom severity, $t(8) = -2.39$, $p<.05$. The anxiety subscale indicated a significant improvement in symptom severity, $t(8) = -2.63$, $p<.05$. The depression subscale indicated an improvement in symptom severity approaching significance, $t(8) = -2.26$, $p = .054$.

PCL. A paired samples *t*-test was conducted using the PCL measures, and was found to be approaching significance, $t(8) = 2.17$, $p = .062$. This suggests that there is a possible decrease in self-reported posttraumatic stress symptoms after participating in the intervention.

Clinical significance. Literature on psychotherapy has demonstrated that while comparing pre- and post-intervention means to assess statistical significance is a common method of assessing outcomes, it lacks practical meaning (Jacobson & Truax, 1991). Jacobson

and Truax (1991) suggest that clinically significant change is a more meaningful way of assessing change, and offer a formula for calculating such change, the Reliable Change Index (RC):

$$\text{RC} = \frac{x2 - x1}{S_{\text{diff}}}$$

where x_1 represents a participant's pre-intervention score, x_2 represents a participant's post-intervention score, and S_{diff} is the standard error of difference between the two test scores.

$$S_{\text{diff}} = \sqrt{2(S_E)^2}$$

where

$$S_E = s_1\sqrt{(1 - r_{xx})}$$

where r_{xx} is the test-retest reliability for a specific measure, and s_1 is the standard deviation of the pre-intervention score for a specific measure. S_{diff} describes a score distribution if no change was to be expected. When the RC is greater than 1.96 (95 percent confidence interval), this is indicative of this outcome unlikely being due to chance (Jacobson & Truax, 1991). Thus, each participant's RC was calculated for each measure. Test-retest reliabilities were obtained for each measure using psychometric data available in the literature. See Tables 3, 4, and 5 for clinical significance, as determined by one's RC. This calculation demonstrated that: a) three participants experienced clinically significant improvement in their quality of life; b) two participants experienced clinically significant improvement in their depression, anxiety and stress symptoms; and c) three clients experienced clinically significant improvement in their posttraumatic stress disorder symptoms.

The DASS also includes thresholds of severity such that a score below or equal to 78 indicates normal functioning, a score between 78 and 87 indicates mild symptoms, a score between 87 and 95 indicates moderate symptoms, a score between 95 and 98 indicates severe

symptoms, and scores of 98 or greater indicate extremely severe symptoms (Lovibond & Lovibond, 1995). Change in symptom severity may also be indicative of clinically significant change (Jacobson & Truax, 1991). Table 4 demonstrates clinically significant change according to this criterion. Using this method, one client experienced clinically significant change, shifting from extremely severe symptoms to being in the range of normal functioning. An additional participant was nearing clinically significant change. Overall means on the DASS at the time of pre-intervention demonstrate fairly low means, such that only one participant reported distress above 78. Tables 5, 6, and 7 further break down DASS scores by subscale (depression, anxiety, and stress) in order to demonstrate in what areas Healing the Whole Self had the most clinically significant change; however, it should be noted that the DASS was not meant to be explored by subscale. These tables demonstrate that two participants experienced clinically significant improvements in depressive symptoms, two participants experienced clinically significant improvements in anxiety symptoms, and four participants experienced clinically significant improvements in levels of stress.

The PCL is meant to be used for screening and supporting diagnosis (Weathers et al., 1994). As such, there are specific criteria that need to be met in order to assess whether an individual meets criteria for a diagnosis of posttraumatic stress disorder (see Weathers et al., 1994 for more information about this process). Clinically significant change can be determined if an individual experiences decreases in symptom severity to the point of no longer meeting diagnostic criteria for a disorder (Jacobson & Truax, 1991). Moreover, Monson and colleagues (2008) suggest that a change in score of at least ten demonstrates clinically meaningful change. Table 8 demonstrates clinically significant change according to these criteria. According to these

approaches, three individuals no longer met diagnostic criteria for posttraumatic stress disorder, and four individuals experienced clinically meaningful change related to their symptom severity.

Discussion

This study offered an initial evaluation of the Healing the Whole Self group therapy for women survivors of intimate partner violence. Results indicate that the women who participated in the therapy experienced statistically significant change in their quality of life, and their depression, stress and anxiety symptoms after the intervention. Moreover, several participants experienced clinically significant change, reflecting a real improvement in symptom severity and feelings of well-being. While this study included a small sample size, the findings suggest that the Healing the Whole Self model is a promising approach to working with culturally diverse women surviving the effects of intimate partner violence. It also seems that its effects on women may vary, as seen by the range in differences in scores between women pre- and post-intervention.

It should be noted that some women reported worsening of symptoms at post-intervention. More specifically, four women reported worsening of posttraumatic stress disorder symptoms (ranging from increases of 1.25 to 9, $M = 3.81$), two women reported worsening of depression, stress and anxiety symptoms (with increases of .5 and 6.5), and one women reported a decrease in quality of life (with a decrease of 3 from her pre-intervention score). While it is unclear why this may have occurred, it is possible that some participants had only just begun to process their traumatic experiences by the end of the twenty sessions. As such, they may have been experiencing higher levels of distress at the end of the intervention. Research has suggested that individuals with histories of traumatic experience may require a longer period of time in therapy, and that short-term therapies may be inadequate (Leichsenring & Rabung, 2011).

Negative life experiences are also likely to have a strong deteriorative effect on therapy outcome, and these effects are likely greater than the positive effects of the therapeutic process (Mohr, 1995). Women experiencing intimate partner violence are likely to have negative life experiences occur frequently and feel less in control over their lives (for example, in dealing with lawyers, child welfare, etc.; Chapter Three). Thus, it is possible that the increase in symptom severity may be due to these factors. It is also possible that these increases can be attributed to normal variance in test-rest reliability, suggesting that their responses do not reflect actual changes in symptom presentation but changes in response style. For many of the scores that did increase at post-intervention, the change score was quite minimal and within one standard deviation; thus, this change of scores may simply be a representation of variance as opposed to a worsening of symptoms. Another explanation is that the increase in reported distress may be a true reflection of worsening symptoms, suggesting that this intervention may not have been appropriate for these clients. Regardless of the cause of reported increase in symptoms, interviews were conducted with all participants after the intervention, and all participants reported feeling better and thinking that the program was helpful (see Chapter Five). While this does not speak directly to the increase in reported symptoms, it does suggest that participants were not experiencing augmented distress due at the time of the post-intervention interview. In addition, all participants were provided with a list of community resources, and continued to be able to access services through the organization at which the group therapy was run. Thus, all women, regardless of their symptom severity, had the opportunity to seek out support if they felt it necessary to do so.

Limitations and Recommendations

As this was an initial study, the sample size was extremely small. This increases the likelihood that statistical findings may include error. Moreover, responses across scales included large variances, suggesting that the sample included a broad range of presenting symptom severity. Considering the small sample size and the large variance within the sample, it is even more likely that conclusions drawn from this study may not reflect true statistical difference. With the small sample size, it is also possible that the findings may not be generalizable to the general population.

Future research should seek to include more participants in order to better assess the efficacy and effectiveness of the Healing the Whole Self model. Moreover, considering the therapy was developed to be used with culturally diverse groups, engaging such groups, assessing outcomes, and inviting feedback may be helpful in determining how the model can be improved, and for who the therapy model may be most effective.

Conclusions

Research has demonstrated the lack of culturally competent and evidence-informed therapies for women survivors of intimate partner violence (Chapter Two and Three, American Psychological Association, 2001). The Healing the Whole Self group therapy sought to fill this gap. Results suggest that the findings are promising but may vary by individual. Future research should aim to evaluate the intervention with more women, and assess for which women the Healing the Whole Self model may be particularly helpful.

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Tables

Table 4
Distribution of Means across Measures, Standard Deviation in Parentheses

Measure	Time One	Time Two	Change
WHOQOL-BREF	60.02 (9.62)	69.11 (11.35)	-9.09
DASS	57.22 (30.03)	33.58 (23.39)	23.64
PCL	51.89 (17.22)	39.58 (14.09)	12.31

Table 5
Clinically Significant Change: WHOQOL-BREF

Participant Number	Time One	Time Two	Reliable Change Index Score (RC)	Clinically Significant Change?
1	59	56	.44	No
2	74	80	.88	No
3	57	81	3.52	Yes
4	50.5	64	1.99	Yes
5	66	70	.59	No
6	69	76.5	1.10	No
7	67	76	1.32	No
8	45	47.5	.37	No
9	52.69	71	2.69	Yes

Table 6
Clinically Significant Change: DASS

Participant Number	Time One	Time Two	Reliable Change Index Score (RC)	Clinically Significant Change?	Change in Diagnostic Severity?
1	30.5	31	.025	No	No
2	34	9.14	-1.22	No	No
3	77.5	24.5	-2.60	Yes	Borderline
4	73	49	-1.18	No	No
5	63	51	-.59	No	No
6	13	11	.10	No	No
7	42	8	-1.67	No	No
8	71	77.5	.32	No	No
9	111	41.14	-3.43	Yes	Yes

Table 7
Clinically Significant Change: DASS Depression Subscale

Participant Number	Time One	Time Two	Reliable Change Index Score (RC)	Clinically Significant Change?
1	13.5	11	-.26	No
2	2	2	0	No
3	28	3	-2.61	Yes
4	39	25	-1.46	No
5	18	18	0	No
6	2	7	.52	No
7	21	3	-1.88	No
8	31.5	31.5	0	No
9	39	14	-2.61	Yes

Table 8
Clinically Significant Change: DASS Anxiety Subscale

Participant Number	Time One	Time Two	Reliable Change Index Score (RC)	Clinically Significant Change?
1	10	9	-.15	No
2	11	4.14	-1.03	No
3	18	9	-1.35	No
4	13	10	-.45	No
5	27	13	-2.10	Yes
6	4	0	-.60	No
7	6	3	-.45	No
8	23	27	.60	No
9	33	13.14	-2.97	Yes

Table 9
Clinically Significant Change: DASS Stress Subscale

Participant Number	Time One	Time Two	Reliable Change Index Score (RC)	Clinically Significant Change?
1	7	11	.57	No
2	21	3	-2.54	Yes
3	31.5	12.5	-2.68	Yes
4	21	14	-2.38	Yes
5	18	20	.28	No
6	7	4	-.42	No
7	15	2	-1.84	No
8	16.5	19	.35	No
9	39	14	-3.53	Yes

Table 10
Clinically Significant Change: PCL

Participant Number	Time One	Time Two	Reliable Change Index Score (RC)	Clinically Significant Change?	Change in Diagnostic Criteria	Clinically Meaningful Change
1	52	61	1.07	No	No	No
2	25	27	.24	No	No *	No
3	67	51	-1.90	No	No	Yes
4	76	39	-4.39	Yes	Yes	Yes
5	45	48	.36	No	No	No
6	27.5	22	-.65	No	No *	No
7	52.5	24	-3.38	Yes	Yes	Yes
8	51	52.25	.15	No	No	No
9	65	32	-3.91	Yes	Yes	Yes

* did not meet diagnostic criteria at pre-intervention (score of 44 or greater indicates meeting diagnostic criteria)

List of Appendices for Chapter Five and Chapter Six

Chapter Seven:

From the Ivory Tower to the Ground: Describing a Community-Based Participatory Approach to the Dissemination of a Mental Health Intervention

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Preamble

The paper describes the community dissemination and training of Healing the Whole Self. The purpose was to invite service providers and students aspiring to work as service providers to teach them about trauma, cultural competence, and how to implement Healing the Whole Self, or some of its components. The idea of hosting a community-wide dissemination came from one of the community stakeholders who thought that more people needed to learn about the Healing the Whole Self program. The approach taken by the community dissemination was in line with community-based research methods that advocate the importance of capacity building, sustainable change, and the democratization of knowledge (Cargo & Mercer, 2008).

Abstract

There has been a push to offer more culturally competent mental health services. Using community-based research methods to develop, implement and evaluate such services may be a valuable approach. However, in order to make meaningful change, it may be necessary to ensure dissemination of the information from this research is accessible, meaningful and applicable. This paper described a community-based approach to the dissemination of a mental health intervention. More specifically, the research describes a training workshop the researcher facilitated to community members, some of the ways this contributed to the community-based approach to research she used, and provides some reflections on this process.

Chapter Seven:

From the Ivory Tower to the Ground: Describing a Community-Based Participatory Approach to the Dissemination of a Mental Health Intervention

Culturally competent psychotherapy has been described as necessary to providing optimal care (American Psychological Association, 2002; Sue, Zane, Hall, & Berger, 2009). However, it has been unclear how culturally-specific a therapeutic intervention needs to be in order for it to increase effectiveness (Sue et al., 2009). Some of this debate stems from the fact that cultures are unique and diverse, and thus, one approach to meeting the cultural needs of an individual or a group, may not necessarily be relevant for others, even within the same cultural group.

One way to tackle this complexity is by using community-based methods in the development of psychological interventions. As Harris (2009, p. 3) outlines, both counselling and community-based research focus on: a) Relationship and partnership; b) Collaboration and capacity building; c) Learning, growth, and development; d) Process and context; e) Cultural appreciation and inclusion; f) Empowerment; and g) In-depth discovery and understanding. Despite this overlap, there has been limited engagement between the two fields (Spong & Waters, 2015). In Israel and colleagues' (1998) seminal piece on community-based research methods, they emphasize a) the importance of building on the strengths and resources within the community; b) building capacity of partners; c) maintaining collaborative partnerships in all phases of the research; d) promoting co-learning and empowering processes; e) involving cyclical and iterative processes, and f) disseminating findings/knowledge to all partners in an accessible and respectful manner. Other researchers also emphasize the importance of taking into

account contextual experiences such that knowledge can be authentic, and effect sustainable and meaningful change (Cargo & Mercer, 2008).

Community-based methods in therapy research could be useful for several reasons (Spong & Waters, 2015). Those who are interested in delivering a therapy or a certain model of intervention are often also the individuals doing the research, often resulting in bias. Participatory methods would necessitate a different approach to engaging in this research, thus reducing or eliminating this bias (Spong & Waters, 2015). Community-based approaches would also challenge conventional therapeutic approaches, and offer creative methods of identifying alternative processes (Spong & Waters, 2015), something that may be especially important when working cross-culturally (American Psychological Association, 2002). Community-based methods can also help researchers and clinicians understand community priorities and develop more targeted therapy services (Spong & Waters, 2015).

Spong and Waters (2015) argue that therapy currently lacks external perspective, a focus on community and client priorities, engagement with the social and structural context, and pays insufficient attention to client empowerment. The current paper describes a dissemination process that sought to use community-based methods to teach community members (and specifically service providers) about a new model of therapy that was developed using community-based methods.

The Healing the Whole Self Training Workshop

The Healing the Whole Self model was developed as part of the researcher's dissertation work, and is a culturally competent group therapy intervention developed using community-based methods, including feedback from community stakeholders (Strand, Maurullo, Cutforth,

Stoecker, & Donohue, 2003; Tremblay, 2009). For more information about the Healing the Whole Self model, see Chapter Four and Therapy Manual.

In efforts to ensure accessible knowledge translation, continuous feedback, capacity building, and sustainable change, the researcher organized a community training workshop and invited service providers who work with survivors of intimate partner violence. The workshop was free for students, and was offered at a minimal cost to community members ($20). Food, transportation reimbursement, and child care were all provided in the hopes of reducing barriers to attendance. Forty-eight individuals attended, and included students (n = 17) in psychology, social work and social services programs, and service providers in child welfare, community mental health providers, addictions counsellors, psychometrists, researchers, psychotherapists, social workers, and more. In attendance included individuals who self-identified as students but informally shared that they were service providers or mental health practitioners as well. Thus, a wide range of professionals and aspiring professionals were in attendance, all with the desire to learn more about how to support their future clients.

The training included six hours of content. The first hour was spent informing participants about the development of the Healing the Whole Self model. The next two hours were spent explaining the rationale for the Healing the Whole Self model. This included a) the potential physical, mental, emotional and spiritual effects of intimate partner violence, and some of the social factors (such as poverty and isolation) that may contribute to the experience of intimate partner violence; b) best practices for working with trauma and complex trauma (including cognitive behavioural, narrative, empowerment, and eye movement desensitization and reprocessing); and c) cultural competence. The rest of the day was spent discussing the Healing the Whole Self model, its various modules, and its applications. This included engaging

in several mindfulness exercises, completing a culturally competent self-care plan (Wellness Wheel), participating in group discussions, and more didactic approaches to teaching. Participants were invited to give feedback, ask questions and/or provide examples throughout the day. A detailed therapy manual was provided to each participant to help her follow along, and gain a more concrete understanding of the therapy model.

The researcher introduced herself and placed herself as a student—in doing so, she was being transparent in her role as an expert and learner. This allowed for acknowledgement and celebration of the wealth of knowledge and experience in the room. Participants were encouraged to provide feedback and ask questions of the researcher and other attendees throughout the day. The researcher emphasized the community-based nature of the project, and requested that attendees with suggestions related to the model and its applications share these with her. By doing this, she was able to continue with the collaborative feedback process with stakeholders, and attempted to have participants think about how they could use this model in their own workplace.

The information on cultural competence was especially important as many of the attendees reported experiencing less comfort when working cross-culturally. This was assessed informally by asking participants to raise their hands. Literature has also demonstrated that cultural-competent clinical training is inadequate, and many clinicians feel ill-equipped for working cross-culturally (Olfert, 2006). Considering the diversity that exists in Thunder Bay, Ontario (Statistics Canada, 2011), and the lack of culturally-specific psychological services (Chapter Three), practicing culturally competent counselling is essential. This component was included to help build the skills and confidence of clinicians, regardless of their intention on adopting the Healing the Whole Self model. Moreover, this section offered several theories and

definitions of cultural competence, and was delivered in a way that was meant to re-assure clinicians as opposed to demonstrate deficits. This included the assertion that all clients are "cross-cultural", and thus, there is necessarily a level of competence that each clinician possesses (American Psychological Association, 2002). At the same time, some of the unique experiences of marginalized individuals was highlighted, and participants were encouraged to be mindful of such experiences and how they may be barriers to accessing or following-through with care (Sue et al., 2009). The importance of such considerations was reiterated throughout the day, and specific examples were given to illustrate how a potential client may be affected, and what clinicians can do to support their clients.

Outcomes of the Healing the Whole Self Training Workshop

The purpose of the training was to not only inform service providers about the Healing the Whole Self model and its applications, but to provide education about evidence-based practices, trauma, intimate partner violence, and cultural competence. In an attempt to assess whether these goals were met, evaluation forms were provided to all participants. Of the 48 participants, 39 completed evaluation forms (81.25%). The evaluation form included quantitative questions related to the structure and process of the training, and open-ended questions related to the model and its applicability in the participants' workplace.

Almost all participants (97.44%) indicated that they agreed or strongly agreed that they would be able to apply what they had learned in the training within their workplace. Most participants also indicated (through responses of "agree" or "strongly agree") that the trainer was knowledgeable (100.00%) and that the quality of instruction was good (97.44%). Almost all participants (94.87%) ranked the overall training as "good" or "excellent". These responses

indicate that participants learned information that is relevant to their work, and that they found the presenter to be credible.

Open-ended questions included:

a) What aspects of the training could be improved?

b) What parts of the Healing the Whole Self model do you think are relevant for your clients?

c) What parts of the Healing the Whole Self model do you think are less relevant or irrelevant for your clients?

d) Which, if any, three components/strategies do you think are essential to keep within the Healing the Whole Self model?

e) Which, if any, components/strategies do you think are unnecessary or unhelpful in the Healing the Whole Self model?

f) Will you be able to use some of the things you learned today in your workplace? If so, what?

There was also an opportunity for participants to include other comments.

Feedback relating to how the training could be improved related to logistical feedback (e.g., making the PowerPoint presentation available beforehand, and increasing/decreasing the length of the training) and process-based suggestions (e.g., including more "out of chair" participation, and more discussion). Participants commented on the content of the training, and feedback included presenting different applications of the model (e.g., adapting the group format for individual counselling and working with non-heterosexual violence), and offering more information (e.g., additional research, vicarious trauma and burnout of service providers, and teaching about the historical trauma experienced by many Indigenous peoples in Canada).

In terms of what aspects of the Healing the Whole Self model are relevant for clients and essential to keep, many participants shared that it was all relevant/essential, and therefore could not indicate specific aspects. For those participants that did indicate specific aspects of the model, participants listed the Dialectical Behaviour Therapy skills, including specifically referring to mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness skills; a "Wellness Wheel" self-care exercise; information on trauma; information related to the Power and Control Wheel, and contextualizing this within cultural understandings of relationships; and the Life History Journal. Participants also shared more process-based components, including the group format; the importance of being non-judgmental and having a client-centred approach; the focus on the strength of clients; the emphasis on empowerment and personal choice; the focus on the client and her healing, as opposed to the abuse and the abuser; and the cultural context, including encouraging service providers to be aware and reflective of biases and assumptions, and the holistic conceptualization of well-being.

Most participants did not respond to the questions asking about less relevant and unhelpful aspects of the model. For those that did, some commented on how they were not comfortable enough with mindfulness to teach it to their clients, while others felt that it would not be helpful for their clients. Some participants also shared that the work they do is generally crisis-response, and thus, they would need to use the model more flexibly or in parts. A few participants commented on the length of the program (twenty sessions), suggesting it was too long for clients to commit to.

In response to what participants would be able to use in the workplace, many participants indicated that all of the information would be applicable and useful. Participants found that the cultural considerations and tools for integration were particularly helpful, as was the focus on

mindfulness. They reported that the importance of a non-judgmental approach and a holistic conceptualization of well-being were also relevant for them. Lastly, participants listed specific aspects of the training, including the Dialectical Behaviour Therapy skills, the "Wellness Wheel" self-care exercise, and the specific tools for working with trauma.

These findings demonstrate that participants were actively thinking about what they learned in the training, including the Healing the Whole Self model and its applications. Moreover, their responses are a potential indicator for having learned new ways for working with survivors of intimate partner violence and trauma, and working cross-culturally in a competent manner. If this is the case, then the researcher's goals of building capacity and knowledge translation were achieved. Through the evaluation and invitation for discussion, the researcher was able to encourage continuous feedback. Lastly, by training individuals in the Healing the Whole Self model, she was able to allow for the model and her research to exist, grow, and further develop after the completion of her Doctoral dissertation—thus enabling sustainability. This sustainable change was further demonstrated through the request by several organizations to consult with the researcher about implementing the Healing the Whole Self model for their clients.

Discussion and Conclusion

Community-based research methods allow for a collaborative, meaningful, and empowering way to conduct research and create change (Israel et al., 1998; Strand et al., 2003; Tremblay, 2009). These methods involve several steps, including needs assessment, consistent participation and feedback from stakeholders, and dissemination in meaningful and accessible ways (Strand et al., 2003). Mental health interventions have often been developed by "experts" and without the collaboration, feedback or input from important stakeholders (i.e., the clients and

populations for whom these interventions were developed; Spong & Waters, 2015). This is the case, even though counselling is often intended to be a collaborative and empowering process (Harris, 2009). In aiming to offer culturally competent practices, this collaboration and participatory approach is especially important (American Psychological Association, 2002; Sue et al., 2009).

While there are a few interventions that were developed using community-based methods and are culturally competent (e.g., Davis et al., 2009), none discuss the sharing of this knowledge outside of the organization with which the intervention was developed and scholarly publications. In order to share the knowledge and voices of those who have developed such interventions, and to increase the capacity and improve best practices of those working and living within communities, a more accessible dissemination process is necessary. This paper, using the example of the Healing the Whole Self Training Workshop, illustrated how this may be done, and the importance of feedback and evaluation to this process.

Through this process, the researcher had several reflections:

a) Inviting community members from different organizations may help strengthen the supportive skills of non-mental health care providers who work with individuals with mental health concerns.
b) Discussing cultural competence, self-awareness, and people's concerns about working cross-culturally may build on the strengths of service providers. Doing this in a warm and approachable way can open discussion about concerns and hesitations in engaging in this work, while reducing fear, shame and embarrassment related to expectations of competence.

c) Including many opportunities for connection, collaboration, networking and discussion amongst service providers can further build capacity, allow for the recognition that each person is an expert but that there is much to learn, and for community members to work together to develop creative approaches to decreasing barriers to service provision.

d) Training workshops that provide more information than one specific model allows for the development of other skills and knowledge. For example, if participants decided that the Healing the Whole Self model was not going to be relevant for their specific clients, they had now learned about other best practices for working with trauma and the psychological effects of intimate partner violence. This in itself can be quite beneficial for participants.

e) Due to the diversity of service providers represented at the training, there were different perspectives on issues (e.g., whether to tell a woman she is in an abusive relationship or to let her understand the relationship through her own perspective; the service provider's role in keeping a woman safe; etc.). Managing such discussions can be challenging, but remembering that individuals have their own value systems, practices, and approaches to working with women may help validate each person's experience. Contextualizing facilitator responses within a lens of best practice may help manage some of these conflicting perspectives.

Limitations

There were several limitations to this training. Primarily, many of the attendees (n = 17) were students or recent graduates. While the training may have been beneficial for their learning and to build their capacity as future clinicians, it is likely that their ability to speak from experience and provide feedback on the model was limited. As such, this may have affected the

continuous feedback goal of this dissemination process. This may have occurred through the offering of free admission to students. While the goal was to encourage student participation and decrease barriers to attendance, this may have skewed the demographics of attendees to be heavily weighted by students. If planning on organizing such an event in the future, researchers should think about having a maximum enrolment for students, and/or having a lower registration fee for students in order to ensure that those registering are committed to attending. Researchers should also think carefully about their target audience, and ensure that the training is well-marketed for that audience.

Next, and on a similar note, because of the diversity of professions and organizations represented at the training, several attendees' primary role in the workplace was not to provide group therapy for women survivors of intimate partner violence. In considering this, it is possible that their ability to provide feedback may have been affected by the applicability of the model to their workplace and population of clients. Having said this, it is also important to recognize that while one goal of the training was to get feedback, the skills, theories and process-based information covered throughout the training was likely still helpful in the work that many of these service providers do. Moreover, in acknowledging the lack of therapeutic services available for women survivors of intimate partner violence (American Psychological Association, 2001), and culturally-based services for this population (Chapters Two and Three), equipping service providers with evidence-based and culturally competent skills may be especially important for working with this population.

Another limitation is that while the researcher hoped that this one day workshop and the provision of a detailed therapy manual would equip service providers to implement the program, some informal feedback suggested that this may not have been enough training. While the

researcher did invite individuals to contact her for further consultation and support if they wanted to implement the Healing the Whole Self model, perhaps an additional day of training for those interested in a more elaborate understanding of the model may have been helpful.

Community-based research is meant to democratize modes of inquiry and knowledge-generation processes, promote inclusion, build community capacity to tackle issues, create new social networks, and create change that will endure beyond the end of a project (Minkler & Wallerstein, 2003). In being able to meet these goals, one can hope to create meaningful, relevant and sustainable change—a community-based dissemination model is one step toward making this change.

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List of Appendices for Chapter Seven

Chapter Eight: Conclusion

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Chapter Eight: Conclusion

This dissertation consists of a program of research that comes together to demonstrate ways through which clinicians can think about engaging in culturally competent evidence-based practice, and with a population whose mental health is often overlooked (i.e., women survivors of intimate partner violence). Intimate partner violence can be a physically, emotionally, psychologically and spiritually challenging situation for anyone. For women who belong to marginalized groups (e.g., women of colour, with disabilities, who belong to immigrant or refugee groups), it is not only through intimate partner violence that they may experience emotional and psychological distress.

Through engaging in a needs assessment with Indigenous women living in Thunder Bay, Ontario (Chapter Three), it was demonstrated that there is often shame, guilt, and anger involved in experiences of intimate partner violence. This is different from the often-cited posttraumatic stress response (Dutton et al., 2006; Jones, Hughes, & Unterstaller, 2001). Research on the cognitive contributors to posttraumatic stress suggests that one contributing factor of such a response is that an individual's worldview has been disrupted, and that trust in beliefs about the self and the world have been broken (Park, Mills, & Edmundson, 2012). For individuals who have experienced traumas since childhood, historical trauma, and who have felt unsupported and undervalued within the systems in which they live may not be as likely to have their worldviews disrupted because of intimate partner violence. As the needs assessment and other research (e.g., Lane, Bopp, & Bopp, 2003; LaRocque, 1994) have demonstrated, there is often a cycle of violence with Indigenous peoples. This may also be the case for other marginalized populations (e.g., Hampton, Oliver, & Margarian, 2003). Moreover, it is not only through abusive interpersonal interactions that marginalized women may experience violence. Research

consistently demonstrates that women in general are less likely to be satisfied with the health care services they receive (Vlassoff, 2007), and individuals who experience marginalization are likely to have difficulty accessing services, and are less likely to be satisfied with the services they do get (Burman, Smailes, & Chantler, 2004; Williams & Becker, 1994). Such experiences may normalize the violence, lead to internalization of such oppressions, and communicate messages of being undeserving of respect, adequate care, and being less valuable than non- or less marginalized peoples (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011; Community Tool Box, 2014).

Some ways through which the effects of such internalizations can be combatted is through working from empowerment and participatory frameworks (Donaldson, 2005; Israel, Schulz, Parker, & Becker, 1998; McIntyre, 2008; Tremblay, 2009). By collaborating with the populations that are affected by the issues, and allowing them to direct how change can be effected, this communicates that they know what is best for themselves, they can take control of their well-being, that their well-being is important, and it increases ownership of such strategies (Donaldson, 2005; Kagan et al., 2011; McIntyre, 2008; Tremblay, 2009). Efforts to engage in a collaborative process were made throughout the development of the Healing the Whole Self model. A needs assessment was completed, and feedback from stakeholders was sought at different periods of time throughout the development. Moreover, the community training workshop offered space for more feedback and reflections, and was also a means of disseminating in a meaningful and sustainable way. A community-based approach was the strategy used by most of the culturally competent therapy programs included in the scoping review (Chapter Two). This lends support for this kind of approach to the development and evaluation of such programs.

The Healing the Whole Self program was then implemented and evaluated. Evaluation was an important component of this project because of the shortage of programs and outcome data on similar programs for marginalized groups (Gone & Alcántara, 2007), as demonstrated through Chapter Two. Outcomes demonstrated the satisfaction with the therapy model and facilitation style. For most of the clients who attended, data also suggest that favourable outcomes occurred, with participants integrating Dialectical Behaviour Therapy skills into their everyday lives, experiencing more enjoyment with life, and building a life worth living. Quantitative findings demonstrated that the clients' symptom severity related to stress and anxiety decreased significantly, and symptom severity related to depression and posttraumatic stress approached significance. Quality of life improved significantly for participants. Moreover, for several clients, these changes were clinically significant. It is hoped that the Healing the Whole Self program can continue to be implemented at different agencies throughout Thunder Bay, Ontario and elsewhere. Through both formal and informal dialogue with community agencies, it appears to be the intention of several organizations within the city to adopt the group therapy as part of their regular programming. Strategic support has been offered to facilitate this process.

This dissertation sought to fill a need within the community in Thunder Bay—a need that extends beyond Thunder Bay as well. While the needs assessment aspect of the project was specific to Indigenous women's experiences in Thunder Bay, it is likely that similar concerns are experienced by other marginalized groups. Ways through which culture can be integrated into therapy should be tailored to the specific group with whom one is working, with an understanding that how this is structured and facilitated should be decided upon by the clients. Part of the needs communicated included additional training for service providers, in therapeutic

strategies and cultural integration, so that service providers can feel more comfortable in their work. Thus, the training workshop sought to fill this need as well. The scoping review sought to investigate other culturally competent therapeutic services for women surviving the effects of intimate partner violence, in order to gain a better understanding of what currently exists for these populations. The findings from this review showcase the value of offering culturally competent and culturally-specific programs for culturally diverse and often marginalized women surviving the effects of intimate partner violence—a finding that can likely be extended to other populations as well.

Reflections

Working on this dissertation has presented several challenges, and opportunities for growth and learning. This project grew from a desire to understand the strength of Indigenous women in surviving the effects of intimate partner violence. However, there was a recognition that simply because there was a lack of research on this topic was not reason enough to engage in the research process—it was important for the research process to be mutually beneficial for all stakeholders. I knew what the benefits would be to myself, but the benefits to the women who would participate was less clear. A thought that came to mind was to offer emotional support to the women who participated, with an understanding of how violence can affect individuals, but that these women are already surviving, and may not want or need the support that I can offer. However, upon further thought and guidance from committee and community members, the idea of integrating both of these came to mind. It is through the desire to learn about women's strengths, and to support them through their healing, that the Healing the Whole Self group therapy was created.

The intention was to have this project be community-based from beginning to end; however, this was difficult to achieve. As such, the way in which this project was developed and implemented was different than how it was originally envisioned. More specifically, I was hoping that I could develop formal community partnerships with agencies so that I would have been able to connect with both service providers and consumers at the particular agencies. While I was able to connect with service providers, I was only able to connect with service consumers at one organization, and I was fortunate that many of the women at this organization were open to sharing their experiences with me. While the service providers and consumers continued to provide guidance and feedback to me throughout the development of the Healing the Whole Self model, there were no formal partnerships with organizations, but with individuals. Part of the challenge was that organizations had their own mandates related to how they participate in research, and what they endorse through such participation. I imagine there was also some skepticism about my intentions and goals with the research, especially considering I am non-Indigenous to Canada, and that I have affiliations with the University and Psychology. It was promising, however, that individuals from these organizations were willing to support me through the research process, and this served as an indicator that my work was moving in the right direction.

Another goal of developing community partnerships was that I would be able to either train service providers at the partnering organizations, or facilitate the groups myself (ideally with a co-facilitator from that organization so that she could get trained and continue to run the program). However, because partnerships with organizations were not formed, this process could not be implemented. Instead, I contacted several agencies, including those from where participants of the needs assessment came, in order to ask them about program implementation.

Most organizations explained that this would not be feasible, either because offering therapy was outside of their mandate, their population was more crisis-based or was not likely to commit to attend for twenty sessions, or because of ethical and/or organizational concerns related to a non-employee offering services. One organization in Thunder Bay (Catholic Family Development Centre) allowed for me to run the program there, and two separate groups were facilitated. However, because the agency does not work primarily with Indigenous populations, it was not possible to implement the program with solely (or mostly) Indigenous women. While this was disappointing at first, it provided a platform to engage with literature on cross-cultural approaches to working with diverse groups. Through this research, it was discovered that many of the approaches and techniques that were included in the Healing the Whole Self program could be appropriate for individuals of all backgrounds. It is through this finding, and some modification to the Healing the Whole Self program to incorporate new findings from the research process, that the program transitioned from being for Indigenous women, to being for all women, using a culturally competent approach.

Through the process of trying to partner with organizations, despite the little success, relationships with these organizations continued to develop, and all of the contacts established from the initial phases (Spring 2013) until Spring 2015 were invited to the training workshop. Invitations were circulated from this network of people. From the training workshop and through the contacts already established, several individuals approached me about implementing the program at their organizations. Almost a year was spent trying to partner with an organization to implement the group, and my initial reactions were that perhaps this group was not meeting the needs of the population it was meant to serve. However, being able to get feedback and guidance

from the partners developed, and unsolicited positive feedback from organizations that I tried to but could not partner with, led me to believe the barrier was not the program itself.

In reflecting on this difficulty, I think it relates back to the challenges in implementing the needs assessment and developing partnerships—people were unsure of my intentions. I have also come to learn that many organizations offer programming that is funded through grants. As such, my program may have been perceived as a competing program, and implementing it within their organization may have potentially met a need for which they were actively seeking funding. As I was implementing the program for free and willing to absorb all costs, this may have unintentionally interfered with these processes—something I did not understand at the time.

Much of the literature on community-based research discusses the importance of fostering relationships with the stakeholders and partners (Kagan et al., 2011; McIntyre, 2008; Tremblay, 2009). While I tried to do this, I believe I underestimated the amount of time that it would take for these relationships to develop. However, having gone through this process, I believe that I have been able to develop meaningful partnerships, and to be perceived as a credible and genuine ally. Some ways through which I have come to this conclusion have been through the various invitations I have received by organizations with whom I had no affiliation to facilitate workshops and presentations. For example, in March 2015, Bingwi Neyaashi Anishinaabek First Nations asked me to give a presentation on intimate partner violence within Aboriginal populations, and to facilitate a two hour workshop on the Healing the Whole Self model. Another example includes the Neighbours, Friends and Families organization (an organization meant to create awareness and intervene in family violence), housed in the Thunder Bay Multicultural Association, which requested I give a presentation on domestic violence as it may uniquely affect new immigrants and refugees in May 2015. Other ways through which I

believe I have become an ally are through the attendance at the Healing the Whole Self training program, and the number of organizations that are now interested in partnering.

This dissertation was a great opportunity for me to integrate research and clinical practice—something that is often encouraged in clinical psychology. This experience allowed me to take something theoretical that I had developed, and to apply it in real life. I was fortunate to have my clinical work supervised by Dr. Josephine Tan, as clinical supervision and guidance, especially when trying new therapeutic methods, is essential (Centre for Addiction and Mental Health, 2008). In being able to work with some survivors of intimate partner violence, and learn from them about their needs and concerns, as well as how they responded to the Healing the Whole Self group therapy was an invaluable experience. I was fortunate to be facilitating the group therapy with clients who were able to attend regularly and consistently, as this is often not the case for women who are surviving the effects of intimate partner violence (Chapter Three). Thus, it is possible that this client group was not representative of most women who are surviving the effects of intimate partner violence. However, it is also possible that the setting (a community mental health centre) and the referral process was more able to reach out to women who were ready to begin their healing journey (as they had initiated contact with the counselling centre), and were likely no longer experiencing constant crises.

In considering this, it is troubling that many of the women were experiencing difficulties with the Justice system. Several of the participants reported being wrongfully charged for assault, an example of manipulation from their ex-partners. Moreover, according to the participants, the process of uncovering the falsehood of these accusations took several months, further marginalizing the participant, and assumed the credibility of, and therefore gave more power to, the perpetrator. Many of the participants shared stories of how traumatizing these

experiences had been. Other participants shared stories of attempting to press charges against their ex-partner for the physical assaults they had experienced, but that this process was long, traumatizing, and often did not have favourable outcomes. The process of getting a divorce, although a different court system, presented similar challenges. Many of the participants shared their difficulties in having a divorce be processed, getting what they were entitled to, and feeling manipulated by the system or their partner's use of the system. Most of the women were actively dealing with their lawyers at the time of the therapy, and this seemed to consume much of their time. Thus, it seems that the processes of ensuring one's safety and having one's basic needs met are simply initial steps in the process of moving forward. The current structure of the Justice system continues to marginalize women and survivors of violence, and, despite women's desires to move forward, they seem to be held back by this process.

Implications and Recommendations

This project demonstrated ways that one can work with community to collaboratively meet its needs. In addition, it attempted to utilize evidence-based practice with a focus on patient characteristics, values and preferences. Using community-based methods with a focus on intersectionality, the Healing the Whole Self model is structured to be culturally competent and flexible, yet is evidence-informed. Considering the way through which the Healing the Whole Self model was developed, and the shortage of culturally competent therapies for survivors of intimate partner violence, it is possible that this model serves as a promising practice.

Recommendations for future research include:

1) Through narrative and qualitative approaches, further assess the outcomes of the Healing the Whole Self model in order to determine how effective it is for women.

2) Continuing to seek feedback from clients and service providers about how the Healing the Whole Self model can be adapted to meet the needs of the specific population with whom one is working.
3) Exploring the value and desire of culturally-specific exercises with each client group.
4) Consider the appropriateness of measuring quantitative outcomes with client groups. This should be done carefully, as many psychological assessment measures were not developed or validated with specific cultural groups. Moreover, the use of such tools may pathologize women and specific culture groups—a process that could further oppress and marginalize the people it is intending to serve. Should quantitative psychological measures be used, this would further the understanding of the benefits and utility of the Healing the Whole Self model. The quantitative measures selected for this study were based on common presenting concerns as described in the literature and the needs assessment (Chapters Three and Four). Future research should aim to include larger and more varied samples.
5) Working with community partners in order to assess the feasibility of the Healing the Whole Self in its entirety. Recognizing that there are many components to the therapy, seek to understand which aspects of the therapy may be most relevant and helpful for the clients with whom one is working (if it cannot be applied in its entirety).
6) Furthering attempts to evaluate the outcomes of the Life History Journal should be made.

7) Engaging in long-term follow-up with clients who participate in the group, as this would illustrate ways that the program can be improved, and offer a better understanding of outcomes.
8) Connecting with agencies that are using their own group therapy protocols with survivors of intimate partner violence in order to evaluate the effectiveness of such models. It is likely that other strategies and best practices are currently being implemented—a process of evaluation and dissemination would allow this information to be shared.
9) Apply the steps used to develop Healing the Whole Self (Chapter Four) to other populations to assess the feasibility of this approach to intervention development.

There continue to be gaps in the literature on how to best engage in culturally competent therapy. This dissertation suggests that culturally-specific strategies may not be necessary, but that the client knows what is best for her. As such, it is the role of the clinician to engage in culturally competent practices with all clients, regardless of cultural identities, and to pose questions about client needs with clients. It seems that many clinicians hesitate in working cross-culturally, and there are often assumptions that one must know everything about a client's culture in order to not offend or marginalize (Sue, Zane, Hall, & Berger, 2009). However, I would argue that this very concern and the hesitation continues to "other" clients of diverse backgrounds, making it more challenging for them to access services, and for them to work with clinicians who feel comfortable doing so. Thus, it is important for clinicians to reframe the ways in which they think about diversity. One possible way of doing this is by considering that all clients with whom one works are diverse, as such, clinicians are familiar and competent in working cross-culturally. However, this must be accompanied with knowledge about cross-

cultural approaches—anti-oppressive techniques, collaboration, and open discussion are likely helpful starting points.

This dissertation demonstrated an approach to developing a community-based mental health intervention. Using this approach allowed the opportunity for individual and community needs to be the primary focus of the development of the intervention. While the community-based strategies were not implemented exactly how the researcher intended, or would have liked, this process reflected the nature of community-based research. The researcher advocates that community-based research methods should be used more often in the development of interventions, as such approaches ensure client needs are being met, are empowering, and can be especially helpful in working cross-culturally.

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Appendices A – I

Lakehead
UNIVERSITY

Department of Psychology

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Dear Potential Participant,

You are being invited to participate in a project that aims to better understand First Nations women's experiences of intimate partner violence. The purpose of the study is to better understand how First Nations women are affected by and cope with intimate partner violence, as well as to understand what they need to heal.

You are being invited to participate in this project because you have been identified as an individual who has experienced physical, emotional or sexual abuse by your romantic partner, and they thought you may have valuable thoughts and opinions to contribute to the discussion.

If you decide to participate, you will be welcome to withdraw at any point in time, and participation is completely voluntary. Additionally, you can choose not to answer specific questions and/or sections of the focus group.

You are invited to participate in one of two focus groups, being held _____. The focus group should last approximately 2 to 3 hours, and will consist of questions related to health, experiences and effects of violence, and healing. Alternatively, you may participate in an interview covering the same material, and should last approximately one hour. The focus groups and interviews will be audio recorded for data analysis purposes, however the data will be stripped of any identifying information to ensure anonymity. This means that after the focus group/interview, no one will be able to connect what you said to who you are. However, because of the focus group structure, and because other women who attend the focus group will be able to see who you are, confidentiality and anonymity cannot be ensured throughout the research process. However, all participants will be asked to agree to keep the information discussed in the focus group confidential. With the interview, confidentiality and anonymity can be ensured.

Themes will be identified by listening to what is being discussed in the focus group/interview. Once themes have been identified and conclusions drawn, this information will be sent back to participants to ensure that data have been correctly understood and reflect accurate information, if they are interested in this process.

There are minimal risks included in this study. Discussing issues related to experiences of violence and healing may cause some emotional discomfort. In case this occurs, a list of resources will be distributed to you. Moreover, a community Elder and a First Nations registered Psychologist will be present at the focus group, should you, or any participants, require immediate support. This project will benefit the community by helping build a greater understanding of how First Nations women understand the effects of intimate partner violence on themselves and their communities, and what the healing process would look like for them. This project may benefit participants by allowing them to recognize that they are not alone in their experiences, which may help facilitate a process of healing and empower them.

Issues of Informed Consent to be Discussed with Potential Participants of Focus Groups with First Nations Women

Potential participants will be informed about the purpose of the study as well as the involvement expected from participants. While this will not be used as a script, below is information that will be communicated to potential participants.

- The purpose of the study is to better understand how First Nations women are affected by and cope with intimate partner violence, as well as to understand what they need to heal
- The individual is being invited to participate because she has been identified as someone who has experienced intimate partner violence, and may have valuable thoughts and opinions to contribute to the discussion
- This project is being conducted by a research team at Lakehead University
- If the individual decides to participate, she is welcome to withdraw at any point in time, and participation is completely voluntary. Additionally, the participant can choose not to answer specific questions and/or sections of the focus group
- The focus group should last approximately 2 to 3 hours, and will consist of questions related to health, experiences and effects of violence, and healing
- The focus groups will be audio recorded for data analysis purposes, however the data will be stripped of any identifying information to ensure anonymity
- No one but the research team will have access to the raw data (i.e., audio transcripts), and data will be stored at Lakehead University in Dr. Mirella Stroink's laboratory, under lock and key, for five years.
- Because of the focus group structure, confidentiality and anonymity cannot be ensured throughout the research process. However, all participants will be asked to agree to keep the information discussed in the focus group confidential
- There are minimal risks included in this study. Discussing issues related to experiences of violence and healing may cause some emotional discomfort. In case this occurs, a list of resources will be distributed to participants. Moreover, a community Elder and a First Nations registered Psychologist will be present should any participants require immediate support.
- This project will benefit the community by helping build a greater understanding of how First Nations women conceptualize the effects of intimate partner violence on themselves and their communities, and what the healing process would look like for them. This project may benefit those who participate by allowing women to recognize that they are not alone in their experiences, help facilitate a process of healing, and may empower participants
- Through the data analysis process, once themes have been identified and conclusions drawn, this information will be sent back to participants to ensure that data have been correctly understood and reflect accurate information
- The research will be disseminated through scholarly publications, as well as more accessible processes

Focus Group Questions

What does it mean to be healthy?

- How do you feel spiritually, mentally, physically and emotionally when you are healthy?
- What does it mean to be a healthy Anishinaabek woman?
- How do you know when you are unhealthy?

What are the impacts of intimate partner violence on your life?

- How does the violence affect your spiritual, mental, physical and emotional health?
- What are the impacts on your relationships, your family, your community, and society?
- When experiencing violence, what do you need from your relationships, your family, your community and society to feel well?

Partner violence is often not the only thing that affects a woman's mental, physical, spiritual and emotional health. What are some other factors that affect your health (or, in other words, what are some other things that you feel you need to be healed from)?
What are some ways in which you cope with the violence and other traumas?

- Are these strategies helpful?
- Are these strategies healthy? If they are not, why do you choose to use them?
- What are some useful strategies you could use? If these are not the strategies of choice, why not?
- What strengths to do you draw on within yourself, your family, and your community to go on and to cope with the violence?

What does healing mean to you?

- If you felt healed, how would your life be different?
- How would your spiritual, mental, emotional and physical well-being be different?
- How would your relationships be different?
- What do you need to heal?
    - What can services and people offer to you to help with the process of healing?
    - What in the past has hindered the healing process?

Lakehead
UNIVERSITY

Department of Psychology

(807) 343-8010 x 6642
(807) 346-7734
talani@lakeheadu.ca

To Whom It May Concern,

My name is Taslim Alani and I am a Ph.D. student in Clinical Psychology at Lakehead University. I am writing to you today to request your assistance in a project that I am working on.

I am hoping to gain a better understanding of First Nations women's experiences of intimate partner violence, as well as the effectiveness of the services they use. The project involves two components, of which I am hoping to have your support in both.

Firstly, I am hoping to hold a focus group with service providers that work with First Nations women who have experienced intimate partner violence, who work in the area of First Nations health, or who work with women who have experienced intimate partner violence. In this focus group, we will be discussing successes and challenges in service provision, as well as how cultural and traditional practices have been integrated. Bus passes and child care can be provided if necessary. The time commitment would be approximately 2 to 3 hours. This focus group will be held _____.

Secondly, I am hoping to hold a second focus group with First Nations women who have experienced intimate partner violence, in order to better understand how they are affected by the violence and what they need to heal. Ideally, the women who participate in this study would be already receiving emotional support and be at relatively low risk (i.e., be living in a stable place, not be at risk of harming themselves or someone else, and not at risk of violence). Bus passes and child care will be provided as needed. The time commitment for this focus group would be 2 to 3 hours. Participants are invited to attend a focus group on _____. Potential participants are also welcome to participate in an interview, if they would prefer this option. Potential participants may contact the researcher to schedule an interview. Alternatively, it potential participants wish, their service provider may pass along their contact information to the researcher who will then contact the potential participant.

Each of the focus groups will include a set of rules to help ensure confidentiality, respect, honesty and to create a safe space. In addition, while focus groups and interviews will be audio recorded for transcription purposes, all information will be stripped of identifying data in order to ensure anonymity and confidentiality. Moreover, no one outside of the research team will have knowledge of the individuals participating in this project. This research study has been approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone other than the researchers, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

I am hoping that, should your organization like to assist with this project, that you inform any individuals you think would be interested in participating in either focus group or interviews about the opportunity to do so.

I would be happy to speak with you about additional details of this project. I can be reached by telephone at (807) 343-8010 ext. 6642, or by email at talani@lakeheadu.ca.

Thank you in advance for your time. I look forward to hearing from you.

Sincerely,

Taslim Alani

Issues of Informed Consent to be Discussed with Potential Participants of Focus Groups with Service Providers

Potential participants will be informed about the purpose of the study as well as the involvement expected from participants. While this will not be used a script, below is information that will be communicated to potential participants.

- The purpose of the study is to better understand how services are provided to First Nations women that experience intimate partner violence, including what strategies work, challenges in providing services and how cultural practices are integrated into services
- The individual is being invited to participate because she/he has been identified as someone who has expertise in working with First Nations women who have experiences intimate partner violence, working in areas of First Nations peoples' health, or women who have experienced intimate partner violence, and may have valuable thoughts and opinions to contribute to the discussion
- This project is being conducted by a research team at Lakehead University
- If the individual decides to participate, she/he is welcome to withdraw at any point in time, and participation is completely voluntary. Additionally, the participant can choose not to answer specific questions and/or sections of the focus group
- The focus group should last approximately 2 to 3 hours, and will consist of questions related to services provided to First Nations women who have experienced intimate partner violence, challenges in providing services to this population, and how traditional practices have been integrated into service provision
- The focus groups will be audio recorded for data analysis purposes, however the data will be stripped of any identifying information to ensure anonymity
- No one but the research team will have access to the raw data (i.e., audio transcripts), and data will be stored at Lakehead University in Dr. Mirella Stroink's laboratory, under lock and key, for five years.
- Because of the focus group structure, confidentiality and anonymity cannot be ensured throughout the research process. However, all participants will be asked to agree to keep the information discussed in the focus group confidential
- There are minimal risks included in this study. Discussing issues related to service provision to this population may elicit emotional discomfort or frustrations. In case this occurs, a list of resources will be distributed to participants
- This project will benefit the community by helping build a greater understanding of how to effectively provide service to First Nations women who have experienced intimate partner violence. This project may benefit those who participate by allowing them to learn from the experiences of others and to learn that they are not alone in their concerns
- Through the data analysis process, once themes have been identified and conclusions drawn, this information will be sent back to participants to ensure that data have been correctly understood and reflect accurate information

- The research will be disseminated through scholarly publications, as well as more accessible processes, as decided upon by the research team

Focus Group Questions for Service Providers

What are some of the impacts of intimate partner violence on a woman?

- Do you think that intimate partner violence impacts First Nations women differently that non-First Nations women? If so, how?
- How does intimate partner violence against First Nations women affect the women involved?
- How does the violence affect the family and community?

What are some strategies you use to help support and heal First Nations women from the violence they experience?

- Are the strategies used with First Nations women different from strategies used with non-First Nations women?
- Which strategies have you found to be most effective with this population?

Do you attempt to integrate cultural and traditional practices into services?

- If so, how have you/has your organization done this?
- Do you feel that the strategies that you've used been effective?
- How have you selected what practices to integrate?
- What are some of the benefits of integrating cultural practices?
- What are some of the shortcomings of attempting to do this?

Are there some services/strategies you wish you could use, but that you are not able to?

- If so, what are some of these strategies/services?
- Why do you want to try these?
- Why are you unable to use them?

What do you think are the most pressing needs of First Nations women who have experienced intimate partner violence?

What are some challenges that service providers experience in trying to engage this population?

- How have you dealt with these challenges?
- How do you think other service providers deal with these challenges?

What strategies have you found to be effective in maintaining motivation and attendance in service provision?

- Do time, location, involvement or other factors affect participation?
- What are some of the best experiences you've had in working with this population? What made them the best experiences?

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Office of Research Services

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Fax 807-346-7749

July 04, 2013

Principal Investigator: Dr. Mirella Stroink
Co-Investigator: Taslim Alani/Krista Tocker
Health and Behavioural Sciences\Psychology
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Mirella Stroink:

Re: REB Project #: 020 13-14 / Romeo File No: 1463327
Granting Agency: n/a
Granting Agency Project #: n/a

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Healing the Whole Self: Understanding First Nations Women's and their Service Providers' Experiences of Intimate Partner Violence".

Ethics approval is valid until July 4, 2014. Please submit a Request for Renewal form to the Office of Research Services by June 4, 2014 if your research involving human subjects will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Research Ethics Board forms are available through the Romeo Research Portal at:

http://romeo.lakeheadu.ca

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Richard Maundrell
Chair, Research Ethics Board

/scw

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MEMORANDUM

Date: July 31, 2013

To: Dr. Mirella Stroink, Taslim Alani and Krista Tocker

From: Dr. Richard Maundrell

Subject: Amendment for REB Project #020 13-14 / ROMEO #1463327

Thank you for your request for amendment to your project titled, "Healing the Whole Self: Understanding First Nations Women's and their Service Providers' Experiences of Intimate Partner Violence".

You've requested the addition of interviews utilizing the same questions proposed for the focus groups. As noted, this may be a more appropriate approach for those participants not comfortable with a group setting. Thank you for providing amended information letters.

This amendment is acceptable to the Research Ethics Board.

Please continue to advise us of any future changes to this project.

Sincerely,

Dr. Richard Maundrell
Chair, Research Ethics Board

/scw

Data Analysis Protocol for Healing the Whole Self: Study One
Written by Taslim Alani

Please read the following protocol before starting the data analysis process. The transcripts from the interviews may be long so try to remain focused and mindful as you go through this process. Moreover, if possible, keep track of any thoughts or reactions you have while reading the transcripts or identify themes.

The process of data analysis being used is called thematic analysis (also known as content analysis). A useful article to refer to will be referenced at the end of this document.

Steps for Analysis

1) Read over the interview questions (see end of document). Use these questions as a guide for indentifying information.
2) Work with the first transcript.
    a. Read it from beginning to end.
    b. Write down any information that stands out as important or useful.
    c. Read over the transcript and highlight (in **yellow**), any information that ties directly to the information you identified above.
    d. Add any additional information to your list.
3) Repeat Step 2 for all transcripts.
4) Refer to the first set of interview/focus group questions. Read over all transcripts. Highlight (in **red**) any information that you think pertains to the first set of questions. Once you have read over all of the transcripts, write down any information that seemed prominent as you read through the transcripts (as they directly relate to question set one).
    a. Make sure that all information you have written down can be identified in the transcripts (i.e., make sure you are not making assumptions about the data but are using information directly found within the transcript).
    b. Once you have written down the information you identified as important, try to categorize the information under different themes or umbrellas. There is no wrong way to do this, so as long as you can support your findings with what is written in the transcripts.
5) Repeat Step 3, with all question sets.
    a. Use **blue** for the 2nd question set
    b. Use **orange** for the 3rd question set
    c. Use **purple** for the 4th question set
    d. Use **green** for the 5th question set
    e. Use **pink** for 6th question set
    f. Use **light blue** for 7th question set
    g. Use **brown** for 8th question set
    h. Use **teal/turquoise** for 9th question set
    i. Use **grey** for 10th question set
    j. Use **golden yellow** for 11th question set

Additional Reading:

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi: 10.1191/1478088706qp063oa

List of Themes from Needs Assessment (Study One)

Impacts of IPV

- Isolation and loneliness
    - Withdrawn and lonely
    - Unable to connect with others
    - Feeling difficulty trusting others
    - Feeling shame
- Emotional impacts
    - Sadness
    - Anger
    - Loss
    - Guilt, Shame, hopelessness, Regret
    - Disliking self, mistrusting self, loss of identity, discomfort in one's body
- Physical impacts
    - Stress, chronic illness
    - Lack of sleep and nutrition
    - Injuries related to violence
- Reactions/resistance to violence
    - Crying
    - Substance use/abuse
    - Jealousy
    - Aggression and violent behaviour
    - High boundaries
- Reasons for staying
    - Nowhere to go
    - Fear of being re-victimized
    - Financial dependence/lack of resources
    - Partner a good person/still love partner/still care about partner
    - Wanting to keep family intact/role of mother and wife
    - Police involvement/CAS
- Family and community
    - Family may make the situation worse
    - May not support the woman leaving
    - Pressure to maintain family ideals
    - Family may fear partner
    - Broken homes related to historical trauma and lack of education around parenting

Impacts of Violence on FN women

- Reasons for staying
    - Expectations and family values
    - Isolation of the community/nowhere to go
    - Violence normal/accustomed to it
- Violence more complex

    - Tend to be more severe/lethal/more access to firearms
    - Intergenerational experiences of DV makes it harder to heal
- Families supportive
    - Assist with childcare

Other factors that affect Health
- Historical/lifetime trauma
    - Effects of residential school
    - Effects of foster care
    - Prior experiences of DV
- Loss of identity
    - Detached from one's culture/community
    - Disconnected from family or origin
- Life circumstances
    - Housing
    - Poverty
    - Lack of accessibility to services
    - Mental/physical illness
    - Involvement with justice system/crim. Record
    - Racism
- Adaptive coping
    - Family and friends
    - School/work
    - Self-care
    - Self-awareness
- Maladaptive copin
    - Drugs/alcohol/partying
    - Risky sexual behaviour
    - Neglecting self-care
    - Socially withdrawing

Meaning of health
- Self-care (physical emotional mental spiritual)
- Talking to one's self
- Celebrating one's self
- Unhealthy
    - Immersed in one's issues/being too self-focused
    - Repeating cycles
    - Grief starts to affect health

Healing
- Happiness/being in a good place
- Feeling confident with one's decisions
- Finding balance

- Feeling in control/empowered
- Not wanting to change yourself for others
- How healing can be achieved
    - Process
        - Takes time
        - Importance of self-awareness
        - Letting go of pain and hurt
        - Learning about one's own identity
    - Needs one one's self
        - Establish identity through self-exploration/self-awareness
        - Connecting with one's community
        - Taking time to heal and find stability
    - Education
        - Learn about identity and history
        - Signs of abuse and what a healthy relationship looks like
        - Re-educating about own needs, feelings and how to be self-aware
        - Knowledge about resources

    Most pressing needs
- Eligibility and accessibility
    - Many services are difficult to access because of things like childcare and transportation
    - Needs to be better information about what can be accessed
    - Women need a safe space for themselves
- Needs that women present with
    - Anger
    - Grief/los
    - Lack a sense of balance
    - Difficulty trusting others
    - Housing/poverty
    - Diet/nutrition
    - Trouble navigating OW/ODSP
    - Need to relax/time for themselves
- Within services
    - Need to incorporate what is working
    - Explain violence
    - Let women know their options
    - Address long waitlists
    - Power imbalance between client and therapist → needs to be minimized
    - Need to recognize women's strengths

Therapeutic strategies for working with women
- Therapeutic alliance
    - Non-judgmental

    - Validate one's experienced
    - Support women wherever they're at
    - Being caring
    - Build trust
    - Ensure woman's basic needs (housing, physical safety, etc.)
    - Diverse experiences of abuse/different needs/different perspectives of their (ex)partner→need to respect this
- Therapeutic approaches
    - Safety planning
    - Allow women to define presenting problem/define their own goals
    - Anger management
    - Therapy for grief and loss
    - Exposure therapy
    - Build self-esteem
    - Mindfulness
    - Grounding techniques
    - Focusing on negative aspects of abuse may be a deterrent
    - Learn about women's strengths/resiliencies
    - Many crises happen → adequate crisis intervention
- Practical considerations
    - Dissemination of resources so women know their options
    - Offer services through different media
    - Be flexible/incorporate feedback/adapt therapy as necessary
- Considerations for service providers
    - Need to be creative with how services are offered
    - Creative safety-planning
    - Being available as necessary for clients/outside of scheduled session/spend as much time as necessary debriefing
    - Allow women to make decisions

Cultural considerations

- Women have different cultural affiliations/practices
- Therapeutic strategies
    - Offer information/resources for women to connect with
    - Allow client to guide the therapy
    - Knowing, validating, acknowledging traumas
    - Some may already be connected to resources
    - Discuss spiritual abuse
- Specific strategies
    - Elder, smudging, healing circles, drumming, sweat lodges, incorporating medicine wheel
    - Creating safe/welcoming space
- Hesitation
    - May feel uncomfortable in trying to offer services

        - Don't want to do an inadequate job
        - Feel foolish
        - Complex process/inadequate training

Challenges and areas improvement

- Challenges to the service provider
    - Difficulty obtaining adequate information/training about available resources
    - Long waitlists
    - Rigid rules and guidelines
    - Funding shortages
- Methods for dealing with challenges
    - Spend informal/real person/human time
    - Learn about and breakdown myths and stereotypes
    - Seek out and incorporate feedback
    - Create a more welcoming environment
- Services they wish they could offer
    - Couples/family counselling
    - Counselling for men
    - Provide services for longer periods of time
    - More accessible hours
    - Spend more "human" time
    - Site-based cultural and traditional practices
        - Integrate use of outdoors
        - More holistic healing
    - Anger management/grief counselling
- Challenging circumstances SPs may encounter when working with IPV
    - Worries about confidentiality/concerns with trust
    - Transitioning from home community/leaving home community
    - Large families
    - Lots of crises
    - Internalized violence/blamed themselves
    - May perceive lack of support from community/family/friends
    - May hesitate to share in a group setting (esp. if non-FN women in group)
- SP wish they could change in society
    - Strong chiefs/band councils/leadership
    - Funding (long-term, more money, permanence)
    - Hold men accountable
    - Opportunities for men to heal
    - Lack of communication between organizations/leads to fragmented service provision→thus more collaboration/communication

Appendices J – S

Healing the Whole Self: A Psychological Intervention for Indigenous Women Experiencing Intimate Partner Violence

There is an abundance of evidence to suggest that psychological support for women who have experienced intimate partner violence is limited and not well-developed (APA, 2001). Moreover, psychotherapy for Indigenous peoples is often not tailored to meet their needs, and can be unhelpful and sometimes even be harmful (McCabe, 2007). The current project aims to implement and evaluate a group therapy developed by integrating community-determined needs with empirically supported treatments, in order to support Indigenous women in Thunder Bay on their healing journey. More specifically, interviews were conducted with Indigenous women who have experienced intimate partner violence as well as service providers from different agencies across Thunder Bay, Ontario who offer support to Indigenous women who have experienced intimate partner violence. In order to help fill a perceived gap in mental health service provision, this project sought to develop a potential evidence-based practice.

The American Psychological Association (2006) outlines a three-legged stool model to allow for better understanding of how evidence-based practice can be conceptualized more practically. They point to the best available research evidence as the first leg of the stool. This involves research that is well-constructed with outcomes that are well-defined and methods that meet the needs of the question being asked. The next leg is clinical expertise, and this involves the clinician demonstrating characteristics such as warmth and empathy—characteristics that have been demonstrated to make therapy more effective, regardless of theoretical orientation. Clinical expertise is not to be understood as the clinician having the expertise to conduct therapy how she or he sees fit, as this would directly contradict the first leg's focus on using the best available research evidence. However, it is also important for clinicians to work within their realm of expertise, meaning that they should only deliver interventions in areas where they have established competency. Lastly, patient preferences balances out the model as the third leg of the stool. Patient preferences offer space for shared health decision-making, where clients have the opportunity to voice their preferences and needs, and have them met, within the therapeutic model. This also involves clinicians that are more culturally informed, in order to be able to better understand the needs of their clients.

While research is generally conducted to inform the first leg of the stool (empirically supported treatments), and the second leg (clinical expertise) is fairly consistent across training, the third leg (patient characteristics) is often left unaddressed. In some training programs, there may be one course on cross-cultural practice in clinical psychology, but many individuals are left feeling unprepared to deal with individuals who they may perceive as dissimilar to themselves. Moreover, research has demonstrated that without being adequately equipped to work with individuals of a different culture than one's self, clinicians may actually do harm.

Thus, the current project made use of a community-based participatory research method in order to better ascertain the needs, strengths and barriers to treatment that Indigenous women may experience when surviving intimate partner violence. Women (n = 19) were interviewed

individually or in groups. When permission was granted, interviews were audio recorded (6 audio recordings in total) and data were analyzed using thematic content analysis. Many of the women who were interviewed were also survivors of violence, and thus the distinction between survivor of violence and service provider became blurred, however approximately 8 women were service providers and 15 women were survivors of violence.

Through an assessment of community needs, it was found that women are in need of resources to meet their basic needs (such as housing, food, safety, etc.) and want a service provider who is non-judgmental, caring, good at listening, and open-minded. Women may experience anger, sadness, guilt, shame, confusion and more because of the violence, and this may often be amplified through previous traumas, racism, difficulty accessing services, mistreatment by police and the Justice System, and concern about child welfare. Thus, while violence may play a factor in their current situation, it is not the only thing that is affecting their well-being. One of the other prominent themes was around culture. While research suggests there is a need for individuals to re-connect with their traditions and culture, what this means for each individual can be quite different, and no one person should be forced to practice something that may bring them discomfort or distress—culture should be practiced however one feels most comfortable.

With these findings in mind, the current therapy seeks to support women in their healing process by integrating what is known to work for helping people dealing with trauma (i.e., the empirically supported treatment), with what is known (within the literature and from the study looking at women's needs) about what women need (client characteristics) and how a therapeutic relationship can best be fostered (clinical expertise). The therapy being proposed integrates aspects of dialectical behaviour therapy (Linehan, 1993) with the tri-phasic model for trauma (Herman, 1992).

Dialectical behaviour therapy suggests that while individuals must be motivated to change, change is a gradual process and thus improvements will not always be seen, and clients may sometimes resort to previous, less helpful methods of coping in high stress situations. Clients should feel as though there is no judgment from clinicians or group members, however; this does not mean that clients are not accountable for their behaviours—clients should expect to be questioned by therapists, this process encourages clients to do their best and to be thinking about their decisions and behaviours. It has been suggested that the intervention serves the following five functions: enhances behavioural capabilities; improves motivation to change; assures that new capabilities generalize to the natural environment; structures the treatment environment in the ways essential to support client and therapist capabilities, and enhances therapist capabilities and motivation to treat clients effectively.

There are four modules to the group therapy: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. With all of these skills put together, individuals should be able to take a more non-judgmental approach to their situation, feel more confident when dealing with distress and when interacting with people while being assertive, have better awareness and control of their emotions, and have strategies they can use that may be helpful in

stressful situations. The skills offered to clients within this model would be provided as suggestions, and feedback and collaboration would be an essential part of this process. In this sense, the therapy is not telling women what they need to do to feel better, but instead suggests potential strategies that women can try out in order to help regain control over aspects of their lives—clients can choose whether to accept these, modify them, or reject them, and will also have space to offer their own strategies.

The tri-phasic model for trauma suggests that individuals who have experienced intense/repetitive trauma have a unique experience and set of symptoms with their trauma. Thus, individuals first need to have a sense of safety and ensure their basic needs are being met, then they can start processing the trauma in order to integrate their experience within their life narrative. At the third stage, they should re-establish their identity with their trauma being part of (but not defining) who they are and what they want to do next.

By integrating both dialectical behaviour therapy and the tri-phasic model for trauma, it is hoped that the women who participate in this group will not only be able to process their traumatic experiences, but gain skills and confidence that can help them in their futures.

The proposed therapy will last 20 weeks, and each session will last 2-3 hours (this can be modified as necessary by each organization). Each session will begin with a cultural sharing process, in which one member of the group shares a cultural practice that is of importance to her (e.g., drumming, a song her mother used to sing her, etc.). Then there will be a mindfulness exercise, followed by everyone in the group sharing something about their week. The second half of the session will be used for learning new skills (somewhat modified from dialectical behaviour therapy to be more holistic). The first two weeks of the therapy will occur in individual sessions where a comprehensive assessment of women's needs and strengths will be evaluated. Before anyone begins attending the group, each person's safety and basic needs will try to be met. This will be through safety planning, helping women find immediate shelter and/or long term housing, ensuring there is food available, etc. Once women start the group, approximately halfway through, each woman will begin processing their life history in a life history journal. This will be an opportunity to document one's life story (and can include space for women to explore historical trauma that may have not directly impacted them). If writing is a challenge for anyone, or if other media (such as oral history or through drawing) would be preferable, alternative measures can be put in place for women to engage in this process in a way that is most meaningful. In order to ensure that women are not experiencing too much distress through this process, brief individual phone sessions will be put in place to have an opportunity for clients to "check in".

As this will be one of the first times this therapy is being run, there will also be an evaluation component. The women who participate in the group will be invited to fill out surveys, as well as to have their initial and final interview be included in this process. This is not a necessary component of the therapy, and as such, women will not have to participate in the research component in order to participate in the group. For those participating in the research component, there will be an honorarium of $50 to thank women for their time and knowledge.

If the content of the group, the time commitment or the therapeutic aspect of the group seem out of the scope of your organization's abilities, an option may be to have a social work or psychology student do a placement at your organization. The research team will ensure that all people are adequately trained. From a liability perspective, because the researcher (Taslim Alani) has a clinical psychology background and will be supervised by a registered clinical psychologist (Josephine Tan, Ph.D., C. Psych.), her training and supervision should allow her to adequately assess for client risk and refer/support them as necessary.

For more information about this project, please contact Taslim Alani at talani@lakeheadu.ca, or Dr. Mirella Stroink at mstroink@lakeheadu.ca.

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Healing the Whole Self – Cover Letter and Informed Consent

Dear Potential Participant,

You are reading this form because you are obtaining more information about the Healing the Whole Self group therapy.

Information about the Therapy

As part of the therapy process, there are a few things that clients should know.

1) This is a 20-session program. While there are no consequences to not attending, it is expected that you will attend to the best of your abilities. Each group session will last a maximum of 3 hours (each group is scheduled to last 2 hours, with extra time available as necessary).
2) Child care, food, and bus passes will be provided every time you come in, to make sure that we are making attending as easy for you as we can. If there is anything else we can be providing, please let us know, and we will do our best to accommodate this.
3) There will be seven individual (phone or in-person) sessions that will take place. These will be scheduled at a time that is convenient for you and one the group facilitators. Most of these individual sessions will be brief (20 minute) check-in sessions, however more time can be provided as needed. Bus passes and child care will also be provided for this.
4) If you will not be able to make it to a group or to an individual session, please let your therapists know as soon as possible.
5) The benefits of this therapy will be seen the more you put into it. There will be several tasks for you to do outside of the therapy setting (more specifically, filling out your daily diary card, practicing the skills you are learning outside of the therapy time, and the trauma journal). Please do your best to complete these as often as expected.
6) There will be three questionnaires, plus a weekly diary card, for you to fill out so we can keep track of how well you are doing. Because this program is fairly new, we want to make sure that it is doing what is set out to do (i.e., help support you on your healing journey).

Information to Consider in Deciding to Participate in the Therapy

We would like you to know that everything that you discuss with the group will stay between the members of the group—the therapists and other clients will not be talking to others about what you talk about in group, nor will others know that you are even attending this group. It will be confidential. However, there are a few things you should know about this as well:

1) Because most of this therapy happens in a group format, we cannot guarantee that what you share in group will be confidential. While there will be a group expectation of confidentiality, please keep in mind that we cannot control what others do outside of group.
2) If we believe that you are at serious risk of hurting yourself or committing suicide, we may legally break confidentiality in order to protect you. We would explore all other options with you before doing this, and if at that point you were unable to take steps to ensure your safety, we would have to take action to make sure that you were protected from harming yourself.
3) If you tell us that you are seriously planning to hurt or kill an identifiable person, and we have reason to believe that you will follow through with it, we are legally required to try to inform that person and protect them from harm. We must also inform the police of your intentions.

4) If you tell us about a child or dependent adult who is being exposed to violence, being abused or being neglected, then we are legally required to take steps to protect that child or adult by reporting this information to child protection authorities.
5) If you are involved in a court case and a request is made for information about our work together, we may ask you for written consent to disclose the requested information. We may be required to disclose information without your consent, but we will do all that we can within the law to protect your confidentiality, and we will inform you of anything that we disclose.
6) If you request that we coordinate care with another care provider, we will get a signed release from you and discuss with you what information will be shared.

In order to protect your confidentiality, we will not acknowledge you if we run into each other in public. You are welcome to approach us, however. You are free to talk about our professional relationship with whomever you choose.

In the first session(s), your counselor(s) will ask questions to try to get a sense of what brings to therapy. You will talk together about a plan for your time in this, and discuss what your goals are. You have the right to decide what you are comfortable sharing, and may choose not to discuss certain topics. However, sometimes it is helpful to push yourself a little and see whether some benefit may come from confronting the discomfort. A therapeutic relationship is supportive, but it can also be challenging sometimes.

If you need to reach either one of your therapists outside of group or individually-planned sessions, please call: _____. They will try respond to all client phone calls within 24 hours. If there is an emergency, please call the Talk4Healing Crisis Line at 1-855-554-HEAL (4325).

Client Consent to Participate in Therapy

I have read this statement, had sufficient time to consider it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I understand my rights and responsibilities as a client, and my therapists; responsibilities to me. I know I can end therapy at any time I wish.

Client Name: _____

Signature: _____

Dated: _____

Therapist Signature: _____

Dated: _____

Information about Evaluating the Therapy

This is the first time that this therapy will be running and we would like to make sure that it works. Because of this, if it is okay with you, we will be using the information you provide us from the questionnaires you fill out, and from the first and last sessions, to get a better idea of how well this therapy is working. All of the information you provide to us will be anonymous (your name will not be on anything, and no one will be able to know it was you who provided it) and confidential (no one but the therapists and the researchers will have access to your information). You do not have to participate in the research part of the therapy in order to attend, and your participation is completely voluntary. You can choose to have your information removed from the research part of the therapy at any point in time. The data you provide to us for research will be stored at Lakehead University under lock and key, in Dr. Mirella Stroink's lab. After 5 years, this data will be destroyed. However, your client file will be kept at _____ (agency name), as per their policy for keeping client information.

We also would like your permission to video record all of the sessions. This would be to look at group dynamics, to better understand how people react to the information provided throughout the therapy, and

measure how well the therapy is being followed and how we are receiving the information provided in the group. I understand that this is voluntary and that I can continue to participate in therapy without having the sessions video recorded. I can also change my mind at any time, and others in the group will not find out whether I have given my permission to have the sessions video recorded. The sessions will be recorded only if everyone in the group gives their permission to do so.

Client Name: _____

Signature: _____

Dated: _____

Witness Signature: _____

Dated: _____

Interview and Intake Form

Client Name: _____
Contact Information: _____ Can we leave voicemails? □YES □NO
If possible, what is an alternate way to get in touch with you?
_____

Emergency Contact Name: _____ Contact Phone number: _____
Is this person your partner? □YES □NO What is their relationship to you?
_____

If emergency contact provided is your partner, is there another individual with whom you feel safe that we could contact in case of emergency? If so,
Secondary Emergency Contact Name: _____
Phone Number: _____

Presenting Problem (What Brings You Here)

What Are Some Immediate and/or Current Concerns/Needs of Yours?

Current Physical Concerns (headaches, cuts, etc.)

Current Emotional Concerns (feeling sad, angry, etc.)

Current Mental Concerns (memory problems, difficulty focusing, etc.)

Current Spiritual Concerns (difficulty connecting with Creator, feeling disconnected from Creation, etc.)

Married? Living with Partner? Currently in an abusive intimate relationship? (unnecessary to go into detail here)

Children?

Housing?

Employment?

Current social supports?

Alcohol Use?
Past?

Current?

Substance Use?

Past?

Current?

Current obstacles in your life?

Coping strategies

What are you hoping to gain from attending this therapy?

What are some short term and long term goals you have?

With a focus on healing, how do you think your healing process can be supported? What does this process look like for you? When you are feeling closer to being healed, how will your life be different?

Post-Intervention Evaluation Form

Client Name: _____

Number of Group Sessions Attended: _____ Number of Group Sessions Made-Up: _____

Number of Individual Sessions Attended: _____ Number of Trauma Journal Entries: _____

How has how you were feeling at the beginning of this therapy changed? (refer back to original presenting problem and psychological concerns)

We had discussed some goals you had set out for yourself. Do you think you have achieved them? Are you still working on them? Have your goals changed?

We also talked about what life would look like once you were feeling closer to being healed. Do you feel this way? How has your understanding of your healing journey changed or remained the same?

Have you learned of any new strengths within yourself since having started this therapy?

What did you find helpful about this therapy? How did it help? (think specific strategies as well: mindfulness, self-care, distress tolerance, life history journal, connecting with others, learning about emotions, learning about assertiveness, vision board?)

What did you find less helpful about this therapy? What can we do to improve it?

Do you have any feedback or suggestions for us?

What things have you learned about yourself from this therapy? How will this continue to help you throughout your healing journey?

World Health Organization Quality of Life – Brief (WHOQOL-BREF)

MSA/MNH/PSF/97.6
Page 17

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither	Good	Very good

				poor nor good		
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

Do you have any comments about the assessment?

.....

.....

THANK YOU FOR YOUR HELP

Depression Anxiety Stress Scales (DASS)

DASS

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3

19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Please turn the page ☞

Reminder of rating scale:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3

40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Posttraumatic Stress Disorder Checklist – Civilian Version (PCL)

PTSD Checklist (PCL) – Civilian Version for DSM-IV

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully. Circle the response that indicates how much you have been bothered by that problem in the past month.

1. Repeated, disturbing *memories, thoughts, or images* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

2. Repeated, disturbing *dreams* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

3. Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

4. Feeling *very upset* when *something reminded you* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

6. Avoiding *thinking about* or *talking about* a stressful experience or avoiding *having feelings* related to it?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

7. Avoiding *activities* or *situations* because *they reminded you* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

8. Trouble *remembering important parts* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

9. *Loss of interest* in activities that you used to enjoy?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

10. Feeling *distant* or *cut off* from other people?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

12. Feeling as if your *future* will somehow be *cut short*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

13. Trouble *falling* or *staying asleep*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

14. Feeling *irritable* or having *angry outbursts*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

15. Having *difficulty concentrating*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

16. Being *"super-alert"* or watchful or on guard?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

17. Feeling *jumpy* or easily startled?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Domestic Violence Risk Assessment (B-SAFER)

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CONFLICT MANAGEMENT

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B-SAFER Worksheet

Brief Spousal Assault Form for the Evaluation of Risk

By P. Randall Kropp, Stephen D. Hart, and Henrik Belfrage
Development of the B-SAFER was funded in part by the Department of Justice, Canada, and the Rikspolisstyrelsen, Sweden

Instructions

The B-SAFER is a guide for the assessment and management of risk for spousal assault. It helps users to exercise their best judgement. The administration procedures and risk factors included in the B-SAFER were determined from a review of hundreds of scientific and professional publications on spousal violence. There are no cutoff scores or other rules that can be used to determine the nature or degree of risk posed by an offender/suspect; the presence of a single risk factor may justify a conclusion that the person poses a high risk for future spousal violence.

This Worksheet is intended to assist administration of the B-SAFER. It should be used as described in and only in conjunction with the B-SAFER *User Manual*. Users evaluate and document the presence of each risk factor "Currently" (in the past four weeks) and "In the past" (prior to the past four weeks). These judgements are documented as "Y" for Yes, the factor was present; "?" for Unsure, the factor was possibly or partially present; or "N" for No, the factor was absent. If a risk factor was not considered due to missing information, it should be omitted. Following consideration of individual risk factors, users recommend risk management strategies and document conclusory opinions.

Use of the B-SAFER requires the gathering and documenting of sensitive information. Every effort should be made to keep confidential any information that could jeopardize the safety of the victim/complainant. The language used in the Worksheet assumes the offender/suspect is male and the victim/complainant is female, but the B-SAFER can be used regardless of the gender or marital status of the people involved.

Identifying Information

Name/case number(s):	Date of completion:
Completed by:	Signed:

Information sources:

- ☐ Interview with offender/suspect
- ☐ Interview with victim
- ☐ Review of police/criminal records
- ☐ Other:

Section I: Spousal Violence This section includes risk factors related to the person's history of violence against intimate partners, including any wife, common-law spouse, or girlfriend.	Presence
1. Assault ➢ Actual or attempted physical and sexual assault, including assault with a weapon ➢ Excludes threats and threatening behavior, which are considered under Factor #2	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
2. Violent Threats or Ideation ➢ Statements or intimidating behavior indicating intent to harm others, including stalking and threats with a weapon ➢ Thoughts, urges, fantasies, or plans concerning causing harm to others	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
3. Escalation ➢ Increase in the frequency or severity of violence or of threats/ideation	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
4. Violation of Court Orders ➢ Breach of conditions of bail, probation, parole, restraining orders, peace bonds, and so forth that were imposed because of spousal violence or to prevent spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
5. Negative Attitudes ➢ Beliefs and values that encourage or excuse abusive, controlling, and violent behavior, including sexual jealousy, misogyny, and patriarchy ➢ Minimization or denial of spousal violence or the consequences of spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
Other Considerations ➢ Specify any additional risk factors related to the person's history of spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N

Section II: Psychosocial Adjustment This section includes risk factors related to the person's history of psychological (personal) and social (interpersonal) adjustment problems.	Presence
6. Other Antisocial Behavior ➢ Criminal conduct that is persistent, frequent, or diverse ➢ Excludes criminal conduct related to spousal violence, which is considered in Section I	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
7. Intimate Relationship Problems ➢ Failure to establish or maintain stable, long-term intimate relationships as indicated by such things as separation from partner and extreme conflict regarding relationship status ➢ Includes any intimate relationship problems that result from spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
8. Employment Problems ➢ Failure to establish or maintain stable, long-term employment, as indicated by such things as chronic unemployment, frequent job changes, poor work performance, and significant financial difficulties ➢ Includes any employment problems that result from spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
9. Substance Use Problems ➢ Impairment of health or social functioning due to use of illegal drugs, alcohol, or prescription drugs, as indicated by such things as overdose, physical illness, arrest, job loss, or relationship difficulties ➢ Includes any substance use problems that result from spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
10. Mental Health Problems ➢ May suffer from serious mental disorder, as indicated by such things as irrational beliefs or perceptions, serious disturbance of mood, and long-standing problems related to anger, impulsivity, or instability ➢ Includes any mental health problems that result from spousal violence	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N
Other Considerations ➢ Specify any additional risk factors related to the person's history of psychological (personal) and social (interpersonal) adjustment problems	Currently ☐Y ☐? ☐N In the Past ☐Y ☐? ☐N

Recommended Risk Management Strategies

Monitoring/Surveillance ➢ What are the most appropriate ways to monitor changes in risk?	Face-to-face interviews ☐Offender/suspect ☐Victim/complainant Notes:	Telephone interviews ☐Offender/suspect ☐Victim/complainant	Visits ☐Offender/suspect ☐Victim/complainant
Control/Supervision ➢ What restrictions on activity, movement, association, or communication are most appropriate?	☐Remand in custody ☐Restraining order ☐Report as directed Notes:	☐Reside as directed ☐No weapons ☐No alcohol/drugs	☐Don't contact (specify) ☐Don't associate (specify) ☐Don't travel (specify)
Assessment/Treatment ➢ What assessment, treatment, or rehabilitation strategies are most appropriate?	Emergency ☐Hospitalization ☐Certification Notes:	Assessment/treatment ☐Mental health ☐Crisis intervention	Counseling ☐Spousal violence ☐Substance use
Victim Safety Planning ➢ What steps could enhance the physical security or self-protective skills of the victim/complainant?	Counseling ☐Support/advocacy ☐Mental health Notes:	Improve security ☐Residential (specify) ☐Workplace (specify)	Lifestyle changes ☐Residence ☐Work/travel

Conclusory Opinions

Case Prioritization ➢ What is the level of concern that the person will commit spousal violence in the future if no intervention is taken?	☐ High/Urgent ☐ Moderate/Elevated ☐ Low/Routine
Life-Threatening Violence ➢ What is the level of concern that any future spousal violence will involve life-threatening physical harm if no intervention is taken?	☐ High/Urgent ☐ Moderate/Elevated ☐ Low/Routine
Imminent Violence ➢ What is the level of concern that the person is an imminent risk to commit spousal violence if no intervention is taken?	☐ High/Urgent ☐ Moderate/Elevated ☐ Low/Routine
Likely Victims ➢ Who are the likely victims of any future spousal violence?	☐ Current or former intimate partner ☐ Family/friends of current or former intimate partner ☐ Other:

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

September 29, 2014

Principal Investigator: Dr. Mirella Stroink
Co-Investigator: Ms. Taslim Alani
Psychology
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Mirella Stroink:

Re: REB Project #: 052 14-15 / Romeo File No: 1464033
Granting Agency: N/A
Granting Agency Project #:N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Healing the Whole Self: Implementing and Evaluating the Efficacy of a Group Therapy Developed for Indigenous Women Experiencing Intimate Partner Violence".

Ethics approval is valid until September 29, 2015. Please submit a Request for Renewal form to the Office of Research Services by August 29, 2015 if your research involving human subjects will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Research Ethics Board forms are available through the Romeo Research Portal at:

http://romeo.lakeheadu.ca/Romeo.Researcher/login.aspx

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Lori Chambers
Chair, Research Ethics Board

/rks

Data Analysis Protocol
Evaluating Outcomes for Healing the Whole Self

The Healing the Whole Self model was developed to be culturally-informed and was meant to be used with a diverse population. As such, evaluating outcomes across different conceptualizations of health and well-being, and different presenting concerns is not easily or appropriately done using quantitative measures, even those that have been psychometrically-supported.

Single case design honours each client's individuality, as it does not assume normality or aggregate results in a way that silences this individuality. Thus, in order to assess outcomes from this therapy, data will be analyzed using the interviews that occurred prior to and at the end of the therapy. Change will be through client self-report and researcher observation. Below are the steps that were involved in the data analysis process, including the training of the research team.

Data Analysis Process

1) Familiarize yourself with Dialectical Behaviour Therapy and the Healing the Whole Self model. This can include through learning about it in class, reading the suggested literature at the bottom of this protocol, reading the Healing the Whole Self therapy manual, and/or attending the Healing the Whole Self training workshop. The more exposure and participation that occurs, the more thorough the data analysis process can be.
2) Once both pre- and post-intervention interviews are available, read each client's interview sets as pairs.
    a. With the pre-intervention interview, make notes of reported presenting concerns, challenges, and goals, as well as communication styles, areas of focus, and anything else noteworthy.
    b. Use the above notes as a guide in analyzing the post-intervention interview. Make note of any changes (self-reported or observed) as they relate to the findings from the pre-intervention interview. The participant may also allude to changes they have experienced that were not necessarily addressed in the pre-intervention interview; make note of these as well.
    c. Using what you know about the contents of the Healing the Whole Self therapy, including the Dialectical Behaviour Therapy modules, evaluate whether the change the participant is discussing is related to mechanisms of therapy.
3) Considering client change, and how this relates to mechanisms of therapy, decide whether client change can be confidently attributed to the therapy.
4) Once this process is complete for all participants, discuss your findings with the research team, and come to a consensus about change related to therapy.

Suggested Readings

Dimeff, L., & Linehan, M.M. (2001). Dialectical behavior therapy in a nutshell. *The California Psychologist, 34*, 10-13.

Linehan, M.M. (1993a). *Cognitive behavioral therapy of borderline personality disorder*. New York, NY: Guilford Press.

Linehan, M.M. (1993b). *Skills training manual for treating borderline personality disorder*. New York, NY: Guilford Press.

Appendices T - U

Lakehead UNIVERSITY

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

September 25, 2014

Principal Investigator: Dr. Mirella Stroink
Student Investigator: Taslim Alani
Psychology
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Mirella Stroink:

Re: REB Project #: 051 14-15 / Romeo File No: 1464034
Granting Agency: N/A
Granting Agency Project #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Healing the Whole Self: Assessing the Outcomes of Facilitator Training on Service Providers' Approaches to Working with their Clients.".

Ethics approval is valid until September 25, 2015. Please submit a Request for Renewal form to the Office of Research Services by August 25, 2015 if your research involving human subjects will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Research Ethics Board forms are available through the Romeo Research Portal at:

http://romeo.lakeheadu.ca/Romeo.Researcher/login.aspx

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Lori Chambers
Chair, Research Ethics Board

/rks

Lakehead UNIVERSITY

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

MEMORANDUM

Date: April 28, 2015

To: Dr. Mirella Stroink

Subject: Amendment Approval for REB Project #051 14-15 / Romeo #1464034

Thank you for your requested amendment for your project titled, "Healing the Whole Self: Assessing the Outcomes of Facilitator Training on Service Providers' Approaches to Working with their Clients."

You've requested to add questions to the post-training evaluation and the post-training interview in order to better capture the diversity of potential experiences from the training, and to better assess the therapy model being presented and whether training objectives were met.

I am pleased to inform you that this amendment is approved.

Please continue to advise us of any future changes to this project.

Sincerely,

Dr. Florin Pendea for Dr. Lori Chambers
Chair, Research Ethics Board

/rks

Healing the Whole Self Training Evaluation Form

What is your profession? _____

What was your main purpose for attending today's training? _____

_____

Please indicate your impressions of the items listed below.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The training met my expectations.	☐	☐	☐	☐	☐
2. I will be able to apply the knowledge learned.	☐	☐	☐	☐	☐
3. The training objectives for each topic were identified and followed.	☐	☐	☐	☐	☐
4. The content was organized and easy to follow.	☐	☐	☐	☐	☐
5. The materials distributed were pertinent and useful.	☐	☐	☐	☐	☐
6. The trainer was knowledgeable.	☐	☐	☐	☐	☐
7. The quality of instruction was good.	☐	☐	☐	☐	☐
8. The trainer met the training objectives.	☐	☐	☐	☐	☐
9. Participation and interaction were encouraged.	☐	☐	☐	☐	☐
10. Adequate time was provided for questions and discussion.	☐	☐	☐	☐	☐

11. How do you rate the training overall?

Excellent	Good	Average	Poor	Very poor
☐	☐	☐	☐	☐

12. What aspects of the training could be improved?

13. What parts of the Healing the Whole Self model do you think are relevant for your clients?

14. What parts of the Healing the Whole Self model do you think are less relevant or irrelevant for your clients?

15. Which, if any, three components/strategies do you think are essential to keep from within the Healing the Whole Self model?

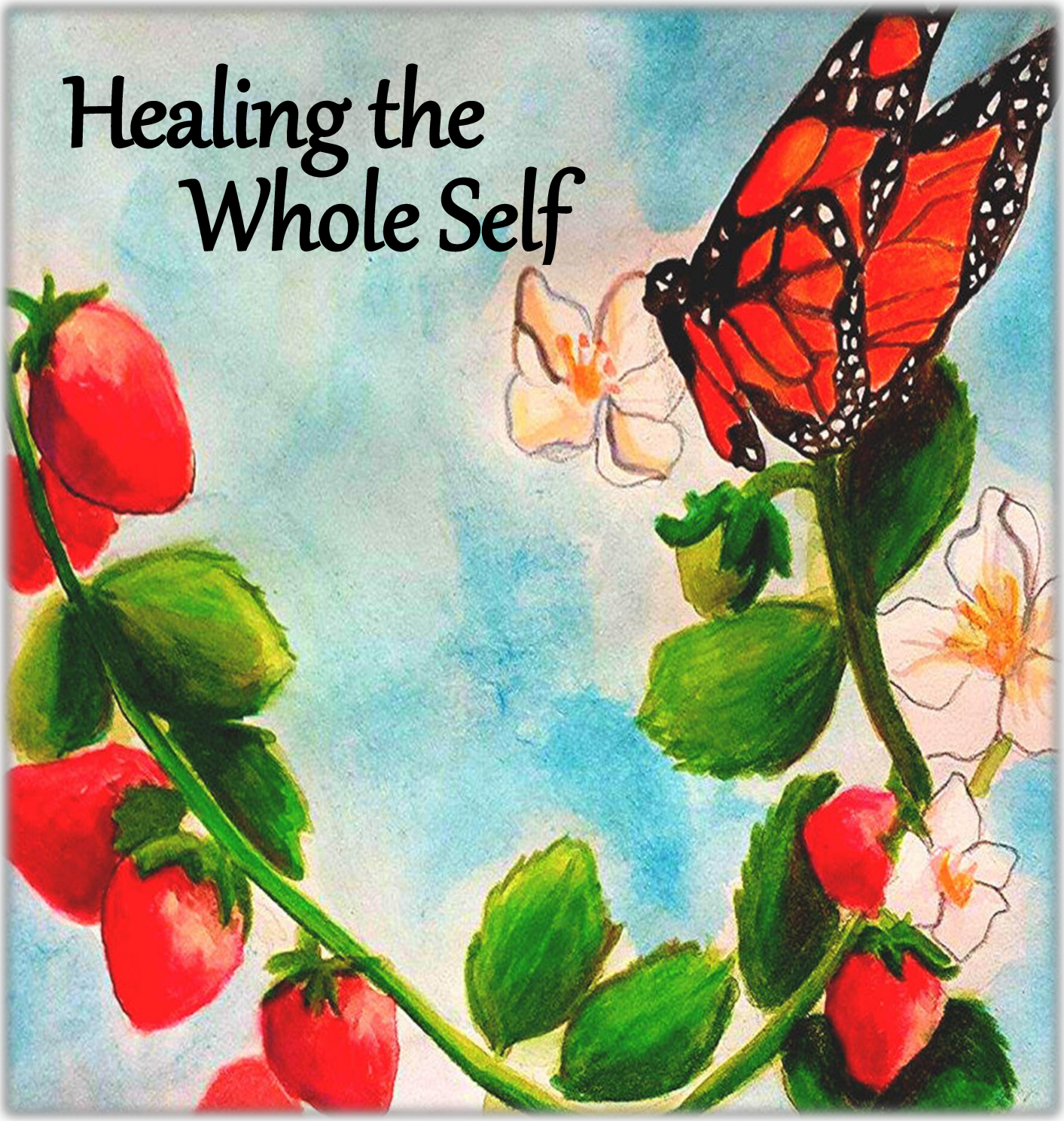
16. Which, if any, components/strategies do you are unnecessary or unhelpful in the Healing the Whole Self model?

17. Other comments?

18. Will you be able to use some of the things you learned today in your workplace?

□Yes □No

If so, what?



A Group Therapy for Women Surviving the Effects of Intimate Partner Violence

HEALING THE WHOLE SELF:

A GROUP THERAPY FOR WOMEN SURVIVING THE EFFECTS OF INTIMATE PARTNER VIOLENCE

THERAPIST MANUAL

TASLIM ALANI, PH.D. CANDIDATE

LAKEHEAD UNIVERSITY

Author's Note

This manual was created for my dissertation as part of a Doctorate in Clinical Psychology. It has been a pleasure working through the development of this model, including its implementation and evaluation.

The Healing the Whole Self model was developed through many conversations with women living in Thunder Bay who have experienced intimate partner violence and/or work with these women. The therapy model was initially developed for Indigenous women living in Thunder Bay, and the model was also informed in consultation with many of these women. However, in receiving continuous feedback from survivors of violence and service providers, and continuing with my research on best practices, it became clear to me that many of these strategies would be helpful for all women. Thus, instead of having this model be applied exclusively to Indigenous women, it has instead become a culturally-competent and –sensitive model to working with women survivors of intimate partner violence.

I am grateful for the number of conversations, the guidance, the suggestions and the feedback that have been offered in the creation of this model. I am also thankful to the many women who have participated in the Healing the Whole Self group, and provided me feedback as clients and participants.

My dissertation committee, including Mirella Stroink, Christopher Mushquash, and Josephine Tan, have supported and lead me through this process, and this therapy model would not be possible without them.

I kindly ask that if you decide that you would like to use the Healing the Whole Self therapy in its original or in an adapted form, that you please let me know. This will allow me to have a good understanding of where and how it is being used. It would be beneficial to evaluate the outcomes of the Healing the Whole Self therapy within your organization as well. This will help determine what is most effective and helpful for clients. If I can be of any help with respect to how to modify this model for your client base, or on ways to evaluate the model, please do not hesitate to contact me.

Artist's Note

Victoria is from Thunder Bay and works at Lakehead University as the Aboriginal Transitions Advisor with Aboriginal Cultural and Support Services. She is passionate about mental health, well-being and breaking the stigma surrounding the current dialogue relating to mental health and wellness. In her free time she is a practicing artist.

Victoria Bolduc, HBFA, B.Ed., M.Ed.

Table of Contents

Note to therapists

Healing the Whole Self was developed as a culturally-competent group therapy model for women who have experienced intimate partner violence. It is essential to recognize a few things as you engage women in this therapeutic process:

1) Women have had diverse experiences of violence, and all of these experiences should be validated. Some women may have experienced childhood abuse, intimate partner violence from several partners, and may have experienced different frequencies and severities of emotional, physical, verbal and sexual abuse. It is important to validate all people's experiences of violence.
2) Moreover, because some women experience violence that may be considered more "severe", some women may compare experiences of violence and feel as though they do not deserve to be seeking services (i.e., that their experiences of violence and trauma are not "that bad"). In validating women and their experiences, you will also be giving space for women to acknowledge that their trauma is real, and that everyone is affected by violence differently.
3) Women who are surviving from violent relationships have many priorities, and seeking therapy may not be the most important factor for them at the time. If it can be avoided, do not have strict policies around attendance. While attendance should be encouraged, and women should be supported so that their other needs can be met, there should not be any penalties for not attending (although conversations about the importance of attendance can take place).
4) Women need a space in which they feel safe and they can trust. This trust may take quite some time to develop. Thus, therapists should be understanding of this, and not push women to participate beyond their comfort level. By providing a space where women can choose to participate, this can be an empowering process. While women should be encouraged to participate verbally, and while therapists can let women know that their voice is appreciated and valuable to the group, women may be participating non-verbally—this should not be undervalued.
5) Similarly, part of the process of creating a safe space for women is being warm, empathic, respecting confidentiality, and being available. Women want to work with therapists who are genuine, can demonstrate their ability to learn from the experiences of others, someone who will listen to their trauma history (when they are ready to share it), and someone who actually wants to be there to support them. This can all be communicated by the way in which you interact with women, thus do your best to be yourself, learn from others, and actively listen to women's experiences. Tensions may arise within the group, or between the therapist and the client. Do your best to address this in a sensitive and genuine way. Be willing to be accountable for your behaviour, and to hold others accountable for theirs—it is the process of accountability that demonstrates mutual respect.
6) Use the language that women are using. If women call their experiences "abuse" then call it "abuse"; however, some women may not be comfortable with such a label, and thus terms used by women to explain their experiences should be used.
7) Be non-judgmental of women's choices. Some women may decide they want to stay with their partners, others may feel they have no choice, while some women may want nothing to do with their (ex)partner. This decision is completely up to them. The responsibility of the therapist is to help women in their journey to healing, feeling safe, and feeling healthy and well. How women choose to have this life is up to them. Similarly, in women's treatment of their families, friends, children and themselves, continue to have this non-judgmental attitudes—assume that women make decisions based on what they see as best for them at the time. Thus, they were doing the best they could. Your role as a therapist is to teach skills so that the clients can see other options, and perhaps make more adaptive decisions. The goal is to validate and support women

to accept themselves as they are in the present, while encouraging and facilitating a process of change.

8) Considering this is a group, and women will be at different stages of their healing journey, part of your role is also to manage group dynamics. Some women may try to "save" other women, tell them that their partner is bad, pressure them to leave their relationship or take specific action, etc. Some women may also be focused on talking about their (ex)partners instead of their own experiences. Creating a safe space means not only monitoring your own reactions and behaviours, but those of others as well. Thus, make it clear that participants may not tell others what to do, and should be mindful of the effect they have on others. Remind the clients that they are all on separate stages of the healing journey, and that it can be unhelpful or harmful to rush or pressure one another. This therapy is also meant to focus on the self—thus, focusing on one's partner defeats the purpose and can hinder this journey. This may be a difficult transition, but encourage the group to try their best.
9) Your number one role as a therapist is to maintain client safety. This means following the ethical guidelines of confidentiality and its limits. As such, if you find out that a child under the age of 16 is at risk of abuse or neglect or that a client is at risk of harming herself or someone else, appropriate reports need to be made. These are requirements, but can be done in an empowering way—by letting the client lead or facilitate this process, she is still in control of the situation.
10) The way in which women identify with and engage in traditional cultural practices will vary. It is not your role to explicitly help women connect with their culture. Instead, it is important to recognize that clients all have cultural practices with which they identify. Part of the therapy process is celebrating clients' culture and traditions, regardless of what these look like. As such, please do not force women to engage in any practices, as this could lead to distress and/or shame.
11) Offer the skills and interventions as suggestion, rather than assuming that these strategies will help—they may not resonate with the client's worldview, with how she thinks/behaves, what she needs to do to keep herself well, etc. As such, you are offering a tool set, she may or may not need the tools you have. She also has her own, and part of making this program effective is helping strengthen the tools she already has. If clients would like to work on something specifically or if you think that a certain activity/strategy would be particularly effective for group members, feel free to offer this to the group. Do you best to get through the curriculum provided, but not at the expense of demonstrating strategies that you think clients would find particularly helpful. There are sessions built into this model to allow for some flexibility.

Working with this population can be emotionally difficult on therapists. As part of the therapy process, please ensure that you are taking good care of yourself. This can involve meeting your basic needs (such as nutrition, sleep, exercise), but also having good social support, taking time to process, and consulting/debriefing with other health professionals.

The Healing the Whole Self model largely consists of Dialectical Behaviour Therapy skills. As such, it may be especially helpful to be trained in this approach, and to use the works of Marsha Linehan to provide a solid foundation in these skills and their rationale.

Rationale for Therapy Structure

This therapy has been structured to offer Western approaches to mental health well-being. However, recognizing that Western strategies may not be the most appropriate for some women, these skills will be suggested, discussed, and accepted, adapted or rejected, as appropriate. Moreover, the clients will

be invited to share some of their own strategies to the group, so that the process will be one of collaborative learning.

Mindfulness skills teach an individual to be aware of their sense of self and their environment. This is thought to address depersonalization, concerns around identity, and brief cognitive disturbances (e.g., flashbacks). It will also enhance the client's abilities to use the rest of the skills she is learning. Mindfulness allows a person to pay attention to the present moment and be non-judgmental about this. In doing this, rumination and anxiety are likely to decrease.

Distress tolerance skills will be helpful because women may still be working through the immediate effects of the violence (e.g., the court system, reactions from family members/community, justice system, finding housing, still dealing with (ex)partner, etc.). Moreover, for intrusive traumatic memories, distress tolerance will be useful. Distress tolerance offers potentially more adaptive methods of coping with distressing thoughts, emotions and situations.

Re-learning interpersonal effectiveness skills will help women reconnect with individuals around them—rebuilding a sense of community. These skills may have deteriorated as a result of the violent relationship, struggling with anger and/or passivity, and difficulties recognizing what one wants and asking for it. It is possible that these skills were never taught in a way that feels right to the individual. As such, working through the (re)development of these skills in a safe and supportive environment may be transformative for the client.

It has been suggested that many of the mental health struggles that individuals experience are due to difficulties with emotion regulation. This is not to say that they are "too emotional", but more so that individuals do not think they have control over their emotions. More specifically, literature on intimate partner violence as well as childhood trauma suggests that the consequences of such experiences can overlap with emotional dysregulation symptom presentation. Thus, teaching women skills on how to feel more in control of their emotions (as opposed to feeling controlled by them or pushing them away) may help increase health and well-being. Such skills have been demonstrated to be effective for decreasing symptom severity for emotional disorders (including post-traumatic stress disorder, depression and anxiety).

Therapy for trauma suggests that exposure may be essential. However, many clients will have experienced several incidences of trauma and it may not be helpful to focus on exposure of one specific traumatic event. Thus, by having a trauma diary (life history journal), clients can describe the many traumas they have had in their lives (as well as traumas that have occurred before them that have affected their identity), make changes to these journal entries as necessary, and have control over the process. Moreover, this can give them the space to reflect on these traumas, and talk about moments of strength despite traumatization. These reflections can occur through writing, drawing, photography or through oral story sharing.

Resources necessary

- Agency Informed Consent form
- Diary Card
- A white board or flip chart paper, if possible
- Before the life history journals begin, ensure that clients have the necessary materials (e.g., journals, voice recorder, etc.)

- Snacks

- Child care, preferably in a close by but separate space
- Bus passes

At the initial meeting, administer the B-SAFER (or another risk assessment). Moreover, if the client is staying with her partner or is in close contact with her partner, do risk assessments regularly.

An Outline of the Therapy

This therapy will offer the use of adapted Dialectical Behaviour Therapy skills to help strengthen one's well-being. Dialectical Behaviour Therapy was developed by Marsha Linehan. These skills relate to Mindfulness, Distress Tolerance, Emotional Regulation, and Interpersonal Effectiveness, but may be adapted to be more appropriate and authentic for each client. Every session will be spent working on the development of skills, and mindfulness will be woven through every session.

Moreover, every session will open with a sharing activity, in which one client will share a cultural practice of hers. This can include a song her mom used to sing to her when she was young, drumming, a prayer, a beading exercise—anything she pleases. Women also have the option to not participate, although they should be encouraged to do so. It should be ensured that all women get an opportunity to share at least once with the group.

If the group is being run with Indigenous women, at every session, there should be the opportunity to engage in a smudge. This can be done at the beginning or the end of the session, and can be decided upon by the organization or the participants. The smudging ceremony will be completely voluntary, and can be facilitated by anyone in the group that feels comfortable doing so (e.g., clients, facilitators, or an individual outside of the group who joins specifically for the ceremony). It may also be a beneficial and empowering experience for an Indigenous client to teach other Indigenous clients how to smudge, and to act as a leader and mentor throughout this process.

The first two sessions of therapy will be spent establishing goals, assessing risk, explaining the therapeutic process, and making sure that women are safe (i.e., have safe housing, stable access to food, are not fearful for their lives, their children are safe, etc.). These two sessions will also be spent building therapeutic alliance (without the expectation that adequate therapeutic alliance will be developed within this time). If necessary, this can be condensed into one session; however, ensure that an adequate risk assessment and safety plan have been completed.

There will be a life history journey aspect of therapy that will begin on the 7th session (or 5th group). It is through this process that the clients will have the opportunity to record the life events that have contributed to their sense of self, as part of their life narrative. They can write, speak, or draw about these events (or representations of these events). These "journal entries" can be in chronological order, or in an order that makes sense to them, and can include events that occurred prior to their birth (e.g., examining the impacts of collective historical trauma on them). They should be encouraged to consider what they were thinking, feeling and doing at the time of these events, what else was going on in their lives, and how the events impacted their life. This can be a rather sensitive and difficult process; thus, women should be encouraged to take their time with this, and only work on it for 20 minutes a day. Moreover, they should begin and end their writing with a relaxation exercise.

Cultural Integration

The clients should facilitate the process of bringing their culture into the group therapeutic process. Having established this, however, there are a few guidelines that therapists should consider as they engage in the facilitation of the Healing the Whole Self program.

1) Be as educated as possible about the different aspects of present day and historical oppression and discrimination. For Indigenous peoples, this may be through residential schooling, Indigenous people's treatment by the foster care system and Justice System, systemic racism, and through colonization. For immigrants, this may be systemic racism, discrimination, difficulty with balancing cultural expectations, difficulty accessing services, and language barriers. While being educated is essential to this process, it also imperative to not make assumptions about how clients identify with these forms of oppression. For example, some women may not express having been impacted by residential schooling. It is not the therapist's place to tell women otherwise. You may provide objective and factual information about forms of discrimination and oppression, and some of their effects on people, but do not try to convince a woman that she was impacted by this.
2) Prior to colonization for many cultures, it has been reported that women were generally respected within communities, with several communities being matriarchal. Women were often recognized as life givers, and main teachers in preparing youth for future survival of the people. Moreover, there were often strong familial relationships, and rules in place to maintain justice. Thus, abuse and mistreatment of others within communities was not normal in the past, and there were community-based methods of addressing violence is restorative ways. Many people have been, and are, traumatized by colonization and the systemic racism is has created for many peoples. It is important to recognize and acknowledge everyone's suffering, including that of the abuser. While excuses should not be made for abusive behavior, men should not be vilified because of their behavior—they are people in need of healing as well.
3) Use the Seven Grandfather teachings as much as possible (but do not force them on clients). These teachings are gifts given to people, in order to live in harmony with Creation, and are helpful to strive for, regardless of an individual's cultural background. They include (obtained from Native Women's Centre, Aboriginal Healing and Outreach Program, 2008):
    a. **Wisdom: to cherish knowledge is to know wisdom.**
        i. To have wisdom is to know the difference between positive and negative and know the result of your actions. Sound judgment, ability to see inner qualities and relationships. Listen and use the wisdom of elders, spiritual leaders and healers. Wisdom is sound judgment and the ability to use good sense, to have a good attitude and reason of action, that runs through and binds the seven teachings together. Wisdom is given by the Creator to be used for the good of the people
    b. **Love: to know love is to know peace.**
        i. Feel and give absolute kindness for all things around you. To love yourself is to live at peace with the creator and in harmony with all creation. Love is to feel and give complete kindness for all things around you. Love is based upon affection, respect, kindness, unselfish loyalty, devotion and concern. Love your brother and sister and share with them. Love cannot be demanded...it must be earned and given freely from the goodness of your heart
    c. Respect: to honor all of creation is to have respect.
        i. Showing respect is showing honor for the value of persons or things by polite regard, consideration and appreciation. Honor our teachings. Honor our families, others, and ourselves. Don't hurt anything or anyone on the outside or the inside. Respect, also is not to be demanded, You must give respect freely from the goodness of your heart if you wish to be respected
    d. **Bravery: to face life with courage is to know bravery.**

i. The personal strength to face difficulties, obstacles and challenges. Have courage, make positive choices. Stand up for your convictions--show courage in communicating and decision-making. Do things even in the most difficult times. Be ready to defend what you believe and what is right. Never give in. Never give up.

e. **Honesty: is to be honest in action and character, be faithful to fact and reality--to walk through life with integrity is to know honesty**.
   i. Being truthful and trustworthy. Tell the truth. Be honest with yourself, recognize who and what you are. Accept and act on truths with straightforward and appropriate communication. Be honest in every action and provide good feelings in the heart. Do not be deceitful or use self-deception. Honesty keeps life simple.

f. **Humility: to accept yourself as a sacred part of creation is to know humility.**
   i. Reflecting, expressing or offering in a spirit of deference or submission. Balance of equality with all of life. Recognize the human need for balance in life. Know that you are equal to everyone else. Take pride in what you do, but the pride that you take is in the sharing of the accomplishment with others.

g. **Truth: to know of these things is to know the truth.**
   i. Faithfully apply the teachings of our seven grandfathers and trust in the creator. To show honor is to be truthful and trustworthy, to tell the truth. Sincerity in action, character, and utterance. Be faithful to fact and reality. Be true in everything that you do. Be true to yourself and true to your fellow man. Understand it - Speak it - Live by it.

4) Be knowledgeable about the power dynamics and social factors that play into violence against women. Generally, intimate partner violence is not the consequence of an argument or disagreement that escalated. Instead, it is often a conscious (or unconscious) effort to control one's partner through a variety of tactics. While some education about power and control is included in the therapy model, facilitators should be well-versed in this literature and how it can surface (see Michael Johnson's work on the four different types of violence; Johnson, 2008).
5) Consider the clients as whole people who have physical, emotional, mental and spiritual needs—and that these needs are all interconnected and contribute to well-being. While, as a therapist, you may not be able to meet all of your clients' needs, you can do your best to facilitate connections to other individuals who can help her with what you cannot.

20 session protocol

Intake, Sessions One and Two

- During this time, find out how the client is doing, what they need, whether they have stability in housing, food, etc., help them connect with a lawyer if necessary, etc.
- Initial assessment of symptoms
- Risk assessment
- Safety planning as necessary
- Initial opportunity to hear their story
- Establishing short and long term goals
- Helping connect them with community resources
- Identify people with whom they feel safe

Group One

- Explain mindfulness and the concept of "wise mind"
- Teach "what" skills: observe, describe, participate

Individual Session 3: individual 20 minute session to check-in and see how group went, seek feedback, ensure sense of safety (can be phone session)

Group Two

- Mindfulness continued
    - "how" skills: non-judgment, one mindfulness, effectively
    - Letting go of judgments
- Chain analysis
- Pros and cons

Group Three

- Distress tolerance, part 1
- Crisis Survival Strategies
    - Distract with Wise Mind ACCEPTS
    - Self-soothe with the five senses
    - IMPROVE the moment
- Practice observing breath

Group Four

- Distress tolerance continued
- Radical acceptance
- Psychoeducation about intimate partner violence and its effects
- Self-validation

Group Five

- Finish Psychoeducation about intimate partner violence
- Discuss effects of trauma
- Have clients discuss the ways in which their traumas have affected them physically, emotionally, mentally and spiritually → write this out on paper, keep track of it
- Introduce trauma journal
    - Discuss the importance of exposure
- Discuss keeping one's self safe throughout exposure exercises
    - Practice self-soothing exercises

Individual Session 4: individual 20 minute session to check in (can be phone session)

Group Six

- Finish distress tolerance
- Discuss some of the challenges around trauma journal → allow group to collaboratively problem solve

- Discuss the importance of self-care and reducing vulnerabilities (sleep, diet, exercise, etc.)

Group Seven

- Review of mindfulness and its importance

Group Eight to Ten

- Emotion regulation

Individual Session 5: individual hour session to check in

- See where goals are at
- Trauma journal check-in
    - Go through trauma journal with the client
    - Talk about what is unclear
    - Talk about what has been distressful so far
    - Talk about methods of coping with the distress
    - Fill in gaps

Group Eleven

- The importance of interpersonal effectiveness to emotion regulation
- Self-worth as it relates to interpersonal effectiveness
- Practicing these skills safely in the context of current (potentially) abusive relationships

Group Twelve

- Interpersonal effectiveness continued
- DEARMAN, GIVE, FAST

Group Thirteen

- Interpersonal effectiveness continued
- Factors that reduce interpersonal effectiveness, factors to consider, and how to support one's self

Group Fourteen

- Set aside to work on anything women want
- Problem solving/developing prevention and/or interventions for women

Group Fifteen

- Set aside to work on anything women want
- Problem solving/developing prevention and/or interventions for women

Individual Session Six: individual one hour session to check-in

- Trauma journal check-in
    - Go through trauma journal with the client
    - Try to consolidate experiences with the client

    - Talk about loss that has occurred because of trauma
    - Talk about what has been gained through the trauma
- New goal setting
    - What do you want your life to be
    - How will you move on
- Talk about the ending of group

Group Sixteen

- Re-engage in exercise that allows clients to talk about how their traumas have affected them physically, mentally, emotionally and spiritually
- Engage in an additional exercise that demonstrates the ways in which clients can and do care for themselves physically, emotionally, mentally and physically

Group Seventeen

- Thorough review, and practicing of skills and remembering their rationale

Group Eighteen

- Wrap-up and review, celebrate successes

Individual Session 7

- Check-in with the clients
- Talk about how they've been feeling
- Evaluate symptoms
- Evaluate how they are doing with reconnecting with themselves and others
- Consolidate and validate new self and how she will be able to move on

Weekly Protocol

Start with a sharing of tradition: This can be something cultural, something from childhood, a practice that makes you feel strong. Every week, someone new leads this activity.

Mindfulness activity (eventually, this will be able to be part of the initial sharing of tradition, but for the first 5 weeks, this should be a separate exercise)

Weekly check-in/sharing about week/diary card review

BREAK: 15 minutes

Skills training

End of session check-out → what are you taking away? What do you want to work on this week?

A smudge should be offered for those who would like to partake. This can occur at the beginning or end of the group.

Individual Sessions One and Two

Week one will be the intake session and as such, an initial assessment of needs. The informed consent should be given, and the therapy explained, as well as the research.

After this, all of the self-report assessment batteries should be given.

After these initial steps have been taken, this is an opportunity to have the client share with you. The following information should be gathered through an interview, allowing the client to elaborate as much as she would like:

- Presenting problem (what brings her in today?)[1]
- How concerned she is by her current situation?
- Her needs (including housing, food, transportation, legal support, spiritual support, etc.)
- Information about her family and current living situation

After the initial interview, complete the B-SAFER (or another) risk assessment. If safety planning is necessary, this should done in collaboration with the client. Remember that she knows her situation best, and thus should be guiding the process. This is also a good time to talk about at what point you, as the therapist, will intervene. For example, if her risk is deemed too high, determine what precautions will be taken by you (for example finding a shelter for her, calling the police, etc.). This process must be collaborative and can change with time.

The items to be included in her diary card (the Simplified Personal Questionnaire items) should then be developed. If this cannot be done by the end of the first session, it can be done during the second session.

If the client identified having needs that the current intervention does not currently target, spend some time this session connecting her with resources. These connections should ideally have been prepared over the week, so that you can share accessible information and facilitate connections, as opposed to just giving her a phone number with no name, or being unsure of whether someone can help.

Develop short term and long term therapy goals. Keep track of these as well. Ensure that goals are well-defined and achievable. Also take some time to understand why these are the client's goals.

[1] While it may seem counterintuitive to ask this question, it is important to remember that just because women are experiencing (or have experienced) intimate partner violence in their lives, this does not mean that healing from this is their first priority. Having clients define their presenting problem and the reason they have sought out support is essential to goal setting and understanding the client's needs.

Group One

This first group meeting should be spent first with introductions and having people get comfortable with the group. Have each person introduce themselves, as well as one thing they are looking forward to in attending the group, and one thing they are nervous about in attending the group.

Establish the Group Rules collaboratively. These should be put up on the wall every week and should be developed collaboratively. Ensure things like “arrive on time”, “respect others; don’t say negative things”, and “confidentiality” are on the list.

Re-explain the structure of the group and expectations about homework completion. Take this time to explain the diary card.

One of the therapists should then facilitate the first sharing activity. This will consist of having the clients draw an animal on a stone. This animal will represent one characteristic about themselves that they would use to describe themselves.

After this exercise is complete, explain that every week someone new will be sharing with the group. Develop a schedule. Make the expectations about this exercise clear.

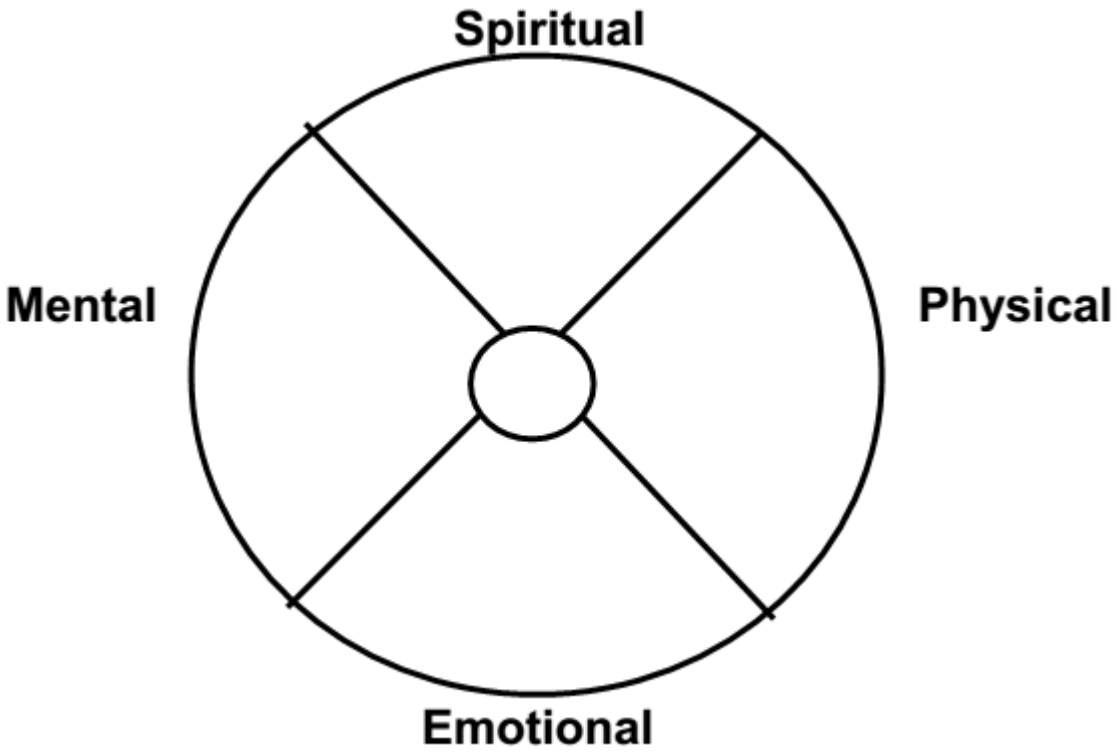
Take a break for 15 minutes. After the break, introduce the concept of mindfulness.

Mindfulness is about living in the present moment, experiencing one’s emotions and senses fully, but with perspective. In order to do this, individuals needs the capacity to pay attention and be non-judgmental towards the situation and themselves.

Take some time to discuss this with the clients. Ask them what some of the benefits to this may be, and whether this would fit with their current way of life. What would change? Would these changes be helpful? When would it not be helpful for them?

In DBT, there are three primary states: reasonable mind, emotional mind, and wise mind (see Chapter 7 of Skills Training Manual). Reasonable Mind is when a situation is being approached intellectually, thinking logically and rationally, attending to empirical information, and planning a situation out, having focused attention and being cool in how the situation is dealt with. In Emotion Mind, an individual’s thinking and behaviour are controlled primarily by emotional state. Cognitions are “hot”, reasonable and logical thinking is difficult, facts are distorted to be congruent with current emotion, and energy is also congruent with the current emotional state. Wise Mind is the integration of Emotion Mind and Reasonable Mind. It also goes beyond these, by adding intuitive knowing to emotional experiencing and logical analysis. However, with a recognition that balance cannot be achieved without an integration of body and spirit (in whatever way this might be defined for the client), the model should be taught incorporating these aspects of whole life balance as well, with the goal of living a healthy life.

It is important to explain that we all have moments when we find ourselves too much in one part of our selves (emotion, mental, spiritual or physical); however, the goal is to recognize our current state, and find the balance so that we can achieve Wise Mind.



"What" skills involve learning to observe, to describe, and to participate. Observing is about non-judgmentally observing one's environment within or outside oneself. It is helpful in understanding what is going on in any given situation. Describing is used to express what an individual has observed with the observe skills. It is to be used without judgmental statements, and this can help with letting others know what you have observed. Lastly, participating can be used to become fully focused on, and involved with, the activity that one is doing.

Engage in activities to help practice these skills.

End with session checkout → What is each person taking away? What does each person want to work on this week? Are there concepts similar to "mindfulness" that the clients already use? Do these strategies work for them?

Core Mindfulness Skills—WHAT Skills

Take hold of your mind

Observe

♦ Be curious about what you feel.

♦ Just notice how you feel, without trying to make feelings stronger, or weaker, go away, or last longer.

♦ See how long your feeling lasts, and if it changes.

♦ Notice how feelings flow in and out of your body like waves.

♦ What comes through your senses? Touch, smell, sight, sound, taste.

♦ Be like a non-stick pan, letting things slide off of your body and your emotions.

Describe

♦ Use words to describe your experience.

♦ Use "fact" words, call a thought "just a thought", call a feeling "just a feeling."

♦ Use words that everyone would agree with.

♦ Don't paint a colorful picture with words, or magnify a situation with words. Try to avoid emotional words.

♦ Try to let go of your emotions about being "right" or about someone else being "wrong" while searching for words to describe.

Participate

♦ Get "lost" in an activity.

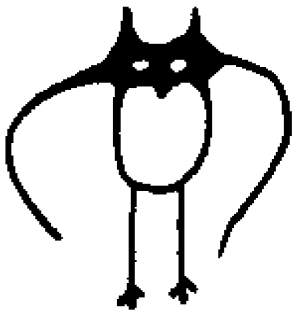
♦ Let go of your sense of time while you are doing something.

♦ Allow yourself to be natural in the situation. Do just what is needed in the situation.

♦ Practice your skills until they become a part of you.

Spirit Stone Designs

Crane – Independence



Owl – Seeing through deception

Wolf Paw – Prowler

Bear – Protection

Moose – Survival, Headstrong

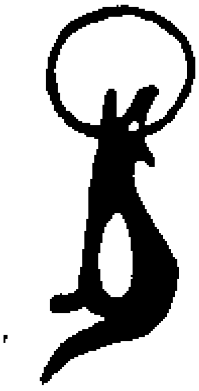
Buffalo – Sacredness, Abundance

Spider – Creativity

Wolf – Loyalty, Perseverance

Caribou – Grace, Adaptability

Raven - Cleverness



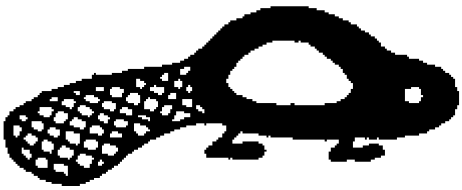
Coyote - Prankster

Swan - Grace

Together - Friendship

Otter - Laughter

Squirrel - Trust



Beaver - Builder

HEALERS ARE REPRESENTED BY WATER CREATURES
FROG
TURTLE
SNAKE

LEADERSHIP IS REPRESENTED BY SKY CREATURES
EAGLE
RAVEN
OWL

PROTECTORS ARE REPRESENTED BY LAND CREATURES
BEAR
WOLF

Group Two

In the second group, have everyone re-introduce themselves. Offer an opportunity for everyone to share a story about their name. This could be how they were named, the meaning of their name, what their name means to them, etc.

Begin immediately with the sharing activity and then do a mindfulness activity.

Go over diary cards individually. Note what went well for each client, and what did not. Without obliging the client to share very personal information about themselves or their situation, have them share with the group something from their diary card. Diary cards are meant to be personal and confidential, so do not share the diary card with anyone, but ask about specific situations that are noticeable within it. As the weeks go on and clients get more comfortable with each other, these questions can become more personal, but remember to always respect the clients' wishes and boundaries.

Break

Review what was learned last week and engage in another mindfulness activity.

Explain "How" skills. These relate to how individuals can attend, describe and participate, and involve taking a non-judgmental stance, focusing on one thing in the moment, and being effective (i.e., doing what works). A non-judgmental stance includes describing facts, and not thinking about what is "good" or "bad", "fair" or "unfair". These are judgments because this information is about how you feel about the situation—it is not a factual description. Being non-judgmental helps to get your point across in an effective manner, without adding a judgment that someone else might disagree with. Focusing on one thing at a time, or being one-mindful, encourages people to keep their mind from straying into Emotion Mind by a lack of focus. When doing something effectively, this means that an individual is doing what works. Instead of client's doing what they think is "right", it emphasizes doing what is actually needed in a particular situation. This may involve giving in at times, however this should be framed as doing what is best in the moment and doing what works, as opposed to needing to be right.

Engage in a few exercises of "what" and "how" skills. Begin with things that may not evoke many strong emotions in the clients, but slowly increase the relevance to the clients as they continue to practice these skills. This will enable them to let go of judgments about the situation, as well as about themselves (especially if a situation involves an evaluation of the self).

Chain Analysis involves looking at the different steps that occur before, during, and after a behaviour. It includes understanding "Vulnerablities", such as not sleeping or being hungry, "prompting events", or what lead to the problem behaviour, then listing the "problem behaviour" and its "consequences". By teaching clients how to break down their behaviours, they can begin to see things more than in an all-or-nothing way. Moreover, they can begin to identify when a situation becomes difficult for them, and potentially note other options than the problem behaviour.

Chain analyses are meant to be conducted individually, however can be done in a group to collaboratively problem solve. Moreover, clients can bring their chain analyses to group to be looked at by the therapists.

The pros and cons list is a 2 by 2 table that explores the pros and cons of doing something, and the pros and cons of not doing something. This task can allow clients make weighted decisions, and explore their rationale for making a specific decision. It allows them to see all the sides of the situations.

Session Wind-down → Ask whether the clients think these strategies will work. What do they think will be most useful? What do they think will not work?

"How" Skills

Practice to use these all at the same time

Non-Judgmental Stance

♦ See, but don't evaluate. Take a non-judgmental stance. Just the facts. Focus on the "what", not the "good" or "bad", the "terrible", the "should" or "should not".

♦ Unglue your opinions from the facts, from the "who, what, when, and where.

♦ Accept each moment, each event as a blanket spread out on the lawn accepts both the rain and the sun, each leaf that falls upon it.

♦ Acknowledge the helpful, the wholesome, but don't judge it. Acknowledge the harmful, the unwholesome, but don't judge it.

♦ When you find yourself judging, don't judge your judging.

One Mindfully, In The Moment

♦ Do one thing at a time. When you are eating, eat. When you are walking, walk. When you are working, work. When you are in a group, or a conversation, focus your attention on the very moment you are in with the other person. Do each thing with all of your attention.

♦ If other actions, thoughts, or strong feelings distract you, let go of distractions and go back to what you are doing—again, and again, and again.

♦ Concentrate your mind. If you find you are doing two things at once, stop and go back to one thing at a time.

Effectively

♦ Focus on what works. Do what needs to be done in each situation in order to meet your larger goals. Stay away from thoughts of "right", "wrong", "should", "should not", "fair" and "unfair".

♦ Play by the rules. Act as skillfully as you can, meeting the needs of the situation you are in, not the situation you wish you were in.

♦ Let go of vengeance, useless anger, and righteousness that hurts you and doesn't work.

Questions to Guide Discussion on Observing and Describing Thoughts

Prompting Event?

Feelings and their intensity (mad, sad, glad, ashamed, scared?)

Thoughts?

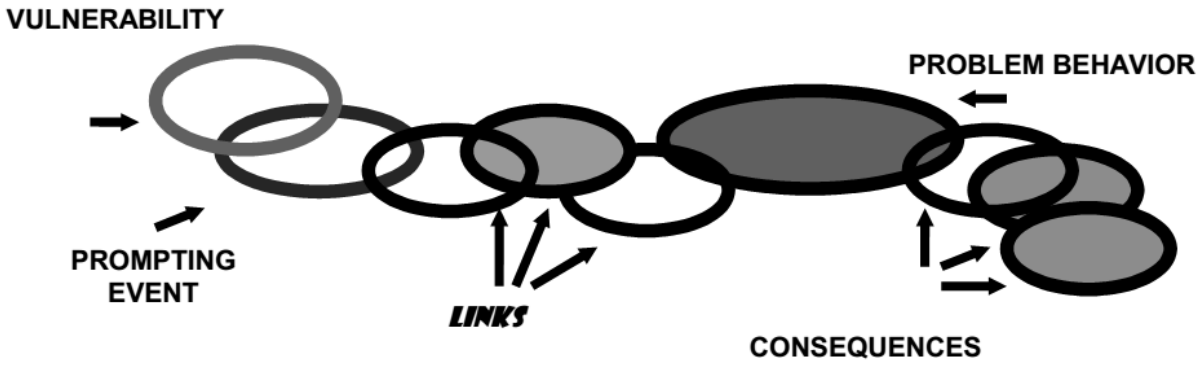
Were there any MUST thoughts?

Were there any SHOULD thoughts about yourself?

Were there any SHOULD thoughts about others or the situation?

Try picking a SHOULD thought and change that to a non-judgmental DESCRIBE

CHAIN ANALYSIS



PROS and CONS table

Pros of doing something	Cons of doing something
Cons of not doing something	**Pros of not doing something**

Group Three

Begin with sharing exercise and then a mindfulness activity, followed by diary cards and break.

In Week Five, begin explaining distress tolerance skills. Distress tolerance involves allowing distress to exist in one's life without feeling the need to change it (although the person may want to). Many therapies involve training individuals to change their situation; however, for some women, changing their situation (or at least some parts of it) may not be feasible. Thus, learning to tolerate the distress when change is not possible will help them cope with this distress. Essentially, it is about training an individual to bear pain skillfully. This will help clients deal with the realities of life—that pain and distress are inevitable—and also tolerate the distress in order to not make impulsive decisions in order to alleviate pain.

Have a discussion with the clients about the kinds of things they do in difficult situations. These do not always have to be "healthy" (i.e., drug use, alcohol, self-harm). Have a conversation about what has worked in the past, and what has not. Ask what they think would happen if they did not use these skills. What would happen if they tried something else? What are some of the harms and benefits of trying something else?

Distress tolerance skills are most often used in crisis situations. Thus, the initial skills taught will be about dealing with crisis situations.

The first skills is to distract one's self from the distracting situation. A helpful acronym to remember some tools for distracting is ACCEPTS:

- With **A**ctivities: engaging in exercise or hobbies; cleaning; go fishing; etc.
- With **C**ontributing: contribute to someone; volunteer; make something nice for someone else; etc.
- With **C**omparisons: compare yourself to others who are less fortunate; read about disasters in other parts of the world
- With opposite **E**motions: seek out something that will elicit an emotion other than the one you are currently experiencing. This may be through reading an emotional book, watching your favourite movie, reading a joke book, etc.
- With **P**ushing away: push the situation away by leaving it for a while. Leave the situation mentally. Build an imaginary wall between yourself and the situation.
- With other **T**houghts: count to 10; count colours in a painting or tree; do a puzzle; watch television; etc.
- With intense other **S**ensations: hold ice in your hand; squeeze a rubber ball; listen to very loud music; etc.

Next, engage in self-soothing exercises by focusing on soothing each of your senses. For example, you can soother your **vision** by buying one beautiful flower, or lighting a candle and watching the flame. You can soothe your **hearing** by listening to beautiful music or paying attention to the sounds in nature. You can soother your **smell** by using your favourite perfume or by baking. You can soothe your **taste** by having a good meal or having a dessert. You can soothe your **touch** by taking a bubble bath or by sitting in a very comfortable chair. By focusing on the five senses (and being mindful while doing so), clients can learn to focus on the enjoyable and soothing experiences, rather than the distressing ones. Below are some more examples for self-soothing techniques.

SELF-SOOTHE

A way to remember these skills is to think of soothing each of your five senses

Vision - *Notice what you see, find soothing things to look at.*

Notice the play of light on a clean wall. Enjoy the richness of colours in the floor tile. Look out the window and watch the grass gently blow in the breeze, the sun dancing on leaves, the graceful movement of the birds, or the smooth movement of passing cars. Close your eyes and notice the textures and light colors behind your eyelids.

Hearing - *Pay attention to what you can hear around you.*

Listen to beautiful or soothing music, or to invigorating and exciting music. Pay attention to sounds of nature (waves, birds, rainfall, leaves rustling). Sing to your favorite songs. Hum a soothing tune. Learn to play an instrument. Be mindful of any sounds that come your way, letting them go in one ear and out the other. Notice how sounds may feel different at various times of day. Quietly notice the sounds of your own breath. See if you can hear the sound of your own circulation.

Smell - *Be aware of the memories that smell can bring.*

Notice the scent of your soap and shampoo while showering. Try to find brands of deodorant, lotion, and other things that have a soothing smell to you. Sit quietly for a few minutes and try to identify all of the smells that you notice. Enjoy the smell of your meals while you are in the dining room. See if you can smell each type of food individually. Savor the smell of popcorn and remember other times in your life when you have enjoyed popcorn.

Taste - *Carefully savor flavors that the day brings you.*

Have a good meal; enjoy your dessert; have a favourite soothing drink such as herbal tea or hot chocolate. Treat yourself to a favorite snack from the canteen. Suck on a piece of peppermint candy. Chew your favourite gum. Really taste the food you eat; eat one thing mindfully.

Touch - *Find comfort in touch.*

Take a bubble bath. Savor the feeling of crisp, clean sheets on the bed. Soak your feet. Soften your skin with lotion. Put a cold compress on your forehead. Brush your hair for a long time. Place your hand on a smooth, cool surface. Enjoy the feeling of a favorite piece of clothing, or clean clothes. Notice the comforting warmth of clothing that is fresh from the dryer. Experience whatever you are touching; notice touch that is soothing.

Attempting to improve the situation may also be helpful for clients who are experiencing a crisis. An acronym to remember some techniques for improving one's situation is IMPROVE:

- With **I**magery, for example imagining a very relaxing scene.
- With **M**eaning. This can involve finding or creating some purpose, meaning or value in the pain.
- With **P**rayer. Open your heart to a supreme being, greater wisdom, Creator, or your own wise mind.
- With **R**elaxation. Try muscle relaxation or deep breathing.

- With **O**ne thing in the moment. This involves focusing your entire attention on just what you are doing right now. An awareness exercise might help with this.
- With a brief **V**acation. This can involve getting into bed and pulling the covers over your head for 20 minutes, unplugging your phone for a day, or taking a one hour break from hard work that must be done.
- With **E**ncouragement. Cheerlead yourself and remind yourself that it won't last forever. Also remember that you are doing the best you can do.

What are some real life examples of how the clients can use these skills? Discussing this in concrete terms will help them apply these skills later on.

Teach clients how to observe their breath by engaging in deep breathing. There are several activities that can be done while observing one's breath. Deep breathing can help individuals relax, feel in control, and decrease anxiety. Individuals can engage in deep breathing; measuring one's breath by one's footsteps; counting one's breath; following the breath while listening to music; and breathing to quiet the mind and body. Below are some more strategies and explanations for observing the breath.

Observing-Your-Breath Exercises

OBSERVING YOUR BREATH

Focus your attention on your breath, coming in and out. Observe your breathing as a way to centre yourself in your wise mind. Observe your breathing as a way to take hold of your mind, dropping off non-acceptance and fighting reality.

METHODS

1. DEEP BREATHING

Lie on your back. Breathe evenly and gently, focusing your attention on the movement of your stomach. As you begin to breathe in, allow your stomach to rise in order to bring air into the lower half of your lungs. As the upper halves of your lungs begin to fill with air, your chest begins to rise and your stomach begins to lower. Don't tire yourself. Continue for 10 breaths. The exhalation will be longer than the inhalation.

2. MEASURING YOUR BREATH BY YOUR FOOTSTEPS

Walk slowly in a yard, along a sidewalk, or on a path. Breathe normally. Determine the length of your breath, the exhalation and the inhalation, by the number of your footsteps. Continue for a few minutes. Begin to lengthen your exhalation by one step. Do not force a longer inhalation. Let it be natural. Watch your inhalation carefully to see whether there is a desire to lengthen it. Continue for 10 breaths.

3. COUNTING YOUR BREATH

Sit in a comfortable position on the floor or in a chair, lie down, or take a walk. As you inhale, we ware that "I am inhaling, ONE." When you exhale, be aware that "I am exhaling, ONE." Remember to breathe from the stomach. When beginning the second inhalation, be aware that "I am inhaling, TWO." And, slowly exhaling, be aware that "I am exhaling, TWO." Continue up through 10. After you have reached 10, return to ONE. Whenever you lose count, return to ONE.

4. FOLLOWING YOUR BREATH WHILE LISTENING TO MUSIC

Listen to a piece of music. Breathe long, light, and even breaths. Follow your breath; be master of it while remaining aware of the movement and sentiments of the music. Do not get lost in the music, but continue to be master of your breath and yourself.

5. BREATHING TO QUIET THE MIND AND BODY

Sit or lie in a comfortable position that you can sustain without movement. Deliberately relax your body. Scan and relax several times. Breathe through any areas of tension. Half-smile. Follow your breath. When your mind and body are quiet, continue to inhale and exhale very lightly; be aware that "I am breathing in and making the breath and body light and peaceful. I am exhaling and making the breath and body light and peaceful." Continue for three breaths, giving rise to the thought, "I am breathing in while my body and mind are at peace. I am breathing out while my body and mind are at peace." Continue for 5-25 minutes, as you are able.

Check-in with clients about whether they think these would help. What might be more helpful or less helpful? Are they willing to try these things? Do they make sense for the client? What are some concerns or challenges they may experience?

Finish the session with the wind-down exercise.

Group Four

Begin the session with the sharing activity, a mindfulness exercise, and going over diary cards.

Break

Review the distress tolerance skills from last week and problem solve.

Radical acceptance is a key component to therapy, and can be very difficult to learn and apply. It is letting go of fighting reality. It is an acceptance of one's situation that comes from deep within—it does not mean they have to like the situation. It is about accepting that something is the way it is. Recall that this does not make their situation okay, or suggest that they are deserving of what has or is happening to them. It is, however, about accepting what one cannot change so that one can begin to move on. Below are some points to share with clients. Let clients know that this concept will be re-visited over the weeks.

Radical Acceptance

Everything is as it should be.
Everything is as it is.

o Freedom from suffering requires ACCEPTANCE from deep within of what is. Let yourself go completely with what is. Let go of FIGHTING REALITY.
o ACCEPTANCE is the only way out of suffering.
o Pain creates suffering only when you refuse to ACCEPT the pain.
o Deciding to tolerate (endure) the moment is ACCEPTANCE.
o ACCEPTANCE is acknowledging what is.
o To ACCEPT something is not the same as judging that it is good, or approving of it.
o ACCEPTANCE is turning my suffering into pain that I can endure.

Turning the Mind

o Acceptance of reality as it is requires an act of CHOICE. It is like coming to a fork in the road. You have to turn your mind towards the acceptance road and away from the "rejecting reality" ("I don't have to put up with this!") road.

o You have to make an inner COMMITMENT to accept. The COMMITMENT to accept does not itself equal acceptance. It just turns you toward the path. But it is the first step.

o You have to turn your mind and commit to acceptance OVER AND OVER AND OVER again. Sometimes, you have to make the commitment many times in the span of a few minutes.

WILLINGNESS

Cultivate a WILLING response to each situation.

o Willingness is DOING JUST WHAT IS NEEDED in each situation, in an unpretentious way. It is focusing on effectiveness.

o Willingness is listening very carefully to your WISE MIND, acting from your inner self.

o Willingness is ALLOWING into awareness your connection to the universe—to the earth, to the floor you are standing on, to the chair you are sitting on, to the person you are talking to.

WILLFULNESS

Replace WILLFULNESS with WILLINGNESS

o Willfulness is SITTING ON YOU HANDS when action is needed, refusing to make changes that are needed.

o Willfulness is GIVING UP.

o Willfulness is the OPPOSITE OF"DOING WHAT WORKS," being effective.

o Willfulness is trying to FIX every situation.

o Willfulness is REFUSING TO TOLERATE the moment.

Discuss with the group whether these concepts resonate for them. Have there been moments in their lives where radical acceptance would have been helpful? What about when they chose to be willful instead of willing, or vice versa. What are some of the benefits and concerns around radically accepting? Remember that accepting is not the same thing as being passive. It is about recognizing what will work best in a specific moment, and that under some circumstances, we have no control, and the best thing to do is to accept.

If there is time, bring in the women's experiences of intimate partner violence. Ensure that there is enough time to process and debrief before beginning this. This may be the first time that some of them are talking about the violence in their relationships with the group, and therefore it will be important not to rush this conversation. Talk about what it would be like to radically accept what happened/is happening to them. What are some of the benefits and consequences of this? This does not need to be a "leave him" vs. "stay with him" conversation, or one where women feel the need to defend their choices. Rather, provide a space for women to be able to talk about their struggles with such decisions, and what their decisions mean to them. This can be an extremely validating conversation around their struggles and the decisions they have had to make for themselves. This will also provide a platform to discuss how what works at one time may not be what is effective at a later point in time.

Engage in an observing-the-breath exercise (or several) before ending the session, and ensure that the women are feeling safe before ending the session.

Session wind-down.

Group Five

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Re-visit the topic of radical acceptance, and discuss whether the clients had any realizations over the past week.

After the discussion on radical acceptance, begin talking about intimate partner violence. Using flip chart paper or a white board, ask clients to share what they believe abuse is. If clients are having some difficulty, create the subheadings of “physical”, “emotional”, “mental”, and “spiritual”. Ensure that you are validating clients as they share, and that there is space for all clients have a space to share their thoughts.

It may also be helpful to create a separate list of experiences that the clients are unsure of whether they consist of violence. These could be “red flags”, things that made them feel uncomfortable or unsure of themselves without being explicit acts of violence, etc. This can allow an opportunity for women to think about what safety and comfort mean to them, and act as a reminder to trust one’s instincts (although this should also be contextualized within the fact that sometimes our “warning signals” may be a little too sensitive. This can happen after traumatic experience or when people experience high levels of anxiety. When it comes to safety, people should be encouraged to trust themselves, and if they are unsure, they should approach cautiously and evaluate risks before proceeding).

Explain how violence generally boils down to power and control, and show the Power and Control wheel. Have clients add to this or modify it as they would like to. Remember that Power and Control exists outside of patriarchy, and that many of the women will have experienced violence by other systems (for example through systemic discrimination). Thus, men may not be the sole people by whom clients have experienced violence. Keep this in mind while facilitating this conversation.

Explain that violence is dynamic, that individuals are not powerless in their situations, but cope with violence in very particular ways. On a new piece of paper, discuss some ways in which clients have tried to take care of themselves and/or maintain power/safety in situations. This may be earning some money through work, trying not to keep alcohol in the home, going to a friend’s home when one’s (ex)partner is getting aggressive, or more. Clients may have some trouble with this task, but may begin to ease into the process. The key message to communicate is that even though individuals who are experiencing violence may be in very difficult situations, there are still ways in which they can maintain power while still keeping themselves safe. This is the first step in demonstrating that clients are not powerless over their situations.

At this time, it may also be helpful to have clients make a list of some of the consequences of violence (for example, nightmares, difficulty sleeping, fear, difficulty concentrating), and for them to rate (on a scale from 0 to 10) how badly they were affected by these things when their situation was at its worse, and then to rate how much they are affected by these things now. This may demonstrate that they are already on their healing journey. If these ratings have not decreased, this may be because these things are still there for a reason, and emphasize the importance of how participating in this program will hopefully help them manage some of these as well.

Check-in with the clients about whether this model makes sense for them. What parts of the model fit for them? What parts would they change? Provide an opportunity to change the model to be more fitting for them. A couple of options for this include printing a copy of the Power and Control Wheel for each client and letting her change it to be more appropriate for her. Another option is to print the Wheel on an overhead and to change it as a group.

Next, discuss the effects of trauma. Explain symptoms of trauma as they relate to post-traumatic stress disorder, but that some women will also experience depression, anxiety, panic attacks, hopelessness, self-harm and suicidality, substance abuse, amongst many other things. Then have clients describe how their traumas have affected them. If it makes it easier, divide these into “physical”, “emotional”, “mental”, and “spiritual”.

Then, on a piece of paper, have individuals write down how their traumas affect them in different ways. These will be tracked and re-explored later on in the group.

Then explain the trauma journal and its importance. Explain that clients are to write down about different life experiences of theirs. They may begin by writing about their childhood, or about anything they feel emotionally prepared to write about. As they write, they should think about what was going on in their life at the time of the trauma, the different ways in which the trauma affected them and the people in their lives, aspects of their lives that changed due to the trauma, and ways that they have managed to cope through the trauma. They may also write about experiences that occurred before their lifetime that have affected them, if they choose to do so. If writing does not feel authentic for them, suggest different ways they can do this, including drawing, or recording themselves speaking about their experiences. Clients should aim to engage in this process for no more than 20 minutes every day, as it may be difficult, and they should begin and end with a self-soothing exercise. Discuss the importance of self-soothing throughout this difficult task.

Engage in a group self-soothing exercise.

Session wind-down.

DOMESTIC ABUSE INTERVENTION PROJECT
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Group Six

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Review last week's session. Check-in with clients about how discussing their experiences of intimate partner violence affected them. Go over any concepts that seemed difficult for the clients last week.

Review trauma journals and their importance. Help clients problem solve with respect to the trauma journal.

Complete the distress tolerance skills:

- Half-smile: this is an exercise of relaxing one's face, neck and shoulder muscles, and half-smiling with one's lips. Some theories demonstrate that our bodies communicate to our minds. Thus, be engaging in a half-smile, this may in fact change how you are feeling in the moment. This is different than a grin, which is a more forceful smile and may feel incongruent or inauthentic. Below are some different ways of engaging in half-smiling.

1. HALF-SMILE IN A LYING DOWN POSITION

Lie on your back on a flat surface without the support of mattress or pillow. Keep your two arms loosely by your sides and keep your two legs slightly apart, stretched out before you. Maintain a half-smile. Breathe in and out gently, keeping your attention focused on your breath. Let go of every muscle in your body. Relax each muscle as though it were sinking down through the floor, or as though it were as soft and yielding as a piece of silk hanging in the breeze to dry. Let go entirely, keeping your attention only on your breath and half-smile. Think of yourself as a cat, completely relaxed before a warm fire, whose muscles yield without resistance to anyone's touch. Continue for 15 breaths.

2. HALF-SMILE WHEN YOU FIRST AWAKE IN THE MORNING

Put something in plain view on the ceiling or a wall so that you see it right away when you open your eyes. This sign will serve as your reminder. Use these seconds before you get out of bed to take hold of your breath. Inhale and exhale three breaths gently while maintaining a half-smile. Follow your breaths.

3. HALF-SMILE DURING YOUR FREE MOMENTS

Anywhere you find yourself sitting or standing, half-smile. Look at a child, a leaf, a painting on a wall, or anything that is relatively still, and smile. Inhale and exhale quietly three times.

4. HALF-SMILE WHILE LISTENING TO MUSIC

Listen to a piece of music for 2 or 3 minutes. Pay attention to the words, music, rhythm, and sentiments of the music you are listening to (not your daydreams of other times). Half-smile while watching your inhalations and exhalations.

5. HALF-SMILE WHILE IRRITATED

When you realize, "I'm irritated" half-smile at once. Inhale and exhale quietly, maintaining a half-smile for three breaths.

6. HALF-SMILE WHILE REMEMBERING YOUR ANGER DURING A RECENT DISAGREEMENT OR ARGUMENT

Sit quietly. Breathe and smile a half-smile. Bring to mind a recent conflict with another person in which you had strong feelings of disagreement, or anger. Remember the situation in as much detail as possible, until the original anger begins to return. Allow your body to remember the hard sensation of self-righteousness and frustration. Now refresh your half-smile and take three deep breaths. Imagine having compassion for the other person. Find one thing that makes their position valid, or true and willingly say to yourself, "I see their point" without necessarily agreeing with them. Bring to mind the person's positive qualities, a time they were kind to you or someone else. Remember the worth and value of that person that cannot be erased by one argument. Continue until you feel compassion rise in your heart like a dry well filling with fresh water, and your anger and resentment disappear. Practice this exercise many times on the same situation.

Discuss the importance of reducing one's vulnerabilities. This can be achieved be engaging in an exercise called PLEASE MASTER. This is an acronym to help clients remember the ways in which they can engage in self-care. Moreover, clients should be reminded of the importance of engaging in self-care.

- Treat **P**hysical illness
- Balance **E**ating
- Avoid mood-**A**ltering drugs
- Balance **S**leep
- Get **E**xercise
- Build **Master**y

Session wind-down.

Group Seven

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Review Mindfulness and Distress Tolerance Skills. Check in with clients on trauma journals and assist with problem solving. Use chain analyses and pros and cons lists to help clients with decision-making.

Session wind-down.

Group Eight

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Having emotion regulation skills allows clients to recognize and acknowledge their emotions, while at the same time maintaining control over themselves and the situation. Through many forms of abuse, individuals may have had their emotions be invalidated, or may feel as though their emotional experience is incorrect or unimportant. Because of this, many individuals may stop understanding their emotions and may no longer know how to label them. This module offers a re-training of emotional awareness and regulation to clients. Take some time to discuss whether clients have had such experiences, and some of the effects of this.

The goals of emotion regulation training are to understand the emotions one experiences, reduce emotional vulnerability, and decrease emotional suffering. Here are some tips to help people better experience their emotions:

Healthy Perspectives on Emotion

- Emotions are neither good or bad, right or wrong. Feelings just ARE. They exist. It is not helpful to judge your emotions.
- There is a difference between having an emotion and doing something or acting on the emotion.
- Emotions don't last forever. No matter what you're feeling, eventually, it will lift and another emotion will take its place.
- When a strong emotion comes, you do not have to act on your feeling. All you need to do is recognize the emotion and feel it.
- Emotions are not facts. When emotions are very powerful they feel just like "the truth", but they are not.
- You cannot get rid of emotions because they serve important survival functions. Be willing to radically accept your emotions as they arise.

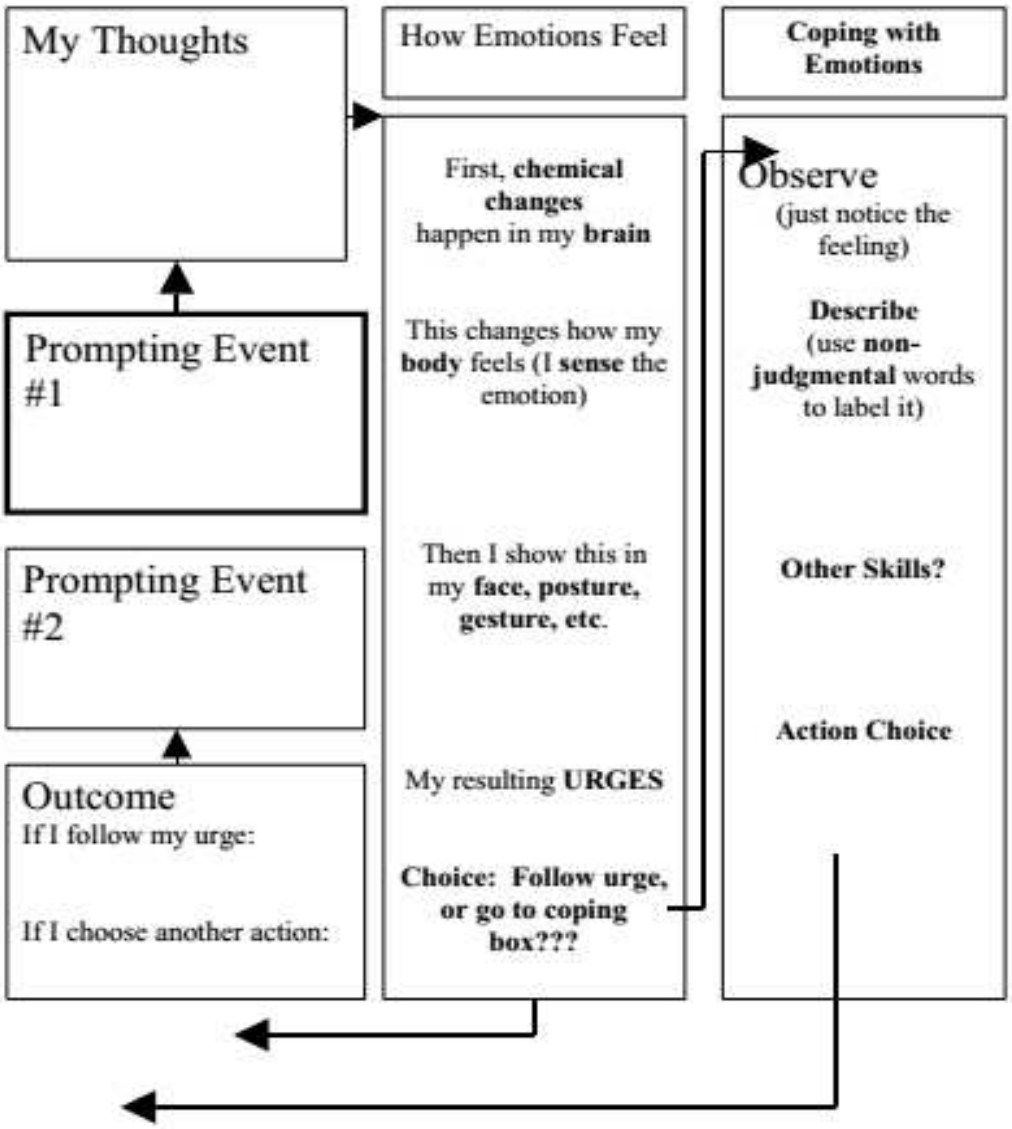
The first step is to understand the model for describing emotions and understand their importance.

The model for describing emotions involves assessing an event, having physiological and physical changes to the body, as well as associated thoughts. All of these work together to elicit an emotion.

Have a discussion around some commonly felt emotions. These may be stereotypical emotions (such as happiness and sadness, or more complex or culturally-defined emotions).

Have clients collaboratively work through the worksheets on describing emotions.

Session wind-down.



Ways to Describe Emotions
(from Linehan, 1993)

LOVE WORDS

Love	Compassion	Longing
Adoration	Desire	Lust
Affection	Enchantment	Passion
Arousal	Fondness	Sentimentality
Attraction	Infatuation	Sympathy
Caring	Kindness	Tenderness
Charmed	Liking	Warm

Other (think about some culturally specific words or words in another language that you might use):

_____

_____

_____

Prompting Events for Feeling Love

A person offers or gives you something you want, need, or desire.
A person does things you want or need the person to do.
You spend a lot of time with a person.
You share a special experience together with a person.
You have exceptionally good communication with a person.
Other: _____

_____

_____

_____

Interpretations that Prompt Feelings of Love

Believing that a person loves, needs, or appreciates you.
Thinking a person is physically attractive.
Judging a person's personality as wonderful, pleasing, or attractive.
Believing that a person can be relied upon, and will always be there for you.
Other: _____

_____

_____

_____

Experiencing the Emotion of Love

When with someone or thinking about someone, you feel

- Excited and full of energy.
- A fast heartbeat.
- Self-confident.
- Happy or joyful.
- Warm, trusting, safe and secure.
- Relaxed and calm.

Wanting the best for that person.
Wanting to give things to a person.
Wanting to see and spend time with a person.
Wanting to spend your life with a person.
Wanting to be physically close and intimate with a person.
Wanting closeness.
Other: _____
_____
_____
_____

Expressing and Acting on Love

Saying "I love you".
Expressing positive feelings to a person.
Physical affection.
Smiling.
Sharing time and experiences with someone.
Doing things the other person wants or needs.
Other: _____
_____
_____
_____

Aftereffects of Love

Only being able to see a person's good side.
Feeling forgetful or distracted; daydreaming.
Feeling openness and trust.
Remembering other times and people you have loved.
Remembering and imagining other positive events.
Remembering other people who have loved you.
Other: _____
_____
_____
_____

JOY WORDS

Joy	Enjoyment	Optimism
Amusement	Enthusiasm	Pleasure
Bliss	Excitement	Pride
Cheerfulness	Gladness	Relief
Contentment	Glee	Satisfaction
Delight	Happiness	Thrill
Eagerness	Hope	Zest

Other (think about some culturally specific words or words in another language that you might use):

_____
_____
_____
_____

Prompting Events for Feeling Joy

Being successful at a task.
Getting what you want.
Receiving praise or respect.
Receiving a wonderful surprise.
Things turning out better than you thought they would.
Being accepted by others.
Belonging (being around or in contact with people who accept you).
Receiving love, liking, or affection.
Other: _____
_____
_____
_____

Interpretations that Prompt Feelings of Joy

Interpreting joyful events just as they are, without adding or subtracting anything.
Other: _____
_____
_____
_____

Experiencing the Emotion of Joy

Feeling excited.
Feeling physically energetic, active, or “hyper”.
Feeling like giggling or laughing.
Feeling your face flush.
Other: _____
_____
_____
_____

Expressing of Acting on Joy

Smiling.
Having a bright, glowing face
Being bouncy or bubbly.
Communicating good feelings.
Sharing the feeling.
Hugging people.
Jumping up and down.
Saying positive things.
Using an enthusiastic or excited voice.
Being talkative or talking a lot.
Other: _____
_____
_____
_____

Aftereffects of Joy

Being courteous or friendly to others.
Doing nice things for people.
Having a positive outlook; seeing the bright side.
Having a high threshold for worry or annoyance.
Remembering and imagining other times you have felt joyful.
Expecting to feel joyful in the future.
Other: _____
_____
_____
_____

ANGER WORDS

anger	disgust	grumpiness	rage
aggravation	dislike	hate	resentment
agitation	envy	hostility	revulsion
annoyance	exasperation	irritation	scorn
bitterness	ferocity	jealousy	spite
contempt	frustration	loathing	torment
cruelty	fury	mean-spiritedness	vengefulness
destructiveness	grouchiness	outrage	wrath

Other (think about some culturally specific words or words in another language that you might use):
_____
_____
_____

Prompting Events for Feeling Anger

Losing power.
Losing status.
Losing respect.
Being insulted.
Not having things turn out the way you expected.
Experiencing physical pain.
Experiencing emotional pain.
Being threatened with physical or emotional pain by someone or something.
Having an important or pleasurable activity interrupted, postponed, or stopped.
Not obtaining something you want (which another person has).
Other_____
_____
_____

Interpretations That Prompt Feelings of Anger

Expecting pain.
Feeling that you have been treated unfairly.
Believing that things should be different.
Rigidly thinking "I'm right."
Judging that the situation is illegitimate, wrong, or unfair.
Ruminating about the event that set off the anger in the first place, or in the past.
Other_____
_____
_____

Experiencing the Emotion of Anger

Feeling incoherent.
Feeling out of control.
Feeling extremely emotional.
Feeling tightness or rigidity in your body.
Feeling your face flush or get hot.
Feeling nervous tension, anxiety or discomfort.
Feeling like you are going to explode.
Muscles tightening.
Teeth clamping together, mouth tightening.
Crying; being unable to stop tears.
Wanting to hit, bang the wall, throw something, blow up.
Other_____
_____
_____

Expressing and Acting on Anger

Frowning or not smiling; mean or unpleasant facial expression.
Gritting or showing your teeth in an unfriendly manner.
Grinning.
A red or flushed face.
Verbally attacking the cause of your anger; criticizing.
Physically attacking the cause of your anger.
Using obscenities or cursing.
Using a loud voice, yelling, screaming, or shouting.
Complaining or bitching; talking about how lousy things are.
Clenching your hands or fists.
Making aggressive or threatening gestures.
Pounding on something, throwing things, breaking things.
Walking heavily or stomping; slamming doors, walking out.
Brooding or withdrawing from contact with others.
Other_____
_____
_____

Aftereffects of Anger

Narrowing of attention.
Attending only to the situation making you angry.
Ruminating about the situation making you angry and not being able to think of anything else.
Remembering and ruminating about other situations that have made you angry in the past.
Imagining future situations that will make you angry.

Depersonalization, dissociative experience, numbness.
Intense shame, fear, or other negative emotions.
Other_____
_____
_____

FEAR WORDS

fear	fright	panic
apprehension	horror	shock
anxiety	hysteria	tenseness
distress	jumpiness	terror
dread	nervousness	uneasiness
edginess	overwhelmed	worry

Other (think about some culturally specific words or words in another language that you might use):
_____
_____
_____

Prompting Events for Feeling Fear

Being in a new or unfamiliar situation.
Being alone (e.g., walking alone, being home alone, living alone).
Being in the dark.
Being in a situation where you have been threatened or gotten hurt in the past, or where painful things have happened.
Being in a situation like the one where you have been threatened or gotten hurt in the past, or where painful things have happened.
Being in situations where you have seen other people be threatened, get hurt, or have something painful happen.
Other_____
_____
_____

Interpretations That Prompt Feelings of Fear

Believing that someone might reject you, criticize you, dislike, or disapprove of you.
Believing that failure is possible; expecting to fail.
Believing that you will not get help you want or believe you need.
Believing that you might lose someone or something you want.
Losing a sense of control; believing that you are helpless.
Losing a sense of mastery or competence.
Believing that you might be hurt or harmed, or that you might lose something valuable.
Believing that you might die, or that you are going to die.
Other_____
_____
_____

Experiencing the Emotion of Fear

Sweating or perspiring.
Feeling nervous, jittery, or jumpy.
Shaking, quivering, or trembling.
Darting eyes or quickly looking around.
Choking sensation, lump in throat.
Breathlessness, breathing fast.
Muscles tensing, cramping.
Diarrhea, vomiting.
Feeling of heaviness in stomach.
Getting cold.
Hair erect.
Other_____
_____
_____

Expressing and Acting on Fear

Engaging in nervous, fearful talk.
A shaky or trembling voice.
Crying or whimpering.
Screaming or yelling.
Pleading or crying for help.
Fleeing, running away.
Running or walking hurriedly.
Hiding from or avoiding what you fear.
Trying not to move.
Talking less or becoming speechless.
Frozen stare.
Other_____
_____
_____

Aftereffects of Fear

Losing your ability to focus or becoming disoriented.
Being dazed.
Losing control.
Remembering other threatening times, other times when things did not go well.
Imagining the possibility of more loss or failure.
Depersonalization, dissociative experiences, numbness, or shock.
Intense anger, shame, or other negative emotion.

Other_____
_____
_____

SADNESS WORDS

sadness	Despair	grief	misery
agony	Disappointment	homesickness	neglect
alienation	Discontentment	hopelessness	pity
anguish	Dismay	hurt	rejection
crushed	displeasure	insecurity	sorrow
defeat	distraught	isolation	suffering
dejection	Gloom	loneliness	unhappiness
depressing	glumness	melancholy	woe

Other (think about some culturally specific words or words in another language that you might use):
_____
_____
_____

Prompting Events for Feeling Sadness

Things turning out badly.
Getting what you don't want.
Not getting what you want and believe you need in life.
Thinking about what you have not gotten that you wanted or needed.
Not getting what you worked for.
Things being worse than you expected.
The death of someone you love.
Thinking about deaths of people you love.
Losing a relationship; thinking about losses.
Being separated from someone you care for or value; thinking about how much you miss someone.
Being rejected or excluded.
Being disapproved of or disliked; not being valued by people you care about.
Being with someone else who is sad, hurt or in pain.
Discovering that you are powerless or helpless.
Reading about other people's problems or troubles in the world.
Other_____
_____
_____

Interpretations That Prompt Feelings of Sadness

Believing that a separation from someone will last for a long time or will never end.
Believing that you are worthless or not valuable.
Believing that you will not get what you want or need in your life.
Hopeless beliefs.

Other_____
_____
_____

Experiencing the Emotion of Sadness

Feeling tired, run-down, or low in energy.
Feeling lethargic, listless; wanting to stay in bed all day.
Feeling as if nothing is pleasurable any more.
Feeling a pain or hollowness in your chest or gut.
Feeling empty.
Crying, tears, whimpering.
Feeling as if you can't stop crying, or feeling that if you ever start crying you will never be able to stop.
Difficulty swallowing.
Breathlessness.
Dizziness.
Other_____
_____
_____

Expressing and Acting on Sadness

Frowning, not smiling.
Eyes drooping.
Sitting or lying around; being inactive.
Making slow, shuffling movements.
A slumped, drooping posture.
Withdrawing from social contact.
Talking little or not at all.
Using a low, quiet, slow, or monotonous voice.
Saying sad things.
Giving up and no longer trying to improve.
Moping, brooding, or acting moody.
Talking to someone about sadness.
Other_____
_____
_____

Aftereffects of Sadness

Feeling irritable, touchy, or grouch.
Having a negative outlook.
Thinking only about the negative side of things.

Blaming or criticizing yourself.
Remembering or imagining other times you were sad and others losses.
Hopeless attitude.
Not being able to remember happy things.
Fainting spells.
Nightmares.
Insomnia.
Appetite disturbance, indigestion.
Yearning and searching for the thing lost.
Depersonalization, dissociative experiences, numbness, or shock.
Anger, shame, fear, or other negative emotion.
Other_____
_____
_____

SHAME WORDS

shame	discomposure	humiliation	mortification
contrition	embarrassment	insult	regret
culpability	guilt	invalidation	remorse

Other (think about some culturally specific words or words in another language that you might use):
_____
_____
_____

Prompting Events for Feeling Shame

Doing (feeling or thinking) something you (or people you admire) believe is wrong or immoral.
Being reminded of something wrong, immoral, or "shameful" you did in the past.
Exposure of a very private aspect of yourself or your life.
Having others find out that you have done something wrong.
Being laughed at, made fun of.
Being criticized in public, in front of someone else; remembering public criticism.
Others attacking your integrity.
Being betrayed by a person you love.
Being rejected by people you care about.
Failing at something you feel you are (or should be) competent to do.
Being rejected or criticized for something you expected praise for.
Having emotions that have been invalidated.
Other_____
_____
_____

Interpretations That Prompt Feelings of Shame

Believing your body (or body part) us too big, too small, or not the right size.
Thinking that you are bad, immoral, or wrong.
Thinking that you have not lived up to your expectations of yourself.
Thinking that you have not lived up to other's expectations of you.
Thinking that your behavior, thoughts, or feelings are silly or stupid.
Judging yourself to be inferior, not "good enough," not as good as others.
Comparing yourself to others and thinking that you are a "loser."
Believing yourself unlovable.
Other_____
_____
_____

Experiencing the Emotion of Shame

Pain in the pit of the stomach.
Sense of dread.
Crying, tears, sobbing.
Blushing, hot, red face.
Wanting to hide or cover your face.
Jitteriness, nervousness.
Choking sensation, suffocating.
Other_____
_____
_____

Expressing and Acting on Shame

Withdrawing, covering the face, hiding.
Bowing your head, kneeling before the person, groveling.
Eyes down, darting eyes.
Avoiding the person you have harmed or the people who know you have done wrong.
Sinking back, slumped posture.
Saying you are sorry; apologizing.
Asking for forgiveness.
Giving gifts, trying to make up for the transgression.
Trying to repair the harm, fix up the damage, change the outcome.
Other_____
_____
_____

Aftereffects of Shame

Avoiding thinking about your transgression, shutting down, blocking all emotions.
Engaging in distracting, impulsive behaviors to divert your mind or attention.
Believing you are defective.
Making resolutions to change.
Depersonalization, dissociative experiences, numbness, or shock.
Intense anger, sadness, fear, or other negative emotions.
Isolation, feeling alienated.
Other_____
_____
_____

Group Nine

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

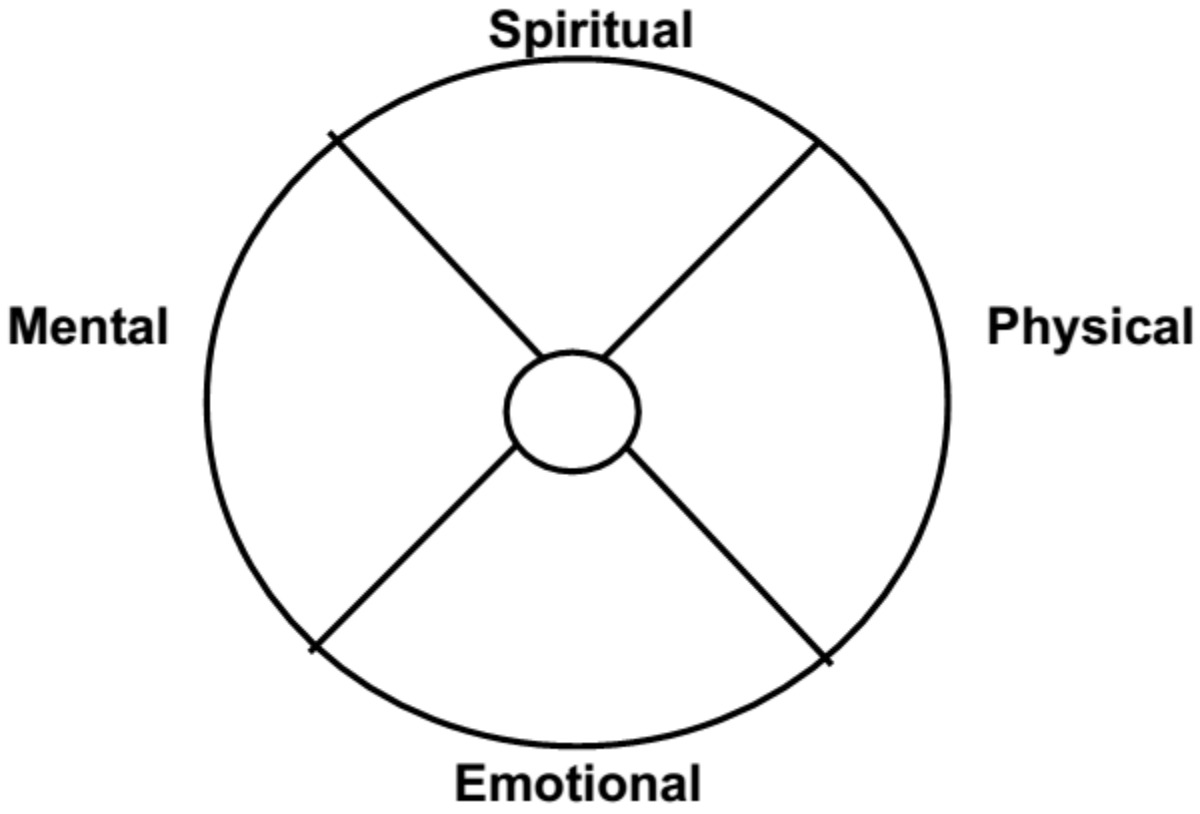
Finish the exercise on describing emotions.

There are also several ways in which positive emotions can be increased, and negative emotions can be decreased. These involve building positive experiences by doing pleasant things that are positive now, and making changes in one's life so that positive event will occur more often (i.e., build a life worth living). Have the clients engage in the Wellness Wheel exercise, where they can describe the different areas in their lives where they could strengthen their self-care practices. Are there any areas of their life that are missing from this wheel? Allow space for such areas to be added.

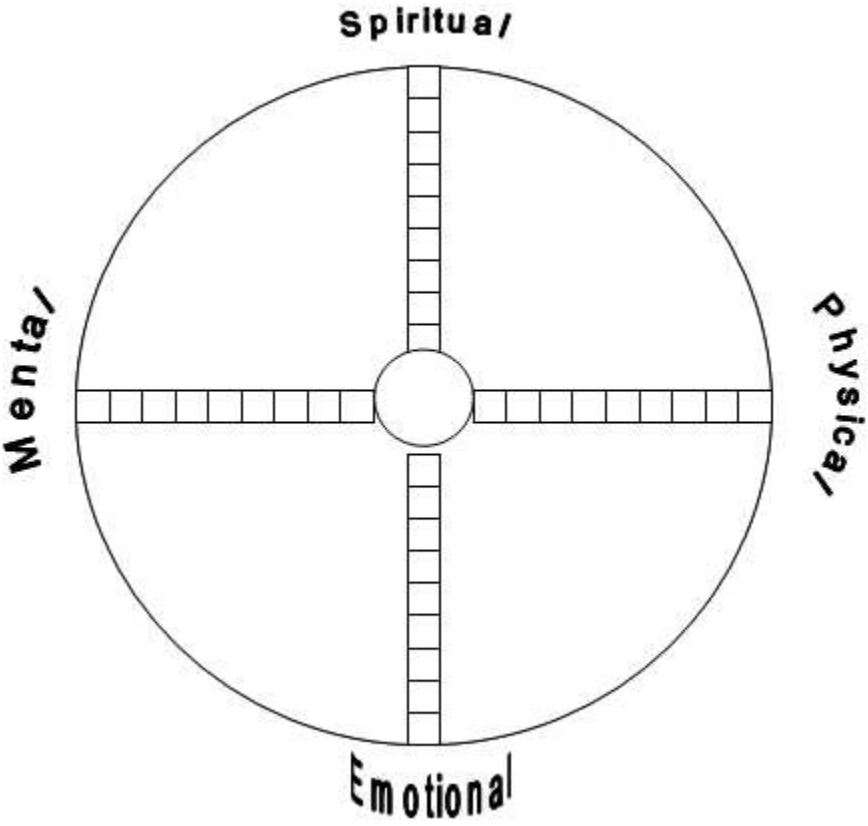
Wellness Medicine Wheel Exercise
(adapted from Margot and Lauretta, 2006)

Provide each client with three blank Medicine Wheels.

On the first Medicine Wheel, each client should engage in a self-assessment. She should write her name at the centre of the Wheel. Then she should ask herself "what am I doing presently to enhance my physical well-being?". She should begin by listing all the actual positive activities or things that she is doing in the physical quadrant of the circle. The same procedure is carried out, with the same basic question, for the completion of the other three quadrants.



The aim of the second exercise is to provide the client with a graph depicting the first Wheel. Using the second Wheel, the client again writes her name at the centre of the Wheel. Beginning with the physical quadrant, the client is asked to start from the centre of the circle and to shade one square for each activity that is on her list in the first wheel. For example, if the client has three activities listed in the physical quadrant, then the first three squares will be shaded. The person continues this process for the three other aspects of life, filling the number of squares corresponding to her positive activities listed in each quadrant. After each section is completed, the person joins the outermost shaded boxes of the four sections by drawing a continuous line in a circular motion from the first to the last. The joining together of her activities in the four aspects of life will demonstrate whether her wheel is balanced (i.e., if a circle was made) or if it looks uneven. If it's not a round circle, then her Wheel is out of balance. The client's strengths and weaknesses become clear.



In the third exercise, the client will have an opportunity to reflect, so that she can choose other positive activities to incorporate into her life, and identify negative behaviours that need to be avoided. Throughout the process, the emphases is mainly on strengths. The following questions can help guide the client:

Physical / Material Aspects:

1. In what condition is my physical health?
2. What are my physical needs right now?
3. What does my body language tell me? Do I like myself?
4. What are my priorities to improve my physical well-being?
5. What positive activities can I do to enhance my physical well-being? (areas of example: nutrition, sleep, personal hygiene, exercise,

appearance, posture, rest & relaxation, clothing, home tidiness, financial situation)
6. What harmful things must I avoid to achieve health? (examples: various dependencies).
7. What do I see about my future on the physical and on the material planes?
8. What are my goals? How do I see myself in two years from now?

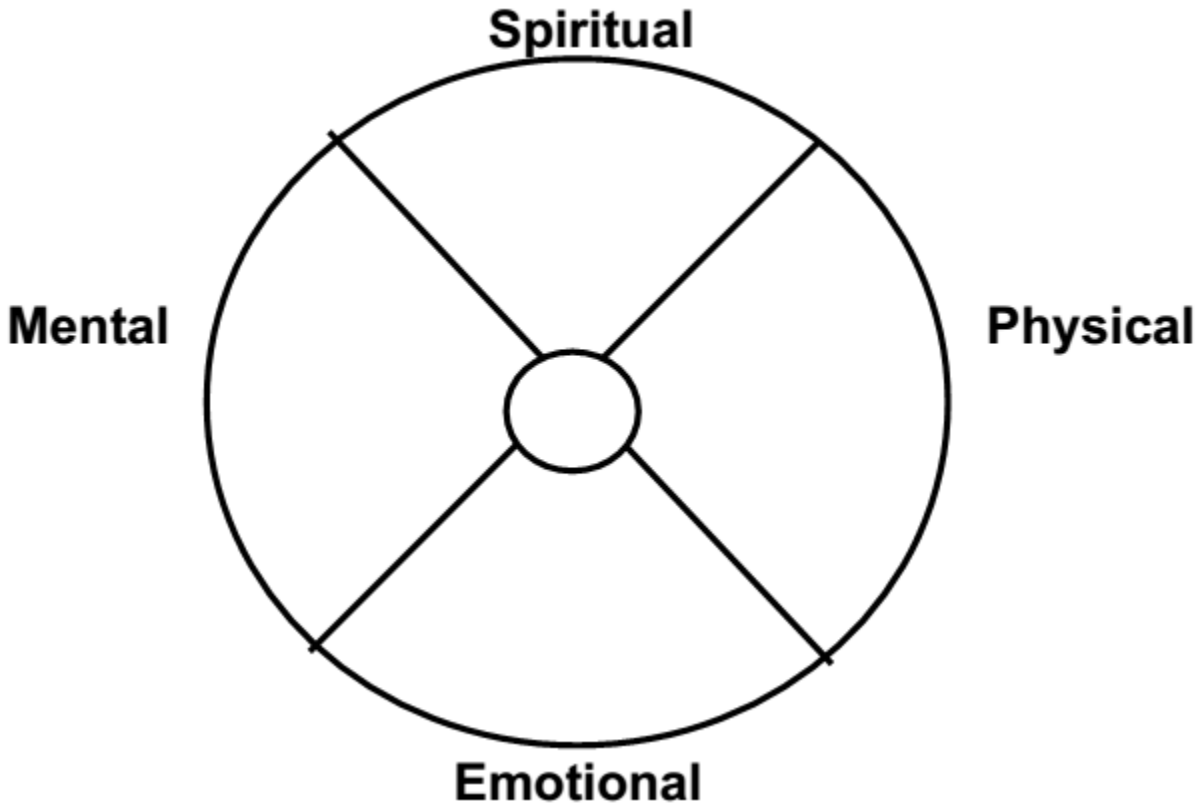
Emotional / Social / Relational Aspects:
1. In what condition is my emotional health?
2. What are my emotional needs at this time?
3. Do I have a positive self-esteem and a strong sense of self-worth?
4. Am I able to express my feelings and do I have someone I can confide in?
5. Do I trust people?
6. Do I feel the need to control others / situations?
7. Am I maintaining healthy relationships? (Examples: with my life partner, family, relatives, friends, co-workers, neighbours, etc…)
8. What are my coping strategies?
9. What positive things can I do to enhance my emotional and social wellbeing?
10. Am I taking time to nurture the relationships in my life?
11. Do I have unresolved issues from the past?
12. What do I feel about the future?

Mental / Intellectual / Cognitive Aspects:
1. What is my self-talk (or inner dialogue) usually like? (For example, is it affirmative, positive, optimistic or self-deprecating or generally negative about others?)
2. What are my general intellectual activities?
3. What are the mental stimulations in my life? (Examples: creative activities, reading, writing, studying, puzzles, crosswords, etc…)
4. What are my creative abilities and how do I foster them?
5. Am I satisfied with my level of education as well as intellectual and cognitive development?
6. Am I satisfied with the kind of work I am doing?
7. Do I take time to reflect and analyze what is happening in my life?
8. What are my problem solving skills and how can I improve them?
9. Is time management a problem in my life?
10. What positive activities can I do to enhance my life in the mental, intellectual and cognitive spheres?

Spiritual / Ethical / Cultural Aspects:
1. Do I have meaning and purpose in my life?
2. Do I live up to my principles, beliefs and values?
3. What are my spiritual / religious beliefs and practices? Or do I have any?
4. Do I take time out for prayer, fasting, silence, meditation, enjoyment of nature?
5. Do I have a grateful attitude about life?
6. Do I fear death and dying, and if so for what reason(s)?
7. What efforts do I make to develop qualities or ‘virtues’ or ‘moral principles’ or ‘ethical values and behaviours’?
8. Am I honest, loving, caring, sharing, respectful, trustworthy, humble and helpful?
9. In what ways am I respectful of nature?
10. Do I feel a sense of connectedness to and pride for the values of my culture?
11. What positive activities can I do to nurture my spiritual life?

Following this exercise, the client is now prepared to identify a set of positive activities to be taken in each quadrant of the Wheel. She is also able to determine which attitudes and behaviours she must avoid on the transforming path towards well-being.

In the fourth step, the client is given the third Medicine Wheel, which will become her personal Wellness Wheel or self-care plan. Her name will be put at the centre of the wheel. Next, the client will list attainable positive activities for each quadrant that she intends to practice in her daily life. Care must be taken to ensure that the activities listed in the Wheel are equally balanced among the four quadrants. The person may also choose to list, and even prioritize, some harmful behaviours or things to be avoided. At this point, the clinician may feel free to suggest some helpful activities or techniques that are relevant to the client's situation and culture.



Some Steps for Increasing Positive Experiences

Build Positive Experiences

Short Term: Do pleasant things that are possible NOW.

Make your own list of joyful experiences that you can have every day. Do at least one or two of these experiences MINDFULLY each day and record on your diary card.

Long Term: Make changes in your life so that positive events will occur more often.

Build a "life worth living."

- Work toward goals: ACCUMULATE POSITIVES. Make a list of positive events you want. List small steps toward goals. Take first step.
- ATTEND TO RELATIONSHIPS. Repair old relationships. Reach out for new relationships. Work on current relationships.

- AVOID AVOIDING. Avoid giving up.

Be Mindful of Positive Experiences

- FOCUS attention on positive events that happen (even very small ones).
- REFOCUS when your mind wanders to future worries, past regrets, current distractions and other thoughts while you PARTICIPATE mindfully in the joyful experience.
- Make a list of things that interrupt enjoyment for you and be prepared to TURN the MIND when these things appear.

Be Unmindful of Worries

DISTRACT from:
Thinking about when the positive experience WILL END.
Thinking about whether you deserve this positive experience.
Thinking about how much more might be EXPECTED of you now.

Below is a list of enjoyable activities that the clients can use as a guide as they develop their own self-care plans.

Pleasant Events List

1. Meditating.
2. Making plans for the future.
3. Finishing something.
4. Talking with a friend.
5. Browsing in a catalogue.
6. Watching TV.
7. Sitting/Lying in the sun.
8. Listening to others.
9. Drawing.
10. Playing an instrument.
11. Looking outside.
12. Watching people.
13. Watching a movie.
14. Meeting a friend.
15. Repairing something.
16. Memory of the words of loving people.
17. Wearing nice clothes.
18. Taking care of plants.
19. Going to a party.
20. Thinking about buying things.
21. Praying.
22. Thinking “I’m a good person.”
40. Taking a warm bathe.
41. Paying bills.
42. Playing a game.
43. Remembering good times.
44. Relaxing.
45. Reading a book.
46. Laughing out loud.
47. Painting.
48. Singing.
49. Remembering beautiful scenery.
50. Watching the birds.
51. Eating.
52. Gardening.
53. Thinking about retirement.
54. Doodling.
55. Exercising.
56. Having a quiet evening.
57. Arranging flowers.
58. Drinking a favourite beverage.
59. Going on a picnic.
60. Losing weight.
61. A day with nothing to do.

23. Writing a letter.
24. Cooking.
25. Sleeping.
26. Fixing your hair and makeup.
27. Daydreaming.
28. Making a list of tasks/goals.
29. Watching sports.
30. Thinking about pleasant events.
31. Writing in a diary.
32. Reading a letter.
33. Discussing books.
34. Having lunch with a friend.
35. Solving riddles/puzzles.
36. Looking at/showing photos.
37. Learning to play a new card game.
38. Reflecting on how I've improved.
39. Thinking I'm a person who can cope.
62. Buying clothes.
63. Going to the hairdresser/salon.
64. Making a gift for someone.
65. Having your picture taken.
66. Listening to music.
67. Taking a walk.
68. Playing sports.
69. Acting.
70. Dancing.
71. Cleaning.
72. Being alone.
73. Playing cards.
74. Having a political discussion.
75. Playing Pool.
76. Learning to play a new game.
77. Talking on the phone.
78. Helping a friend cope.

Moreover, individuals can be mindful of positive experiences and be unmindful of worries. This can be done more effectively when we understand the purpose of emotions.

Emotions Have Three Jobs

Communication

• Emotions are communicated most powerfully by our faces, our voice tone and volume, our posture, and our gestures. Often, other people can tell what we are feeling, even we're trying to hide it.

• Non-verbal communication of this type is very rapid. If we need to communicate alarm, we can do it with our faces and don't have to provide a lengthy explanation to someone.

Motivation

• Emotions tell us to "ACT NOW!" and "STAY FOCUSED". They give us motivation to change a situation.

• Emotions save us time in important situations. We don't have to think everything through (e.g., you don't want to have to think for a long time about running away from a mean dog).

• Strong emotions help us overcome obstacles—in our mind and in the environment (e.g., mothers lift cars off their children due to fear, someone expresses an opinion to authority figure due to anger)

Validation

• Emotions can be information about a situation. Think of a time that you had a "gut instinct" in a situation. Emotions can be SIGNALS or ALARMS.

• When this is carried to extreme, emotions are treated as facts (e.g., "I feel self-righteous, so I must be right", "I have hurt feelings, so the other person must not care about me.")

Some ways in which individuals can let go of emotional suffering include observing one's emotion, experiencing one's emotion like a wave, remembering that an individual is not her emotion and she does not necessarily have to act on it, and by practicing loving one's emotion.

Letting Go of Emotional Suffering: Mindfulness of Your Current Emotion

OBSERVE YOUR EMOTION

- NOTE its presence.
- Step BACK.
- Get UNSTUCK from the emotion.

EXPERIENCE YOUR EMOTION FULLY

- As a WAVE, coming and going.
- Try not to BLOCK emotion.
- Try not to PUSH the emotion AWAY.
- Don't try to KEEP the emotion around.
- Don't try to INCREASE the emotion.
- Just be a witness to your emotion.

REMEMBER: YOU ARE NOT YOUR EMOTION

- Do not ACT on the sensation of urgency.
- Remember when you have felt DIFFERENT.
- Describe your emotion by saying "I have the feeling of _____", rather than, "I am ____."
- Notice OTHER feelings that you have at the same time you feel the strong emotion.

PRACTICE RESPECTING, LOVING YOUR EMOTION

- Don't JUDGE your emotion.
- Practice WILLINGNESS with your emotion.
- Radically ACCEPT your emotion.

Session wind-down.

Group Ten

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Review last session and continue with emotion regulation training. The next part of this training involves teaching clients to act opposite to their current emotion. For example, if they are feeling fearful, they should do what they are afraid of doing until they are no longer afraid. If they are feeling sad, they should do things that make them feel competent and self-confident. If they are feeling anger, they should try to imagine sympathy and empathy for the person, rather than acting out of anger. Through all of these things, it is essential to keep in mind that feelings are justified; however, what an individual does with them, and how much control she lets the emotion have is within her control.

Changing Emotions by Acting Opposite to the Current Emotion

FEAR

- Do what you are afraid of doing…OVER and OVER and OVER.
- APPROACH events, places, tasks, activities, people you are afraid of.
- Do things to give yourself a sense of control and MASTERY.
- When overwhelmed, make a list of small steps or tasks you can do.
- DO THE FIRST THING ON THE LIST.

GUILT OR SHAME

When guilt or shame is JUSTIFIED (the emotion fits your wise mind values)

- REPAIR the transgression.
  - Say you're sorry. APOLOGIZE.
  - Make things better: do something nice for the person you offended (or for someone else, if that is not possible).
- COMMIT to avoiding that mistake in the future.
- ACCEPT the consequences gracefully.
- Then LET IT GO.

When guilt or shame is UNJUSTIFIED (emotion does not fit your wise mind values):

- Do what makes you feel guilty or ashamed…OVER and OVER and OVER.
- APPROACH, don't avoid.

SADNESS OR DEPRESSION

- Get ACTIVE, APPROACH, don't avoid.
- Do things that make you feel COMPETENT and SELF-CONFIDENT.

ANGER

- Gently AVOID the person you are angry with rather than attacking. (Also avoid thoughts about that person, rather than dwelling on them).
- Do something NICE rather than mean or attacking.
- Imagine SYMPATHY AND EMPATHY for the other person rather than blame.

How much of this makes sense to the client? What are some other ways that people can change their emotions? Are the clients willing to try some of these techniques?

Session wind-down.

Group Eleven

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Review what was covered in past weeks and engage in problem solving as necessary.

Discuss the importance of self-care to self-worth. Discuss the ways in which how we interact with others can affect how we feel about ourselves, and some particular reasons for this. Have the clients share some interactions they have with individuals in their lives (e.g., children, bosses, partners), and how these interactions might affect an individual's mood and evaluation of herself.

Discuss the rationale for interpersonal effectiveness within this context. With the emotion regulation, distress tolerance and mindfulness, clients may now have the skills to better manage their interpersonal relationships so they can ask for what they need, say no when they cannot do something, and be kind yet assertive. What does assertiveness mean to these clients? What does it mean to ask for something you want, deserve or expect? What are some benefits and harms of doing this?

Discuss the importance of doing this safely within the context of their intimate relationship. If a client's partner is abusive, it may not be in her best interest to be assertive or say no under all circumstances. Clients should gage when this would be appropriate, and first practice these skills with others. The priority is always client safety.

Below are some ways through which interpersonal effectiveness may be helpful:

Attending to Relationships

- Don't let hurts and problems build up.
- Use relationship skills to head off problems.
- End hopeless relationships.
- Resolve conflicts before they get overwhelming.

Balancing Priorities vs. Demands

- If overwhelmed, reduce of put off low-priority demands.
- Ask others for help; say no when necessary.
- If not enough to do, try to create some structure and responsibilities; offer to do things.

Balancing the Wants-to-Shoulds

- Low at what you do because you enjoy it and "want" to do it, and how much you do because you feel it has to be done and you "should" do it. Try to keep the number of each in balance, even if this means
    - Getting your opinions taken seriously
    - Getting others to do things
    - Saying no to unwanted requests

Building Mastery and Self-Respect

- Interact in a way that makes you feel competent and effective, not helpless and overly dependent.
- Stand up for yourself, your beliefs and your opinions.

GOALS FOR INTERPERSONAL EFFECTIVENESS

OBJECTIVES EFFECTIVENESS:

Getting the "thing" I want

- When it's your legitimate right.
- Getting another to do something for you.
- Refusing an unwanted or unreasonable request.
- Resolving an interpersonal conflict.
- Getting your opinion or point of view taken seriously.

QUESTIONS

1. What is the "thing" that I want from this interaction?
2. What do I have to do to get the results? What will work?

RELATIONSHIP EFFECTIVENESS:

Getting and Keeping a Good Relationship

- Acting in such a way that the other person keeps liking and respecting you.
- Balancing immediate goals with the good of the long –term relationship.
- Remembering why the relationship is important to you now and in the future.

QUESTIONS

1. How do I want the other person to feel about me after the interaction?
2. What do I have to do to get (keep) this relationship?

SELF-RESPECT EFFECTIVENESS:

Keeping or Improving Self-Respect and Liking for Yourself

- Respecting your own values and beliefs: acting in a way that makes you feel moral.
- Acting in a way that makes you feel capable and effective.

QUESTIONS

1. How do I want to feel about myself after the interaction is over?
2. What do I have to do to feel that way about myself? What will work?

Session wind-down.

Group Twelve

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Review interpersonal effectiveness.

Begin with the first assertiveness exercise: DEAR MAN. This involves:

- **D**escribe: the current situation and telling the person exactly what you are reacting to. Try to stick to the facts
- **E**xpress your feeling and opinions about the situation
- **A**ssert: ask for what you want or say no clearly.
- **R**einforce: reinforce or reward the person ahead of time by explaining the consequences.
- Stay **M**indful: focus on your objectives, maintain your position, and try not to be distracted.
- **A**ppear confident: try to be as effective and competent as you can.
- **N**egotiate: be willing to give to get. Offer and ask for alternative solutions to the problem.

In addition, clients should remember some key aspects of communicating (GIVE). These include:

- Be **G**entle: Be courteous and temperate in your approach.
  No attacks - No verbal or physical attacks. No hitting, clenching fists.
  Express anger directly.

  No threats - No "manipulating" statements, no hidden threats. No "I'll kill myself if you…".
  Tolerate a "no" to requests. Stay in the discussion even if it gets painful. Exit gracefully.
  No judging - No moralizing. No "if you were a good person, you would…," No "you should…,"
  "You shouldn't…"
- Act **I**nterested: LISTEN and be interested in the other person.

  Listen to the other person's point of view, opinion, reasons for saying no, or reasons for making a request of you. Don't interrupt, talk over, etc. Be sensitive to the other person's desire to have the discussion at a later time. Be patient.

- **V**alidate

  Validate or ACKNOWLEDGE the other person's feelings, wants, difficulties, and opinions about the situation. Be non-judgmental out loud: "I can understand how you feel, but…", "I see that you are busy, and…"

- Use an **E**asy manner
  Use a little humor. SMILE. Ease the person along. Be light-hearted. Wheedle. Use a "soft sell" over a "hard sell."

By asking for something (DEAR MAN) while communicating effectively and empathically (GIVE), clients are more likely to see positive outcomes. However, clients should also be reminded that they can only control their actions—not those of someone else. Thus, just because they are using these skills does not mean that they will have a favourable outcome.

Have clients role play this with each other.

Next, have clients engage in an exercise on building and maintaining self-respect (FAST). This involves:

- Be **F**air: being fair to yourself and the other person
- No **A**pologies: do not be overly apologetic for your behaviour, your request, or your opinion
- **S**tick to your values
- Be **T**ruthful: do not lie, act helpless when you are not, or exaggerate.

Continue role playing exercises.

Session wind-down.

Group Thirteen

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Review interpersonal effectiveness skills from last week.

Discuss factors that may reduce interpersonal effectiveness. These can include lack of skill, worrying thoughts, overwhelming emotions, indecision, and one's environment. All of these things can be changed, to some extent; however, each person needs to be ready to make those changes.

There are also some circumstances in which it may not make sense to expect certain things of individuals. Some things to consider are the priorities (for example, how important is what you are asking for?), capabilities (for example, is the person able to give you what you want?), and timeliness (for example, is this a good time to ask?). If client's take the time to consider these things, they are more likely to see success. Moreover, they should think about the intensity with which they assert themselves. Some situations may require a very firm response, whereas others may not. Matching one's request with the urgency of the situation is also important.

LACK OF SKILL

You actually DON'T KNOW what to say or how to act. You don't know how you should behave to achieve your objectives. You don't know what will work.

MYTHS THAT CONFUSE YOU

You know what to say or do in order to be effective, but habits in the way that you think increase your emotions about the situation and cloud your vision of the effective choice.

- Myth: Everyone must like me. (What if people don't like me?!)
- Myth: I am not a good enough person to deserve good things.
- Myth: I have to do everything right or I'm stupid/incompetent.

EMOTION MIND

The strength of your emotions (ANGER, SADNESS, FEAR, GUILT) gets in the way of your ability to act effectively. You have the ability, but your emotions make you unable to do or say what you want. Emotions, instead of skill, control what you say and do.

INDECISION

You CAN'T DECIDE what to do or what you really want. You have the ability, but your indecision gets in the way of doing or saying what you want. You are ambivalent about your priorities. You can't figure out how to balance:

- Asking for too much versus not asking for anything.
- Saying no to everything versus giving in to everything.

ENVIRONMENT

Characteristics of the environment make it impossible for even a very skilled person to be effective. SKILLFUL BEHAVIOR DOESN'T WORK.

- Other people are too powerful.
- Other people will be threatened or have some other reason for not liking you if you get what you want.
- Other people won't give you what you need or let you say no without punishing you unless you sacrifice your self-respect, at least a little.

Lastly, clients should consider a few statements to help encourage them to seek support from others. This can be especially difficult if clients have been hurt by people they trusted in the past. Thus, requesting things of other should be a very gradual process.

Self-Encouragement

1. It is OK to want or need something from someone else.
2. I have a choice to ask someone for what I want or need.
3. I can stand it if I don't get what I want or need.
4. The fact that someone says no to my request doesn't mean I should not have asked in the first place.
5. If I didn't get what I wanted, that doesn't mean that I didn't go about it in a skillful way.
6. Standing up for myself over "small" things can be just as important as "big" things are to others.
7. I can insist upon my rights and still be a good person.
8. I sometimes have a right to assert myself, even though I may inconvenience others.
9. The fact that other people might not be assertive doesn't mean that I shouldn't be.
10. I can understand and validate another person, and still ask for what I want.
11. There is no law that says other people's opinions are more valid than mine.
12. I may want to please people I care about, but I don't have to please them all the time.
13. Giving, giving, giving is not the be-all of life. I am an important person in this world, too.
14. If I refuse to do a favour for people, that doesn't mean I don't like them. They will probably understand that, too.
15. I am under no obligation to say yes to people simply because they ask a favour of me.
16. The fact that I say no to someone does not make me a selfish person.
17. If I say no to people and they get angry, that does not mean that I should have said yes.
18. I can still feel good about myself, even though someone else is annoyed with me.

Others:

Session wind-down. Ask the clients about if they would like to do an activity next week during the discussion.

Groups Fourteen and Fifteen

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

These sessions are allotted to help clients problem solve, review material, and work on anything they would like further support with.

One way to facilitate this discussion is to bring in an activity. This could be drumming, listening to some fun music, sewing, etc. Ask the clients what they would like to do this week ahead of time.

If clients are interested, they may collaboratively discuss some ways through which they can change their situation or the situation of others within the community.

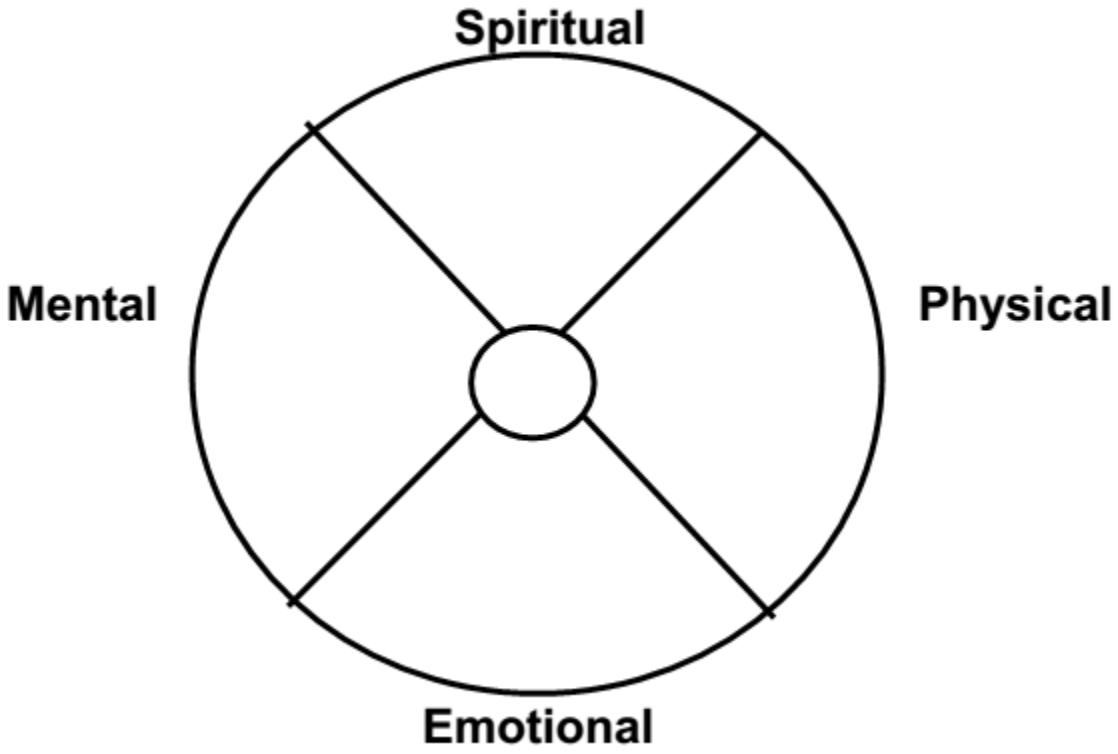
Session wind-down.

Group Sixteen

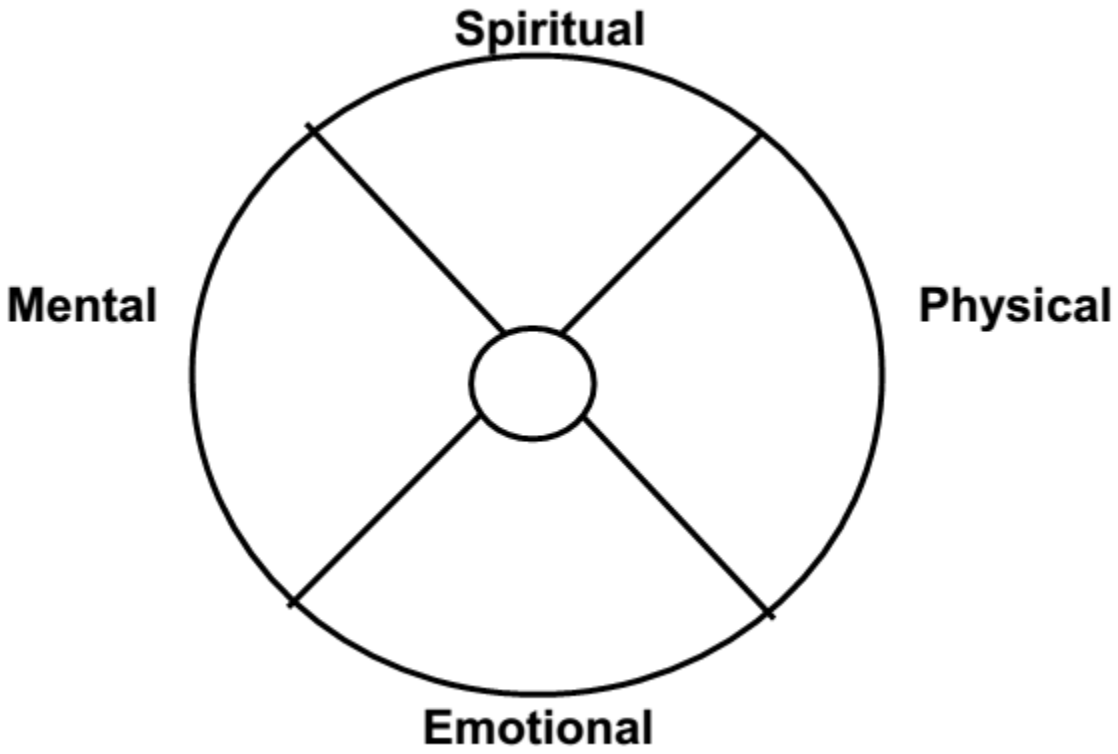
Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Have a discussion with the clients about the ways in which their trauma currently affects them. Engage in the individual exercise in which the clients write down how their traumas currently affect them physically, emotionally, mentally and spiritually.



This should be followed by another exercise in which the clients write down the ways in which they can and do care for themselves physically, emotionally, mentally and physically.



Through both of these tasks, it is important to continue to validate clients, recognize that everyone will be making different gains, and that each individual's journey to healing is unique. Ideally the therapists can assist the clients by comparing what they initially wrote down to how they are currently feeling. Ask the clients what they need now from the group, and how they can prepare themselves and each other for the end of the group.

Session wind-down.

Group Seventeen

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

Engage in a thorough review with clients, going over the four DBT modules, and Psychoeducation around violence and trauma. Practice skills and make sure clients remember the rationale for using these skills.

Have a discussion around next week being the last week. Plan a celebration for each person's growth throughout the group.

Session wind-down.

Group Eighteen

Begin the group with the sharing activity, the mindfulness exercise, and a review of the diary cards.

Break

This last half of the session will be similar to a party. Fun snacks will be provided, and this will be an opportunity for the clients to celebrate their successes. Each client will have a turn sharing something positive about herself.

A potential activity includes having clients fold a piece of paper four times and write their name on one side. Then each paper will be passed around the circle, and each client is to anonymously write a positive message to the individual to whom the paper belongs. At the end, when the paper makes its way back to the client, she can read it and have some time to reflect on what is written.

At this time, therapists should also seek feedback from clients about what they found most effective, and what they would like to have been different.

If possible, the therapists should aim to write a therapeutic letter, find an object or create a drawing for each of the clients in the group, to symbolize growth and hope. These should be distributed at the end of the group.

Session wind-down.

It may be beneficial to allot more time to be available after the group this week, in case any clients need some extra support after the group.

Community Resources

Thunder Bay Indian Friendship Centre
401 Cumberland St. N, Thunder Bay, ON
(807) 345-5840

Anishnawbe Mushkiki Nurse Practitioner Led Clinic
101 Syndicate Ave. N., #2B, Thunder Bay, ON
(807) 623-0383

Faye Peterson Transition House
Crisis line: (807) 345-0450 or 1-800-465-6971

Talk4Healing
Crisis line: 1-855-554-HEAL (4325)
24 hours a day, 7 days a week crisis line, with services available in English, Ojibway, Oji-Cree, and Cree.

Canadian Mental Health Helpline
Crisis line: 1-866-531-2600

Métis Nation of Ontario
226 May Street South
Thunder Bay, ON P7E 1B4
807-624-5025.

Thunder Bay Regional Health Sciences Centre Sexual Assault/Domestic Violence Treatment Centre
(807) 684-6751
Offers individualized 24-hour services, including emergency medical and psych-social treatments

Beendigen Inc.
100 Anemki Drive, Suite 103, Fort William First Nation, Ontario
(807) 622-1121; Crisis Line: (807) 346-HELP (4357) or 1-888-200-9997

Thunder Bay Counselling Centre
544 Winnipeg Ave., Thunder Bay, ON
(807) 684-1880
Walk-in counselling offered 1st and 3rd Wednesday of every month from 12:00PM to 8:00PM.

Catholic Family Development Centre
380 Dufferin St., Thunder Bay, ON
(807) 345-7323

Children's Centre Thunder Bay
283 Lisgar St., Thunder Bay, ON
(807) 343-5000
Walk-in counselling offered every 2nd and 4th Wednesday of the month from 12:00PM to 8:00PM

Assaulted Women's Helpline
Toll-free in Ontario: 1-866-863-0511

Thunder Bay Multicultural Association
17 N. Court Street, Thunder Bay, ON
807-345-0551 or 1-866-831-1144

Ishaawin Counselling Centre
532 Edward Street North
Thunder Bay, ON P7C 4P9
Phone: 622-5790
Email: ishaawin@risingabove.ca