Evaluation of Psycho-Educational Interventions in Treating Traumatized Latinas: Awareness, Coping, and Behavior Change

Ruby Berdine
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Abstract
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Hypothesis 1 said SEP groups could be held performed to fidelity (>70%). One group exceeded the fidelity requirement at 73% or above. Three groups failed to complete the 25-session protocol and could not be ranked.

Hypothesis 2 said participants would experience an increase in awareness, coping and pro-recovery behavior. The completing group (n=5) showed mixed results. Two showed overall gains in the pro-recovery direction. Three show gains on only some scales. Context factors that inform score interpretation are discussed

Hypothesis 3 and 4, which related to customer satisfaction, attendance and symptom reduction, could not be adequately explored due to low n. However preliminary data does appear to support a positive relationship between attendance and satisfaction, as well as attendance and symptom relief, particularly when participation is defined as not only attendance but also by “showing up” in a cognitive sense. Further research into the qualitative experience of trauma related distress for Latinas, as well as review and clarification of scale construction should be addressed in future research.

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EVALUATION OF PSYCHO-EDUCATIONAL INTERVENTIONS IN TREATING
TRAUMATIZED LATINAS: AWARENESS, COPING, AND BEHAVIOR CHANGE

A DISSERTATION
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ABSTRACT

The current study is descriptive and takes a look at the *Saber es Poder*, or SEP curriculum. The treatment groups were offered in the Portland, Oregon Metropolitan Area, at 4 outpatient mental health clinics. Data was gathered 4 times; once at baseline and at the end of each treatment phase. The Posttraumatic Diagnostic Scale (PDS), the Brief Symptoms Inventory-18 Questions (BSI-18), The Trauma Recovery and Empowerment Scale (TRES), The Trauma Recovery and Empowerment Protocol (TREP) were the published measures used. Other measures were the Culture, the Participant Satisfaction, the Awareness, Coping, and Behavior Scales. A fidelity measure was also used to test adherence.

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INTRODUCTION

Women who have experienced physical, emotional, and sexual abuse, either in childhood or in later parts of their lives, particularly those who lack economic resources and live on the margin as adults, rarely find the help they need to recover from the impact of these abuses within our current mental health system (Harris, 1998; U.S. Department of Health and Human Services [DHHS], 2001). They are often too poor for individual therapy and may be judged too fragile or emotionally volatile for group therapies that are typically offered through non-profit social service agencies and public clinics (Harris, 1998; Herman, 1997).

Historical and socio-cultural factors suggest that as a group Latinos are in great need for mental health services. According to the Mental Health Care for Hispanic Americans chapter of the Mental Health Supplemental to the 2001 Surgeon General’s Report (DHHS, 2001, p.133), Mexican Americans and white Americans have very similar rates of psychiatric disorders. Latina women, while being characterized in the literature as highly resilient, are also more socially vulnerable than white women, and as vulnerable as black women, to developing mental health and substance abuse problems, particularly in coping with trauma (Amaro et al., 2005; Ramírez, 1991). Latinas generally have lower levels of educational attainment, fewer financial resources, and fewer job skills. Additionally, employment opportunities are often blocked by their status as undocumented residents. Health research also indicates that Latinas experience greater mortality and morbidity than other groups due to health problems such as diabetes (DHHS, 2001). They also face greater barriers to treatment due to social and contextual factors such as gender relations, racial discrimination, political disadvantage and poverty (Chang & Gibbons, 2008). Due to these social vulnerabilities, they are more likely than the population in
general to have experienced childhood sexual or physical abuse, institutional abuse, rape in
adulthood, or domestic violence, all of which are sufficiently traumatizing to have long-term
negative impacts on mental health (Amaro et al., 2005; DHHS, 2001).

In 2003, as part of a large study on Women, Co-Occurring Disorders and Violence
(Moses, Reed, Mazelis & D’Ambros, 2003), the plight of Latina survivors of trauma became the
focus of work by researcher-clinicians Fabiana Wallis, PhD, and Hortensia Amaro, PhD.
Working out of the Boston Consortium of Services for Families in Recovery, Wallis and Amaro
teamied up with Maxine Harris of Community Connections in Washington DC, to adapt the
treatment manual for the Trauma Recovery Empowerment Model (TREM), which was originally
developed and manualized by Harris in 1998. The resulting adaptation, titled Saber es Poder, is
designed for Spanish-speaking Latina women who are survivors of trauma.

Saber es Poder (SEP) is a 25 session psycho-educational group (see appendix A for a
brief outline of group themes and goals). While no studies have been conducted on the adapted
model to date, the need is rapidly increasing for empirically validated, culturally and
linguistically appropriate trauma-informed services for Latinas in many communities across the
U.S., and SEP appears to be a promising option warranting further study.

A recent spike in Latino populations in Oregon (based on U. S. Census Bureau, 2000
Figures; Wozniacka, 2008) drives increased need in local communities such as Hillsboro,
Gresham, Cornelius, and Portland for appropriate mental health services for Latinos. In
Multnomah and Clark counties, the number of Hispanics climbed the most, by 7 percent in 2007,
while Washington and Clackamas counties each saw a 6 percent increase last year (US Census
Bureau, 2000; Wozniacka, 2008). Despite multiple barriers, the consensus among local bilingual
mental health providers is that monolingual Spanish-speaking Latina survivors of trauma are
presenting in ever-increasing numbers at local community and private mental health clinics for care.

In an effort to address the mental health needs of these women, the researcher arranged for trainings for local bilingual health care providers in the SEP model. Providers received training from Washington DC based expert Lori Beyer, LICSW, MSWAC, and Fabiana Wallis, PhD, on TREM and the *Saber es Poder* curriculum. Local agencies and providers--namely Conexiones, Morrison Center, and Pacific University’s Iris Clinic and Psychological Services Center—then launched treatment groups in response, providing the opportunity to conduct this study.

**Statement of the Problem**

Latinos are the fastest growing ethnic minority in the U.S. with the most recent census data currently available (U.S. Bureau of Census, 2000) indicating that at the end of 2010, Latinos comprised more than 20 percent of the total US population. Overall, they are the third largest minority group in the US, and in the West, they are the second largest. To date, in Oregon, the Latino population is growing five to six times faster than non-Latinos, and in Multnomah, Clark, Washington and Clackamas counties, the total number of Latino residents climbs even faster, (estimated to be between 6 and 7 percent annually, Woznaicka, 2008).

Studies suggest there are conditions in the United States that place Latinos at increased risk for psychiatric disorders, and in particular, for trauma-related mental health problems (Burnam, Hough, Karno, Escobar & Telles, 1987; Robins & Regier, 1991). Latinas appear to be at the greatest risk for trauma-related mental health problems (DHHS, 2001). A critical review of the literature and a survey of local availability of linguistically and culturally appropriate
services for Latinas with chronic trauma-related mental health problems indicates that very few local agencies offer these services.

There are also few options available in terms of empirically validated manualized treatment; however, these treatments do exist as a result of a call for proposals from SAMSHA in 1996 to address the lack of culturally competent treatment protocols for women suffering from trauma (Moses et al., 2003). Local expertise is being developed using SEP (one of these treatments), which has resulted in the rare opportunity for research on this protocol and participant population.

The following section is a brief review of relevant literature related to the study topic. This review includes a discussion of current knowledge regarding the impact of trauma on women’s health; mental health disparities for minorities, including Latina women; the creation of trauma-informed mental health service for women; the development and history of the TREM Model; and the adaptation process of Saber es Poder. Subsequent sections of this dissertation contain a description of the study conducted by the researcher to evaluate the impact of SEP on its participants, including an in-depth discussion of barriers experienced by the project, participant outcomes, and participant satisfaction. The discussion section of this paper includes a summary of the studies strengths and weaknesses, recommendations regarding possible improvements to the materials for the purposes of use in community settings, and directions for future research on this group protocol.
LITERATURE REVIEW

Women and Trauma

The cumulative effects of domestic violence tend to shape every aspect of a woman’s life -- physical, mental, emotional, spiritual, social, and economic -- even years after the experience, especially if the trauma was repeated and/or occurred in early childhood and was perpetrated by an intimate or trusted person (Moses et al., 2003). Historically, trauma survivors have been silenced by societies unwilling to acknowledge abuse (Herman, 1997). The tendency to blame the victim and failure to place blame on the perpetrator, along with a culture-wide denial and amnesia regarding domestic abuse generally, is a pattern predating the birth of modern psychology.¹

Chronic physical and/or sexual abuse is connected with a wide range of mental health, substance abuse, and physical health problems (Moses et al., 2003). Historically, women with abuse histories and trauma symptoms have been multiply and variously labeled and treated -- diagnosed with anxiety and panic disorders, major depression, substance abuse and dependence, personality disorders, dissociative disorders, psychotic disorders, somatization, eating disorders and posttraumatic stress disorder. Women survivors may also experience chronic pain, gynecological difficulties, gastrointestinal problems, asthma, heart palpitations, headaches, and musculoskeletal difficulties. These physical ailments are believed to be common partly due to the survivor’s tendency to live for long periods of time with emotional pain from their abuse without the ability to verbalize or otherwise process their traumatic memories (Carmen & Reiker, 1989).

The literature on women and trauma is characterized by deficit-based discussion and generally overlooks how victimized women display strength and resilience (Herman, 1997).

¹ For the purposes of this review, Modern Psychology is a field first articulated by Freud and his contemporaries prior to WWII in Europe, and then expanded upon post WWII in the US.
Persons who have experienced violence can become locked into a perpetual state of hypervigilance in which they chronically anticipate danger. Bodily systems are heavily taxed by this state and some research indicates that long-term stress of this nature can predispose a woman to serious auto-immune disorders (van der Kolk, 1996; Zierler, Feingol, & Lauíer, 1991).

Many women also suffer as a result of their attempts to get help with symptoms. This issue is an important aspect of the development of appropriate trauma services for women. Retraumatization can occur, as can the erosion of a woman’s sense of safety and her belief that she can be helped. Trauma survivors often cycle in and out of mental health and substance abuse programs for years and may use a number of resources without experiencing any relief (Foa, 2009; van der Kolk, 1996).

Minorities and Mental Health Disparities

There are several sources of data indicating disparities in access to mental health care for minority populations (DHHS, 2001). Access to culturally appropriate interventions in community mental health settings is limited by a variety of factors that include lack of appropriate funding and support for programs to develop these resources, lack of equity in terms of numbers of providers with the requisite language, culturalz skills, and lack of evidence-based research on protocols specially adapted for these groups (Alegría et al., 2002; DHHS, 2001; National Science Foundation, 2009). Griner and Smith (2006) found only 76 studies to be the entire body of published and unpublished research in their recent meta-analysis of interventions adapted for minorities. In a subsequent meta-analysis (Smith, Rodríguez, & Bernal, 2011) the search was refined to only include experimental and quasi-experimental studies with specific characteristics (included studies were to contain quantitative data and explicit accounts of the participants culture, ethnicity or race). This latter search extracted 65 studies and the authors
comment that the rate of appearance of new studies has been only 2 per year since 1981. These numbers are low, particularly when compared with the rate of research being conducted on more generic evidence-based protocols, which appear about 20 times more frequently (Smith et al., 2011). Summary findings from these meta-analytic studies indicate minority clients benefit from efforts made to align treatment with cultural background; intersecting factors of acculturation level and age impact how a client will interact with a culturally adapted treatment (older clients with lower levels of acculturation gain more); whenever feasible, therapy should be conducted in the client’s preferred language; cultural adaptations should occur in multiple domains; and adaptations of interventions are more beneficial when they are specific to client’s cultural background.

Latinos/ Latinas and Trauma

Little specific research has been done on the plight of Latina women with regard to their experiences of violence, and indeed most literature in the public purview at this time is focused more generally on Latinos (both men and women together) and also more generally on “mental health.” Findings regarding this population’s vulnerability to mental illness are mixed, with some studies showing Latinos to be more resilient than other populations, and other studies arguing the presence of greater vulnerability and risk for mental health problems.

The Epidemiological Catchments Area Study (ECA) and the National Comorbidity Study (NCS) are two large-scale studies that were conducted for the purpose of identifying rates of psychiatric illness among adults in the United States (U.S. Public Health Service [USPHS], 2003). Both studies provide data on found differences in illness rates between Latino participants

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2 Smith et al. (2011) refer in their inclusion criteria to the work Bernal, Bonilla and Bellido (1995), which outlines an 8 domain framework for cultural adaptation. A detailed explanation of this framework is included in this review, in the section titled “Saber es Poder: Creating an Adaptation for Latina Women”
who were born elsewhere (namely, Mexico) and those who were born in the United States. Both studies found lower rates of mental disorders among participants born in Mexico compared to Mexican American participants in the U.S. More specifically, in the ECA study there were lower rates of depression and phobias reported in persons born in Mexico compared to Mexican Americans born in the United States. In the NCS, Mexican Americans born outside the United States had lower prevalence rates of any lifetime disorder compared to Mexican Americans born in the United States (USPHS, 2003). While the ECA study concluded that Mexican Americans and Caucasians have similar rates of psychiatric disorders, the NCS found that Mexican Americans have comparatively fewer lifetime disorders overall and fewer anxiety and substance use disorders than Caucasians (USPHS, 2003).

In another study conducted by the U.S. Public Health Services (USPHS, 2003) researchers found that Mexican Americans who had lived for more than 13 years in the United States had higher prevalence rates of disorders compared to Mexican Americans who have lived in the United States for fewer years. Also, Mexican American women born in the US were reported to be twice as likely as Mexican-American women who were born in Mexico, to have babies with low birth rates and to be users of alcohol and cigarettes (Scribner & Dwyer, 1989). Although researchers have yet to identify the variables to explain this phenomenon, one speculation is that there are unique conditions in the United States (e.g. drug and alcohol abuse, lack of social support, immigrant status) that place Latinas and Latinos at increased risk for high risk health behaviors that contribute to psychiatric disorders. However, it is important to note here that no specific efforts were made to include non-English speaking populations as respondents in these surveys (Alegría et al., 2006), and that other contextual factors, such as where individuals with lower acculturation levels live and how they may respond to standardized
efforts for gathering data on mental health disorders, are not taken into account in the design of these studies (Hunt, Schneider, & Comer 2004; Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996).

With regard to reactions to trauma and symptom expression, epidemiological studies report Latinos as having much higher levels of symptom distress than whites (DHHS, 2001). However, measurement of symptoms in these studies does not distinguish between symptoms due to actual disorder and symptoms due to distress associated with contextual and social stressors (Alegría et al., 2006; Schwartz, 1999).

Studies conducted using ECA data support a commonly held idea that Latinos are more likely to express mental health distress through somatic symptoms than European American groups (Escobar, Hoyos-Nervi & Gara, 2002; Golding, Karno & Rutter 1990), but differences in use of health care services, in socioeconomic status, and in cultural understandings of questions related to symptom distress may explain the greater endorsement of somatic symptoms by Latinos in these studies (Flaherty, 1987; Guarnacacia, Rubio-Stipec & Canino, 1989). For example, the higher rates of physical symptoms characterized as “medically unexplained” in the Latino sample may have been due in part to lower rates of access to adequate medical care, or lower rates in general of utilization of health and mental health care resources among Latinos (Villasenor & Waitzkin, 1999).

Another epidemiological study, known as the National Latino and Asian American Study (NLAAS) appears to be the most innovative epi-study yet conducted with Latinos. NLAAS was designed to collect detailed and multidimensional data on the mental health needs and service utilization patterns for Asians and Latinos in the US (Alegría et al, 2006). The designers of the NLAAS acknowledged that there is an absence of clear baseline data about the mental health
needs and rates of services utilization for Latinos and Asians, and indicate that this survey is an attempt to establish that baseline. This survey is a first for the field in terms of it’s attention to the importance of factors such as language (participants were given a choice to be interviewed in their native language) and ethnic diversity within the racial groupings (e.g. subgroups for both Asian and Latino populations captured by the study were identified). The survey design also attempts to capture contextual information pertinent to both expressions of mental illness and barriers experienced in seeking mental health services.

Findings highlight several important issues in the national conversation on mental health disparities for Latinos. A comparison across groups (using data from NLAAS to compare with two other epi-studies focused on non-Latino whites and African Americans\(^3\)) provides evidence that symptom-disease relationship is variable from group to group (Alegría and McGuire, 2003). This finding supports a move toward the use of population specific guidelines for certain diagnoses. This includes the use of culturally syntonic language to identify symptom complexes (e.g. “ataque de nervios” as described by Febo San Miguel et al., 2006) and culturally apt descriptors (e.g. allowing for endorsement of somatic symptoms in three or more bodily systems to be considered a positive sign that the patient may be suffering from mental illness, even when emotional symptoms are denied; Alegría et al., 2009; Balsa, McGuire and Meredith, 2005).

Lower rates of utilization of both mental health and medical care among Latinos and other minorities is linked to a constellation of barriers such as mistrust of providers, cost of health care, fragmentation of services, and societal stigma around mental illness (DHHS, 2001). Low utilization rates and high attrition rates for Latinos and Asians (particularly those who are

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\(^3\) The National Comorbidity Study-Replicated (NCS-R) focused on non-Latino whites and the National Survey of American Life (NSAL) focused on African Americans. Both of these studies are contemporary to the NLAAS study described above.
first generation or immigrants and who have lower rates of English fluency) was also confirmed using NLAAS data (Alegria & McGuire, 2003).

Context factors linked to disease expression were also explored using NLAAS study data. Findings include recognition that health outcomes for minorities are linked to social safety net access, and that in general, minorities have lower access to social safety net resources than whites. For example, Latinos and Asians were found as utilizing fewer proportionate resources in federal housing and health care programs, with more barriers to access (Balsa et al., 2005). Findings also indicate that minorities who do gain access to these supports experience more dramatic relief from poverty than the non-minority recipients (Alegria, Perez & Williams, 2003).

Additionally, a reappraisal of the NLAAS study instrumentation (Alegria et al, 2009) reveals some critical gaps in the data for Latinos. The NLAAS used the World Health Organizations Composite International Diagnostic Interview or WHO-CIDI, and the Structured Clinical Interview for the DSM-IV or SCID, to capture data on clinical diagnoses rates. When concordance rates between the two instruments were calculated, problems with assessing for PTSD were revealed. Specifically, there was little overlap between the two instruments in rendering this diagnosis. That is to say, the most advanced and well-constructed survey yet conducted on Latino mental health issues failed to capture even the baseline data regarding prevalence rates and mental health care needs for Latinos suffering from trauma.

Two recent studies focusing on a major sub-group of Latina trauma survivors—namely Latina sexual assault survivors (Cuevas, Sabita & Picard, 2010) and Latina childhood sex abuse survivors (Ligiero, Fassinger, McCauley, Moore, & Lytinen, 2009)-- help elucidate the complex nature of recovery from these types of traumatic events for Latina women. Sixty-four percent Survivors surveyed by Cuevas et al. (N=2000) reported having experienced polyvictimization
and/or victimization in both childhood and adulthood. Women in the study also experienced higher clinical levels of psychological distress, with higher rates of dissociation, anxiety, depression and anger. These researchers concluded Latina assault victims may need evaluation and treatment that is broad-spectrum, culturally specific, multidimensional, and designed to identify and redress emotional, cognitive and social impacts of repeated victimization.

Ligíero et al. qualitative study (N=9) found various recovery interfering themes for CSA survivors rooted in culture and context. The cultural context was described by participants as being one in which sexual exploitation and/or subjugation of women was acceptable, with men having more rights (p.72). Women in this study also endorsed worry that talking about sexual abuse leaves them vulnerable to more abuse. Some endorsed being silenced by fears of not being believed, being blamed, or being viewed as “tainted” and therefore available for further sexual exploitation. Silencing problems was described as normative in families. Not talking about abuse was also framed allocentrically, with expression of worries about the impact of disclosures on others (from frail elders to the abuser himself, p. 73). The women in this study also revealed themes of negative emotions about themselves (self-blaming, feeling dirty, feeling as if one was “bad” and “not deserving of love,” p.74), as well as having negative experiences such as feelings of disgust about their own sexuality, nightmares and flashbacks detailing the abuse scenarios, and difficulties with attachment and intimacy. Thematic material related to coping included self-punishment and self-abusive behaviors as a form of seeking relief from negative emotions, including the use of drugs and alcohol and the use of isolation. These women also described having to act as if they were doing well when they were not; feeling exhausted by efforts to maintain face; and becoming periodically so paralyzed by painful feelings that they were unable to function and to fulfill all of their responsibilities (p.74).
Trauma Services for Women

Many service providers do not recognize or understand the multiple, varied, and complex effects of violence on the lives of women. Symptoms may not be readily apparent or may be misunderstood, or both, when masked by seemingly unrelated behavior (Moses et al., 2003). Standard approaches to mental health, substance abuse treatment, and other health services may actually retraumatize women who have experienced violence, setting back or delaying their recovery, or else causing them to refuse care (Moses et al., 2003).

Appropriate treatment for women who have survived violence must be “both trauma-specific and trauma-informed” (Moses et al., 2003, p. 7). Trauma-specific services are those designed to directly address the effects of trauma with the goal of healing and recovery, and trauma-informed services are all the other services that could be offered in responding to the impacts of violence (e.g. case management, drug and alcohol treatment, access to appropriate inpatient and outpatient medical and mental health care; Moses et al., 2003).

In 1996, recognizing the failure to address the complex needs of women with alcohol, drug abuse, mental health disorders and histories of violence, the Substance Abuse and Mental Health Services Administration launched the Women, Co-Occurring Disorders and Violence Study (Moses et al., 2003). The study’s goal was to generate and apply protocols using empirical knowledge about comprehensive, integrated, trauma-informed approaches to treating this population. Initially, a multi-site framework for service intervention was formed, local strategies for implementing services were articulated and vetted, local and cross-site process evaluation efforts were made, and a standard methodology for cross-site outcome evaluation was established.
The framework of the study required all service interventions to be gender specific, culturally competent, trauma-informed and trauma specific, comprehensive, integrated, and informed by consumer involvement. Nine sites were initially selected for inclusion in this process: PROTOTYPES System Change Center of Culver City, CA; Allies, an integrated service system in Stockton, CA; New Directions For Families in Thornton, CO; District of Columbia Traumatic Collaborative Study (which included the leading agency for this area, Community Connections); Triad Women’s Project in Avon Park, FL; The Boston Consortium of Services for Families in Recovery in Boston, MA; WELL Women Embracing Life and Living in Cambridge, MA; Franklin County Women’s Research Project in Greenfield, MA; and the Portal Project in New York City.

Out of this process, several manualized treatment approaches were generated, among them the Trauma Recovery and Empowerment Model (TREM), created by Maxine Harris and her staff.

The TREM Model

The TREM model reflects material developed and refined by 27 clinicians and more than 500 participants, over 13 years of clinical work at the Community Connections in Washington, DC. The perspective held by Harris and her staff was that consumer involvement was essential in developing a good approach to healing from the effects of trauma. TREM is a group treatment that combines approaches proven to be highly effective with survivors; including feminist empowerment training, social skills training, psychoeducation, psychodynamic techniques, and peer support (http://www.communityconnectionsdc.org, retrieved 9-30-08).

The original TREM was written as a step-by-step leader’s guide for 33 group sessions with adult women. Additional sessions for special populations within that group (e.g. Women
Diagnosed with Serious Mental Illness, Incarcerated Women, Women Who Abuse, etc.) were also formulated and published. Currently the TREM model has several adaptations, including 24 group-session formats. Protocols exist for working with teen girls (G-TREM), men (M-TREM), incarcerated women, incarcerated men, people in addictions treatment, and for individuals in short-term inpatient psychiatric settings. The TREM approach for women is based on four core assumptions:

1. Some current dysfunctional behaviors and/or symptoms may have originated as legitimate coping responses to trauma.

2. Women who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills necessary for adult coping.

3. Trauma severs core connections to one’s family, one’s community, and ultimately to oneself.

4. Women who have been abused repeatedly feel powerless and unable to advocate for themselves (Harris, 1998, p. xiii).

Each topic includes a rationale and goals for the session, specific discussion questions, a sampling of typical responses, and experiential exercises. The groups are conducted in the following standardized format:

--Each group meeting is designed to last 75 minutes; group meetings are to be conducted on consecutive weeks. Each topic should take one week to discuss, but leaders have the option of continuing for a second week if they and the members so choose.

--Meetings are conducted as structured conversations, with the questions included in the manual to be used as guides or prompts.
--Each topic also includes an experiential exercise, which is designed to promote group cohesiveness and allow for the inclusion of less verbal members. Leaders should participate in the exercises, which involve moving around, sharing of poetry, singing, drawing, and storytelling.

--Ideally, each group member should have a therapeutic support system outside of group, such as a case manager or counselor, however a woman who does not have these resources can still be allowed to participate in the group if the group leaders can reliably provide her with extra time when she needs it.

Inclusion criteria for the group are relatively liberal, and while facilitators are asked to attend to balancing the group composition to protect the interests and comfort of its participants, some usual exclusions, such as of women experiencing psychotic symptoms or having too low of a level of literacy, do not apply here. The manual indicates that a woman experiencing psychotic symptoms may attend the group, and that generally these women either remain silent or become somewhat more organized in response to a structured and relevant agenda (Harris, 1998, P.5). Also, because of the emphasis on skill development and psychoeducation, leaders must assess each woman’s vocabulary, abstract reasoning ability, attention span, and general literacy and attempt to adapt the material to meet her needs. Trainings on the model include strategies for adapting to these needs, such as increased use of concrete examples and word definitions, and reduced use of written materials, wordy charts and lengthy verbal instructions.
Saber es Poder: Creating an Adaptation for Latina Women

The Spanish language and cultural adaptation of the TREM was based on input from both experienced group facilitators and group participants. Clinicians who developed the adaptation had both prior clinical experience working with traumatized Latinas and experience as TREM group leaders. Session by session, revisions were made and vetted in field-testing (see Figure 1 for an illustration of the process).

Figure 1. TREM Adaptation Process Steps. Reprinted here with permission from Fabiana Wallis, PhD.
Theory on cultural adaptation includes a discussion of the impact of ethnicity, culture, and minority issues on the adaptation framework. Wallis and Amaro used Bernal, Bonilla and Bellido’s (1995) framework which considers eight specific dimensions:

1. Language (which should be both culturally appropriate and culturally syntonic)
2. Persons (which identifies a need for acknowledgement of ethnic differences between the clinician and the target group)
3. Metaphor (which refers to symbols and concepts such as *dichos* that are shared cultural knowledge for the target group)
4. Content (which includes knowledge of values, customs, traditions as well as social, economic, historical and political experiences of the target group)
5. Concepts (which includes treatment concepts consonant with culture and context)
6. Goals (which involves transmission of positive and adaptive cultural values as well as acknowledgement and support of adaptive values from the target culture)
7. Methods (which develops treatment methods that are culturally resonant and make use of values and language of the target group)
8. Context (which considers changes in the context of the target-group participant due to factors like acculturative stress, phase of migration, developmental stage, and base of support; also considers fixed factors such country of origin and social or economic class)

Adaptations in the content and context dimensions of the protocol are also informed by Bronfenbrenner’s (1977) concept of ecological validity, which refers to the level of congruence between the environment as experienced by the subject and the properties of the environment that the investigator/researcher assumes exist. An example of this might be the decision to encourage the use of “dichos” (popular saying, or proverbs) both to help the participant express
mastery of a recovery concept (as in “Oh! I understand—it’s like the saying goes . . .”), as well as to facilitate exploration and vetting of specific values, beliefs, traditions, and roles, a process assumed to be integral to recovery for this population by the investigator/researcher. Their adaptation is also informed by Tharp’s (1991) assertion that the integration of emic (or within-culture) perspective and etic (or universalist) perspective is superior to the use of only one or the other of these perspectives. This means that cultural adaptations should attend both to the specific and distinct needs of the target group and to the more global needs shared across all ethnic and culture groups. An example of this type of integration is the use of culturally salient and familiar artwork (Freda Kahlo paintings) to assist in the task of providing psychoeducation about important themes universal to the trauma experience (the tendency for the victim to manifest unacceptable emotions and memories through bodily suffering).

Wallis and Amaro were aware that Latina women have unique experiences due to cultural context, the types of trauma that they are exposed to, the context in which they are expected to recover, and the types of traumatic reactions they have (Harris, Wallis & Amaro, 2006; Wallis, 2008). For this reason, attention to these contexts informs many of the emic-level changes made to the protocol. For example Wallis and Amaro thought broadly about Latino cultural concepts such as collectivism, familism, machismo, and marianismo in creating the adaptation. The following section briefly reviews literature informing these concepts, offering definitions to help concretize the discussion of emic level adaptations of the six dimensions.

Collectivism and Familism

Within Latino culture, the family unit is seen as being more important than the individual. Sue and Sue (2003) argue that certain core goals in western psychotherapies, such as separation and individuation, may be inappropriate for the Latino client due to the collective nature of the
culture. Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) concur, saying that therapies that encourage adult Latino children to separate from their parents or that fail to account for the well-being of the family could be damaging to the patient. Latinos have also been described as allocentric (La Roche, 1999), meaning that they prefer to see and define themselves in light of their roles and relationships with others rather than by distinguishing themselves from others. Allocentrically-minded individuals are also more focused on achieving group-oriented goals rather than individual goals. This concept is central to arguments for the use of group and family therapy interventions rather than individual therapy as an initial response to mental health problems (DHHS, 2001).

Familism is connected to collectivism, and rooted in the belief that family relations are valued above all else (Falicov, 1998; Marin & Marin, 1991). Familism, also referred to as familismo, is considered a core value within Latino culture (Sabogal, Marin, Otero-Sabogal, & Marin, 1987). According to this value, family is tied together by respect, loyalty, and unity (Chong, 2002) and ideally is interdependent, cooperative, and cohesive (Santiago-Rivera et al., 2002). Familism is also associated with the often-noted mental health resiliency of Latinos. Various studies have found that the family acts as a buffer against physical and emotional stressors (Frauenglass, Routh, Pantin, & Mason, 1997; Vega, Gil, Warheit, Zimmerman, & Apospori, 1993).

**Machismo and Marianismo**

Sue and Sue (2003) define machismo as the expectation that men should be strong, dominant, and good providers. However, the literature on machismo also includes descriptions of hyper-masculine characteristics such as being fearless, aloof, promiscuous, dominant, virile, and controlling towards women; having restricted emotions; and using excessive alcohol (Torres,
Solberg, & Carlstrom, 2002). Acceptance of male dominance has been linked by feminist thinkers and researchers to higher rates of domestic violence and child abuse, as well as to a greater level of stigma around seeking mental health interventions (Herman, 1997). Machismo may combine with other Latino values, such as familism, as well as other barriers, such as mistrust of mental health intervention, to block access for Latinas to mental health care (Sue & Sue, 2003).

Marianismo refers to a model for Latina gender identity and is the cultural counterpart of machismo. Sue and Sue (2003) describe marianismo as the expectation that women be nurturing, submissive (to men) and self-sacrificing; and that they assert power only indirectly while outwardly supporting the appearance of male control. Chong (2002) defines marianismo as a woman’s position as devoted wife and mother and holder of power within the family home. Marianismo also refers to a woman’s spiritual strength, as in the expectation that she should model herself after the Virgin Mary: Latinas should be virtuous, humble, tolerant, self-sacrificing, pure and pious, more capable of bearing suffering and making personal sacrifice than the Latino male (Chong, 2002, Santiago-Rivera et al., 2002). In the Maria Paradox, Gil and Vazquez (1996) described ten specific “commandments” linked with marianismo: do not forget a woman’s place; do not forsake tradition; do not be single, self-supporting, or independent minded; do not put your needs first; do not forget that sex is for making babies, not for pleasure; do not wish for more in life than being a housewife; do not be unhappy with your man, no matter what he does to you; do not ask for help; do not discuss personal problems outside the home; do not change. According to Santiago-Rivera et al. (2002), the degree to which a Latina subscribes to these “commandments” will be dependent upon many factors: socio-economic status, migration experience, and language and family composition.
Marianismo and machismo are important in addressing mental health symptoms associated with trauma for Latinas. Aside from the obvious issues around the untenable position of the Latina experiencing domestic violence or abuse, therapeutic intervention has other implications for the Latina and her community. Discussing personal problems with strangers goes against these cultural norms. Her peers indicate that she is expected to buffer the family from outsider scrutiny and manage all of the burdens and difficulties on her own. She may feel as though she is being a traitor and is vulnerable to accusations of being self-centered and anti-family when she seeks help from or discusses personal problems with someone outside the family (Santiago-Rivera et al., 2002). These culturally informed gender-role pressures appear to be particularly toxic for Latinas who experienced childhood sexual traumas (Ligiero et al., 2009). Due to the interplay between marianismo and machismo, Latina women may have special difficulty asserting boundaries, particularly around safe sex and intimacy with male partners, leaving them vulnerable to exposure to STDs and HIV. Indeed, Latina women are one of the groups with the fastest growing numbers of infection with HIV (Amaro et al., 2006).

To further address the eight dimensions of their framework, Amaro and Wallis made several concrete changes to the facilitator instructions for the Spanish language TREM. The cultural adaptations were detailed in instructions for the facilitator and conveyed in questions for the group. The themes and topics of the original TREM were maintained almost intact, while the content and questions of each theme vary according to relevant cultural issues. Facilitators are instructed in the adaptation and in their training as bilingual and bicultural facilitators to use culturally-specific statements in response to a session’s emerging material. For example, in Group 1, “What it Means to Be a Woman,” facilitators are given prompts to help the women explore issues of machismo and marianismo. After discussing what it means to be a woman, the
facilitator is to follow up with the question, “What does it mean to be a Latina in the US?” to spur discussion about the unique experiences of the group participants with immigration, discrimination, and bicultural identity.

In addition to these modifications in the instructions for facilitators, they also made the following changes:

--They reorganized the Empowerment phase to include earlier initiation of conversations about safe sex practices. They include this in Group 4, as part of the discussion on emotional boundaries. They also added a group on HIV prevention and safe-sex negotiation (Group 5), and included a lesson on appropriate condom use in Group 8, where the topic is Sex with a Partner.

-- In the Trauma Recovery phase, they moved the group focused on abuse in relationships later to give the women a greater chance to develop the trust and intimacy that is required for Latinas to discuss in-family issues related to the topic.

--They added or replaced materials in various sessions with materials that are more culturally syntonic; for example self-portraits by Freda Kahlo are used in the session titled The Body Remembers What the Mind Forgets (Group 10).

--In line with Harris’ 24-session TREM, they also eliminated sessions on female sexuality, physical safety, institutional abuse, family myths and distortions, personal healing, and two follow-up/transitional sessions.

Wallis and Amaro also made efforts to identify and retain etic level concepts captured in TREM. Likely due to the development process employed by Harris and her team, namely that participants were involved in identifying and vetting essential content, most of the protocol content, once translated, was retained in the adaptation.
Sources for clinicians attempting the model were cited by Harris in the introduction to the TREM manual. These are *Trauma and Recovery, The Aftermath of Violence—From Domestic Abuse to Political Terror* by Judith Herman (1997), *The Courage to Heal* by Ellen Bass and Laura Davis (1992), *Shattered Assumptions*, by Ronnie Janoff-Bulman (1992), *Healing the Incest Wound*, by Christine Courtois (1988), and *Traumatic Stress* by van der Kolk, McFarlane, and Weisaeth (1996). All of these works share the *etic* perspective, identifying key shared experiences for traumatized individuals, regardless of their background, gender, race, or ethnicity. These reading suggestions were retained in the introduction to the adaptation, and culturally-specific autobiographies and source materials such as Esmeralda Santiago’s book *Cuando era Puertorriqueña*, Olivia Espin’s book *Latina Realities*, and Claire Renzetti’s book *Sourcebook on Violence Against Women* were also added (Wallis & Amaro, 1996, p.19).

**Purpose of this Study**

Due to recent efforts by the researcher and by experts in the SEP and TREM (Fabiana Wallis, PhD and Lori Beyer, LICSW, MSWAC) local bilingual health care providers in Multnomah, Clark and Washington counties received training on these models. Providers interested in the curriculum, as well as both mental health clinics affiliated with Pacific University, then launched SEP groups. This study, which is primarily descriptive in nature, looked at the experiences of participants in those groups.

The present study was designed to describe participant experiences of the protocol using quantitative data, and to explore qualitative data generated by participant responses to the material and interactions with the researcher. The researcher used the data gathered to test the following hypotheses:
1) Local providers trained in the *Saber es Poder* cultural adaptation of the TREM will be able to run groups with fidelity rankings of 70% or higher.

2) The participants in these groups will demonstrate gains in information about trauma and abuse, and awareness of the impact of trauma on their lives. Specifically, the researcher asked the following questions regarding participant outcomes:
   a) Does participation in the group increase the self-awareness about the impact of abuse and trauma?
   b) Does the model teach specific skills that help the participants increase coping?
   c) Did participation impact behavior, particularly with regards to implementation of healthier self-soothing strategies?

3) The number of groups a participant attends will likely be connected to level of satisfaction with the group.

4) The number of groups a participant attends will likely be connected to decrease in symptoms
METHODS AND PROCEDURES:

Study Participants

Participants of this study are Spanish-speaking Latina women (age 18 and up) who were living in the Portland Metropolitan or Hillsboro area and were referred to the group by either mental health providers, or self-referred after hearing about the group in their community. Of the 37 women initially referred, 33 were referred by a mental health professional or physician, 3 were referred by a friend/word of mouth, and 1 referenced other referral sources such as seeing posted flyers about the group. Of the 27 women who selected to participate, 23 heard about the group from a trusted mental health professional, 3 were referred by a friend/word of mouth, and 1 referenced a flyer. Regardless of the type of person who referred the participant to the group (mental health professional or friend) all but one participant endorsed word of mouth from a trusted other as the main source of motivation to contact the researcher about the group.

Participating clinics included were Pacific University’s Iris Clinic in Hillsboro, Oregon; Pacific University’s Psychological Services Center in downtown Portland; Morrison Child and Family Center Clinic in West Gresham, and the MIOS Latino Mental Health Clinic at the Programa Hispano Headquarters building in downtown Gresham. See Figure 2 for a map of the above locations. These sites were chosen based on convenience and access. Both Pacific University clinics (The Iris clinic in Hillsboro and the Psychological Services Center in Portland) were accessible to the student researcher and student clinicians affiliated with this project, as they all enrolled in Pacific’s doctoral program for clinical psychology. The Morrison Center clinic in Gresham was chosen because the student researcher is affiliated with this clinic, initially as an employee and then as an intern, and knew an adequate number of potential study
participants involved in Spanish-language mental health services existed to support a research group. The MIOS program through Programa Hispano was also chosen as a site based on prior knowledge and relationship with the clinic. Both the researcher and one co-author of the SEP protocol (Fabiana Wallis, PhD) had worked for that program and knew of wait-list clients and of the interest from clinical staff prepared to implement the protocol at this site.

Figure 2. A Map of Locations of Participant Clinics Programa Hispano in Gresham (A), Morrison Child and Family Center in West Gresham (B), Psychological Services Center in downtown Portland (C) and Iris Clinic in Hillsboro (D). Map reprinted here from www.googlemaps.com

Initial screenings were conducted over the phone or in person to determine appropriateness for the group. Participant selection was largely based on the inclusion and exclusion criteria in the SEP manual, which allows for participants to be experiencing high levels of symptoms and psychiatric distress, with the one modification that individuals determined to be actively psychotic or presenting suicidal or homicidal ideation were also referred to more comprehensive community resources and a higher level of care. Also, a prerequisite to group participation was the ability of the potential participant to plan on weekly participation over a six-month period. Based on the outcome of the screening, potential participants were then invited to an initial interview and orientation to the study group. Both the screenings and in-person meetings were conducted by masters-level therapists in training for
their doctoral degrees in clinical psychology. Attention was given to the level of distress during the phone and in-person interviews, as well as the clinician’s perception of the potential participant’s ability to tolerate an interactive treatment group.

Of the 37 women were screened for participation, 27 agreed to participate in the study. The match between group and participant was based on the convenience of a location for the individual participant.

Participants all endorsed experiencing mental health symptoms associated with trauma syndrome or PTSD. It was not a prerequisite for participants to meet diagnostic criteria for a diagnosis of PTSD. However, it was necessary that each one had some complaints of depression, anxiety, somatization, ataque de nervios, dissociation, or else that she reported a history of sexual or physical abuse.

Due to the nature of the referral process, the sample for this study may be characterized as a convenience based sample. However, this sample appears to be demographically representative of the population of monolingual Spanish-speaking women seeking mental health services for trauma-related symptoms, in community mental health settings, where adequate structures and resources are in place to provide consultation and interview in their native language.

Table 1 summarizes demographic data for the 27 participants who completed initial interviews for this study. Participants ranged in age from 18 to 52, with a mean age of 38. They endorsed between less than 1 year and 30 years in residence in the US, with 13.5 being the mean number of years in residence. Nine of the 27 (33.3 percent) indicated they spoke some English (a range of fluency levels were represented but further specific data on this was not collected in this research study).
Table 1. Demographics of the study group

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Range (Minimum- Maximum)</th>
<th>Mean Group Score (N=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
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<td>38.41</td>
</tr>
<tr>
<td>Years In US</td>
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<tr>
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<tr>
<td>(other than Spanish)</td>
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<td></td>
</tr>
<tr>
<td>Some English</td>
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</tr>
<tr>
<td>Indigenous Language</td>
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</tr>
<tr>
<td>No other Language</td>
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<td>63</td>
</tr>
<tr>
<td>Number of Children</td>
<td>0-9</td>
<td>3.52</td>
</tr>
<tr>
<td>Has Spouse or Partner</td>
<td>13</td>
<td>48.1</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number of Participants</th>
<th>Percentage of Sample</th>
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<tr>
<td>Educational Attainment</td>
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<td>Primary School</td>
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<tr>
<td>Middle School</td>
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<tr>
<td>High School</td>
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<td>37</td>
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<tr>
<td>Some College</td>
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<td>3.7</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td>Bachelors or Above</td>
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<td>3.7</td>
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<tr>
<td>Employment</td>
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<td>Full Time</td>
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<tr>
<td>Part Time</td>
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<td>25</td>
</tr>
<tr>
<td>Unemployed</td>
<td>16</td>
<td>59.3</td>
</tr>
<tr>
<td>Consider self Religious</td>
<td></td>
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<tr>
<td>Identifies as</td>
<td>24</td>
<td>88.9</td>
</tr>
<tr>
<td>Practices</td>
<td>18</td>
<td>66.7</td>
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<tr>
<td>Uses to Cope</td>
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<td>70.4</td>
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Table 1. Continued

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<thead>
<tr>
<th>Demographic</th>
<th>Number of Participants</th>
<th>Percentage of Sample</th>
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<tr>
<td>Prior Therapy</td>
<td>18</td>
<td>66.7</td>
</tr>
<tr>
<td>Prior Group</td>
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<tr>
<td>Prior Trauma Education</td>
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<td>40.7</td>
</tr>
<tr>
<td>When Trauma(s) Occurred</td>
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<td></td>
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<tr>
<td>Childhood alone</td>
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<tr>
<td>Adulthood alone</td>
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<tr>
<td>Both</td>
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<td>33.3</td>
</tr>
<tr>
<td>Frequency of Event(s)</td>
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<td></td>
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<tr>
<td>Only one time</td>
<td>11</td>
<td>40.7</td>
</tr>
<tr>
<td>Multiple Episodes</td>
<td>16</td>
<td>59.3</td>
</tr>
</tbody>
</table>

One participant indicated she spoke an indigenous language fluently in addition to Spanish. All other participants (63 percent) spoke only Spanish.

Participants endorsed having between 0 and 9 children, with the mean number of children being 3 to 4. Roughly half (13 out of 27 or 48.1 percent) indicated that they were currently married or living in a spousal-type arrangement with another person. No data was collected in this study on sexual orientation and participants were not asked to specify the sex of their spouse.

Participants endorsed a range of educational backgrounds, with the modal endorsement being high school completion. Twenty-four of the 27 participants (88.8 percent) said they had completed high school or less, and only 3 participants indicated any post-secondary education.

Fifty-nine percent of the participants indicated that they were unemployed at the time of the interview (16 out of 27); 25 percent (7) indicated that they were employed part-time, and 14 percent (4) indicated full-time employment.
Twenty-four out of 27 (88.9 percent) self-identified as religious or having significant spiritual beliefs; 18 (66.7 percent) said they were active practitioners of their faith or spiritual beliefs, and 19 (70.4 percent) said they relied on religious or spiritual beliefs to help them cope with life problems.

Eighteen of the 27 participants (66.7 percent) indicated they had participated previously in some form of individual therapy or counseling. Thirteen (48 percent) indicated they had previously participated in some kind of support or therapy group. The types of groups endorsed included alcohol and drug related support groups, domestic violence recovery support groups and parent-training groups. Eleven of the participants (40.7 percent) indicated that they had previously heard about or discussed emotional trauma in one of these two settings.

Six (22 percent) of the participants indicated that the traumatic experiences in their lives had occurred in childhood only. Twelve (44.4 percent) indicated that their traumatic events had occurred in adulthood only. Nine (33.3 percent) endorsed traumatic events in both childhood and adulthood. Eleven participants (40.7 percent) said that the traumatizing event or sequence occurred only once, whereas 16 (59.3 percent) endorsed having experienced multiple traumatic episodes.
Measures

There were several significant factors considered in the selection of measures to be used in this study. One issue was the relative lack of quality Spanish-language versions of trauma-focused measures. At present there is a general lack of well-normed and rigorously developed Spanish-language adaptations of standard mental health measures. As a consequence, options for this research project were restricted when compared to the options available to researchers working with English-speaking trauma survivors. All of the measures used in this protocol are vulnerable to Type II error (failure to reject the null hypothesis when it should have been rejected). A practical example of this is making the decision not to assign a diagnosis of PTSD based on lack of congruence between the individual’s culturally determined reporting style and the catalogue of symptoms available on the measure.

Another factor considered in choosing measures was whether the available translation for a measure was congruent for the target population. For example, measures using standard Mexican Spanish translations would be favored over Western European or Castilian Spanish (Spanish spoken in Spain) language translations. Also considered were whether norm samples used to validate the measure included a significant group of Latina women; whether the instrument allowed for an adequate range in respondent age and level of educational attainment; and whether the measure had been included in previous research with comparable groups or comparable protocols.

One primary goal of the SEP protocol is to provide symptom relief. Self-report of symptom reduction is positively associated with better long-term health outcomes for trauma survivors (Harvey, 1996). To address this content area, two self-report clinical measures -- the Posttraumatic Diagnostic Scale (PDS; Foa, 2009) and the Brief Symptoms Inventory–18 (BSI-
were selected for inclusion in the interview protocols. Other measures chosen for inclusion were either specific to the TREM and SEP protocol or were constructed by the researcher, as described below.

**Clinical Symptom Measures**

*Posttraumatic Diagnostic Scale.* The Posttraumatic Diagnostic Scale, or PDS, is a DSM-IV-referenced measure designed to help clinicians diagnose PTSD. The PDS is also intended for use in monitoring treatment progress. Items 1 through 21 serve to verify that the respondent experienced a traumatic event that involved actual or threatened death or injury to themselves or others and that left them feeling fearful and helpless. This portion of the measure includes items such as yes or no endorsements of specific types of trauma, ranging from sexual assault by a known assailant or stranger to experiencing combat or imprisonment. Items 22 through 38 focus on specific symptoms associated with PTSD, and respondents are asked to indicate whether they are experiencing a symptom and with what frequency. Items ask for a Likert-scale frequency rating of several common symptoms in the domains of reexperiencing (for example, items include questions about flashbacks and nightmares), avoidance (items include questions about memory difficulties, active avoidance of reminders, and decreased interest in formerly enjoyable activities), and arousal (for example, items include questions about hypervigilance, emotional agitation, and tendency to startle easily). Items 39 through 49 describe the duration of the experienced symptoms and the degree to which symptoms are interfering with the respondent’s daily life and functioning. Items in this portion ask the respondent to endorse time frames related to onset and duration of the current symptoms as well as to identify specific areas of her life (work, relationships, sex life) that have been impacted by the trauma experience.

The PDS yields three results:
(1) Whether a diagnosis of PTSD can be established based on the six criteria specified in the DSM-IV (e.g. the individual has experienced at least one traumatic event, they endorse an adequate number of symptoms in the domains of reexperiencing, avoidance, and arousal, the symptom duration is no less than six months, and significant distress or impairment in daily functioning is endorsed);

(2) The level of impairment experienced by the respondent as a consequence of the endorsed traumatic events. This is a severity ranking of “none, mild, moderate, or severe” based on totals from Likert-scale endorsements on symptom items. Clinical cutoffs for each ranking level were determined by Foa and colleagues, using “clinical judgment and experience with 280 female assault victims, and 96 female assault victims with chronic PTSD” [PDS Manual, p. 10]).

(3) The severity of symptoms experienced by the respondent, also ranked as, “no rating, mild, moderate, moderate to severe, or severe.”

The PDS manual includes a norm-referenced scoring system, however the reliability of this system is drawn wholly from a single study (n=248) and some information about the study is omitted in the manual which makes it difficult to determine the representativeness of that sample. Latino and other minority populations may be under-represented and the sample was regionally restricted (limited to five East coast states). On the other hand, certain demographic characteristics of the norm group parallel the demographics participants in this current study. For example, a higher percentage of the norm group participants subscribed to the Catholic faith than is considered representative of the general population (Brewin, 2005). Also, a significant portion of the sample were women, some of whom were referred to the study by PTSD treatment clinics, women’s shelters, trauma centers and residential rehabilitation centers, indicating it is likely that
A community mental health population was adequately captured in the data set. This measure has also been used with participants in studies of the TREM Model (Morrissey, Jackson, Ellis, Amaro, Brown, & Najavits 2005).

A significant caveat is that the version of the PDS used in this study was not published by the original author of the measure. A publisher-endorsed Spanish-language translation of the measure does not yet exist. The version used in this study was encountered in an article in the Psychological Assessment Journal titled the "Psychometric comparability of English- and Spanish-language measures of anxiety and related affective symptoms." (Novy, Stanly, Averal, & Daza, 2001). In this article, the process used to develop the translation is described in detail. Limitations include that the test group was composed largely of college students. However, appropriate techniques were used in the development of the translation, including the use of multiple accredited translators, back translation, and field testing with lay panels. This translation follows the format of Foa’s original PDS in that it includes 49 items. Novy et al.’s psychometric data on the translated version indicates a high and acceptable degree of correlation between language versions; Avoidance scale correlation using Pearson’s \( r = .73 \); Re-experiencing scale \( r = .78 \); Arousal scale \( r = .87 \); and Symptom Severity scale \( r = .82 \). Chronbach’s alpha scores of .92 (Foa, 2009) and .93 (Novy et al., 2001) were also reported for the 17 items used to calculate the Symptom Severity Score, indicating that this index has high internal consistency (with significance >.01).

Foa’s PDS is considered a conceptually and psychometrically sound screening instrument based on DSM-IV criteria, with tests of convergent validity, internal consistency, inter-rater reliability and test-retest stability well within acceptable ranges. Novy et al.’s translation was assumed to share similar characteristics based on its congruence with the original PDS. The PDS
translation was designed specifically with the use of household Spanish in mind and with a goal of making the measure usable with individuals with a sixth-grade reading level. This version is used in the study with permission from Dr. Novy and colleagues (personal communication, Tuesday May 5th, 2009, 2:17 pm). To obtain a copy of this instrument, please contact Dr. Novy and colleagues at dnovy@mdanderson.org. Standard scoring from the original PDS was applied to the translated version to generate the scores reported in this dissertation.

Brief Symptoms Inventory-18. The Brief Symptoms Inventory-18 (or BSI-18) was also selected for inclusion in the study protocol. The BSI-18 was deemed to be an appropriate choice because a publisher-endorsed Spanish Language translation existed. The BSI-18 has a significant development history and strong psychometric properties. The four scales generated by the BSI-18 also provided a degree of content overlap with the PDS such that overlapping response items could be compared and discussed.

The BSI-18 is a screen for psychological distress and psychiatric disorders in medical and community populations. The measure is an 18-item self-report symptom inventory designed to serve as a screen for psychological distress and psychiatric disorders (BSI manual, p. 1). The measure was designed for use with individuals 18 years of age and older who are not currently assigned a mental health diagnosis. The instrument employs a 5-point Likert-type scale ranging from 0 (not at all) to 4 (extremely) to assess three symptom dimensions: Somatization (SOM), Depression (DEP), and Anxiety (ANX). A Global Severity Index (GSI) is also calculated based on all 18 responses. The SOM subscale score measures “distress caused by the perception of bodily dysfunction, focusing on symptoms arising from cardiovascular, gastro-intestinal and other physiological systems” (manual, p. 5). The DEP subscale score measures “core symptoms of various syndromes of clinical depression, such as apathy, dysphoria, and suicidal ideation
The ANX subscale measures “symptoms prevalent in most major anxiety disorders, such as nervousness, tension, and apprehension” (manual, p. 5).

The history of the development of the BSI-18 and its related measures (the 53-item BSI, and the 90-item Symptom Checklist-90) is extensive. The author explains that the screening tool evolved from the Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974). The BSI-18 has the distinct advantage of being significantly shorter than the prior manifestations of the measure. The author indicates that the 18 items selected for the screening represent about 80% of the psychiatric disorders that occur in a primary care practice setting. Internal consistency reliability estimates for the BSI-18 were derived from a community sample, and alpha coefficients for the three symptom scales and the Global Symptoms Index are considered acceptable (SOM =.74, DEP =.84, ANX =.79, and GSI=.89). These estimates compare favorably with those derived from the 53-item version of the BSI, whose coefficients are based on a larger study sample (719 psychiatric outpatients). Test-retest reliability estimates range from .68 to .84 on the three symptom scales (participants were 60 non-patient individuals), however period of time between testing is not specified. The GSI test-retest estimate was .90. While current evidence of the validity of the BSI-18 is limited, correlations between the scales with corresponding scales on the SCL-90-R are all high: SOM=.91, ANX =.96, DEP =.93 and GSI=.93.

Two norm groups are offered by the technical manual and scoring software: a community norm (based on a “community sample,” otherwise described as 1,134 adult employees of an unspecified U.S. Corporation) and an oncology norm (based on a sample of 1,543 cancer patients). Gender-keyed norms for each sample group are offered and strongly recommended for use by the author. A limitation of this measure is that the BSI-18 manual does
not describe the minimum reading level required to complete the instrument. While reading level of the instruments chosen was of general concern, interview strategies including oral administration by the researcher with the supplementary use of culturally syntonic Likert-scale art (see appendix D), were deemed adequate measures to abate concerns regarding the appropriateness of this measure given the anticipated literacy levels of the participants.

The BSI-18 should be interpreted on three interrelated levels. First at the global level, a determination is made whether or not the respondent meets predetermined risk criteria for distress, (e.g. their scores fall in the clinical range). Next, scale scores are evaluated in a prescribed order: first DEP, then ANX, then SOM. Scale scores falling within the clinical range (T>63) indicate that the respondent should undergo further screening for need of intervention in that area. Finally, responses may be reviewed item by item, with particular attention to key items such as those related to high-risk behaviors (e.g. item 17 relates to suicidal ideation) or high levels of incapacitation (items 9, 12, and 18 all relate to the experience of panic attacks). Please contact publisher, Pearson Assessments, for a copy of this instrument.

Protocol-Specific Measures

Another goal of SEP is to increase the participants’ selection and ideation of behavioral and coping strategies that reduce risky behaviors and contribute to a participant’s sense of empowerment and overall well-being. Measures to track the participant’s progress toward more adaptive behavioral choices and positive coping strategies were therefore included in the study. Two of these were originally written by Maxine Harris PhD and Roger Fallot PhD, clinician-researchers involved in significant research on TREM. These measures have a limited history of use and one (The Trauma Recovery and Empowerment Scale, or TRES) has shown limited sensitivity to change in previous TREM studies. However, both measures directly addressed SEP
goals in a theory-congruent manner. For this reason the Trauma Recovery and Empowerment Scale (TRES) and the Trauma Recovery and Empowerment Profile (TREP) were used.

Inclusion of both of these measures required original translations to be contracted. The process included back-translation and “field-testing.” The original English version of each instrument was translated to Spanish with the help of two translators, and then the translation was re-translated into English and checked against the original for linguistic congruence. Any language discrepancies were resolved in consultation with the translators, an author of the SEP protocol, and an additional bilingual reader with expertise in trauma recovery. The Spanish version of the questions were then “field-tested” with a small group of SEP participants (N=6) who were completing a pilot SEP group at Conexiones Clinic. Feedback from the group was then integrated into the final version of the translations. For a copy of the original measures, please contact Dr. Fallot and Maxine Harris at communityconnections.org. Translations have been redacted from this document to protect copy rights of the original authors, but can be obtained from the researcher upon request (berd1209@pacificu.edu). The sections below give further detail regarding these scales, as well as protocol-specific derived scales that were constructed by the researcher specifically for this study, and other scales written by the researcher for the purposes of capturing data related to cultural aspects of change and participant satisfaction.

*Trauma Recovery and Empowerment Scale (TRES).* The TRES is a self-report measure consisting of 25 items, all of which relate to the construct of self-protective behavior and adaptive measures for self-soothing, including interpersonal relationship skills and cognitive strategies for monitoring intrapsychic states. The responses on the scale are not divided into domains. Instead, a global score is created. The higher the overall score achieved, the more skillful the respondent reports being in the areas of self-care and positive coping. According to
the author of the original measure, there are no cutoffs or benchmarks on this instrument. Previous clinical samples have failed to show significant changes on this scale. The mean item score in previous studies using the measure is 3.5, and little change of significance was recorded using TRES with the clinical populations in those studies (Fallot, personal communication on Friday, November 5, 2010, 9:46 am).

**Trauma Recovery and Empowerment Profile (TREP).** The TREP is a clinician report instrument in which 11 dimensions are considered and responded to on a Likert-Scale with behaviorally specific anchors. The 11 dimensions considered by the clinicians are Self-Awareness, Self-Protection, Self-Soothing, Emotional Modulation, Relational Mutuality, Accurate Labeling of Self and Others, Sense of Agency and Initiative Taking, Consistent Problem Solving, Reliable Parenting, Possessing a Sense of Purpose and Meaning, and Decision Making and Judgment. The instrument was originally used in DCTCS studies by clinicians seeing TREM group participants in individual therapy. In the present study, the instrument was instead used as a periodic evaluation to be completed jointly by the group facilitators. This creates a validity concern in that the facilitators were asked to assess client progress based on their own work with the client. However this validity concern was deemed acceptable in this descriptive study as it parallels therapist progress and self-assessment tasks often performed in community mental health settings. For the TREP, there are no clear benchmarks, and scores are expected to vary considerably depending on the particular population. The TREP instrument was used in past studies to yield a continuous measure, with a mean score for the 11 dimensions representing the individual’s score at a given time. In the DC site of the Women and Violence Project (2001) TREP scores for the participants in the TREM protocol increased over the course of 12 months from 1.86 to 2.56, which offers a preliminary standard of .7 for a change score of
possible significance. As no other reasonable benchmark has emerged, all protocol specific scales, including the TRES, TREP, constructed scales that rely on content from these two measures (e.g. Awareness, Coping and Behavior Scales), and scales originally created by the author (e.g. Culture and Participant Satisfaction Scales), use this benchmark as the standard of possible significance.

*Awareness, Coping and Behavior Scales.* Because the researcher was interested in change in the specific domains of awareness level, coping level and behavior (e.g. level of pro-coping behavior) the decision was made to construct three scales using the items from the TRES and TREP to create domain specific measures of change. These three scales have not been used in other studies of the TREM or SEP, so no psychometric data particular to these scales can be reported. There was also no use of statistical convention, such as factor analysis, in deciding what items to include in each scale, and there is some content overlap between scales. The items were instead grouped based on researcher judgment about the domains in question, using clinical experience, consultation, and knowledge from literature reviewed. The benchmark score of .7 was also used in discussing the significance of change scores when comparing these scales on tables summarizing participant outcomes. A caveat regarding the way these scales are constructed is that the scores calculated for Baseline and Times 2 include the same TREP domain scores (e.g. scores from the first clinician ranking, conducted within the first 8 weeks of the protocol).

While Coping and Behavior scales can be more concretely and unambiguously operationalized (items in the Coping domain largely have to do with cognitive-level practices and beliefs, whereas items in the Behavior domain are descriptive of specific actions taken or not taken in response to stressors or as a means of self-protection and self-care), what is meant by
“awareness” in this study requires greater description and articulation. It can be argued that multiple categories of awareness are important in the recovery process: Awareness of trauma facts (as achieved through psychoeducational components of SEP) is one type of awareness. A second type, which is operationalized by the Awareness Scale, might also be described as “self-awareness.” This includes awareness of how internal experiences are shaped by traumatic experiences and one’s ability to identify links between one’s trauma history and one’s characteristic responses to stress. The Awareness Scale used here is focused primarily on this second type of awareness, although there is some item content related to trauma awareness. A list of the items included on each of these scales was originally contained in appendices of this document, but has been redacted to protect the copy rights of the original authors of the TRES and TREM. To obtain a list of items contained by each of these constructed scales, please contact the researcher (berd1209@pacificu.edu).

**Culture Scale.** An additional interest of the researcher and of the authors of the SEP model was to consider whether or not the SEP protocol, when delivered with high fidelity, would adequately address culturally informed maladaptive cognitions, to the extent that participants could reformulate these cognitions into more adaptive ones. For this reason, a “Culture Scale”, henceforth referred to as CULT in this document, was written for inclusion in the protocol. The items were informed by themes identified in recent qualitative works with survivors regarding the impact of culturally-informed ideologies about abuse and victimhood on the self-concept and healing process of Latinas subsequent to abuse (Ahrens, Rios-Mandel, Isas, & del Carmen Lopez, 2010; Ligíero et al, 2009; Marshall et al, 2009) as well as the literature on culturally specific values for Latinos (Chong, 2002; Santiago-Rivera et al., 2002; Gil & Vazquez, 1996). The five cultural items are listed in Appendix B. All cultural items were reverse-scored for the
purposes of scoring congruence with score reporting on other measures. Higher scores on summary tables reflect lesser agreement with maladaptive culturally informed trauma related cognitions.

Participant Satisfaction. An additional question addressed by this project was whether or not the participants would find the SEP group satisfactory. In particular, the researcher wanted to know whether the participants would find the group and its facilitators helpful in gaining recovery and coping skills, as well as understandable and available as needed; whether the participants would recommend the group to a friend; and what types of feedback could be offered about experienced barriers to participation. To gather this information several participant satisfaction items were written in consultation with organizational psychologist and expert, Jay Thomas, PhD, and included in Time 2, 3, and 4 interviews. Please see Appendix B for Participant Satisfaction items.

SEP Fidelity Scales. Another significant concern of the study was whether the SEP protocol could be administered with fidelity in an outpatient community mental health setting. The instrument used to determine fidelity level was a SEP-specific revision of the Trauma Recovery and Empowerment Fidelity Scale (Fallot & Harris, 2003). The revision was created by SEP co-author Fabiana Wallis, PhD (2009). The revision includes all of the original dimensions of the TREM Fidelity Scale, and adds criteria and dimensions related to the proscribed treatment of culturally specific content. Fidelity rankings are performed through live observation or video sampling, and tallies of facilitator actions that contribute to each domain are then ranked on a Likert-type 5 point scale with explicit criteria-informed anchors. The dimension titles are Structure, Leaders, Training, Content, Control, Activity, Question/Comment Ratio, Session Structuring, General Psychoeducation, Trauma Education, Cultural Referencing, Empowerment
and Affirmation, Positive Problem Solving, Leader Style, and Goal Achievement. Anchor descriptions for each of these 15 domains are too elaborate and numerous to describe here. However, in general, adequate adherence to the protocol in each domain area results in a ranking of 4 or higher. The authors of the original TREM Fidelity Scale indicate that the instrument had no absolute cutoff, but in general the target score for each dimension on the scale was also 4 or above. Fidelity scores of 4.5 were considered strong and those of 4.75 were considered very strong. Experienced TREM group leaders obtained fidelity rankings ranging from 4.04 to 4.93 (Fallot, personal communication on November 5, 2010, 9:46 A.M) on the original TREM-based fidelity measure. The SEP-based version of this fidelity instrument is likely more stringent (meaning scores will skew lower than on the TREM-based version used in previous studies), as several domains are more concretely articulated with regard to culturally explicit skills and content demands. For a copy of the SEP-based Fidelity measure, please contact the author at fwallisphd@comcast.net.
Apparatus

In the initial interview all potential participants were given an explanation of the study, its contingencies and commitments as well as an orientation to the informed consent document. All participants were given a Spanish-language copy (see Appendix C). The informed consent document included permissions to video record participants during select groups, as well as to follow-up with participants if they decided to drop out of the group. The groups were offered to participants free of cost. If an individual agreed to become a participant after this orientation, the initial survey questionnaire was administered. Questions on this survey were targeted to obtain relevant demographic data (see Appendix B for these items), level of symptom distress (using the PDS and BSI-18), participant’s baseline knowledge of trauma and abuse, and strategies for coping (using demographic items related to coping strategies, treatment history and the TRES).

The rest of the study design mirrors the structure of SEP, which is delivered in three phases (Empowerment, Recovery and Advanced Recovery), such that participants were asked to complete a survey interview in each phase of the group. Questionnaires administered at Times 2, 3, and 4 were identical in content and included the following: PDS (items 22-49); the BSI-18; the Cultural Scale; TRES; a “questionnaire difficulty” item (e.g. “How hard was it for you to answer the questions on this survey?”); and Participant Satisfaction Items. To increase incentive to participate in study interviews, $10 gift cards to local stores selected by the participants were given out after the completion of interviews 2, 3, and 4.
Therapist rankings of individual group participant progress on 11 different recovery dimensions of the TREP were also performed once during each phase of the treatment. Table 2 summarizes the included components for each interview.

Table 2: Interview Format Times 1 through 4

<table>
<thead>
<tr>
<th>Interview Component</th>
<th>Baseline</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Form</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographic Information</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment History</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD Scale Diagnostic Questions</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD Scale Symptom Checklist</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>BSI-18</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TRES</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Participant Satisfaction</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Questionnaire Difficulty</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TREP (facilitator completed)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Exit interviews were attempted with all participants who dropped groups and all participants of defunct groups. Exit interview questions were designed to be brief. Participants were asked about specific barriers they experienced to participation. Exit interviews conducted over the phone used the “Exit Interview Questionnaire” (See Appendix B) as a script.

Fidelity scales were also employed during each phase of group. The facilitators were consulted on rankings of “Context Items” on the fidelity scales after groups 8, 15 and 24. Two independent raters who had received training in the model and on the fidelity instrument then
ranked the content of videotaped sessions using the Group Items portion of the form. While 3 recordings were planned for each group (to occur once within each phase of the protocol) only one group achieved adequate momentum to participate in fidelity rankings.

Data gathered during the study period was coded and entered for analysis using the Statistical Packet for Social Sciences (SPSS) software. As the study was descriptive in nature, descriptive and frequency functions were primarily used to explore the dataset. The apparatus for analysis was also amended due to a high level of attrition during the study (see attrition section of results in this document), such that data profiles for completing participants were explored using a case study format, with identifying information removed or altered to protect participant privacy.
RESULTS

Topic 1: Clinical Characteristics of the Initial Study Group

Table 3 summarizes the clinical characteristics of the study group at the time of the baseline interview. Participant’s endorsements on the Global Symptoms Index (GSI) of the BSI-18 show a mean T-score of 68.85 and a median score of 73. The range of individual scores achieved on this index was 33 to 81 (38 points). In this sample, 21 of the participants (77.7 percent), scored in the clinical range with T-scores of 65 or higher. Endorsements on the Depression Index (DEP) show a mean T-score of 68.15 with a median score of 71. The range of individual scores achieved on this index was 40 to 79 (39 points). Twenty-two of the participants (81.5 percent of the sample) fell in the clinical range, with T-scores of 65 or higher. On the Anxiety Index (ANX), the mean score for the group was 65.30 and the median score was 67. The range of individual scores was 38 to 81 (43 points). Nineteen of the participants (70.4 percent) scored in the clinical range with T-scores of 65 or higher. On the Somatization Scale (SOM) the mean score for the group was 66.07 and the median score was 68. The range of individual scores was 41 to 79 (38 points). Nineteen of the participants (70.4 percent) scored in the clinical range with T-scores of 65 or higher.

Twenty of the 27 participants (74 percent) met criteria for PTSD on the PDS. On symptom severity items, 5 scored in the moderate range (18.5 %), 13 scored in the moderate to severe range (48.1 percent) and 9 scored in the severe range (33.3 percent). On impairment related items, 1 participant endorsed no impairment (3.7 percent), 2 endorsed mild impairment (7.4 percent) 3 endorsed moderate impairment (11.1 percent) and 21 endorsed severe impairment (77.8 percent).
Table 3. Baseline Clinical Characteristics of the Sample

<table>
<thead>
<tr>
<th>Clinical Indicator on BSI</th>
<th>Range (T-Scores)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Symptoms Index</td>
<td>33-81</td>
<td>68.85*</td>
</tr>
<tr>
<td>Depression Index</td>
<td>40-79</td>
<td>68.15*</td>
</tr>
<tr>
<td>Anxiety Index</td>
<td>38-81</td>
<td>65.30*</td>
</tr>
<tr>
<td>Somatization Index</td>
<td>41-79</td>
<td>66.07*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Indicator on PDS</th>
<th>Number of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Diagnosis at Baseline</td>
<td>20</td>
<td>74.1</td>
</tr>
</tbody>
</table>

Severity of Symptoms

- **Moderate**: 5 participants (18.5%)
- **Moderate to Severe**: 13 participants (48.1%)
- **Severe**: 9 participants (33.3%)

Impairment Level

- **None**: 1 participant (3.7%)
- **Mild**: 2 participants (7.4%)
- **Moderate**: 3 participants (11.1%)
- **Severe**: 21 participants (77.8%)

<table>
<thead>
<tr>
<th>TRES</th>
<th>Range (Item Score)</th>
<th>Mean Item Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.2-4.12</td>
<td>3.39</td>
</tr>
</tbody>
</table>

* Clinical Range on this Scale is T>63.
Participant endorsements on the Trauma Recovery and Empowerment Scale (TRES) at baseline yielded a mean item score\(^4\) of 3.39 and a median score of 3.36. The range of individual mean item scores was 2.2 to 4.12 (1.92 points on a 5 item Likert-type scale). Twenty-two of the participants (85.2 percent) endorsed mean item scores of 3 or higher (indicating mostly moderate and higher levels of agreement with pro-recovery items on this measure, and moderate and lower levels of agreement with anti-recovery items).

**Topic 2: Attrition**

*Attrition and Participant Specific Barriers*

Initial high levels of attrition can largely be attributed to institutional barriers (see the Attrition by Group section of this topic area). Other causes include the need for auxiliary services like child care, transportation or relative distance of living/work quarters from the nearest clinic, difficulty with remembering to attend early groups (and no outreach from the group leaders in the form of check-in or reminder phone calls). In general, very few individuals who engaged in the study enough to attend at least one group endorsed any social reasons for discontinuing group. All but one individual who completed the early exit interview indicated they would happily participate in such a group again and would recommend such a group to a friend. Of the women who left the study early, 13 were interviewed using the Exit Interview schedule, whereas 12 were not interviewed due to difficulties with follow-up (change in phone numbers or addresses, or inability of the researcher to reach the person by phone or in person after multiple attempts). The data captured in exit interviews show that the early attrition group breaks down into two general categories: women who expressed ongoing interest and availability to the group but who experienced institution-generated barriers (e.g. the group that

\(^4\) The mean item score is calculated by dividing the total raw score achieved on the measure by the total number of items (25). This score is reported here to aid comparison with scores reported in other studies on this instrument (DCTCS studies), where the mean item score was used.
they planned to participate in was not launched or closed down early due to low attendance; and women who endorsed multiple barriers and indicated interest in the group but a lack of ability to participate due to practical considerations such as timing of the group in relation to other activities, lack of child care, and lack of transportation.

In Table 4, participant endorsements of barriers are presented. Attrition group data consists of responses given on exit interviews by the 13 exiting participants who could be reached, and Completion group data consists of responses given on participant satisfaction items included in the surveys.

Table 4. Comparison of Barriers for Attrition and Completion Group

<table>
<thead>
<tr>
<th>Personal Barrier Type</th>
<th>Attrition Group (n=13)</th>
<th>Completion Group (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation Problems</td>
<td>7 (53%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Lacked Childcare</td>
<td>7 (53%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Work Schedule</td>
<td>6 (46.2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Illness (self or family)</td>
<td>5 (38.5%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Conflict with Other Activity</td>
<td>3 (23.1%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>Didn’t Like Previous group</td>
<td>2 (15.4%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Disliked Theme That Day</td>
<td>1 (7.7%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Felt Afraid to Come</td>
<td>2 (15.4%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Felt Too Sad/Mad/Depressed</td>
<td>2 (15.4%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Forgot—Needed Reminder</td>
<td>5 (38.5%)</td>
<td>1 (20%)</td>
</tr>
</tbody>
</table>

A visual inspection of the data reveals that attrition group participants experienced higher levels of barriers in all domains except the general category of “conflict with other activity” (e.g. an
activity that is not work or child-care related). The most significant barriers for the attrition group appear to have been transportation (53 percent), child care (53 percent), work (46.2 percent), illness related (38.5 percent) or having forgotten to attend (38.5 percent). For the Completion group, the most significant barrier to attendance appears to have been conflict with other activities (40 percent -- or 2 out of 5 endorsed this concern).

Attrition and Demographics

Table 5 allows for a visual comparison of the attrition group (n=22) for which Baseline data was gathered and the completion group (n=5). On continuous variables, the mean score for each group is presented, and on categorical variable, the total number of participants falling into each category (with the corresponding percent) is listed. The scores on this table reveal that two groups are relatively similar. A larger sample is required to determine if the slight differences in the categories of age, number of children, educational attainment level, religious life, and exposure to previous therapy are actually significant. It appears that the largest difference between the completion and attrition group is that 45.5% of the attrition group spoke other languages (9 said they spoke some English and 1 said she spoke a regional indigenous language), whereas the entire Completion group endorsed being monolingual Spanish-speakers. Generally, it can be said that there are very few other differences between the attrition group and the completion group based on demographic variables.
### Table 5 Demographic Comparison of Attrition and Completion Groups

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Attrition Group (n=22)</th>
<th>Completion Group (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>37.41</td>
<td>42.8</td>
</tr>
<tr>
<td>Years In US</td>
<td>13.57</td>
<td>13.6</td>
</tr>
<tr>
<td>Languages spoken (other than Spanish)</td>
<td>10 (45.4%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Educational attainment (high school or higher)</td>
<td>10 (45.4%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Number of children (mean for group)</td>
<td>3.59</td>
<td>3.2</td>
</tr>
<tr>
<td>Marital status (Percent with partner or significant other)</td>
<td>10(45.5%)</td>
<td>3(60%)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td>3 (13%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Part Time</td>
<td>6 (27.3%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>13 (59%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Consider self religious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies as</td>
<td>19 (86%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Practices</td>
<td>14 (63.6%)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Uses to cope</td>
<td>14 (63.6%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Prior therapy</td>
<td>14(63.6)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Prior group</td>
<td>10 (45.5%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Prior trauma education</td>
<td>8 (36.4 %)</td>
<td>3 (60%)</td>
</tr>
</tbody>
</table>
**Attrition and Clinical Data**

Table 6 includes baseline clinical data in the same format on continuous and categorical variables as on Table 5.

Table 6. Comparison by Baseline of Attrition and Completion Groups

<table>
<thead>
<tr>
<th>Clinical Scale</th>
<th>Attrition Group (n=22)</th>
<th>Completion Group (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Diagnosis (meets all criteria)</td>
<td>16 (72%)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Symptoms Severity Score (max=51)</td>
<td>29.73</td>
<td>27.6</td>
</tr>
<tr>
<td>Symptoms Severity Ranking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>8 (36.4%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Moderate-Severe</td>
<td>10 (45.5%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Moderate</td>
<td>4 (18.2%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Level of Impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>17 (73%)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Moderate</td>
<td>2 (9.1%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Mild</td>
<td>2 (9.1%)</td>
<td></td>
</tr>
<tr>
<td>No Impairment</td>
<td>1 (4.5%)</td>
<td></td>
</tr>
<tr>
<td>Number of Types of Traumatic Experience (max=16)</td>
<td>13.68</td>
<td>12.40</td>
</tr>
<tr>
<td>BSI Global Index (mean T-Score)</td>
<td>69.73</td>
<td>65</td>
</tr>
<tr>
<td>BSI Depression Index (mean T-Score)</td>
<td>68.55</td>
<td>66.4</td>
</tr>
<tr>
<td>BSI Anxiety Index (mean T-Score)</td>
<td>65.77</td>
<td>63.2</td>
</tr>
<tr>
<td>BSI Somatization (mean T-Score)</td>
<td>67.05</td>
<td>61.8</td>
</tr>
<tr>
<td>TRES</td>
<td>3.37</td>
<td>3.48</td>
</tr>
<tr>
<td>Culture Scale</td>
<td>3.49</td>
<td>3.08</td>
</tr>
</tbody>
</table>
The scores reveal that both groups are highly similar in their baseline endorsements on clinical measures. On the BSI Scales there may be some evidence that index scores for the attrition group is slightly higher (differences in t-scores range from 2.1 to 5.9), the largest difference between the groups being on the SOM Index (Attrition Group mean T= 67.05, Completion Group mean T= 61.8), but the sample size is not adequate to determine if this constitutes a difference of statistical or practical significance. The similarity of these two groups of women necessitates further exploration of person-specific and context specific variables for the two groups.

Attrition by Group

The attrition data makes most sense when viewed in the context of what occurred in each group setting. For a summary of general barrier-types experienced in launching study groups, as discussed in this section see Table 7.

Group 1. The Program Hispano or MIOS group (Group 1) reached the initial screening phase of the project, but an institutional barrier was experienced that prevented the launch of the group. Upon reviewing the curriculum, Catholic Charities (a partner organization of MIOS program) identified that the mission of their organization was at odds with Session 8 content (Sex with a Partner) because the protocol guide discusses birth control (condoms). The organization initially agreed to support a revised version of the group with that session omitted, but subsequently withdrew this offer when the Catholic Charities board expressed an additional concern that the overall tone of the protocol transmitted a “apparent advocacy of or openness to pre-marital sex” (personal communication from Special Projects Program Manager Nathan Teske on November 30th, 2009, 4:45 pm) that could not be redacted by modifications or session
omissions. At this point, MIOS program support (in the form of space and manpower) was withdrawn. This decision was made after Programa Hispano employees had already participated in trainings for the study, and after significant efforts had been made by both research volunteers and MIOS staff to promote the group with clients on that program’s waitlist⁵.

**Group 2.** The Morrison Center Gresham group experienced organizational barriers in the form of a protracted process for establishing approval from the organization’s administrators to run the group using space donated by Morrison. Initially, there was a need to justify providing support to a project that would not be charging money. The clarification involved explaining that as a dissertation project the researcher believed that generating revenue from the group would not be appropriate. A second hurdle was experienced when the individual in charge of reviewing and approving projects left while the application was still in review, and the new reviewer required that the information be resubmitted. The financial concerns of this community mental health agency precluded use of the group rooms during many of the prime hours during the week, so the group service was scheduled for Saturday mornings. The slow and encumbered institutional approval process for this organization also resulted in a later than expected launch of this group, so that Part 1 of the protocol spanned the holiday season. This, in combination with inclement weather, resulted in low turnout for the fourth, fifth and sixth sessions (some participants traveled out of town to see relatives) at which point the group facilitators decided to discontinue the group. The facilitators’ training stage also was a factor in the decision. The delayed launch for this group was de-motivating to student trainees for whom group facilitation commitments became too burdensome when the planned schedule dovetailed

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⁵ Early discussions about potential research on the SEP with the MIOS client population occurred when the researcher was a student therapist with the program, and the co-author of the protocol, Dr. Wallis, was the MIOS program director. The recognition that there were significant needs for this type of group in the non-insured, monolingual Spanish-Speaking immigrant community helped create the momentum for this project; that is to say the project was planned, in part, as a response to the express needs of the MIOS program client population.
with a change of training phase (e.g. a move from practicum-level to internship-level training). This facilitator pair was also similar to that of group 4 (discussed below) in that both were non-native Spanish speakers. In supervisions, the facilitators expressed concerns about their ability to monitor for group understanding of concepts presented, as well as some felt difficulties with rapport, as their physical presence, cultural identities, and social-status set them apart from the group participants in a way that was difficult to adequately redress at the outset of group.

Group 3. The PSC group was the most successful group in this study. The group launched with slightly lower than ideal numbers (n=6 for the first few groups) but the facilitators for this group were able to continue to promote the group and screen participants in, so that there were eight participants for the first phase of group. The attrition rate for this group was also much more in keeping with norms for groups in general. However, this site also experienced some significant issues related to space coordination and the lack of availability of bilingual support staff. Reception support was necessarily conducted by the researcher at this site until a routine was established for participants. Occasional space conflicts at the busy clinic also required additional coordination efforts, as the group needed to be moved on a number of occasions. Also, the physical plant of the group spaces accessed were typically less than ideal, with heavy tables that needed to be removed for each group in order to achieve enough floor space for a circle of chairs. By the end of phase 1, the group had six members. By the end of phase 2, the group had solidified to include five core members, all of whom completed the 25-session protocol. In the results section, a detailed case-by-case discussion of the experience and outcomes reported by these five participants is included.

Group 4. (The Iris Clinic group) had a later start than the other groups. The primary difficulty with this site appeared to be in recruitment of participants. The group started out with a
list of 20 referrals, but in the screening process several of these individuals indicated they could not

Table 7. Comparison of Site Characteristics and Barriers

<table>
<thead>
<tr>
<th>Barrier Source</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Program Mission/Ideals</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Match to study mission</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Resources (space, materials, staff)</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Complex Permission Process</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Bilingual Support</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Unnatural Population for Site</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Facilitator Specific Variables (training, scheduling &amp; commitments)</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Season/Schedule Barriers</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

X indicates that this factor was present for the group labeled in column heading.

commit to a 25-week course due to significant barriers related to child care, transportation and work schedule conflicts. There were also coordination issues due to the location of the site, and limited availability of on-site volunteers to assist with participant screenings and interviews. This site also had the most difficult of the four sites in finalizing a facilitator team. Initially, a native Spanish speaker was to be paired with a non-native facilitator, but the native speaker dropped from out due to other life and school related pressures. A second non-native speaker
then joined the facilitator team. Of the six individuals who agreed to participate beyond the screening (performed by the native speaker, prior to her decision to withdraw), only two consistently showed up to the first three sessions. A third indicated interest but immediately had difficulty due to changes in a work schedule. By the fourth week the two student facilitators indicated that they believed the group should be closed down due to coordination issues and low participation. Discussion in team supervisions regarding the impact of facilitator characteristics on the delivery of this material to Latina participants revealed concerns that the group attrition was not only associated with the length of time required to start the group, but also with the level of facilitator confidence regarding language skills.

This study intended to test hypothesis regarding participant outcomes (on awareness, coping, and behavioral change), participant satisfaction and overall symptom reductions in addition to capacity to deliver the model at fidelity. However, due to the attrition across three of the four groups, this researcher was unable to perform analysis as planned. The decision was made to instead use a case study format to qualitatively explore the experiences of the five women in the completed group. As a result, all of the hypothesis, except the hypothesis related to fidelity, are explored through a qualitative review of measures, group notes, facilitator reports, videos, and researcher direct interactions with the participants. Fidelity is discussed next (Topic 3), and then case studies are explored in the remainder of this results section.

Topic 3: Fidelity

Hypothesis one stated that local providers trained in the SEP would be able to run groups with fidelity rankings of 70% or higher.

This appears to be true for the group that ran to completion. This group had high fidelity rankings, consistently above the 70% fidelity goal. Inter-rater reliability for the fidelity rankings
was above .9 for individual scales and there was 100 percent concordance in total scaled score derived by adding weighted scale scores. See Table 8 for fidelity rankings by group phase.

An explanatory caveat about the presentation of scores on Table 8 is that a significant contributing scale (the Content Scale) is scored based on the number of sessions completed in the 25 session protocol, with earlier sessions achieving lower rankings on that domain simply due to their earlier placement in the protocol sequence. From the perspective of interest in the overall landscape of the group’s fidelity rankings, a score that includes the Content dimension is of interest, but from the perspective of viewing the session as a snapshot in time and an independent unit to be measured for fidelity against the model, the Content dimension has the effect of erroneously suppressing the total fidelity score for sample sessions occurring earlier in the overall sequence. The researcher therefore deemed it useful to calculate the scaled score for the overall fidelity of each sample group twice, once with the content scale included in the weighted calculation, and once with it removed. Both score sets are presented, as score ranges, in the table 8. While the more stringent criteria (e.g. the calculation that includes the Content dimension) is considered in the rest of the document and discussed in terms the floor of scores obtained on this measure (e.g. the percent fidelity low score was 73 percent, obtained when videos of Group 7), a more revealing score for this session may actually be the one obtained with the Content score removed, making the floor of scores notably higher: The percent fidelity low score would in this case be 81 percent.

The total scaled score for the fidelity ranking for Phase 1, which was performed by two raters viewing a video recording of Session 7 (Intimacy and Trust) while applying the fidelity ranking instrument, yielded a raw score of 106 when the Content dimension ranking was included in the total score and 102 when the Content dimension ranking was omitted.
Table 8. Group 1 Fidelity Rankings

<table>
<thead>
<tr>
<th>Phase/Session</th>
<th>Scaled Score</th>
<th>Raw Score</th>
<th>Percent Fidelity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Empowerment (Group 7)</td>
<td>102-106</td>
<td>3.87</td>
<td>73-81%</td>
</tr>
<tr>
<td>Phase 2 Recovery(12)</td>
<td>119-127</td>
<td>4.4</td>
<td>87.6-91%</td>
</tr>
<tr>
<td>Phase 3 Advanced-Recovery (19)</td>
<td>111-123</td>
<td>4.27</td>
<td>84.8-88.8%</td>
</tr>
</tbody>
</table>

This means that the group appeared to be performing the protocol with 81% fidelity when viewing the group as a stand-alone unit, and with 73% fidelity in the context of the whole protocol. For the second phase (Recovery), Session 12 (What is Sexual Abuse?) was ranked by the same method. A raw score total of 119 was achieved with the Content dimension ranking included, and a raw score of 127 was achieved when the Content dimension ranking was omitted. These scores yielded fidelity percent rankings of 87.6 percent and 91 percent. For Phase 3 (Advanced Recovery) Session 19 (Self-Destructive Behaviors) was scored. The total raw score with the Content dimension ranking included was 111, and the total score with the Content dimension ranking omitted was 123. These scores yielded fidelity percent rankings of 84.8 percent and 88.8 percent.

Previous studies using the comparable TREM fidelity instrument include the DCTCS Women and Violence Study Project, in which experienced clinicians were reported to have achieved scores ranging from 4.04 to 4.93. The raw scores calculated here appear to be somewhat lower, with the range being 3.87 to 4.27 (calculated using all 15 dimensions) but are still well within the acceptable range.
Table 9 summarizes the raw scores achieved for the different dimensions of the fidelity scale for the 3 phases of Group 3. Again, because no other group in the study continued beyond the initial groups in the Empowerment phase of SEP, the researcher was unable to capture the data required to perform parallel fidelity rankings on these other groups.

Table 9. Group 3 Fidelity Domain Scores

<table>
<thead>
<tr>
<th>Dimension Title</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Leaders</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Training</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Content</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Control</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Activity</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Question/Comment Ratio</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Session Structuring</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>General Psychoeducation</td>
<td>5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Trauma Education</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Cultural Referencing</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Empowerment and Affirmation</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Positive Problem Solving</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Leader Style</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Goal Achievement</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
For the dimension of Structure, the degree to which the session format matches the model was considered. High rankings require a session to have appropriate structure in terms of frequency, length, number of participants, and number of leaders. A ranking of 5 (all three sessions received this score by the raters) means that for each session, the group met weekly for 75 minutes, with 3 to 10 participants and 2 to 3 leaders.

For the dimension of Leaders, the degree to which leaders demonstrate appropriate language fluency and understanding of linguistic and cultural nuances is observed. At least one of the leaders present in all 3 ranked sessions met the following criteria: native fluency or high proficiency in Spanish, regular use of “dichos” or sayings, elicitation of words or cultural expressions, and the capacity to adjust word-choice to match group member literacy levels. All three sample groups were given a ranking of 5 on this dimension.

For the dimension of Training, the raters observed the degree to which the leaders have had training and access to supervision. The score for this dimension was the same for all three sessions because both leaders met and exceeded the criteria of having participated in six or more hours of SEP training conducted in Spanish. The leaders also participated in on-site peer supervision weekly, and monthly peer supervision with an expert in the model.

For the dimension of Content, the raters observed the degree to which sessions covered the content areas specified in the SEP manual. Scores here reflect sequential progress through the model. For the session sampled in phase 1 (session 7), the content ranking was 1, indicating that fewer than 8 sessions had as yet been covered in order. (Covered is further defined here as having completed at least 75% of the material outlined in the manual for a particular session.) For the session sampled in Phase 2 (group 12), the content ranking was 2, as only 8-14 of the
sessions had been completed. For the session sampled in phase 3 (group 19), the content ranking was 3, as only 15-19 of the sessions had been completed.

For the dimension of Control, the rater observed the degree to which the group leaders controlled the content, affect and process of the group by redirecting and/or allowing some processing when necessary. For the sessions sampled during Phases 1 and 3 a ranking of 3 was given, indicating that there were two or three instances in which a group member presented with tangential material or monopolized the discussion and the leaders did not achieve redirection within three minutes. For the session sampled during Phase 2, the ranking was 5, indicating that no more than one instance of this type of difficulty was observed.

For the dimension of Activity, the raters observed the degree to which the group leaders control the content, affect, and process by talking frequently without dominating. For sessions sampled in Phases 1 and 2, the ranking was 5, indicating that leaders made an appropriate number of comments (more than 70, but fewer than 140). For the session sampled in Phase 3, the ranking was 1, because the group leaders made an excessive number of comments (175; the anchor for this score specifies that leaders made either fewer than 35 comments or more than 160).

For the dimension of Question to Comment Ratio, the raters observed whether leaders made declarative statements with a psychoeducational bent more frequently than they ask questions. The questions and comments tallied and considered in this dimension do not include cultural psychoeducational statements presented as questions (these are considered under the dimension of culture). For sessions considered in Phases 1 and 2, the score was 3, indicating that between 1/3 and 2/3 of the leaders’ comments were questions. For the session considered in
Phase 3, the score was 5, indicating that less than one-third of the leaders’ comments were questions.

For the dimension of Session Structuring, the raters observed the degree to which the group leaders enhanced the safety and predictability of the group by clarifying the agenda and flow of the session through comments like “In today’s session we will be talking about physical abuse,” or “After we define some concepts, we will talk about the emotions that go along with the experience of trauma,” or “This exercise will last 15 minutes and then we will discuss your reactions,” or “Next week we will talk about self-esteem.” For all three of the groups sampled, the ranking was 5, indicating a high degree of structuring occurred. The anchor specifies eight or more structuring comments in each session. For the session rated in Phase 1 the actual total for statements of this type was 23, for the session rated in Phase 2 the actual total was 9; for the session rated in Phase 3 the actual total was once more, 23.

For the dimension of General Psychoeducation, the raters observed the degree to which the group leaders defined and clarified key terms and concepts outside of the trauma-specific and cultural-specific content. The actions ranked in this dimension include explaining patterns of thinking, feeling, and behaving, making interpretations to help meaningful themes emerge, as well as assisting the group in developing shared language and understanding of common experiences. Examples include comments like, “When I talk about compulsions, I am referring to behaviors that we constantly repeat and that are out of our control, like for example, eating compulsively,” or “One aspect of having good boundaries is knowing the difference between what other people want from us and what we want for ourselves,” or “Part of self-esteem is considering yourself a person of value,” or “Healthy relationships help improve our self-esteem.” The scores for the sessions sampled in Phases 1 and 3 were both 5, indicating that the facilitators
made eight or more defining, clarifying, explaining, or interpreting comments in a session. For
the session sampled in Phase 2, the ranking was 3, indicating that leaders made between four and
seven comments. The actual tallies for the sessions sampled in Phases 1 and 2 were both 20; for
the session sampled in Phase 3, the actual tally was 31.

For the dimension of Trauma Education, the raters observed the degree to which the
group leaders maintained a psychoeducational stance through interventions such as providing
information about trauma and explaining common trauma-related experiences (e.g. defining flash
backs, citing prevalence data, describing common responses to abuse or violence); describing
specific links of mechanisms between experiences of trauma and sequelae (e.g. “Abuse can make
you feel vulnerable in relationships because you may feel afraid of how your partner might
react”); and accurately labeling members’ experiences (e.g. “When someone forces you to have
sex, this is rape”). For all three sampled sessions, the score on this dimension was 5, indicating
that leaders made six or more trauma-specific psychoeducational interventions in each session.
The actual tallies for each session (in order) were 11, 16, and 17.

For the dimension of Cultural Referencing or Cultural-Specific Education, the raters
observed the degree to which the leaders facilitated the discussion of the role of culture in trauma
recovery. This is accomplished by providing information about culture and discussing common
culture-related experiences (e.g. citing research focused on Latinas, making reference to cultural
norms, values and constructs, describing common cultural responses to abuse or violence);
describing specific links and mechanisms between experiences of trauma and culture (e.g. “As
women we don’t just suffer in the house, but also outside of the home when we are discriminated
against because we are Latina.”) and using culturally specific materials and resources. In the
session sampled in Phase 1, the dimension could not be given a ranking, as there was not a single
instance of culture-specific psychoeducational intervention identified by either rater. For the session sampled in Phase 2, the ranking was 5, indicating that the leaders made at least four culture-specific interventions (the actual tally was 5 for this group). For the session sampled in Phase 3, the ranking was 3, indicating that the leaders made two to three culture-specific psychoeducational interventions (actual tally was 3).

For the Empowerment and Affirmation Dimension, the raters observed the degree to which the group leaders responded to and encouraged members’ strengths and affirmed the value of the members’ experiences. Examples offered include phrases like “That was very well said,” or “The fact that you can tell us about your experience is a testament to how brave and strong you are,” or “You absolutely had a right to take care of yourself in that situation,” or “That was a very creative solution,” or “Knowing that you are doing so much better now gives us all a lot of hope,” or “This is a very good idea; we will add that to the list,” or “Great question.” For all three sessions sampled here, a ranking of 5 was made in this dimension, indicating that leaders made six or more affirming responses in each session. Actual tallies in order are 13, 15 and 24.

For the dimension of Positive Problem Solving, the raters observed the degree to which group leaders maintained the stance that members’ problems can be addressed and solved effectively. Leader interventions that invite solution-oriented discussions and that reinforce specific ways of responding are tallied. Examples offered include “How could you make yourself feel better, in a healthier way?” or “That is something very important to remember during your recovery process,” or “We are looking for healthier ways to get what we desire,” or “You are dealing with that problem in a very different way than you did when you started this group.” For both sessions sampled in Phase 1 and Phase 2, the ranking on this dimension was 1, indicating that group leaders made two or fewer problem solving interventions in each session.
For the dimension of Leader Style, the raters observed the degree to which the facilitator team’s style matched the following description of desired characteristics: Leaders (1) showed strong interpersonal engagement skills, (2) communicated hopefulness, optimism and encouragement, (3) used a persuasive and appropriately definitive tone, (4) were emotionally expressive and enthusiastic about the session materials, (5) drew clear, direct lessons from the session goals, and (6) were culturally competent. For all three sessions, the Leader Style score was 5, indicating that the team consistently expressed four or more of these style characteristics.

For the final dimension of Goal Achievement, the raters observed the degree to which the group achieved stated session goals. For this dimension, both the raters’ impressions of the videotaped session and the facilitator progress notes for that session were considered. In the session sampled for Phase 1, goals were to deepen understanding of intimacy and clarify conditions that support intimacy and trust. Both raters’ rankings of the video content and facilitator comments in the progress note for that session demonstrate that the session achieved these stated goals to a significant degree, so a score of 5 was given. For the session sampled in Phase 2, goals were to define sexual abuse and to understand its emotional impact. Both raters’ observations of the video and facilitator progress notes offer support for the conclusion that this session also achieved all of its stated goals to a significant degree, so a score of 5 was given. For the session sampled in Phase 3, goals were to explore what precipitates self-abuse, discuss self-destructive behaviors, and identify alternative reactions. According to raters’ assessments of
videos and facilitator progress notes, only 4 of the 5 goals were discussed, and only half of these were achieved to a significant degree. This session was ranked as a 3.

**Topic 4: Participant Outcomes**

As discussed earlier in this document, high levels of attrition prevented exploration of data in planned analysis related to the hypothesis that SEP participants would demonstrate gains in awareness, coping and behavior domains. Furthermore, visual inspection of the score patterns of participants who did complete the entire protocol (n=5) reveals significant heterogeneity. Intermediating characteristics of each participant’s presentation at the outset of treatment, and of events occurring in their lives during the study, appear to also be important in understanding and interpreting score patterns. The low n, the diversity in score profiles, and the heterogeneity of participant characteristics necessitate an exploration of the datasets in context. To facilitate a greater understanding of participant outcomes, a case-presentation format is utilized from this point forward.

A summary of each participant’s demographic characteristics, contextual-support characteristics, and trauma-history characteristics is presented first (See Table 9 for highlights). Next, participant specific themes, as indicated by group progress notes, videos and qualitative observations by the researcher during interviews, are identified. A case-wise description of scores, both on self-report measures (TRES, PDS, BSI, and the Culture Scale) and on the facilitator-generated profiles (TREP) is provided. Once the case for an individual participant has been adequately described, gains in Awareness, Coping and Behavior will be discussed within the participant specific section by answering the following three questions:

1. Did participation in SEP increase her awareness about the impact of trauma and abuse?
(2) Is there evidence that she learned skills to increase coping?

(3) Is there evidence that her participation resulted in significant behavior changes in a positive (pro-recovery) direction?

**Baseline Data for Cases**

Table 10 is a summary of the demographic characteristics and a general description of the presenting problems for the five women who completed the protocol. The names of the individuals have been changed to protect their identity, and in some cases, details of the presenting concern were modified (generalized to a category or type of experience). Rankings on the PDS (including whether or not the person met criteria for PTSD), and on the BSI-18 scales are listed in the right hand column of the table.

**Table 10. Case-wise Demographics and Baseline Data**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Demographics and Context Factors</th>
<th>Baseline Rankings and Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Magda”</td>
<td>Age at interview: 46</td>
<td>PTSD Diagnosis: Yes</td>
</tr>
<tr>
<td></td>
<td>Number of years in US: 12</td>
<td>Level of Impairment: Severe</td>
</tr>
<tr>
<td></td>
<td>Ethnic ID: Mexican</td>
<td>Symptom Severity Rating:</td>
</tr>
<tr>
<td></td>
<td>Religious Practice: Yes, Pentecostal</td>
<td>Moderate to Severe</td>
</tr>
<tr>
<td></td>
<td>Education: High School</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marital Status: Separated</td>
<td>GSI Score: 73</td>
</tr>
<tr>
<td></td>
<td>Number of Children: 2</td>
<td>DEP Score: 71*</td>
</tr>
<tr>
<td></td>
<td>Employment Status: Unemployed</td>
<td>ANX Score: 65*</td>
</tr>
<tr>
<td></td>
<td>Mental Health Treatment: Support Groups in 2009</td>
<td>SOM Score: 73*</td>
</tr>
<tr>
<td></td>
<td>Type(s) of Events: sexual aggression by a family</td>
<td>High Score Item Content:</td>
</tr>
<tr>
<td>Participant</td>
<td>Demographics and Context Factors</td>
<td>Baseline Rankings and Scores</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td></td>
<td>member, physical aggression by a family member, sexual contact as a minor, mortal illness, homelessness, racism and discrimination.</td>
<td>*Scores in the clinical range feeling lonely, nauseated, blue, and weak in certain parts of the body.</td>
</tr>
<tr>
<td></td>
<td>Most Traumatic Event: Loss of pregnancy</td>
<td></td>
</tr>
<tr>
<td>“Lola”</td>
<td>Age at interview: 35</td>
<td>PTSD Diagnosis: Yes</td>
</tr>
<tr>
<td></td>
<td>Number of years is US:18-19</td>
<td>Level of Impairment: Severe</td>
</tr>
<tr>
<td></td>
<td>Ethnic ID: Mexican</td>
<td>Symptom Severity Rating:</td>
</tr>
<tr>
<td></td>
<td>Religion: Yes</td>
<td>Moderate to Severe</td>
</tr>
<tr>
<td></td>
<td>Education: High School</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marital Status: Married</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of Children: 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employment Status: Part Time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Treatment: Consults every other week with child and family therapist for family therapy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Type(s) of Events: Sexual aggression by a family member, sexual aggression by a stranger, sexual contact as a minor, racism and discrimination, spousal infidelity, discovery of sexual abuse between family members</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Most Traumatic Event: Discovery of abuse of a</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>Demographics and Context Factors</td>
<td>Baseline Rankings and Scores</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>“Flora”</td>
<td>Age at interview: 44</td>
<td>PTSD Diagnosis: incomplete</td>
</tr>
<tr>
<td></td>
<td>Number of years is US: 15</td>
<td>Information—too few</td>
</tr>
<tr>
<td></td>
<td>Ethnic ID: Mexican</td>
<td>endorsements of Arousal-</td>
</tr>
<tr>
<td></td>
<td>Religion: Yes, Catholic</td>
<td>related items.</td>
</tr>
<tr>
<td></td>
<td>Education: 5th grade</td>
<td>Level of Impairment: Severe</td>
</tr>
<tr>
<td></td>
<td>Marital Status: Married</td>
<td>Symptom Severity Rating:</td>
</tr>
<tr>
<td></td>
<td>Number of Children: 5</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Employment Status: Unemployed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Treatment: Sept-Oct 2009, Individual therapy</td>
<td>GSI Score: 33</td>
</tr>
<tr>
<td></td>
<td>Type(s) of Events: grave accident involving automobile, emotional abuse from a family member regarding physical disability related to the accident, sexual aggression by a family member, Economic abuse/ control by a family member</td>
<td>DEP Score: 40</td>
</tr>
<tr>
<td></td>
<td>Most Traumatic Event: car accident and subsequent physical disability</td>
<td>ANX Score: 38</td>
</tr>
<tr>
<td></td>
<td>High Score Item Content:</td>
<td>SOM Score: 41</td>
</tr>
<tr>
<td></td>
<td>None—no symptoms endorsed</td>
<td></td>
</tr>
<tr>
<td>Vera</td>
<td>Age at interview: 51</td>
<td>PTSD Diagnosis: Yes</td>
</tr>
<tr>
<td></td>
<td>Number of years is US: 13</td>
<td>Level of Impairment: Severe</td>
</tr>
<tr>
<td></td>
<td>Ethnic ID: Chilean</td>
<td>Symptom Severity Rating:</td>
</tr>
<tr>
<td>Participant</td>
<td>Demographics and Context Factors</td>
<td>Baseline Rankings and Scores</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>Religion: Yes</td>
<td>*Scores in the clinical range</td>
</tr>
<tr>
<td></td>
<td>Education: Bachelors Degree</td>
<td>Severe</td>
</tr>
<tr>
<td></td>
<td>Marital Status: Divorced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of Children: 1</td>
<td>GSI Score: 81*</td>
</tr>
<tr>
<td></td>
<td>Employment Status: unemployed</td>
<td>DEP Score: 79*</td>
</tr>
<tr>
<td></td>
<td>Mental Health Treatment: 1999-2006, individual and group</td>
<td>ANX Score: 78*</td>
</tr>
<tr>
<td></td>
<td>High Score Item Content:</td>
<td>SOM Score: 74*</td>
</tr>
<tr>
<td></td>
<td>Feeling no interest in things,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeling lonely, feeling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>worthless, feeling hopeless</td>
<td></td>
</tr>
<tr>
<td></td>
<td>about the future</td>
<td></td>
</tr>
<tr>
<td></td>
<td>discrimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Most Traumatic Event: Hospitalization in which she felt in mortal peril and helpless to respond</td>
<td></td>
</tr>
<tr>
<td>“Nora”</td>
<td>Age at interview: 38</td>
<td>PTSD Diagnosis: Yes</td>
</tr>
<tr>
<td></td>
<td>Number of years is US:9</td>
<td>Level of Impairment:</td>
</tr>
<tr>
<td></td>
<td>Ethnic ID: Mexican</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Religion: Yes</td>
<td>Symptom Severity Rating:</td>
</tr>
<tr>
<td></td>
<td>Education: 6th Grade</td>
<td>Moderate to Severe</td>
</tr>
<tr>
<td></td>
<td>Marital Status: Married</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>Demographics and Context Factors</td>
<td>Baseline Rankings and Scores</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>*Scores in the clinical range</td>
<td></td>
</tr>
<tr>
<td>Number of Children: 5</td>
<td>GSI Score: 65*</td>
<td></td>
</tr>
<tr>
<td>Employment Status: Full Time</td>
<td>DEP Score: 65*</td>
<td></td>
</tr>
<tr>
<td>Mental Health Treatment: None</td>
<td>ANX Score: 67*</td>
<td></td>
</tr>
<tr>
<td>Type(s) of Abuse: Witnessing sexual assault and physical abuse of her daughter by significant other, racism and discrimination, loss of family housing due to interpersonal conflict with landowner.</td>
<td>SOM Score: 55</td>
<td></td>
</tr>
<tr>
<td>Most Traumatic Event: loss of housing</td>
<td>High Score Item Content: feeling lonely, feeling blue</td>
<td></td>
</tr>
</tbody>
</table>

“Magda”

*Baseline data.* The client referred to as “Magda” self-identified as a 46-year-old, monolingual Spanish-speaking Mexican woman who, while unemployed at the time of her initial interview, was actively seeking employment. Magda reported in her qualifying screening interview a history of physical abuse, domestic violence, depression, anxiety, difficulty with mood, as well as interpersonal difficulties and dissociative experiences (indicating, “Sometimes, I don’t know where I am”). In this interview Magda also denied any history of suicidal or homicidal ideation or substance abuse, and was rated by the screener as “low-risk.”

In her Time 1 interview, Magda reported being recently separated (within a year of initial interview) and that she had no children. She reported no history of incarceration. She also reported that she was just becoming more regularly involved with faith group meetings, and that
her religious beliefs and practices were helpful to her in resolving life problems. Magda also indicated that she had never participated in individual therapy, but had participated in support groups on domestic violence (in the previous year), in which the emotional trauma was discussed.

Magda’s initial disclosures regarding her trauma history (on the PDS) revealed that she had been assaulted physically by members of her family or someone known to her, that she had been raped or sexually assaulted by a member of her family or someone known to her, and that she had experienced verbal aggression and emotional abuse by someone in her family or someone known to her. Magda provided details regarding her most traumatizing life-episode that included the loss of a pregnancy subsequent to physical violence by a member of her family, a hospitalization in which she felt she was in mortal peril, an institutional experience in which racial discrimination may have influenced her care, and eviction from her home followed by a period of homelessness and shelter-living. She reported that this occurred between 1 and 3 months prior to her interview. Based on this presentation, Magda was classified as having entered the group while in the “Early” phase of recovery. Magda was also viewed as suffering from Complex Trauma, where current symptom presentation is precipitated by multiple traumatic events over time.

Magda’s self-reports of her trauma history and experienced symptoms in the domains of re-experiencing, avoidance, and arousal all indicated a diagnosis of PTSD. Magda’s symptom severity was rated Moderate to Severe, because in 7 of the 12 symptoms endorsed, she ranked them as occurring 5 or more times a week, or almost always. Magda endorsed almost always having nightmares about the traumatic events, feeling emotionally disturbed when remembering the events, always trying not to talk about or have feelings about what occurred, always trying to
avoid activities, people, and places that reminded her of the event, always feeling as though she won’t be able to accomplish plans or dreams for her future, always having difficulty getting to sleep and sleeping through the night, and always or almost always having difficulty with concentration. Her level of impairment was also rated as severe, because she endorsed impaired functioning generally in all areas of her life.

In her initial interview on the BSI-18, Magda scored in the clinical range on all 4 indices. Her score on the GSI (T=73) was in the 98th percentile using community norms; her score on the ANX Index (T=65) was in the 93rd percentile. Her score on the DEP Index (T=71) was in the 98th percentile, as was her score on the SOM index (T=73, 98th percentile).

On the TRES, her mean score was 3.46 indicating self-endorsement of a low to moderate level of insight, awareness, and behavior related to coping, self-protection, and recovery skills. After two months of contact (during which she attended 5 out of 8 groups), the facilitators jointly ranked her on the 11 dimensions of the TREP7 and produced a mean score of 2.58, indicating that in their assessment, she had demonstrated a low to moderate level of skill in key areas related to effective coping with trauma.

Her endorsements of culturally-driven nonadaptive beliefs about trauma were split on the 5-item culture scale, producing a mean score of 2.6. On one hand she endorsed total agreement (1) that she needs to control or hide her feelings of agitation about abuses that she has experienced, (2) that it is better to not think about the damages of the past, and (3) that a good

---

6 The mean score in DCTCS study from which the scale is referenced was 3.5
7 Self-Awareness, Self-Protection, Self-Soothing, Emotional Modulation, Relational Mutuality, Accurate Labeling of Self and Others, Sense of Agency and Initiative Taking, Consistent Problem Solving, Reliable Parenting, Possessing a Sense of Purpose and Meaning, and Judgment and Decision Making
8 In the DCTCS study of women in violence from which this scale is referenced, the initial mean score for participants was 1.86. While this may indicate a lower degree of skill was present with that group, it is also significant that the raters using this instrument in that study were individual therapists, not the group facilitators. The higher scores seen with this treatment group may be a function of the tendency for the group-involved clinician to have a higher appraisal of the individual’s skill-set based on context specific contact (e.g. judgments were rendered based on in-group interactions and not based on other sources of input).
woman copes and moves forward in her life regardless of the abuse she has experienced. She endorsed total disagreement with these statements: (1) A woman should endure difficulties in life without complaint, and (2) Bad things that have happened were pre-ordained or prescribed by “fate.”

Before comparing Magda’s baseline scores to scores from subsequent interviews, it is necessary to comment on the quality of the interview experiences with her. Magda generally presented as being somewhat distressed and guarded, even avoidant, particularly during early interview interactions. Additionally, midway through interviews 1, 2, and 3, Magda appeared to experience some disintegration, either needing items to be repeated multiple times (reporting difficulty tracking the question content) or becoming tearful and tangential, endorsing a deficit in coping and the presence of psychiatric symptoms such as intrusive thoughts. The content of these thoughts was reported to be inappropriate responsibility-taking for the actions of others, feelings of extreme guilt, and feelings of self-loathing. Her disclosures about her personal and trauma history were also contradictory in minor ways from one interview to the next, seeming to indicate that particular details held special meaning to her, and for which disclosure (at least initially) seemed too risky. In general, Magda did respond to grounding interventions, and demonstrated tenacity, insisting that she could complete the interviews regardless of her expressions of distress. By the fourth interview, Magda presented as more organized, trusting, and open, referencing relationships with the group facilitators and peers, as well as familiarity and comfort with the interview scenario.

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9 Incidental disclosures in interviews at Time 2 and 4 revealed that Magda actually had 2 children who lived with her, whereas in her initial interview she endorsed having no children. While she had initially denied any history of incarceration in her list of traumatic events, she later disclosed that she actually had experienced a short period of incarceration due to a domestic violence-related assault. Magda also indicated more substantial mental health history later on in the relationship with the researcher, endorsing prior relationships with psychiatric specialists and a history of prior diagnosis and treatment for Bi-polar symptoms, which included homicidal and suicidal thoughts.
Clinical Scores. Table 11 presents her score patterns for the measures administered in the four interview sessions, as well as the mean TREP scores assigned by the group facilitators at 2 months, 4 months, and 6 months into their contact with Magda.

Magda’s score profiles show little change throughout the protocol in most domains, with PDS evaluation of symptom severity and level of impairment continuously assessed in the severe and moderate to severe ranges. While scores on the Severity Index moved down a few points, this change may not be of practical significance. Just as at the outset of treatment, Magda continued to meet diagnostic criteria for PTSD and continued to rank her level of impairment as severe.

On the BSI, similar results were found. Magda’s endorsements of symptoms were stable on the GSI and DEP, and moved only slightly on ANX (in the direction of increased anxiety) and SOM (in the direction of reduced somatic symptoms). For the TRES, CULT and TREP, mean scores appear to show change in the desired pro-recovery direction. Using the .7 as a minimum metric for possibly significant change on these measures, it appears that Magda’s scores changed significantly only on the TREP. While it is not possible to determine whether the changes in the mean scores for these measures is of practical significance, there is evidence she experienced some pro-recovery growth in skills related to coping as assessed by group facilitators (change score =1.1).

On the CULT scale, it appears that recovery-interfering culturally-driven cognitions increased slightly (e.g. in an anti-recovery direction) during her participation in the group protocol. The largest score difference was seen between baseline and Times 2 and 3 scores (both change scores were -.8 from baseline). The main difference appears to be that although Magda totally disagreed that the bad things that had happened to her were predetermined by fate in her
baseline interview, by the end of group she indicated that she was neither in agreement or
disagreement with this statement, or that she believed this to be true half the time.

Table 11. Summary of Magda’s Scores

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Impairment</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>Symptom Severity</td>
<td>Moderate to Severe</td>
<td>Moderate to Severe</td>
<td>Moderate to Severe</td>
<td>Moderate to Severe</td>
</tr>
<tr>
<td>BSI Global T-scores (Percentile)</td>
<td>73 (99)</td>
<td>74 (99)</td>
<td>74 (99)</td>
<td>73 (99)</td>
</tr>
<tr>
<td>BSI – Depression T-scores (Percentile)</td>
<td>71 (98)</td>
<td>66 (94)</td>
<td>77 (99)</td>
<td>70 (98)</td>
</tr>
<tr>
<td>BSI-Anxiety T-scores (Percentile)</td>
<td>65 (93)</td>
<td>70 (98)</td>
<td>67 (94)</td>
<td>70 (98)</td>
</tr>
<tr>
<td>BSI-Somatization T-scores (Percentile)</td>
<td>73 (99)</td>
<td>76 (99)</td>
<td>69 (97)</td>
<td>68 (95)</td>
</tr>
<tr>
<td>TRES (mean score)</td>
<td>3.32</td>
<td>3.68</td>
<td>3.76</td>
<td>3.52</td>
</tr>
<tr>
<td>CULT (mean score)</td>
<td>2.6</td>
<td><strong>1.8</strong></td>
<td><strong>1.8</strong></td>
<td>2.2</td>
</tr>
<tr>
<td>TREP (mean score)</td>
<td>N/A</td>
<td>2.5</td>
<td>2.7</td>
<td><strong>3.6</strong></td>
</tr>
</tbody>
</table>

**Bolded text** on this table indicates a score of potentially significant difference from baseline.

**Participant specific themes.** When the progress notes and other qualitative sources of
data on Magda are compared with those of other participants, it appears that she was the
participant with the most erratic in-group presentation. Repeated characterizations as having
been “dominating” or having encountered interpersonal difficulties with other participants are
present in early session notes, and episodically in later session notes. There also appears to be a movement toward more adaptive interpersonal functioning, interspersed with gestures at withdrawal. Magda’s presentation is also characterized as disorganized to varying degrees throughout, with facilitators observing increasingly quicker reorganization and recovery after an emotional storm as the group progressed. These observations are concordant with researcher observations of Magda in interviews and on video samples of her group participation: In the initial contact with Magda, the researcher encountered her crying uncontrollably in the waiting room before the interview started; during her second interview, Magda presented as guarded for the first 10 minutes and then she disintegrated, becoming tearful and disorganized but recovering with support; At time 3, she experienced episodes of disintegration and endorsed intrusive thoughts but recovered more quickly and with less support; and at Time 4 she presented as smiling, open, eager, and organized. Also notable are facilitator recorded responses to grounding activities. In initial grounding activities Magda appeared to benefit, but needed group support. In a subsequent group, Magda expressed a desire to avoid the Tree Exercise (a grounding activity using guided visualization) after presenting in group with significant disorganization and distress. In the final phase of group, Magda was successful at using more concrete grounding exercises (stretching with the other group members) to assist her in becoming re-organized subsequent to an interview with the researcher that reportedly left her feeling shakier and more anxious than usual at the outset of that group.

In considering endorsed barriers or reasons for missed groups, a theme of isolation as a strategy for avoidance appears to also be significant for Magda. In addition, Magda consistently avoided interaction with themes having to do with sexual activity, sexual abuse, sex life, or assessments of satisfaction related to intimate relationships. In interview sessions, Magda
indicated that she does not have sex, sexual relationships, or interest in discussing or thinking about her sex life or sexual aspects of intimacy with others and accordingly omitted responses on survey items treating these themes.

*Did participation in SEP increase her awareness about trauma and abuse?* Yes. There is evidence that Magda’s awareness of the impact of her trauma and abuse history on her interpersonal and emotional functioning was improved. This is evidenced most directly by her score changes on the derived Awareness Scale (with a change score between baseline and Time 4 of .68, and an even larger change of .75 between baseline and Time 3), but also is indicated by trends in her scores on the more global measures of TREP (on which her change score reaches the benchmark of possible significance at Time 4) and TRES (on which her change scores, while not reaching benchmarks, do consistently trend in a pro-recovery direction).

Table 12. Magda’s Scores on Awareness, Coping and Behavior Scales

<table>
<thead>
<tr>
<th></th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Scale</td>
<td>3.25</td>
<td>3.75</td>
<td><strong>4.00</strong></td>
<td>3.93</td>
</tr>
<tr>
<td>Coping Scale</td>
<td>3.04</td>
<td>3.58</td>
<td>3.69</td>
<td>3.62</td>
</tr>
<tr>
<td>Behavior Scale</td>
<td>3.08</td>
<td>3.08</td>
<td>3.26</td>
<td>3.53</td>
</tr>
</tbody>
</table>

**Bolded text** on this table indicates a score of potentially significant difference from baseline.

*Is there evidence that she learned skills to increase coping?* Yes. While Magda did not accomplish a change score that exceeded the identified benchmark of .7 on the Coping Scale, (her largest change score was .65, between baseline and Time 3 interviews) there are other sources of evidence of her increased coping that amend that finding. Mean score increases on the TREP (1.1) indicate that the facilitators viewed Magda as having significantly improved in
multiple domains on coping skills. Progress notes also show some indications of skill-gain over the course of group. Additionally, qualitative observations by the researcher and facilitators regarding Magda’s progressive improvements in emotional modulation in sessions and interviews also indicate that her coping strategies improved.

*Is there evidence that her participation resulted in significant behavior changes in a positive (pro-recovery) direction?* Yes. Aside from case note evidence of shifts in her in-group presentation and interpersonal practices, and shifts in her demeanor over the course of the interviews, there appear to be a few indications that she was using more pro-recovery coping behaviors at the end of the treatment then at the outset. While the Behavior Scale .7 change score benchmark is not met (the largest change score between baseline and Time 4 is .45), endorsements reveal a consistent increase in score in the desired direction. What is not in evidence is any significant change on self-report measures of symptoms (PDS or BSI-18). Even though Magda appears to have made gains in multiple areas (Awareness, Coping and Behavior) these gains do not appear to have translated to symptom relief during the course of her participation in the study.

“Lola”

*Baseline data.* The participant code-named “Lola” self-identified as a 35-year-old, monolingual Spanish-speaking Mexican woman, who has lived in the US for 19 years. In her screening Lola reported a history of physical abuse, emotional abuse, depression, anxiety, difficulty with mood, and interpersonal difficulties. In her screening, Lola denied any current suicidal or homicidal ideation or substance abuse, but did admit attempts at suicide more than a decade prior to the interview. She was rated as “low-risk.”
In her Time 1 interview, Lola reported that she worked part time, was married, and had 5 children. Lola reported education through high school in Mexico. She endorsed being a religious person (Catholic), currently active in her faith, and said that she relied on faith beliefs to help her cope with problems. Lola also indicated a past history of therapy, citing two episodes; individual therapy ending 2 years prior to the interview, and family therapy on a bimonthly basis, concurrent with her participation in SEP. She also reported past participation in another group (Parent-Training), in which she endorsed having cursorily discussed the topic of trauma.

On the PDS she endorsed having been sexually assaulted or raped by someone known to her as well as by a stranger, sexual contact as a minor, verbal aggression and emotional abuse by someone known to her, as well as repeated exposure to racism and discrimination on interpersonal and institutional levels. Lola’s most traumatizing life episode involved her discovery of both sexual abuse within her immediate family and spousal infidelity by her partner, each revealed within a short window (less than a month apart).

Lola’s endorsed sufficient re-experiencing, avoidance, and arousal symptoms on the PDS to meet criteria for PTSD. Lola’s symptom severity was Moderate to Severe, with 6 of the 17 symptoms endorsed occurring 5 “almost always.” She endorsed almost always having thoughts that bothered her or images of the traumatizing events cross her mind unbidden, feeling emotionally disturbed when remembering the events, not being very interested in participating in activities formerly important to her, always having difficulty getting to sleep and sleeping through the night, and feeling nervous or jumpy most of the time. Her level of impairment was rated as severe, because she endorsed impaired functioning generally in all areas of her life.

Lola initially scored in the clinical range on all 4 scales of the BSI-18. Her score on the GSI (T=73) was in the 98th percentile. Her score on the DEP Index (T=77) was in the 99th
percentile, her score on the ANX Index (T=68) was in the 96th percentile, and her score on the SOM Index (T=66) was in the 95th percentile.

On the TRES, her baseline mean score was 3.64 indicating self-endorsement of a moderate level of insight, awareness, and behavior related to coping, self-protection, and recovery skills. After two months of contact (during which she attended 5 out of 8 groups), the facilitators jointly ranked her on the 11 dimensions of the TREP and produced a mean score of 3.6, indicating that in their assessment, she had also demonstrated a moderate level of skill in key areas related to effective coping with trauma.

Her Time 1 endorsements on the CULT scale produced a mean score of 3.0. She endorsed total agreement that (1) she needs to control or hide her feelings of agitation about abuses that she has experienced and (2) A good woman copes and moves forward in her life regardless of the abuse she has experienced. She endorsed ambivalence (agreeing only sometimes) that it is better to not think about the damages of the past. She endorsed total disagreement with these statements: (1) A woman should endure difficulties in life without complaint, and (2) Bad things that have happened were pre-ordained or prescribed by fate.

Compared with interviews of other participants, Lola’s interview demeanor was organized. She endorsed little or no difficulty in understanding the interview questions, and only occasionally required deviation from the structured interview to assist with containment or emotion regulation. Lola also appeared to be in mid-recovery, having engaged in other therapy services prior to the group, as well as family therapy during the group. However, she also endorsed having daily, unavoidable contact with the people and places most saliently connected to her recent trauma sequence, and so it is possible that during the course of her participation in SEP, traumagenic events continued to occur. For the purposes of this study, Lola was therefore
characterized as being in the “Early to Mid” phase of recovery. Lola also was considered to have complex trauma, with previous traumatic episodes in her life impacting her symptom presentation.

Clinical scores. Table 13 is a summary of Lola’s clinical scores. Lola’s score profile shows change in a positive direction throughout the protocol in most domains, particularly on the BSI-18, TRES, CULT and TREP. However, on the PDS, her symptom severity and level of impairment continuously fell in the moderate to severe range.

Table 13. Summary of Lola’s Scores

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Impairment</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>Symptom</td>
<td>Moderate to</td>
<td>Moderate to</td>
<td>Moderate to</td>
<td></td>
</tr>
<tr>
<td>Severity</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>BSI Global T-scores (Percentile)</td>
<td>73 (99)</td>
<td>63 (88.5)</td>
<td>61 (85.8)</td>
<td></td>
</tr>
<tr>
<td>BSI - Depression T-scores (Percentile)</td>
<td>77 (99)</td>
<td>65 (93)</td>
<td>62 (87.6)</td>
<td></td>
</tr>
<tr>
<td>BSI-Anxiety T-scores (Percentile)</td>
<td>68 (96)</td>
<td>59 (81)</td>
<td>59 (81)</td>
<td></td>
</tr>
<tr>
<td>BSI-Somatization T-scores (Percentile)</td>
<td>66 (95)</td>
<td>61 (84)</td>
<td>59 (81)</td>
<td></td>
</tr>
<tr>
<td>TRES (mean score)</td>
<td>3.6</td>
<td>3.6</td>
<td>3.76</td>
<td></td>
</tr>
<tr>
<td>CULT (mean score)</td>
<td>3.0</td>
<td>3.4</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>TREP (mean score)</td>
<td>N/A</td>
<td>3.59</td>
<td>3.8</td>
<td>4.27</td>
</tr>
</tbody>
</table>

**Bolded text** on this table indicates a score of potentially significant difference from baseline.
While the data set for Lola is incomplete (she did not participate in the Time 4 interview), Lola met diagnostic criteria for PTSD in all complete interviews.

On the BSI scales, some change did occur, with all of her scores falling below clinical cut-offs in her Time 3 interview. Lola’s change score on the TREP is .68, indicating that the change approaches possible significance (benchmark for this study is .7). Growth in skills by her own assessment (TRES) is less remarkable (.16).

On the CULT items scale, it appears that recovery-interfering culturally-driven cognitions decreased, with a total change between baseline and Time 3 of .8. At Time 3 Lola indicated that she mostly or totally disagreed with the statements that (1) she needed to control or hide her feelings of agitation about abuses that she has experienced, (2) it is better to not think about damages of the past, (3) a woman should endure difficulties in life without complaint and (4) bad things that have happened were pre-ordained or prescribed by fate. She continued to agree strongly with the statement that a good woman copes and moves forward in her life regardless of the abuse she has experienced.

*Participant-specific themes.* Themes of low self-esteem, self-blame, withdrawal/inhibition, and mistrust of intimacy (particularly of friendship relationships with other women, but also in the context of her relationships with men) emerge as themes for Lola. Therapist notes from session 1 remark that Lola’s opening statements are “negative and self-deprecating.” Facilitator notes also generally reflect that Lola is often present in group but not contributing much verbally. Video samples of Lola’s participation show a range of engagement, with a lower degree of verbal participation in session 7 and a slightly high degree of verbal participation in sessions 12 and 19.
Facilitator comments regarding Lola’s participation in later sessions detail repeated use of self-blame, with Lola retroreflecting anger more appropriately directed at abusers. Lola’s denial of upsetting feelings towards others was also observed to impede her ability to identify and acknowledge her needs in relationships. One facilitator recalled the group having spent the bulk of a session trying to help Lola notice this pattern, seemingly to no avail. Lola deflected the group members’ efforts, and continued to deny feelings toward others, focusing instead on perceived personal shortcomings. Facilitator notes also recorded that Lola arrived to group for session 12 (on Sexual Abuse) wearing sunglasses and bandages, explaining that she had just completed plastic surgery. Lola described the surgery both as something she had always wanted and as something she had done to assert her right with her husband to spend money on her own wants.

Another of Lola’s primary coping tactic for dealing with relationship difficulties appeared to be interpersonal withdrawal and avoidance. An example of this is found in facilitator notes for Session 16, which recorded her announcement of a plan to withdraw early from the group to enroll in a conflicting activity (English classes scheduled for the same night). This announcement stirred reaction from the other participants and triggered group processing about Lola’s importance in the group. Lola continued participation after this, attending 8 out of the 9 remaining groups. However, facilitator notes reflect meaningful participation in only two of these groups: in session 19 on self-destructive behavior, Lola is attentive to other’s contributions, self disclosing little, but taking copious notes; and in session 23 on Relationships, Lola shared feeling ashamed about putting too much responsibility on others for the abuse that had occurred in the family.
In interviews with the researcher, Lola also indicated a related thematic concern with isolation—reacting with increased emotion and disclosure of betrayals when cued by TRES items related to relationship functioning. For example, when asked if she only passed time with safe people (TRES Item 1), she responded that she passed time with mostly her family, some of whom had been unsafe in the past, and that she does not have any friends due to her feelings of mistrust toward other women. When asked if she felt connected to others, and had friends (TRES Item 4) she responded each time that the item was not applicable or that she did not know how to answer, because she had no friends.

Facilitator comments about her affect during the closing group also provide evidence that Lola struggled with interpersonal trust and attachment. After having spent 24 hours over six months with group members, Lola chose silence, and was characterized as “apathetic” during closing rituals of the final session. Lola also cancelled her interview that day, and did not show up to two attempted reschedulings in the following weeks. One facilitator observed Lola also lacked support from significant family members for her participation, which may have impacted her initial ability to bond with other members, as well as her ability to participate meaningfully in closing rituals.

*Did participation in SEP increase her awareness about trauma and abuse?* No. Her scores on the Awareness Scale (with a change score between Baseline and Time 3 of .17), and on the TRES and TREP do not approach benchmarks of potential significance. Qualitative observations also reflect little or no shifts in her overt endorsement of new awareness about connections between her trauma history and her current functioning.

*Is there evidence that she learned skills to increase coping?* No. When Coping-focused behaviors are evaluated independently using the Coping Scale, there appears to be little
evidence of change in level of coping endorsed (.08). Qualitative data supports the conclusion that Lola continued to use the same coping strategies at the end of treatment that she appeared to be using at the outset, namely self-deprecation, retroflection, and social isolation.

Table 14. Lola’s Scores on Awareness, Coping and Behavior Scales

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Scale</td>
<td>3.96</td>
<td>3.89</td>
<td>4.14</td>
</tr>
<tr>
<td>Coping Scale</td>
<td>3.54</td>
<td>3.46</td>
<td>3.62</td>
</tr>
<tr>
<td>Behavior Scale</td>
<td>3.32</td>
<td>3.63</td>
<td>3.79</td>
</tr>
</tbody>
</table>

*Is there evidence that her participation resulted in significant behavior changes in a positive (pro-recovery) direction?* No. A total change of .47 was achieved on the Behavior Scale, so while Lola did endorse some changes in the pro-recovery direct, the level of change endorsed did not reach the .7 benchmark of possible significance. Qualitative observations support this conclusion: Lola attempted to withdraw early, and effectively did so in a cognitive sense, by reducing her level of participation during the Advanced Recovery phase.

“Flora”

*Baseline data.* The participant code-named “Flora” identified as a 44 year-old, monolingual Spanish-speaking Mexican woman who had lived in the US for 15 years. In her screening she reported a history of physical abuse, domestic violence, depression, and interpersonal difficulties. She denied any history of suicidal or homicidal ideation or substance abuse, and was rated as “low-risk.”

In her Time 1 interview, Flora reported being married, unemployed, and having 5 children. Her employment status was due to physical disability, was a recent change, and was
related to her trauma. She indicated completing her education through primary school in Mexico, and acknowledged a need for oral administration of surveys. Flora also indicated she considers herself a religious (Catholic), and that she actively practiced her religion and relied on her religious beliefs and practices to help her cope with and solve problems. Flora also endorsed having once seen an individual counselor for one month (during the previous year), but stated that she had never previously participated in any type of therapy or support group, and had never discussed the topic of trauma.

Flora’s initially reported she had been in a grave accident (car accident), and she had experienced verbal aggression and emotional abuse by someone known to her. Flora provided details regarding her most traumatizing life-episode that included the loss of a significant degree of mobility (she was only able to walk with a cane) as a consequence of the grave accident. She also endorsed chronic pain. She described a shift in her relationship with family members subsequent to the accident, reporting that emotional abuse by significant family members and their refusal to assist her economically since she had become disabled had compounded her problems. Flora reported that the accident occurred two years ago, and that interpersonal and support system difficulties had been ongoing since that time. For the purposes of this study, Flora was characterized as being in the “Early” phase of recovery.

It is difficult to assess the relative complexity of Flora’s trauma history. At her initial interview, the level of trauma complexity was categorized as “low” since her trauma-related symptom presentation appeared closely linked to her accident. However, during her participation in the Recovery Phase of the group, Flora disclosed more information about past episodes of rape and institutional discrimination that likely also had traumatic impact, and therefore revealed

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10 All interviews with participants were actually conducted orally, in-person, regardless of the person’s reported or assessed literacy level.
increased overall complexity. A distinction between what occurred in Flora’s history and what ultimately informed her trauma-related symptom expression is further complicated by the possible presence of long-term cognitive difficulties. These difficulties might have alternately been a consequence of her car accident since, since little follow-up medical attention had been received, and head injuries were not ruled out. It is likely that some combination of these and other factors, including her lower acculturation level, influenced her identification of traumatizing events and related disclosure decisions. Ultimately, the desire to attune assessment of complexity with Flora’s own self-assessment leaves us with a practical categorization of moderate to low complexity.

Flora’s initial reports of re-experiencing and avoidance met PDS criteria for PTSD, however Flora’s endorsements on arousal symptoms did not. Her symptom severity was rated Moderate, with 4 of the 7 endorsed symptoms occurring “almost always.” Flora endorsed that she always attempts to not to think about or talk about her feelings regarding the event; has much less interest than prior to the event in participating in important activities; feels as though her plans and hopes for the future will not be realized; and has problems falling asleep and sleeping through the night. Her level of impairment was also rated as severe, because she endorsed impaired functioning generally in all areas of her life.

In her initial interview on the BSI-18, Flora endorsed never having experienced most of the items on the measure. Context surrounding the few endorsements that were made on the BSI-18 in subsequent interviews is instructive: in interviews 2 and 3 she indicated that she “frequently” (four or more times a week) felt as though she couldn’t sit still because of physical pain she experienced when sitting for too long. However, Flora consistently denied emotional explanations for any symptoms endorsed on this measure.
On the TRES, her initial mean score was 3.56 indicating self-endorsement of a moderate level of insight, awareness, and behavior related to coping, self-protection, and recovery skills. After two months of contact (during which she attended 7 out of 8 groups), the facilitators jointly ranked her on the 11 dimensions of the TREP and produced a mean score of .89 with omissions on the Reliable Parenting and Judgment and Decision Making Dimensions (facilitators indicated not having enough information about these domains); their rankings indicate that she had demonstrated low skill in key areas related to effective coping with trauma.

Her endorsements on the CULT scale produced a mean score of 3.4. She endorsed total agreement with the statements that (1) A good woman copes and moves forward in her life regardless of the abuse she has experienced and (2) It is better to not think about the damages of the past. She endorsed total disagreement with the statements that (1) a woman should endure difficulties in life without complaint, (2) Bad things that have happened were pre-ordained or prescribed by fate and (3) One needs to control or hide her feelings of agitation about abuses that she has experienced.

In interviews, Flora presented as irritable, taciturn, and withdrawn. She deviated from this demeanor in Interview 3, engaging the researcher in a more extended conversation about the meaning of certain protocol questions, and acknowledging more fully her struggles related to cognition and literacy. In this interview she cued the researcher to assist her in understanding the definitions of words and phrases that were novel to her. Prior to this interview, and in the subsequent interview (Time 4), Flora instead indicated a heightened level of irritability and physical discomfort in the interview scenario. Significantly, Flora was referred after interview 1 for evaluation and treatment of her sleep problems. She was referred after interview 2 for consultation with a pain-specialist. Possibly, access to adequate health care and advice on
appropriate referrals had a positive impact on her condition, such that she was better able to regulate her affect in the Recovery Phase groups and in her Time 3 interview, although facilitators expressed doubt that she actually followed up on these referrals.

Clinical scores. Flora’s scores on the PDS profile (see table 15) indicate that she does not meet criteria for PTSD. This is due generally to her lack of endorsement of symptoms in the arousal domain. She does endorse a reduction in the level of severity on symptoms endorsed in

Table 15. Summary of Flora’s Scores

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Incomplete info</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Impairment</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>Symptom Severity</td>
<td>Moderate</td>
<td>Mild</td>
<td>Mild</td>
<td>Mild</td>
</tr>
<tr>
<td>BSI Global T-scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Percentile)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33 (5)</td>
<td>48 (42.4)</td>
<td>45 (31)</td>
<td>45 (31)</td>
</tr>
<tr>
<td>BSI – Depression T-scores (Percentile)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 (16)</td>
<td>40 (16)</td>
<td>40 (16)</td>
<td>40 (16)</td>
</tr>
<tr>
<td>BSI-Anxiety T-scores (Percentile)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>38 (12.4)</td>
<td>38 (12.4)</td>
<td>52* (57.6)</td>
<td>52* (57.6)</td>
</tr>
<tr>
<td>BSI-Somatization T-scores (Percentile)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>41 (19)</td>
<td>61* (85.8)</td>
<td>41 (19)</td>
<td>41 (19)</td>
</tr>
<tr>
<td>TRES (mean score)</td>
<td>3.52</td>
<td>3.6</td>
<td>3.8</td>
<td>3.72</td>
</tr>
<tr>
<td>CULT (mean score)</td>
<td>2.27</td>
<td>3.4</td>
<td>4.2</td>
<td>4</td>
</tr>
<tr>
<td>TREP (mean score)</td>
<td>N/A</td>
<td>2.27</td>
<td>2.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>
the re-experiencing and avoidance domains, moving from Moderate to Mild by the end of treatment. However, her impairment level remains Severe throughout, due to consistent endorsement of impaired functioning in all areas of her life.

Interpretation of her BSI-18 scores is made cautiously, as Flora indicated dubiousness during Interview 3 about her actual understanding of protocol questions in previous interviews. While her score on the DEP index is consistent across time (falling in the non-clinical range) her scores on the SOM scale move into the clinical range in Interview 2, and then back to baseline level in Interviews 3 and 4. Her score on the ANX scale moves into and stay in the clinical range after Interview 2. However, these score changes may express shifts in her level of physical distress rather than an increase in emotional distress. In interview 2, Flora reported never experiencing most symptoms, experiencing a little difficulty with feelings of sadness (raw score =1), and extreme difficulty (4) with feeling as though she can’t sit still due to chronic pain. In interviews 3 and 4, Flora endorsed Moderate difficulty only on one item—sitting still, and denied experiencing any other symptoms related to emotional functioning.

Flora’s self endorsements on the TRES were relatively stable, with scores moving in a pro-coping direction by only .28 and are not likely reflective of any significant change in self-assessments of trauma recovery skills.

Flora showed the most significant level of change on the CULT (change score= 1.73), endorsing a greater number of pro-recovery attitudes by the end of treatment. While her baseline endorsements on this scale indicated total agreement with the statement that a good woman should endure life’s difficulties without complaint by the end of treatment she revised this opinion and totally disagreed. The only item on the CULT scale she does agree with at Time 4 is
“It is better not to think about the damages of the past.” Again, whether or not this score indicates a real change or just a misapprehension of the question intent in initial the interviews, is debatable.

*Participant-specific themes.* The various sources of qualitative data on Flora’s participation (progress notes, videos, interviews with the researcher) show evidence for specific thematic content regarding interpersonal communication (e.g. understanding others and being understood), interpersonal relatedness (e.g. interpersonal difficulties that appeared rooted in periodic lapses in relational mutuality, and the tendency to withdraw or “not contribute” to group discussions) along with significant experiences of physical pain. Emotional themes were related to grief and loss regarding the changes in her physical condition, and feelings of guilt and resentment about need for care and nurturance by others. Flora’s characteristic response to difficulty appeared to be irritation; however this style may also be a feature of the impact of chronic pain or of cognitive difficulties. Even though Flora was present in 24 out of 25 groups, it is likely, that in many of the early groups she was “checked out” in a cognitive sense. Flora’s overall level of insight into her own emotional functioning may also have influenced her reporting on protocol items in interview as well as her responding to emotion-related themes in group. This self-assessment deficit may be indicated in her response to a question from a peer in group 21 about her experience of angry feelings: Flora reported never having had feelings of anger. Flora consistently indicated in interviews with the researcher that items asking about self-awareness, triggers, coping, and characteristic responses to feeling angry, depressed, or out of control, did not apply to her. Regardless, it is clear by her persistence and follow through (she missed only one group because she was confused about whether the group would run on that institutional holiday) that she valued her role as a group member. The content of facilitator
notes also indicates that she benefited from her membership, particularly in the Advanced Recovery Phase of the group. Flora was regularly and effectively using the group for support. For example in group 14 (Psychological Symptoms of Abuse) Flora was noticed as having been more engaged than usual, at times tearful, and as self-disclosing about her emotional reactions to her loss of mobility. In group 17 (Decision Making) Flora was noted as having sought support and encouragement from the group regarding letting down her guard, and not needing to be so tough and independent. In Group 20 (Guilt, Acceptance and Forgiveness) Flora sought help from the group and leaders in solving a family crisis.

*Did participation in SEP increase her awareness about trauma and abuse?* Yes. There is some evidence in facilitator notes and comments, video recordings, and in qualitative observation from researcher interviews, that Flora’s awareness of the impact of her trauma and abuse history on her interpersonal and emotional functioning was improved by her participation in the group. On an Awareness Scale (See Table 16) constructed of only awareness-related items on the TRES and TREM, Flora’s change scores (which may not be entirely valid) seem to fluctuate to a significant degree over the course of the protocol, with the largest score difference between Time 2 (low score) and Time 4 (high score) being .94. Flora’s scores at Baseline and at the end of treatment are not significantly different (.53). The qualitative data available supports the observation that for Flora, the group experience appears to be one in which she was exposed to many new ideas about how to think about and label her previous trauma-related experiences. Additionally, in Flora’s case, it appears that there may be significant interaction between her changes in level of awareness and her shifts in level of endorsement of recovery-interfering cultural ideas and attitudes.
Table 16. Flora’s Scores on Awareness, Coping and Behavior Scales

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Scale</td>
<td>3.36</td>
<td>2.93</td>
<td>3.14</td>
<td>3.87</td>
</tr>
<tr>
<td>Coping Scale</td>
<td>3.62</td>
<td>4.08</td>
<td>4.38</td>
<td>3.92</td>
</tr>
<tr>
<td>Behavior Scale</td>
<td>2.53</td>
<td>2.74</td>
<td>2.84</td>
<td>2.84</td>
</tr>
</tbody>
</table>

**Bolded text** on this table indicates a score of potentially significant difference from baseline.

*Is there evidence that she learned skills to increase coping?* Yes. There is some evidence of increased coping skills, particularly in progress note documentation of shifts in Flora’s in-group demeanor and behaviors across interviews. If Flora was able to access health care for her chronic pain and sleep problem she may have done so as a consequence of her participation in the group. Arguably, the difficulty experienced by facilitators in ranking her on some of the domains of the TREP, and the expressed concern regarding her understanding of protocol items on the TRES increases the chances that her score pattern on the Coping scale are invalid. Change scores between Time 1 (baseline, low score) and Time 3 (high score) appear to meet the benchmark for possible significance (difference=.78) if scores are indeed valid.

*Is there evidence that her participation resulted in significant behavior changes in a positive (pro-recovery) direction?* Yes (maybe). There are indications in the progress notes for the group of shifts in her in-group presentation and interpersonal practices; for example, she experimented with increased self-disclosure at various points in the group. There were also shifts in her demeanor in interviews that seemed to indicate some movement toward positive coping; for example, she was able to articulate without experiencing excessive shame that she
had difficulty understanding interview questions and needed additional help. Behavior Scale score changes, if valid, do not, however, support significant shifts toward pro-coping.

“Vera”

*Baseline data.* Participant code named “Vera” identified as a 51-year-old, monolingual Spanish-speaking Chilean\(^1\) woman who has lived in the US for the past 13 years. In her screening interview, Vera reported a history of physical and emotional abuse, domestic violence, substance use, depression, anxiety, mood difficulties, interpersonal difficulties, episodes of dissociation, and problems with attention. In this interview Vera denied any history of suicidal or homicidal ideation or current substance abuse (stating she has been in recovery for several years) and was rated by the screener as “low-risk.”

In her Time 1 interview, Vera reported being unemployed, having 1 adult child, and being divorced. She indicated educational history through bachelor’s level certification in Chile. Vera also indicated that she considers herself a spiritual but not a religious person, who currently actively practiced spirituality-informed practices that she found helpful in coping with problems. Vera also endorsed having participated in individual therapy in 2006, and having participated in some form of support group or therapy group for the past 10 years. She endorsed having discussed and learned about trauma in both settings.

Vera’s initially disclosed having had sexual contact as a minor with someone more than 5 years older than herself; having experienced torture; and having had a “health-related accident” in which she was hospitalized felt in mortal peril; having suffered emotional and physical abuse by people known to her, and having experienced racism and discrimination in institutional settings. Vera described her most traumatizing event as having been her recent hospitalization

\(^1\) Vera is the only participant in the completion group from a country other than Mexico. Differences in her response sets may be attributed to variations in culture not discussed herein, due to lack of sufficient data.
during which she feared she would die, and during which she received treatment that made her feel as though she was of little value\textsuperscript{12}. Her trauma history disclosures indicate that she has complex trauma and that her symptom presentation was impacted by multiple traumatic episodes over time.

On the PDS Vera self-reported enough symptoms in the domains of re-experiencing, avoidance, and arousal to justify a PTSD diagnosis. Vera’s symptom severity was rated as Severe, with 7 of the 16 symptoms endorsed occurring almost always. Vera almost always tried not to think about or talk about her feelings regarding the event; re-experienced the event, acting and feeling as if it is occurring once more; felt emotionally agitated when she thought about the event; had much less interest than prior to the event in participating in important activities; felt distant from others in her life; felt as though her plans and hopes for the future would not be realized; and was nervous or jumpy. Her level of impairment was also rated as severe, because she endorsed impaired functioning generally in all areas of her life. For the purposes of this study, Vera was considered to be at a “mid phase” of her recovery process, having previously sought out recovery related resources.

In her initial interview she was in the clinical range on all four scales of the BSI. On the GSI (T=81), the DEP Index (T=79) and the ANX index (T=78) she achieved scores in the 99\textsuperscript{th}. On the SOM index (T=74) she achieved a score in the 98\textsuperscript{th} percentile.

On the TRES, her initial mean item score was 3.64 indicating self-endorsement of a moderate level of insight, awareness, and behavior related to coping, self-protection, and recovery skills. After two months of contact (during which she attended all 8 groups), the facilitators jointly ranked her on the 11 dimensions of the TREP and produced a mean baseline

\textsuperscript{12} The actual recorded statement was “Me hace sentir muy poca,” or “They made me feel less than.”
score of 3.45, indicating that in their assessment she had demonstrated a moderate skill-level in key areas related to effective coping with trauma.

Her initial endorsements on the CULT Scale yielded a mean score of 1.6, indicating a high degree of agreement with recovery-interfering beliefs. She endorsed total agreement with the statements that (1) a good woman copes and moves forward in her life regardless of the abuse she has experienced, (2) she needs to control or hide her feelings of agitation about abuses that she has experienced, (3) a woman should endure difficulties in life without complaint, and (4) bad things that have happened were pre-ordained or prescribed by fate. She indicated that she somewhat disagreed with the statement that it is better to not think about the damages of the past.

Vera’s orientation toward the interview scenario was one of positive inquisitiveness. She was assertive in requesting clarification on protocol items when the wording was confusing to her, and expressed interest in the study process, asking well formulated questions about the focus of the study and the significance of her commitment to participate. Vera experienced only one episode disintegration (during interview 3) while discussing family dynamics that had been triggering for her in recent dialogues with her siblings in Chile. The episode was brief (lasting fewer than 10 minutes) and Vera was easily redirected to completing the interview protocol afterwards. Vera consistently indicated that she found the interview protocol “easy” to complete.

Clinical scores. By the end of treatment, Vera’s scores on the PDS no longer justified a diagnosis of PTSD (see table 17). While her level of Impairment score on the PDS remained at severe (due to consistent endorsement of an item indicating impaired functioning in all areas of her life), her symptom severity index moved steadily in a pro-recovery direction, from severe at baseline to mild at the end of treatment.
Table 17. Summary of Vera’s Scores

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Impairment</strong></td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td><strong>Symptom Severity</strong></td>
<td><strong>Severe</strong></td>
<td><strong>Moderate</strong></td>
<td><strong>Moderate</strong></td>
<td><strong>Mild</strong></td>
</tr>
<tr>
<td><strong>BSI Global</strong></td>
<td>81</td>
<td>69</td>
<td>63</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>(99)</td>
<td>(97)</td>
<td>(89.4)</td>
<td>(89.4)</td>
</tr>
<tr>
<td><strong>T-scores (Percentile)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSI – Depression</strong></td>
<td>79</td>
<td>63</td>
<td>67</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>(99)</td>
<td>(89.4)</td>
<td>(95.1)</td>
<td>(93)</td>
</tr>
<tr>
<td><strong>T-scores (Percentile)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSI-Anxiety</strong></td>
<td>78</td>
<td>70</td>
<td><strong>54</strong></td>
<td><strong>54</strong></td>
</tr>
<tr>
<td></td>
<td>(99)</td>
<td>(98)</td>
<td>(65.2)</td>
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<td><strong>T-scores (Percentile)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSI-Somatization</strong></td>
<td>74</td>
<td>68</td>
<td>63</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>(98)</td>
<td>(96)</td>
<td>(89.4)</td>
<td>(93)</td>
</tr>
<tr>
<td><strong>T-scores (Percentile)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TRES</strong></td>
<td>3.6</td>
<td>4.12</td>
<td><strong>4.24</strong></td>
<td>4</td>
</tr>
<tr>
<td>(mean score)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CULT</strong></td>
<td>1.6</td>
<td>2.8</td>
<td>3.6</td>
<td><strong>4.2</strong></td>
</tr>
<tr>
<td>(mean score)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TREP</strong></td>
<td>N/A</td>
<td>3.73</td>
<td>4.18</td>
<td>5</td>
</tr>
<tr>
<td>(mean score)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bolded text** on this table indicates a score of potentially significant difference from baseline.

Vera’s BSI-18 scores show a similar trend, generally moving in a pro-recovery direction on all four scales, and the level of change appears to be of practical significance. While most of Vera’s scores on the BSI-18 scales (with the exception of her ANX Index score) were still in the clinical range at the end of treatment, all of her scores moved 1 standard deviation or more in a pro-recovery direction (SD for T-Scores =10). Her total T-score change on the GSI was 17. Her
total change on the DEP index was 14. Her total change on the ANX Index was 24, and her total change on the SOM Index is 9.

Her self-endorsements on the TRES, like those of other participants, are relatively stable, moving in a pro-coping direction, but not to a sufficient degree to meet the .7 benchmark for this study. The change score of greatest difference is the comparison between Baseline and Time 3 (.64). Comparison between baseline and end of treatment scores is less impressive (.4). Her score pattern on this self-report measure seems to indicate that Vera experienced the least overall change in her own assessment of her own recovery related skills over the course of treatment.

On the CULT scale the most significant degree of change was apparent (change score=2.6) with Vera endorsing a greater number of pro-recovery attitudes by the end of treatment. By the end of treatment, Vera endorsed only that she agreed somewhat with the statement that a good women should endure life’s difficulties without complaint. She indicated total disagreement with all other culture-scale items.

On the TREP, facilitator evaluations of Vera’s coping skills steadily increased. Vera was given a perfect score (mean score =5) on all domains of the TREP by the third and final ranking. The total change score on this measure was 1.27. The practical significance of this change is reinforced by the fact that Vera no longer met criteria for PTSD by treatment end.

Participant-specific themes. Themes in the qualitative content for Vera (progress notes, paper artifacts, videos and interactions with the researcher) indicate that she initially had difficulty coping with irritation or frustration in interpersonal relationships, and that she used the assumption of leadership as a way of coping with her need for acceptance, admiration and control. These themes appear linked to her endorsements of having multiple significant relationships where verbal and emotional abuse have occurred, as well as to her status as one of
the more highly educated and skillful members of the group. Vera alternately assumed the roles
of martyr and aggressor/confronter, particularly in the forming phase of the group. Implicit in
both of these stances is the assumption of leadership responsibilities. Whether self-sacrificing or
critical of others, her contributions were typically framed allocentrically, as in, for the good of
the whole group. In her more vulnerable moments, she is also noted to use “kick the dog” tactics
to cope, particularly when deflecting perceived rejection.

In progress notes, Vera is described as periodically becoming offended by the comments
of others, sometimes on behalf of others, and as being reactive to perceived slights while
assuming responsibility for the quality of relational mutuality in the group. On occasion, her
attempts to protect the group (or herself) show up in harsh assessments of the skills of the others.
For example, in group 3 Vera is noted as feeling irritated with another participant’s “long
stories,” stating they were negatively impacting the group. In group 14 progress notes document
her irritation with one co-participant about a comment on a sensitive issue (DHS custody of
children) by another co-participant. In group 15, Vera questions the non-Latina facilitator’s level
of Spanish fluency with whom she had conversed extensively in the previous 15 groups. She
presumably employed this type of “kick the dog” tactic as a reaction to feeling abandoned by the
other facilitator who was unexpectedly absent that day.

Facilitator notes on Vera also document a healthful evolution of her relational style and
leadership role by the middle phase of the group where she made attempts to be supportive and
nurturing. For example, in group 9 Vera begins the group by spontaneously confronting the other
participants about arriving late (a critical stance aimed at addressing cohesion and inclusion
concerns). Then in group 10, she offers to model her investment in the group by hand-copying all
of the group notes from the easel pad so that the members might have a booklet of notes to keep
from the group (a supportive stance addressing these same concerns). She followed through on that task, creating a very nice document that was then given as a gift to the participants in the closing group.

In interviews with the researcher and in video samples of her participation in group, Vera repeatedly explored themes of power-sharing, control in relationships and shame in relationships. The theme of shame was evidenced both in having been subject to shaming by significant family members and by taking responsibility for using shame in her own approach to others, including group members. By the Advanced Recovery phase, she appeared to be experiencing greater empathy toward peers whose behaviors had previously provoked irritation and disdain. There is some evidence to suggest that her gains in empathy were connected to gentle confrontations by the facilitators and group peers about her interpersonal habits, while simultaneously receiving ample validation and support regarding her expressed concerns.

By the close of group Vera participated as if she had become another co-leader, showing an evolved ability to acknowledge and honor her own role-needs. By the end of treatment, she also appeared to have moved out of alienation and into comfortable relatedness with the other members of the group. It is also important to acknowledge that Vera was highly engaged partly due to her strong cognitive abilities, so her status as the group member with the most advanced literacy level may have intermediated how much she gained from the group.

*Did participation in SEP increase her awareness about trauma and abuse? Yes. As indicated by her largest change score (Baseline compared to Time 3= .89), Vera’s level of change in the Awareness domain appears to be of practical significance, although the difference between her final score and baseline score is less convincing (.43). Qualitative evidence also supports the conclusion that she did experience a practically significant level of change in this*
area. By the end of group, Vera was a regular contributor of psychoeducational facts related to trauma, as well as useful anecdotes about her own intra-psychic experiences in dealing with trauma, which clearly her understanding and awareness had increased.

Table 18. Vera’s Scores on Awareness, Coping and Behavior Scales

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Scale</td>
<td>3.75</td>
<td>4.11</td>
<td>4.64</td>
<td>4.14</td>
</tr>
<tr>
<td>Coping Scale</td>
<td>3.62</td>
<td>3.77</td>
<td>4.23</td>
<td>4.5</td>
</tr>
<tr>
<td>Behavior Scale</td>
<td>3.66</td>
<td>4.03</td>
<td>4.32</td>
<td>4.53</td>
</tr>
</tbody>
</table>

**Bolded text** on this table indicates a score of potentially significant difference from baseline.

*Is there evidence that she learned skills to increase coping?* Yes. It appears that a significant degree of change occurred on the Coping Scale in the pro-recovery direction by the end of treatment. The change score between baseline and Time 4 is .88, showing a consistent and likely significant trend in the pro-recovery direction throughout. Vera also appeared to be making more accurate assessments of her safety and power in interpersonal relationships by the end of treatment, which provides a clue that she was better able to cope with usual sources of stress. Also, her reduced endorsements in the domains of re-experiencing, arousal and avoidance provide evidence of better coping, so much so that she no longer meets PTSD criteria by the end of treatment.

*Is there evidence that her participation resulted in significant behavior changes in a positive (pro-recovery) direction?* Yes. It appears that a significant degree of change also occurred on the Behavior scale (change score =.87) in the pro-recovery direction. By the end of treatment, qualitative evidence reveals Vera is engaging more empathically with others and also reports having taken first steps in developing new relationships outside of group. Her perfect
scores on the TREP also provide some evidence that Vera was “walking the talk” by the end of treatment, as facilitators picked up on clear increases in her abilities across all 11 domains of the instrument by the end of treatment.

“Nora”

Baseline data. The participant code-named “Nora” identified as a 38-year-old, monolingual Spanish-speaking Mexican woman who has lived in the US for the past 9 years. In her screening she reported a history of depression and anxiety, but denied any history of suicidal or homicidal ideation or substance abuse, and was rated as “low-risk.”

Nora reported being married, having 5 children and being employed full time. She completed primary school through the sixth grade in Mexico. Nora also considered herself a religious person (Catholic) currently an active in her faith and using faith-practices help her cope with problems. Nora endorsed having had family therapy sessions with her daughter in the past year, but never having participated in a therapy or support group, and never having discussed or learned about emotional trauma.

Nora reported a history of vicarious traumatization (witnessing sexual and physical assaults on a family member). Unlike other participants in this group, Nora did not identify having experienced racism or discrimination. She identified her most traumatizing life episode as having included witnessing interpersonal violence against her daughter and learning that her daughter had been raped. In the initial interview, Nora also endorsed significant distress regarding her housing situation, indicating that subsequent to her daughter’s assault the family had fled the rental property to protect her from further contact with her attacker. Earlier in the week she had received notice from the property owner of intention to sue due to breaking of the lease agreement. Nora’s emotional distress was so pronounced in the beginning of this interview
that the protocol was discontinued after completion of the PDS, and rescheduled for the following week.

Nora reported adequate symptoms in the domains of re-experiencing, avoidance, and arousal to justify a PTSD diagnosis. Nora’s symptom severity was rated as Moderate to Severe with 4 of the 11 symptoms endorsed ranked as occurring almost always. Vera almost always tried not to think about, talk about or have feelings about the event, not being able to remember an important part of the event, having much less interest in participating in important activities than prior to the event, feeling nervous or jumpy, and startling easily. Her level of impairment was rated as moderate, indicating that she experienced impaired functioning when trying to accomplish chores around the house, in her relationship with friends, in her leisure activities, in her work and studies, and in her relationships with family members. However, she denied global impairment, indicating that her satisfaction with life in general had not been impacted, nor had her sex life. For the purposes of this study, Nora was considered to be in the “Early phase” of her recovery process.

Nora’s trauma history appears simple compared to other participants, and therefore can be characterized being stimulated vicariously by events in her daughter’s life. Her symptoms appear to be related directly to the current traumatizing sequence (e.g. witnessing assault).

In her initial interview on the BSI-18, she endorsed being in the clinical range on all four scales. On the GSI (T=65) and the DEP Index (T=65) she achieved scores in the 92\textsuperscript{nd} percentile. On the ANX index (T=67) she achieved a score in the 95\textsuperscript{th} percentile. On the SOM index (T=55) her initial score did not fall in the clinical range, and she achieved a score in the 68\textsuperscript{th} percentile.

On the TRES her mean raw score was 3.36, indicating self-endorsement of a moderate level of insight, awareness, and behavior related to coping, self-protection, and recovery skills.
After two months of contact (during which she attended 3 of 8 groups), the facilitators jointly ranked her on the 11 dimensions of the TREP and produced a mean score of 2.55, indicating that in their assessment, she had demonstrated a low to moderate skill-level in key areas related to effective coping with trauma. (Please see Appendix B.15 for anchor descriptions for rankings of 2 to 3 on the 11 different dimensions of this scale)

Her initial endorsements on the CULT Scale yielded a mean score of 4, indicating little overall agreement with recovery-interfering beliefs at baseline. She endorsed agreeing somewhat that it is better to not think about the damages of the past. She endorsed ambivalence (agreeing only half the time) that she needs to control or hide her feelings of agitation about abuses that she has experienced. She indicated she was in total disagreement with the statements that (1) a good woman copes and moves forward in her life regardless of the abuse she has experienced, (2) a woman should endure difficulties in life without complaint, and (3) bad things that have happened were pre-ordained or prescribed by fate.

Nora’s orientation toward the interview scenario was one of cautious trusting. Nora appeared comforted in the interview scenario by establishing the researcher as an expert, and did this at the outset of each interview by requesting to consult on various current personal issues, for which she received relevant referrals and resources. Nora was able to express a full range of affect appropriately in her interviews, only becoming tearful in the first interview (as described above) and third interview (this time while discussing ongoing difficulties related to her daughter’s victimization). Nora chose her rankings on each item carefully and asked clarifying questions when the items wording was confusing to her, and consistently indicated that she found the interview protocol “somewhat difficult” to complete.
Clinical scores. Nora’s score profile over the course of treatment appeared to reflect ongoing exposure to distressing scenarios. In particular, her symptom severity on PDS and BSI scales appeared to spike in Interview 3, which makes sense in the context of her lived experience at that moment of feeling hopeless and horrified in the face of family-related problems. While Nora’s endorsements on items regarding level of impairment returned to baseline in her final interview, Nora continued to indicate a severe level of symptom-related distress, which was below her baseline level (e.g. in the anti-recovery direction), and indicate that her symptoms had worsened over the course of treatment. BSI scores showed a similar trend, generally moving in a pro-recovery direction on all 4 scales in her Time 2 and 3 interviews. However at Time 4, Nora endorsed a slightly higher level of distress in all domains than she did at Baseline. All of Nora’s scores on the BSI-18 were in the clinical range at each interval. Her T-score on the SOM scale went up by 11 points, likely a change of significance. Her scores on other BSI-18 scales stayed closer to Baseline. Her largest change score for GSI (between baseline and Time 3) was 2. Her largest change score for the DEP Index (between Time 1 and Time 2) was 7. Her largest change score for ANX Index (between baseline and Time 3) was 2.

Her self-endorsements on the TRES were relatively stable, moving only slightly in a pro-recovery direction in the first three interviews (with a change score between baseline and Time 3 of .56). Her score dropped back to Baseline level in the closing interview, with a change score between last interview and baseline of -.08. Her score profile indicates that she did not experience much change in her own assessment of her trauma-recovery skills.

Her scores on the CULT scale are also stable, with the largest change occurring between Time 1 Interviews and Time 2 (change = .6), but with a regression to her baseline score on this measure in Interviews 3 and 4. By the end of treatment, Nora agreed somewhat that 1) a good
woman should endure life’s difficulties without complaint; and that 2) she needs to control or hide her feelings of agitation about abuses that she has experienced. On all other items she indicated she was in total disagreement.

Table 19. Nora’s Scores

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Impairment</td>
<td>Moderate-Severe</td>
<td>Moderate-Severe</td>
<td>Severe</td>
<td>Moderate-Severe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom Severity</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI Global</td>
<td>Moderate</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>T-scores</td>
<td>65</td>
<td>63</td>
<td>62</td>
<td>68</td>
</tr>
<tr>
<td>(Percentile)</td>
<td>(92)</td>
<td>(89.4)</td>
<td>(87.6)</td>
<td>(96)</td>
</tr>
<tr>
<td>BSI - Depression T-scores</td>
<td>Moderate</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>T-scores</td>
<td>65</td>
<td>58</td>
<td>61</td>
<td>65</td>
</tr>
<tr>
<td>(Percentile)</td>
<td>(92)</td>
<td>(93)</td>
<td>(85.8)</td>
<td>(93)</td>
</tr>
<tr>
<td>BSI-Anxiety</td>
<td>Moderate</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>T-scores</td>
<td>67</td>
<td>65</td>
<td>65</td>
<td>69</td>
</tr>
<tr>
<td>(Percentile)</td>
<td>(95)</td>
<td>(93)</td>
<td>(93)</td>
<td>(97)</td>
</tr>
<tr>
<td>BSI-Somatization T-scores</td>
<td>Moderate</td>
<td>Severe</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>T-scores</td>
<td>55</td>
<td>65</td>
<td>55</td>
<td>66</td>
</tr>
<tr>
<td>(Percentile)</td>
<td>(69)</td>
<td>(93)</td>
<td>(69)</td>
<td>(93)</td>
</tr>
<tr>
<td>TRES (mean score)</td>
<td>3.36</td>
<td>3.92</td>
<td>3.44</td>
<td>3.28</td>
</tr>
<tr>
<td>CULT (mean score)</td>
<td>4</td>
<td>3.4</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>TREP (mean score)</td>
<td>N/A</td>
<td>2.55</td>
<td>4.27</td>
<td><strong>4.68</strong></td>
</tr>
</tbody>
</table>

Bolded text on this table indicates a score of potentially significant difference from baseline.

On the TREP, facilitator evaluations of Nora’s coping skills steadily increased, with a total change score (Baseline to Time 4) of 2.13 in a pro-coping direction. While this level of change is most certainly significant, it is important to note that initial rankings made by
facilitators were done on the basis of only 3 contacts. Subsequent rankings (after more regular 
participation was established) resulted in much higher appraisals of her skill level by the 
facilitators.

**Participant-Specific Themes.** One of Nora’s main themes in the qualitative data was her 
heightened level of experienced barriers to participation. Of all of the group participants, Nora 
by far endorsed experiencing the greatest number of total barriers. Nora sometimes called to say 
that she would not be able to attend a group (for example, because of needing to pick a child up 
from school). She also reached out to the group’s facilitators during times of crisis. This seemed 
to imply that the barriers experienced were mostly practical rather than sourced as a strategy of 
avoidance.

Nora’s difficulties were also cultural and systemic in nature, with her presenting 
concerns were exacerbated by her undocumented status. For example, her re-experiencing, 
avoidance and vigilance, as well as anxiety and depression symptoms worsened when she faced 
seeking help for her daughter with local police. Nora endorsed not knowing whether doing so 
would put her and family members at risk for deportation. In interviews 2 and 3 with the 
researcher, Nora spoke of having fragile relationship ties, both to significant family members 
and to the community. Nora indicated awareness that her problems seemed overwhelming to her 
in part because she lacked adequate access to community safety nets, and indeed did not fully 
understand her rights to remediation or support from significant social resources (police, 
housing supports, welfare, etc.). Nora also endorsed feeling helpless about current family 
problems, stating that acts she might take with the intention to protect her daughter might result 
in loss of or damage to the relationship.
General notes on her participation indicate that, when present, Nora was attentive and engaged. She appeared to place a high value on her relationships with group peers, particularly in the Recovery and Advanced Recovery phases. While Nora self-identified as being worried about her ties to others, timid in the group, and frequently was absent during the “forming period,” she also appeared to have significant skill in forging bonds of attachment with other members. For example, in group 16, she spontaneously disclosed that the group had been very important and helpful to her, and in group 21, Nora indicated distress sourced in not having many natural supports close at hand and appeared to use the group as a family-surrogate to discuss and generate ideas for solving current family problems.

Nora was also remarkable among her peers for having consistently endorsed having a positive relationship with a male partner. Her capacity to engage in and maintain an apparently healthy relationship in which her intimacy needs are met provides further evidence of her strong interpersonal and attachment skills. One facilitator commented that her relative health and skill in this area made her seem “odd” compared to peers. Nora was frequently asked to verify the solidity of her relationship with her spouse by other group members, the facilitators and the researcher, who were accustomed to thinking of problems of abuse or neglect in primary relationships as a common factor for survivors of trauma.

*Did participation in SEP increase her awareness about trauma and abuse?* Maybe. There did appear to be a pro-awareness trend to her scores, however it is uncertain whether the trend was strong enough to be of practical significance. The largest change score (baseline compared to Time 2) on the Awareness scale is .65 and the change score between baseline and the end of treatment on this measure is slightly smaller (.57). Qualitative data also seems to indicate that her gains in this area may have been impacted by ongoing exposure to the
traumatic scenario. In Nora’s case, increasing her present awareness about her trauma experience may be evidenced by her increase in symptoms. That is, through her participation in the group, Nora gained an increased awareness of the impact that her traumatic stress was having on her self-concept and intra-psychic functioning.

Table 20: Nora’s Scores on Awareness, Coping and Behavior Scales

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Scale</td>
<td>3.14</td>
<td>3.79</td>
<td>3.43</td>
<td>3.71</td>
</tr>
<tr>
<td>Coping Scale</td>
<td>3.46</td>
<td>3.77</td>
<td>3.62</td>
<td>2.96</td>
</tr>
<tr>
<td>Behavior Scale</td>
<td>3.37</td>
<td>3.47</td>
<td><strong>4.11</strong></td>
<td>3.97</td>
</tr>
</tbody>
</table>

**Bold Text** on this table indicates change in score of potential significance from baseline.

Is there evidence that she learned skills to increase coping? No. There is actually evidence of dips and declines in overall coping. These correspond to family-life crisis episodes occurring during treatment. The largest difference in scores is actually between Time 2 and Time 4, with an overall change of -.81, indicating potentially practically significant shifts toward poorer coping by the end of treatment. In this instance, endorsements of poorer coping should be viewed in light of the impending termination of group, which had become an important resource for Nora.

Is there evidence that her participation resulted in significant behavior changes in a positive (pro-recovery) direction? There does not appear to be evidence that a shift of practical significance had occurred toward pro-coping behavior, however her largest change score (baseline to Time 3 = .73) and her final change score (baseline to time 4=.6) do indicate that in general, her scores on this scale did trend upward.
Topic 4: Participant Satisfaction

Hypothesis 3 was that the number of groups a participant attends will likely be connected to level of satisfaction with the group, as well as to an increase in coping skills and a decrease in symptoms on the BSI. Low n precluded planned analysis. Instead, exit interview data with the attrition group and case-level data is used here to explore satisfaction related themes. Trends are explored using comparative rankings on participation levels, satisfaction, and symptom relief.

Attendance and Satisfaction

All satisfaction ratings were high throughout, both by individuals in the completing group (n=5) and attrition group exit-survey respondents (n=13). The completing group data is likely reliable, as the women in this group responded to the satisfaction items after having long-term investment in the group. There are also several reasons that satisfaction may have been high for this group; namely the group was free, culturally specific and in Spanish. The group was also led by highly educated and qualified providers. These facts may be considered a significant counterweight to arguments that culturally proscribed behavior dictates responding about satisfaction-related questions\(^\text{13}\) for this population. The data for this group indicates that the women who participated in this group felt respected by the leaders, as though they learned important skills, as though the group was beneficial to them, and that the group was worth recommending to others.

Findings are similar regarding attrition group responses on satisfaction items.

Anticipation of satisfaction with the attrition group was high with 12 of 13 respondents indicated

\[^{13}\text{The participant satisfaction questions included in this protocol were ranked on a 5-item Liker-type scale, with low scores indicating higher levels of dissatisfaction and high scores ranking higher levels of satisfaction. The items on this scale are 1) The leaders of this group respect my values and beliefs; 2) I feel that I have been treated like a complete person and not as someone only defined by my problems 3) I have enjoyed my participation in the group, 4) I learned techniques to calm myself down or relax myself in this group, 5) I would recommend this group to other women in recovery.}\]
Table 21. Comparison of Attendance and Participant Satisfaction

<table>
<thead>
<tr>
<th>Participant</th>
<th>Attendance</th>
<th>Mean score Time 2</th>
<th>Mean score Time 3</th>
<th>Mean score Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vera</td>
<td>25</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Lola</td>
<td>19</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Magda</td>
<td>17</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Nora</td>
<td>17</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Flora</td>
<td>23</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

that given the opportunity to participate in another group they would do so, and that they would recommend the group (based on the information they had from either participating in the group or participating in preliminary interviews) to others in recovery. While a significant number of participants in the attrition group (12) could not be contacted for follow up, there seems to be a general level of agreement among the women who participated in the study that the group was of value to the women in their community. While this interpretation is made with caution (given the social factors that influence responding to satisfaction items for this population) it does appear that should other barriers to access to such a resource be redressed that the protocol is a good fit for the target population.

Relationship between Attendance Level and Score Change on BSI

While it is not possible to accept or reject the hypothesis that BSI score reductions are positively related to number of groups attended with such a small data set, it is noticeable, in Table 22 that the number of groups attended mostly line up with total change scores on the BSI (Global Index).
### Table 22. GSI Change Level and Attendance

<table>
<thead>
<tr>
<th>Participant (Rank Ordered by Level of Change)</th>
<th>BSI-18 Global Severity Index Change Score</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vera</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Lola</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Magda</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Nora</td>
<td>-3</td>
<td>17</td>
</tr>
<tr>
<td>Flora</td>
<td>-15</td>
<td>23</td>
</tr>
</tbody>
</table>

“Flora’s” responses buck this trend, however, as previously discussed, there is some concern that her rankings on the BSI-18, and also about validity related to her general understanding of items on the protocol during Baseline and Time 2 interviews. The BSI-18 is also only a gross screening instrument, on which it is possible to achieve Clinical Rankings of distress based on endorsement of moderate to high distress on a single item, as was the case with Flora on the ANX scale.

There also does not appear to be a discernable link in this data set between the number of groups attended and the overall change scores (Awareness, Coping and Behavior Scales). See Table 23 for a visual comparison of the rank ordering of attendance data by total change. While clearly the small number of participants precludes rejection of the hypothesis, evaluation of the available scores does provoke interesting questions about what other factors could be quantified and measured for their influence on change scores.
Table 23. Compared Rankings by Attendance and Change Scores

<table>
<thead>
<tr>
<th>Participant (Rank Ordered by Level of Change)</th>
<th>Attendance</th>
<th>Awareness Change scores</th>
<th>Coping Change score</th>
<th>Behavior Change score</th>
<th>Summary Score (Mean of mean change scores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vera</td>
<td>25</td>
<td>.89</td>
<td>.88</td>
<td>.87</td>
<td>.88</td>
</tr>
<tr>
<td>Magda</td>
<td>17</td>
<td>.75</td>
<td>.65</td>
<td>.45</td>
<td>.62</td>
</tr>
<tr>
<td>Nora</td>
<td>17</td>
<td>.65</td>
<td>.31</td>
<td>.73</td>
<td>.56</td>
</tr>
<tr>
<td>Flora</td>
<td>23</td>
<td>.53</td>
<td>.80</td>
<td>.31</td>
<td>.55</td>
</tr>
<tr>
<td>Lola</td>
<td>19</td>
<td>.25</td>
<td>.16</td>
<td>.47</td>
<td>.26</td>
</tr>
</tbody>
</table>
DISCUSSION

General Strengths and Weaknesses of the Study

Limits to this study include lack of randomized sampling (participants were referred by known clinicians) with the most effective promotion tactic being the snowball technique (via word of mouth among mental health care providers); small final sample (n=5), and lack of a comparison group. The design of this study also does not enable the researcher to distinguish whether changes observed over the course of the study are alpha, beta, or gamma type changes (i.e., did the data change because of changes in the participants, changes in the context, or changes in the participants’ understanding of the context); only whether or not significant change did occur. However, attempts have been made to contextualize the quantitative results with available qualitative data.

An additional weakness concerns external validity as the participants in this study are not directly comparable to other groups that have been studied using the TREM. Additionally there is some concern that interaction with the researchers for the purpose of data collection or with the survey questionnaires may have influenced recovery outcomes in either direction. There was also no use of statistical convention, such as factor analysis, in deciding what items to include in scales original to this study (Awareness, Coping, Behavior, Culture, and Participant Satisfaction Scales). The items were instead either borrowed and grouped (as was done using the TRES and TREP to construct Awareness, Coping and Behavior Scales) or written (as was done with the Culture and Participant Satisfaction Scales) based on researcher judgment using clinical experience, feedback from consultants and knowledge from literature reviewed. Also, cut-off scores were based on available research on a different population in which a significant change
score was found to be .7 on one of the contributing instruments (the TREP). Taken together, these limitations can have an impact on the validity of the measures.

Strengths of this study are that the author was able to gather evidence on the SEP as implemented with the target population and with a high degree of fidelity to the protocol. This preliminary data may yield useful information that local providers of Latino mental health services can use in determining the value of employing this model with their population. This study also identified multiple barriers consistent with the literature (APA, 2009; NSF, 2009; DHHS 2001) including (a) childcare needs; (b) unreliable or costly transportation; (c) family obligations that impacted attendance; (d) unpredictable and variable work schedules (e) traveling long distances to participate in group; (f) changes in employment status and level of employment; and (g) concerns about confidentiality within a tight knit community. Of note, all participants who completed the study were monolingual Spanish-speakers. One possible explanation could be that bilingual women have a wider range of options for recovery services, while the monolingual Spanish-speaking women thus had a relatively higher level of motivation to remain engaged. In this instance, language, a key component of cultural adaptations, led to higher access to care for the monolingual population. This information will be helpful in addressing barriers in future research or program implementation.

The study is also timely. There is a fast growing local population of monolingual Spanish-speaking residents. Access to mental health services to address the needs of Latina trauma survivors is currently limited by lack of appropriate funding to support and develop programs, lack of equity in terms of numbers of providers with the requisite language, cultural, and trauma specific skills, and lack of evidence-based research on protocols specially adapted for these groups (Alegria et al, 2002; DHHS 2001; NSF, 2009;). When they are available, they
are generally not empirically tested or culturally informed, which means they are not in keeping with best practices recommendations made at the national level by the Surgeon General as much as a decade ago. Looking into the SEP model is a positive step toward greater alignment with best practices recommendation for Latinas in our local clinics.

This study intended to test 4 hypotheses, regarding fidelity, participant outcomes (on awareness, coping, and behavioral change), participant satisfaction and overall symptom reductions. Given the attrition across three of the four groups, this researcher reviewed in a case study format the experiences of the five women in the completed group. As a result, all of the hypotheses except fidelity, were explored through a qualitative review of measures, group notes, facilitator reports, videos, and researcher direct interactions with the participants.

Of the three scales (awareness, coping and behavior), all participant scores revealed a pattern of improvement on at least one scale, with one participant improving on all three scales. There was only one participant who actually had a decrease in her coping skills during the group.

Participant characteristics appear to influence which area showed improvement. For example, the participant with chronic pain showed an increase in coping while the participant with vicarious traumatization showed a decrease. The participant with vicarious trauma also had a crisis toward the end of the group that may have been reflected in her downward trend in coping. Her scores had increased at Time 3, but decreased at Time 4 during the crisis. Meanwhile, she showed her gains in adaptive and self-protective behaviors. For the participant whose presentation was characterized by dissociation and emotional dysregulation gains were made in self-awareness.
A qualitative review of the participant’s scores on the BSI-18 reveals three participants experienced a reduction in overall symptoms, with one remaining unchanged in symptoms, and one increasing in symptoms. The participant with no change was also the one who consistently endorsed the most difficulty in responding to the survey questionnaire.

One of the scales constructed by this researcher (Culture Scale) attempted to collect information on culturally proscribed reactions to trauma. The qualitative review of this questionnaire reveals increased flexibility in culturally informed beliefs about trauma for 3 of the participants, with two experiencing no change. Of interest, the profiles of four of the five participants show a match between the changes on the cultural questionnaire and overall symptom reduction. One potential explanation for this finding is that access to novel information that can provide scaffolding for recovery in individuals with complex trauma is mediated by culturally informed beliefs about the meaning of trauma, such that the participant’s access is impinged during periods of distress (e.g. the individual falls back on culturally informed beliefs) and increased during periods of relative stability. It appears that addressing women’s roles and cognitions about their roles in a culturally savvy and explicit way, such as is done in SEP, is an effective strategy for increasing recovery gains. This finding is also supported by previous research on cultural adaptations for minorities that states that the more specific and comprehensive changes are to a protocol, the more effective the protocol is for the target group (Griner & Smith, 2009).

Despite critical difficulties using clinical diagnostic measures to identify the presence of PTSD in previous studies with this population (e.g. those encountered while using the SCID and CIDI-WHO; Alegria et al., 2009), it is notable that, using an adequate translation of Foa’s PDS, 4 out of the 5 completing participants, and 20 out of the 27 original participants, were identified
as meeting criteria for a PTSD diagnosis. This finding may have implications for the utility of this scale with this population in future research. Another notable result was that the PDS captured the global remission of symptoms with the participant who had the greatest level of treatment gains, such that she no longer met criteria for PTSD on the measure at the end of treatment.

From a clinical perspective, it appears that the BSI-18, PDS and the Cultural scale provided clinically relevant and concordant profiles, whereas the awareness, coping and behavioral scales appear to require further evaluation.

Additional qualitative themes related to expression of psychological distress and contextual factors contributing to distress identified in the present study correspond well with findings in quantitative research on psychopathology among Latina survivors of partner violence (Cuevas, Sabina & Picard, 2010) and in themes noted in qualitative research with Latina sex abuse survivors (Ligiero et al, 2010). For example, women in the present study had similar rates of polyvictimization. Women in the present study also generally endorsed clinically significant symptom distress throughout treatment on measures of anxiety, depression, somatization, avoidance, re-experiencing and hypervigilence. Corresponding findings by Cuevas et al, were that Latina assault survivors, particularly those with histories of multiple and repeated victimizations, experience high rates of psychological distress (categorized as dissociation, depression, anxiety and anger in that study). Also, theme categories identified by Ligiero et al.(2009) in their qualitative study with childhood sex abuse survivors appear relevant to this study as well with themes emerging in the same domains—namely themes relating to self-concept, cultural context, thoughts and feelings, coping behaviors, and sources of support.

While the participant group for this study was highly heterogeneous across these domains,
themes in these domain areas were expressed by each in qualitative source materials (interviews with the researcher, facilitator notes and comments, video samples, and written productions by participants).

Regarding fidelity, it appears that when system-level barriers to implementation--such as mismatch between program missions and ideals, lack of adequate on-site resources, elaborate permission-seeking processes, lack of on-site bilingual reception and support, lack of scheduling-control, and inability to eliminate facilitator-related barriers such as variable levels of training and retention of non-paid volunteers throughout the entire study---are lessened or removed, that well-trained and expert clinicians can provide this service with a high degree of fidelity (73 percent and above) at this time in the community.

Quite apart from the question of whether or not these groups can be run to fidelity in community mental health settings, the level of fidelity achieved by the completing group was sufficiently high so that the data gathered on the group can be considered relevant to the more general experience of participation in SEP. With adequate training, bilingual and culturally skilled clinicians would be able to reproduce a group with adequately similar characteristics to the group run in this study. The facilitators that ran the group were consistently above the anticipated range on all dimensions of the Fidelity scale, and while the demands were higher on the fidelity scale used for the SEP than they were on the fidelity scale used in DCTCS studies of the TREM, the facilitator’s in this study achieved comparable rankings to those running groups in the earlier DCTCS studies (Fallot, personal communication, 2010).

The reasons for difficulty with implementation of these groups are multiple. Managed-care driven decisions appear to shape community mental health so that it is difficult to get access to the resources needed to run groups that exceed 10-12 sessions. Chronic under-funding
of community mental health generally also creates hurdles for new programming. Stagnant wages for clinical and research staff adds the contextual factor of an unstable workforce, which naturally impedes implementation of creative and progressive programming. In settings where vulnerable populations are served, implementation can be slowed by added layers of needed scrutiny as to the aims of the project and the credentials and backgrounds of those involved. As for other resources and avenues of support, the current economic recession makes for a fiscal environment where grant monies for new projects are not readily available. Another type of barrier is present in programs funded by faith organizations. Services can be sidelined due to values conflict, as in what occurred with Group 1. This kind of barrier is particularly problematic for the Latino Diaspora which tends, from mistrust of or lack of familiarity with usual public health and private practice venues, to rely heavily upon church-based venues for access to mental health care. Constraints in discussing sexuality and barrier-protections candidly with women seems emblematic of the difficulties Latinas face in their recovery from post-abuse disability.

The process of implementing the groups also revealed a need for a higher level of both intra- and inter-agency coordination than was anticipated by the lead researcher. The project needed funding and stewardship commensurate with its ambitions. The importance of ancillary supports such as child care and transportation stipends cannot be overemphasized. The multilayered agency approval process involved led to difficulties synchronizing group launch dates with availability of student volunteers who had been trained and who were committed to the project. This disjunction drastically reduced the N. Only in the environment of university-housed health clinics, where affiliation eased access to resources and support, was it possible to implement the group through to completion. In addition, even with doctoral-level trainees as
volunteers, difficulty with buy-in by Latina participants in groups that were facilitated by non-Latina, non-native Spanish speakers also may have impacted retention. The attrition from the two study groups that launched with non-native speakers for facilitators were also the two that experienced the most drastic attrition during the Empowerment phase of the group. While recent studies suggest that ethnic match between therapist and client is not as important as the therapist’s effort to acknowledge differences and adjust interventions accordingly (Smith et al 2009), there may be a need to make distinctions about the importance of match when treating specific mental health issues, such as trauma. This could be because a primary vulnerability of the participant population may be inability to adequately articulate and redress felt discomfort about inherent differences at the outset of a therapeutic relationship, as well as the tendency to use withdrawal and avoidance as a way of reducing stress.

At the outset of the study, the researcher believed there would be a positive relationship between number of groups attended and level of satisfaction with the group. While this question cannot be adequately answered given the current available data, and while there is some evidence that Latina women may be influenced by social desirability in answering satisfaction items, it does appear, for both the women who completed the group and those who dropped out early, that a high level of satisfaction was globally endorsed. Some explanations for this may include that the group was culturally specific, linguistically appropriate, trauma informed (therefore relevant), was run by experts, and that it was free. The finding that these groups were well received by the target group and that a general desire for more access to such groups was expressed is supported by current literature (Griner & Smith, 2009) regarding the impact of cultural adaptation of treatments.
Existing research on the TREM indicates that the greater number of groups attended corresponded significantly with symptom relief (Amaro et al., 2005), with a significant level of impact noted once a participant has attended 12 or more groups. The data in the current study parallels these earlier findings, particularly when attendance is discussed in terms of “showing up” cognitively, as well as more generally attending by arriving to group. Deviation in the comparative rankings of attendance and recovery gains may also be accounted for by person-specific context factors, such as differences in education level, baseline recovery phase, level of functional impairment during treatment, baseline symptom severity, and baseline forehand knowledge about trauma.

Recommendations to the Program:

Based on the experiences of this researcher in attempting to both implement the SEP and measure outcomes in community mental health settings for this study, and because this study could also be described as an informal program evaluation, the following recommendation are offered to the SEP developers in the spirit of enhancing the quality of protocol materials:

1. Conduct collaborative participant-informed research on the participant self-report measure (TRES) to improve the measure’s sensitivity, such that participant gains can be detected and more accurately reflected. Consider ways in which this instrument may need to be tailored to the population, such that differences in how distress and coping are expressed are reflected in the item content.

2. Revisit the inclusion criteria in the introduction, so as to refine the criteria for this population, or otherwise, address more explicitly issues related to balancing the group. For example, support needs for participants with grave mental health problems may be
more intensive when the SEP is delivered in an outpatient setting. Facilitators should be more explicitly informed of the expected impact of the protocol on participants with grave mental health issues, and instructed to anticipate the impact of those participants on the group as a whole.

3. Consider re-integrating a section on institutional abuse so that women who experience discrimination in institutional settings or who have trauma related to their immigration experience or undocumented status have an opportunity to explicitly discuss these concerns and seek support.

4. Therapists who are providers of trauma interventions need environmental supports, in the form of adequate pay for their work, access to a continuum of trauma informed services for their patients; access to trauma specific supervisions; and adequate resources in their clinical settings to provide care to their patients. Providers doing this work without these supports (e.g. in the trenches) are vulnerable to vicarious traumatization which can impact or impede their work and their personal health. This is even more problematic for therapists doing this work for underserved minority populations with complex trauma. Due to the current lack of adequate numbers of cultural minority providers, therapist doing trauma recovery work with this population will also likely be doing the work cross culturally. Developing additional discourse in the manual or in trainings surrounding issues specific to clinician self-care, clinician supports, and special training needs of clinicians doing this complex work, would be beneficial and context responsive.

Directions for Future Research

Research with Latina women accessing manualized trauma recovery treatments is in its infancy and it appears that both qualitative studies and quantitative outcome studies would be
helpful at this time. Theoretical underpinnings for how to measure outcomes with this specific population need to be addressed by further research and development of better protocols (e.g. more measures need to be translated or developed). A more sensitive and trauma-specific metric for symptom distress than the BSI-18 is desirable. A revision of the TRES to include more items that might show change with women in early recovery may also be helpful, particularly in trying to further flesh out what baseline characteristics may correlate with better recovery outcomes using this or similar protocols. Additionally, there appears to be ample evidence that Latinas express both symptoms and relief from symptoms in a manner that may be distinct from other groups. Qualitative research on how Latina trauma survivors both conceptualize their injury and express it may be useful as a preliminary step to refining item content on protocol-specific measures (TRES and TREP) meant to detect change in a pro-recovery direction. Measures of acculturative stress may also be useful to include in further research with this population. Future studies on this protocol looking specifically at changes in awareness, coping and behavior change would benefit from a more articulated review of the type of item content that might best capture changes in those domains for this population.

Future studies that document the participant experience and that document outcomes with larger numbers of participants are needed, as are qualitative studies. A study that mirrors the design of this study but that also includes post-treatment follow-up would help to create a better understanding of the longer-term impact of the program. At present, it remains unclear whether or not gains achieved during treatment increase, decrease or stay stable after a significant period of no treatment.

Another important area of research might also be developing a format for better distinguishing participant readiness for this type of group. A clarification of what may be
expected from early recovery phase participants versus mid-recovery phase participants could be useful in helping agencies and clinicians decide when it is most appropriate and clinically sound to employ the protocol. A rigorous questioning of whether the “wide open” participant inclusion stance is adequate to direct treatment decisions in an outpatient community setting, along with a clarification of how the change process occurs in trauma recovery would also be useful as the focus of either a comparative literature review theoretical work.


Alegría, M., Perez, D., & Williams, S., (2003). The role of public policies in reducing disparities in mental health status for people of color. *Health Affairs.* 22 (3) 51-64. doi : 10.1377/hlthaff.22.5.51


http://ajp.psychiatryonline.org/cgi/content/abstract/147/7/861


APPENDIX A

Summary of Session Goals for Saber es Poder

*Empowerment:*

1. **Introduction/What it means to be a woman** (Topics 1 & 2 from original TREM manual). Goals for the group include understanding the format and agenda of the group, each participant introducing herself to the group, exploring the personal significance and culture of being a woman, and thinking about how being a woman has defined the lives of each participant.

2. **What do you know and how do you feel about your body** (Topic 3 from original TREM manual). Goals include learning more about the body, its functions, rhythms and cycles, non-pejorative vocabulary for parts of the body, clarification of how human reproductive system functions. Additionally, participants will explore how they feel about their bodies and how what they know/don’t know about their bodies may be connected to their trauma histories.

3. **Physical Boundaries** (Topic 4 from original TREM manual). Goals include gaining a better understanding of personal space, and getting a greater sense of how much or how little participants control what happens in their physical space and to their person.

4. **Emotional Boundaries** (Topic 5 from original TREM manual plus HIV prevention). Goals include knowing when one has the right to say “no,” understanding the differences between passive and active strategies for preventing HIV transmission, and understanding what it means to establish interpersonal boundaries.
5. **HIV Prevention** (not in the original TREM manual). Goals include identifying precursors and factors that contribute to having high-risk sex and learning to generate healthy options for intimacy and sexual activity without exposing oneself to increased risk of infection or transmission.

6. **Self Esteem and Self-Soothing** (Topics 6 & 7 from original TREM manual). Goals include beginning to catalogue individual participant’s positive qualities, examining how the opinions of others impact how participants feel about themselves, discussing the participants’ understandings of how abuse affects self-esteem, and beginning to learn what it means to comfort or calm oneself down.

7. **Intimacy and Trust** (Topic 8). Goals include each member gaining an understanding of what it means to be intimate with another person, and each member being able to articulate the conditions that promote or violate trust, reciprocity, and safety.

8. **Sex with a Partner** (Topic 10). Goals include each member understanding what goes into a sexually intimate relationship with a partner.

*Trauma Recovery*

9. **Gaining an understanding of Trauma** (Topic 12). Goals include each member gaining an understanding of what is meant by trauma and the role that trauma has played in her life, as well as gaining insight into the coping strategies that have helped her deal with the feelings associated with trauma.

10. **The Body Remembers What the Mind Forgets** (Topic 13). Goals include members beginning to identify how their feelings toward their bodies are connected to experiences of
abuse and members gaining an understanding of how current physical pain and bodily distress may be connected to prior abuse.

11. **What is Physical Abuse?** (Topic 14). Goals for this group include teaching members to identify what constitutes physical abuse and helping members to gain an understanding of the impact that physical abuse has had on their lives.

12. **What is Sexual Abuse?** (Topic 15). Goals include teaching members what defines and constitutes sexual abuse, and helping members gain an understanding of the emotional impact of sex abuse.

13. **What is Emotional Abuse?** (Topic 17). Goals include helping members to recognize and accurately label emotional abuse, as well as helping them begin to appreciate that emotional abuse may have a life-long impact.

14. **Abuse and Psychological or Emotional Symptoms** (Topic 19). Goals include member exploration of the possible link between past abuse and intense feelings or dysfunctional behaviors, as well as member consideration of the links between currently labeled symptoms and their original responses to trauma.

15. **Trauma and Addictive or Compulsive Behavior** (Topic 20). Goals for this group include helping members to begin to see connections between their own compulsive behaviors and their histories of sexual and physical abuse, and helping member begin to see how their excessive dependence on drugs, alcohol, food, sex may be a form of self-abuse.
16. **Current Family Life** (Topic 23). Goals include helping members explore current relationships with family members, helping them to identify sources of tension, and helping them begin to decide what kinds of relationships they want with family members as well as realistically assess what kinds of relationships are possible.

17. **Decision Making: Trusting your Judgment** (Topic 24). Goals include helping members assess and understand the process by which they make decisions, and helping members identify those factors that caused them to cede decision-making authority in the past.

18. **Communication: Making Yourself Understood** (Topic 25). Goals include members identifying faulty and unsuccessful communication patterns, and members considering alternative styles that might allow them to communicate more clearly.

19. **Self-destructive Behaviors** (Topic 26). Goals include member exploration of precipitants for self-abuse, and giving members opportunities to share experiences of self-abuse in a non-shaming, nonjudgmental atmosphere.

20. **Blame, Acceptance and Forgiveness** (Topic 27). Goals include member exploration of the concepts of blame and responsibility, as well as member discussion of the roles of acceptance and forgiveness in recovery.

21. **Feeling out of Control** (Topic 28). Goals include helping members put words to their responses during an emotional storm, helping members understand triggers and consequences to feeling out of control, and helping members consider ways in which they might be able to modulate their emotions.

22. **Abuse and Relationships** (Topic 21). Goals include helping members identify which interpersonal patterns are hurtful and abusive and which are healthy and supportive; also
helping members connect how past abuses might be related to their current ability to form and maintain relationships.

23. **Relationships** (Topic 29). Goals for this group include members gaining a more sophisticated understanding of the stages of relationship development, and members understanding current impediments to forming healthy relationships.

24. **Truths and Myths about Abuse** (Topic 31). This is 1 of 2 groups dedicated to closing the group. Goals for the group are to help members review how their understanding of abuse has evolved, and helping members solidify a more reality-based perception of what abuse is and is not.

25. **Closing Rituals** (Topic 33). This is the final session. Group goals include helping women have a chance to process their group experience and to say good-bye.
APPENDIX B.1
Instruments and Measures

Demographic Items

1) Study Participant ID Number_____________

2) Date________________

3) Age______________________

4) Ethnicity________________

5) Primary Language: Spanish_____ Other______________________

6) Employment: Full Time___ Part-time___ Unemployed______ Other: _______________

7) Do you have a spouse or partner? : Yes___ No__

8) Number of children________

9) Highest Education (mark one):
   __ grade school
   __ some high school
   __ high school diploma
   __ some college
   __ associates degree (2 years)
   __ bachelors degree (4 years)
   __ Masters or professional degree

10) Number of years living in the United States_____

11) ¿Do you think of yourself as a religious or spiritual person? Yes___ No__

12) ¿Do you regularly practice spiritual or religious rituals? Yes___ No___
13) If yes, then do you rely on spiritual practice or religious belief to cope with, address or resolve emotional problems? Yes__ No___

14) ¿ Have you ever been in therapy or seen a counselor? Yes__ No___

15) If yes, when? ___________________

16) Have you ever participated in group therapy? Yes___ No___

17) If so, when? _________________________

18) If so, did the group therapy address trauma, or did you discuss trauma in the group? Yes___ No___
APPENDIX B.2

Cultural Scale

1) I must control or hide my feelings when I am upset about abuses I have experienced.

2) A woman should endure difficulties in life without complaint.

3) Bad things that have happened were pre-ordained or prescribed by “fate.”

4) A good woman copes and moves forward in her life regardless of the abuse she has experienced.

5) It is better to not think about the damages of the past, and
APPENDIX B.3

Self Awareness Scale

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http://www.communityconnectionsdc.org/web/page/629/interior.html
APPENDIX B.4

Coping Scale

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http://www.communityconnectionsdc.org/web/page/629/interior.html
APPENDIX B.5

Behavior Scale

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http://www.communityconnectionsdc.org/web/page/629/interior.html
APPENDIX B.6

Participant Satisfaction Questionnaire

1) I am getting what I thought I needed from the group

2) The group leaders respect my values and beliefs

3) I feel like I am being treated as a whole person rather than pulling me apart into separate problems.

4) How difficult was it for you to answer the questions on this survey?

5) If you have missed groups, please list reasons why you were unable to come to the groups you missed (check all that apply):

☐ Transportation Problems

☐ No Child Care

☐ I had to Work

☐ I, or someone in my family, was sick

☐ I felt like doing something else that day

☐ I did not like the previous group

☐ I didn’t like topic to be discussed that day

☐ I felt scared to be in the group

☐ I felt too sad, angry or depressed to come that day

☐ I forgot

☐ Other (please explain) ______________________________
APPENDIX B.7
Exit Survey

Date__________
Participant Number________________________

Circle the questionnaires you have filled out: 1, 2, 3, 4

Do you have a counselor? Yes / No

Do you have a case manager? Yes / No

Number of times a week you are seen by your case-manager or therapist (outside of this group): ____

Number of SEP Groups you have attended: ____

Number of weeks since you last attended a group______

Number of contacts you have had with group leaders outside of group (phone calls, letters, in-person conversations) ____

Provide a general explanation as to why you have decided to stop coming:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you missed groups before deciding to stop coming all-together, please list reasons why you were unable to come to the groups you missed (check all that apply): Transportation Problems

☐ No Child Care

☐ I had to Work
☐ I, or someone in my family, was sick
☐ I felt like doing something else that day
☐ I did not like the previous group
☐ I didn’t like topic to be discussed that day
☐ I felt scared to be in the group
☐ I felt too sad, angry or depressed to come that day
☐ I forgot

Please list other reasons you may have missed a group that are not in the list above:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If given another opportunity to participate in a TREM Group, would you do so? Yes/ No

Why or why not?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Would you recommend the group to others? Why or why not?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Informed Consent and Information Sheet

**Study Title:** Evaluation of 3 Key Psycho-educational Interventions in Treating Trauma with Latina Women: Awareness, Coping Skills Acquisition, and Behavior Change.

**PRINCIPAL INVESTIGATOR:** Ruby Berdine, MS (503) 288-2901  
**PROJECT SUPERVISOR:** Robin Shallcross, PhD, APBB ((503) 352-2410  
**CO-INVESTIGATORS:** Fabiana Wallis, PhD  
Lucrecia Suarez, LCSW

**SPONSORS:** Pacific University of Oregon in Hillsboro

**RATIONALE:** You are being invited to participate in a research study because you are going to participate in a group called *Saber es Poder (Knowing is Power).* This study will look at the effects of the Saber es Poder group on your experience of symptoms, knowledge of trauma, and coping skills. This study is being conducted with the help and cooperation of community partners such as the Iris Clinic, the Psychological Services Center, Morrison Center, El Programa Hispano, and Conexiones, and will include between 10 and 48 other women.

Your participation in this study will last approximately 6 months, and in addition to participating weekly in groups, you will be asked to answer our questions about your experiences in the group during 4 additional meetings in group or individually with the study investigator.

**PROCEDURE:** If you decide to be a study participant, you will be asked to complete a series of 4 questionnaires. You may complete them on your own or with the help of the investigator in an
individual interview. The questionnaires will include roughly 100 questions each. The questions will be regarding 1) demographic information and your treatment history, 2) your emotional symptoms, 3) how you are currently coping with your trauma experiences, 4) your level of satisfaction with the group, and 5) what problems you have experienced during the group that have impacted your participation. Each questionnaire will take between 35 and 60 minutes to fill out. You will be asked to complete a questionnaire approximately every 2 months during your participation in the group. If you decide to stop before the group is finished, we will contact you to find out more about why you stopped and to offer you alternative resources for treatment.

Also, we will ask for your permission to videotape 3 groups during your participation. Only the investigator and her trained assistants will see those videos. The reason for the videotaping is to assure that the group counselors who are running the groups are following the appropriate format. The videos will be destroyed after they are evaluated and notes or transcripts taken from the videos will be de-identified.

None of the information obtained during this study will be kept in your personal records if you are also in individual treatment or in other forms of care at the clinics that are participating in this study. It will not be in the files of your individual therapist if that therapist belongs to the clinic where you attend groups. Your data will be confidential, and stored. Separately from any information that could identify you as the source. At the end of the study, the investigators will present their results only in a way that protects your privacy.

**RISKS AND INCONVENIENCES:** Some of the questions that we will ask as part of the study can seem very personal or perhaps, feel embarrassing or uncomfortable to answer. You can decide not to answer whatever questions you don't want to answer. If the questions are overly disturbing to you, we will make sure that you receive the support of a counselor to help you.

Additionally, participating in *Saber es Poder* can sometimes cause an increase in the intensity of the symptoms you are experiencing. Some of the common symptoms experienced by trauma survivors are anxiety, depression, nervousness, or short term alterations in body and sensory experiences. As a study participant, you have permission to leave group or stop participation at
any time that you don't feel comfortable or safe. IF the group content is overly disturbing to you, we will help you get additional help and support.

**BENEFITS:** You may or may not experience personal benefits as a result of your participation in this study. Regardless, as a study subject, you could contribute new information that will benefit other future participants in *Saber es Poder.* The intention of the study is to improve our ability to help Latinas recover and cope better with the impact of their difficult experiences.

**ALTERNATIVES:** Your participation in the group and in this study is voluntary. You can choose not to participate in the study. Deciding to not participate in the study has no effect on your ability to participate in the programs offered at the clinic your are attending, including the *Saber es Poder* group. If you decide not to participate in the study but want to participate in the groups, we will ask that you sign a form to give us permission to record some of the group sessions you will be participating in.

**CONFIDENTIALITY:** Neither your name or any other identifying information will be used in publications or proposed publications. The written records of our conversations with you will not contain your name or the key to your identification number. The records of the study will also be kept under lock and key in the investigators archives for an indefinite period. Under Oregon law, if we discover something that puts you, your children or other persons in immediate danger, we have the obligation to talk with you directly about it, and it is possible that we will also be required to make a report of the information to the appropriate authorities.

**COSTO:** There will be no cost to your participation in this study. You will receive a $10 gift certificate for the store of your choice each time you complete a questionnaire. There is also no cost for participation in the *Saber es Poder* groups if you are a study participant. Every clinic that is participating in this study will also offer discount rates and scholarships for individuals with low-income if they do not wish to be a study participant but would still like to participate in the groups.
CONTACT INFORMATION: If you have question about this study, please call the investigator, Ruby Berdine, MS (503)258-4623. If you have questions related to your rights as a study participant, please call Pacific University’s Institutional Review Board (you will need an interpreter for this call), at (503) 352 – 2112.

RESOURCES:
Portland Women’s Crisis Line 1-888-235-5333 (gratis)
El Programa Hispano (503) 669-8350
Clínica Iris en Hillsboro (503) 352-7333
Conexiones en Portland (503) 235-8057

I understand all of the information in this document and I am satisfied with the answers I have been given for questions that I had. I am older than 18 years of age, and I would like to participate in this study. I have been given a copy of this form for my records.

Participant Signature                                     Date

Interviewer/Investigator's Signature                          Date

17. Contact Information

The investigators will need your telephone number, address and your e-mail address in case there is a reason to notify you of any changes or problems that come up during your participation in the study. Also, please indicate here if you are interested in attending a summary presentation of study results once the study has been completed. We will use the information below to contact you.

Would you like to be notified of when and where the results will be presented?

___Yes ____No

Participant Name ____________________________

Contact Information: ____________________________
APPENDIX C.2
Informed Consent (Spanish)

Hoja de Información y Consentimiento

**TITULO:** Evaluación de 3 estrategias en el Tratamiento de Trauma con Mujeres Latinas: entender cómo funciona el abuso, aprender herramientas para lidiar con síntomas, y hacer cambios en comportamiento

**INVESTIGADORA PRINCIPAL:** Ruby Berdine, Maestría (503) 288-2901
**SUPERVISORA DEL PROYECTO:** Robin Shallcross, PhD, APBB ((503) 352-2410
**CO-INVESTIGADORAS**  
Fabiana Wallis, PhD  
Lucrecia Suárez, LCSW

**PATROCINADORES:** Pacific University de Oregón en Hillsboro

**PROPÓSITO:** Usted ha sido invitada a participar en este estudio de investigación debido a que Ud. va a participar en un grupo llamado *Saber es Poder*. El propósito de este estudio es el determinar si la participación en *Saber es Poder* ayuda a manejar sus experiencias emocionales causadas por episodios difíciles en su vida. Estamos interesados en entender cómo la información que Ud. recibe por medio de este grupo le ayuda a sobrellevar sus problemas emocionales, y a lograr cambios en cómo usted ve y reacciona ante problemas. El estudio se llevará a cabo con nuestros socios de la comunidad, en La Clínica Iris, El Psychological Services Center, Morrison Center, y Conexiones e incluirá aproximadamente entre 10 a 48 mujeres.

Su participación en este estudio durará aproximadamente 6 meses, y además de participar en los grupos, le pediremos que responda a nuestras preguntas sobre sus experiencias en el grupo durante 4 reuniones o charlas individuales.
PROCEDIMIENTO: Si Usted decide formar parte de este estudio, se le pedirá que complete una serie de 4 cuestionarios. Podrá completarlos por su cuenta o con la ayuda de la entrevistadora. Las encuestas tendrán más o menos 100 preguntas cada una. Los cuestionarios incluirán preguntas acerca de: 1) información demográfica e información sobre su historia de tratamiento 2) preguntas sobre síntomas emocionales; 3) información sobre cómo maneja sus experiencias de trauma; 4) que tan satisfecha está con el contenido del grupo; 5) problemas que impactan su capacidad de participar en los grupos. Le llevará entre aproximadamente 35 y 60 minutos cada encuesta. Tendrá la oportunidad de llenar las encuestas aproximadamente cada 2 meses durante su participación en Saber es Poder. Si decide dejar de participar en el grupo, se le pedirá permiso para contactarle para entender mejor su decisión y ofrecerle alternativas.

También se le pedirá permiso para grabar en video 3 grupos durante su participación en el estudio. Solamente las investigadoras y sus ayudantes profesionales verán los videos. El propósito de los videos es para asegurar que las consejeras que manejan los grupos están siguiendo el formato apropiado, y nada de la información que Ud. da durante los grupos grabados será utilizado con otro propósito. Los videos serán destruidos después de evaluarlos, y notas o transcripciones con contenido del los video no tendrán datos que puedan conectarse con las participantes.

Ninguna información obtenida durante la encuesta será incluida en sus archivos de tratamiento individual de las clínicas que participan en este estudio. Tampoco en los archivos de terapia individual si Ud. tiene consejería individual en una de estas clínicas. Sus datos serán confidenciales, y guardados aparte de los datos que identifican su origen. Al final del estudio, las investigadoras presentarán resultados del estudio solamente en un formato que protege su identidad.

REISGO E INCOMODIDADES: Algunas de las preguntas que se le harán como parte del estudio podrán parecerle muy personales o embarazosas o quizá le incomoden. Puede negarse a contestar cualquier pregunta que no desee contestar. Si las preguntas le perturban demasiado, le ayudaremos a conseguir apoyo de parte de una consejera.
Además el participar en *Saber es Poder* a veces puede hacer más intensos los síntomas que uno experimenta. Algunos síntomas comunes son ansiedad, depresión, nerviosismo, o aumento a corto plazo en sus experiencias sensoriales y físicas. Como participante en el estudio y el grupo, Ud. tiene permiso de salir del grupo o dejar de participar en cualquier momento si no se siente cómoda o segura. Si el contenido del grupo le perturba demasiado, le ayudaremos a conseguir apoyo adicional.

**BENEFICIOS:** Puede que Usted obtenga, o no, un beneficio personal por participar en este estudio. Sin embargo, al servir como ejemplo, Usted podrá contribuir información nueva que pueda beneficiar a futuras participantes de *Saber es Poder*. El propósito del estudio es mejorar nuestra capacidad de ayudar las mujeres Latinas a recuperar y lidiar mejor con el impacto de experiencias difíciles.

**ALTERNATIVAS:** Su participación en el grupo y este estudio es voluntaria. Usted puede elegir no participar en este estudio. El negarse a participar no afectará su participación en los programas de la clínica, inclusive en los grupos de *Saber es Poder*. Si Ud. prefiere no participar en el estudio, pero quiere participar en los grupos, le pedimos que firme un permiso de grabar algunos de los grupos en los que estará participando.

**CONFIDENCIALIDAD:** Ni su nombre ni su identidad serán utilizados para publicaciones y propósitos publicitarios. Los registros escritos de nuestra conversación no contendrán su nombre si no una clave de número. Los registros del estudio serán mantenidos en archivos bajo llave en la oficina de la investigadora indefinidamente. Bajo la Ley de Oregón, si descubrimos algo que pone en peligro inmediatamente a Usted, a sus hijos, o a otros, podremos comentarlo con Usted, de ser posible, y deberá ser reportado a las autoridades competentes. Bajo la Ley de Oregón, el sospechado abuso infantil debe ser reportado a las autoridades competentes.

**COSTO:** No habrá costo para su participación en este estudio. Ud. Recibirá $10 por cada encuesta que complete. El costo de participar en *Saber es Poder* es gratis si es participante del
estudio. Además, cada clínica que está participando en este estudio ofrecerá descuentos y becas para las personas de bajos ingresos si usted quiere participar en los grupos pero no en el estudio.

CONTACTAR: Si tiene preguntas acerca de este estudio, por favor llame a la investigadora, Ruby Berdine, MS (503)258-4623. Si tiene preguntas relacionadas con sus derechos como una participante por favor llame a Pacific University’s Institutional Review Board (necesitará un intérprete durante este llamada), al (503) 352 – 2112.

RECURSOS:
Línea de Crisis, Portland Women’s Crisis Line 1-888-235-5333 (gratis)
Raphael House Línea de Crisis en Español (503)222-6507
El Programa Hispano (503) 669-8350
Clínica Iris en Hillsboro (503) 352-7333
Conexiones en Portland (503) 235-8057

Entiendo toda la información en este documento y estoy satisfecha con las respuestas que me han dado para preguntas que tenía. Soy mayor de 18 años, y quiero participar en este estudio. Yo he recibido una copia de esta hoja para guardar.

Firma de participante                                    Fecha

Firma de investigadora                                   Fecha

17. Datos de contacto

Las investigadoras necesitan su número telefónico, su dirección, y su correo electrónico en caso de que necesiten avisarle de cambios o problemas durante su participación en el estudio. También, por favor indique si Ud. está interesada en asistir a una presentación que resume los resultados de este estudio una vez que se haya completado. Usaremos su información en casos necesarios.
¿Quiere Ud. un resumen de los resultados cuando el estudio esté completado?
___Si ___No

Nombre de la participante ________________________________

Dirección y Teléfono: ________________________________
APPENDIX D

Visual Likert-Type Scale Art “El Florero”