

Mindfulness Based Trauma Counselling Program: An Evaluation

**Catholic Family Services of Peel-Dufferin
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Executive Summary

The Mindfulness Based Trauma Counselling (MBTC) program was designed and developed for use with trauma survivors. Broadly, the aim of the program was to teach mindfulness practice and through cultivation of mindfulness help alleviate the suffering of survivors of trauma and abuse. The program was delivered in the form of group counselling which included 12 weekly group sessions, one full-day retreat and homework assignments involving cultivation of mindfulness practice. Participants in the program included women who had experienced adult victimization, childhood victimization or both. The sessions were facilitated by therapists experienced in both trauma counselling and mindfulness meditation. The program was delivered by Catholic Family Services of Peel-Dufferin at three locations in the region of Peel. The study used a pre and post test research design to assess outcomes. A total of 43 women attended and 25 (58%) completed the program.

Results showed that participants made significant improvements on diverse aspects of emotional, psychological and mental functioning. Symptom reductions were noted for mental distress, depression and trauma. Findings indicated that participants learnt and employed mindfulness practices, and experienced an increased sense of well-being by the end of the program. Given that emotional, somatic and mental awareness is central to mindfulness practice it was of little surprise to find that application of these practices resulted in significant improvements in emotional and psychological functioning. Overall, it appears that the MBTC model used in this program had a positive impact on participants.

Introduction

Mindfulness is a practice based in the ancient Buddhist tradition of Vipassana meditation. It teaches individuals to practice moment-to-moment awareness of self in a intentional way in order to be fully present and accepting of internal states. Cultivation of this practice develops the ability for allowing experiences to unfold and accept them as they are, in a compassionate, non-judgmental manner (Carmody & Baer, 2007; Kabat Zinn, 1990). There is an increasing body of empirical research that demonstrates the positive impact of mindfulness practice on physical and mental health (Baer, 2003; Carmody & Baer, 2007; Grossman, Niemann, Schmidt & Walach, 2004; Segal, Williams & Teasdale, 2002). Emerging research suggests that there are clinically significant improvements in psychological functioning that are seen in a wide range of both, clinical and community populations.

The developers of the MBTC program being evaluated in this study focused on female trauma survivors many of who experienced trauma as adults (interpersonal victimization, discrimination) as well as in childhood (sexual abuse, neglect, physical abuse), who also frequently present with numerous emotional, psychological and mental health problems. Experiences of trauma from childhood abuse or victimization as an adult are more prevalent than previously believed. Domestic violence estimated to be as high as approximately 30% (Johnson & Sacco, 1995) and childhood abuse 40% (Tjaden & Thoennes, 2000) to 50% (Finkelhor, Ormrod, Turner & Hamby, 2005). Trocme et al., (2001) in their study of child abuse in Canada found numerous types of child victimization including neglect (43%), physical abuse (34%), emotional maltreatment

(54%) and sexual abuse (38%). The abuse experienced by the women who participated in this study reflects the experience of women and children in society on a broader scale.

Mental health or distress in adulthood can be attributed to a complex combination of factors including biological predisposition, environmental circumstances and personality factors. The impact of victimization and trauma on mental health is now well-documented and the link between childhood abuse and long-term mental health sequelae is well established (Beitchman, Zucker, Hood, DaCosta, Akma & Caasavia, 1992; Briere & Runtz, 1987; Browne & Finkelhor, 1986; Rodriguez, Ryan, Rowan & Foy, 1996). Its effects include Post Traumatic Stress Disorder, problems with arousal modulation, violent nightmares, intrusive thoughts, flashbacks, dissociation, emotional numbing or detachment, problems with affect regulation, depression, anxiety, dissociative states, amnesia, impaired self reference, intimacy disturbances, attachment difficulties, sexual problems, interpersonal difficulties and suicidality (Briere, 1992; Van der Kolk & McFarlane 1996). Self-mutilation, substance abuse, eating disorders, sleep disorders, panic attacks, feelings of powerlessness, betrayal, boundary confusions, low self-esteem, anger and hostility, depersonalization and psychiatric disorders are frequently observed in adults who have been victimized in childhood (Breslau, 2002; Briere & Runtz, 1993). It has been shown that trauma can seriously impact the functioning of the central nervous system, storage and retrieval of memory, arousal regulation and affect regulation (Briere & Scott, 2006; Solomon & Heide, 2005) and biologically alters the body's capacity for homeostasis.

Trauma survivors often experience physiological symptoms, psychological distress, problems with emotional regulation, feelings of loss of control and problems in

coping. Somatic awareness, emotional tolerance, emotional and mental regulation of internal states, acceptance, compassion and increase in the sense of personal agency are integral to mindfulness practice. The rationale for offering this approach to trauma survivors was that survivors could greatly benefit from a practice, which addresses so many core aspects of trauma sequelae. The program which has been in development for the last seven years was first described by its developers Harris and Laskin in 2004 who used it with trauma survivors. Based on the positive feedback from participants and referral sources they agreed to offer it more broadly and later sought out means by which the program could be evaluated on a systematic basis. The aim of the program was to teach mindfulness practice and through the cultivation and application of the skills and attitudes related to mindfulness, help alleviate the suffering of survivors of trauma and abuse.

Description of the Mindfulness Based Trauma Program (MBTC)

MBTC is a group program that combines mindfulness meditation and trauma informed counselling. Participants in the MBTC program cultivate the wisdom and compassion practices of mindfulness that assist them to remain in contact with their experiences. This enhanced ability to stay connected empowers women to deal more effectively with the impacts of trauma and the intrusions of these impacts in their current lives. The program consists of 12 weekly group sessions, each 2 1/2 hrs in length and one, all-day retreat. The program was delivered by Catholic Family Services of Peel-Dufferin in three locations, Brampton, Mississauga and Orangeville. Group sizes ranged from 8-12 participants per group with a maximum of 12 participants per group. Group sessions combined practices of mindfulness meditation with an opportunity to explore women's

experience of the practice. The facilitators intervened directly with individual participants by supporting their application of the practice in the moment. Participants were taught how to apply mindfulness to feelings, sensations and thoughts. Through cultivation of formal meditation practice participants learnt the ability to be ‘present’ to their internal experiences in their entirety, develop acceptance of their internal states and slowly learn to both tolerate and, modulate the intensity of these experiences. Participants learnt the ‘body scan’ where attention is focused sequentially on parts of the body. Participants were also taught compassion and ‘loving kindness’ practices which are integral aspects of the program. These practices addressed the trauma survivor’s internalized sense of unworthiness by building a sense of their innate capacity for goodness and right to well-being. By cultivating the stance of compassionate witness women began to be able to turn toward aspects of their experiences that they had previously avoided. Facilitators also provided psychoeducational interventions relevant to a participant’s sharing that assisted in demonstrating the relationship between trauma, psycho-social and systemic context and what was arising for her in the moment. These psychoeducational moments were intended to normalize and validate participants’ felt experiences and habitual responses as well as build compassion for the victimized self. Participants were expected to practice between sessions and discussed their progress in the group sessions. Each week women were provided with optional readings and handouts describing ways to practice both formally in sitting meditation and, informally in everyday life.

Two therapists facilitated each of the group sessions. One therapist, the most senior of the team, with over thirty years of experience in therapy was the consistent,

senior facilitator in all four groups. Three of the four groups were co-facilitated by a therapist with over twelve years experience in therapy and one of the groups was co-facilitated by a therapist with over ten years experience in therapy. One out of the four group sessions included a therapist in training, an intern at Catholic Family Services who was supervised by the senior therapist facilitating the groups.

Method

Sample

Participants in the study were women living in the region of Peel-Dufferin who were seeking counselling services. Participants were survivors of partner abuse, sexual assault, interpersonal violence, discrimination and childhood victimization (physical abuse, neglect, emotional abuse, sexual abuse and discrimination). Participants who attended came from various areas in the region of Peel-Dufferin including Brampton, Mississauga and Orangeville. Participants were either self-referred or were referred by service providers in social service agencies who knew about the program.

One consideration in sampling was that it was a non-random, convenience sample. Forty-three women entered the study and 58% (25) completed the program including the post-testing measures. Eighteen women dropped out of the study constituting 42% of the sample. Statistical analyses using t-tests and chi-square were used to examine the 'drop-out' sub-group. The 'drop-out' group did not differ significantly from the 'completers' on demographic characteristics or psychological variables. See Appendix A for a detailed breakdown of differences. This group was dropped from the analyses. They were included only for purposes of descriptive information of the full sample. The final sample consisted of twenty-five participants.

Measures

Participants were administered a package consisting of a background questionnaire (Appendix B) and a battery of measures which are described in detail below. The background questionnaire was based on an interview schedule already in use in the agency that was providing the program. The project team added a few additional questions relating to hopefulness, well-being and different ways of coping with stress.

Variables in the study

1. *Hopefulness of relief from distress:* Information on hopefulness was collected using a scaling question in the background questionnaire. This was helpful in establishing the participants mind set at the start of the program in terms of their perceptions about whether the intervention would help them feel relief from distress. The question was also asked at the end of the program to ascertain if they felt the same way at program completion.
2. *Well-being:* Information on participant's overall sense of well-being was collected using a scaling question in the background questionnaire. This was helpful in getting the participants subjective assessment of their own sense of wellbeing at the start and then at the end of the program.
3. *Depression:* Information on depression was gathered using the popular CES-D scale. This variable was considered important given the prevalence of depression symptoms in trauma survivors.
4. *Alexithymia:* Alexithymia is the ability to feel emotion and correctly identify emotion. Given that trauma survivors experience numerous difficulties with

- emotional numbing, emotional regulation and emotional tolerance this variable was included in the study and measured using the TAS which has been specifically designed to measure this construct.
5. *Trauma Symptoms*: This variable was considered important given the presentation of diverse trauma symptomatology in trauma survivors. Information on trauma symptoms was gathered using the TSC-40.
 6. *Self-Compassion*: Given that compassion for self and others is a key component of mindfulness training practice it was considered important for inclusion in this study. It was measured using the Self-Compassion Scale.
 7. *Self-Esteem*: This variable was considered important given the common experience of poor self esteem among survivors of trauma. It was measured using the RSES.
 8. *Mindfulness*: Given that the program was based on teaching mindfulness practice in healing from trauma this variable was considered as critical for inclusion. It was measured using the FFMQ.
 9. *Mental health distress*: Many trauma survivors experience mental health distress. Hence this variable was considered important to include in order to establish the overall levels of mental distress of participants. Information on this variable was gathered using the SCL-90.

Description of scales

1. *Depression*: Information on depression was gathered using the popular Centre for Epidemiological Studies Depression Scale (CES-D) scale which is a 20 item, self-report measure used for screening individuals with depression. Scores range from 0-

60, with higher scores indicating more symptoms. Those with a score equal to or greater than 16 are considered in the depressed range. The CES-D (Radloff, 1977), a widely used scale was found to have strong internal consistency (coefficient alpha was .80 or above in all samples). The scale reports norms for adults and is available in the public domain for widespread use.

2. *Alexithymia*: The Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994 and 1994 b) was used to measure this variable. This 20 item scale assesses the construct of alexithymia, the reduced ability to feel and correctly identify emotion. It has three subscales, Difficulty in Describing Feelings, Difficulty in Identifying feelings and Externally Oriented Thinking or the tendency of individuals to focus their attention externally. Total alexithymia score is the sum of responses to all twenty items with scores equal to or greater than 61 indicating alexithymia, equal to or less than 51 indicating nonalexithymia and scores 52-60 possible alexithymia. The scale has been found to demonstrate good internal consistency (Cronbach alpha of .81), good test-retest reliability (.77) and, adequate levels of convergent and discriminant validity. Its three factor structure has been found to be theoretically congruent with the alexithymia construct and has been found to be stable across clinical and nonclinical populations.

3. *Trauma Symptoms*: This variable was measured using the popular scale Trauma Symptom Checklist -40 (Briere, 1996; Briere & Runtz, 1989) or TSC-40. It evaluates symptomatology in adults associated with childhood or adult traumatic experiences. It measures aspects of post-traumatic stress and other symptom clusters found in some traumatized adults. It is a 40 item research measure consisting of six sub-scales:

Anxiety, Depression, Dissociation, Sexual Abuse, Sexual Problems and Sleep as well as a total score. Studies using the TSC-40 have demonstrated that it is a relatively reliable measure (subscale alphas ranging from .66 to .77). In several studies, the TSC-40 and its predecessor TSC-33 have been found to have strong predictive validity on a broad range of traumatic experiences (Briere, 1996).

4. *Self-Compassion*: This variable was measured using the Self-Compassion Scale (Neff, 2003a). This 26 item scale yields information on six different subscales including self kindness, self-judgment, common humanity (recognizing that suffering and personal failure is part of the shared human experience) isolation, mindfulness and overidentification (overidentifying with mental or emotional phenomena, ruminating or focusing on negative emotions such that one suffers as a result). It has been shown to have internal consistency of .92 and a reliability of .93 over a three week interval and, significant positive correlations with social connectedness, emotional intelligence, life satisfaction and significant negative correlations with perfectionism, anxiety and depression (Neff, 2003 a, b).

6. *Self-Esteem*: This variable was measured using the popular Rosenberg Self Esteem Scale also known as the RSES (Rosenberg, 1989). It is a ten item scale that assesses global positive and negative attitudes towards self. Popularly available in the public domain it has been standardized on diverse community samples and shown to have strong psychometric properties (Gray-Little, Williams & Hancock, 1997).

7. *Mindfulness*: This variable was measured using the Five Factor Mindfulness Scale or FFMQ (Baer, Smith, Hopkins, Krietemeyer & Toney, 2006). This 39 item instrument assesses five facets of mindfulness including Observing, Describing,

Acting with Awareness, Non-Judging of Inner Experience and Non-Reactivity to Inner Experience. It has been shown to have good internal consistency (.86) and findings support a hierarchical factor structure to mindfulness in which describe, actaware, nonjudge and nonreact (more than observe) can be considered facets of a broad mindfulness construct. Correlations were found in expected directions with numerous predictor variables being found related to mindfulness such as experiential avoidance, thought suppression, openness to experience and emotional intelligence (Baer et al., 2006).

8. *Mental health distress*: Mental health distress was measured by the Symptom Check List-90-R (Derogatis, 1994). It is 90 item self-report inventory that helps evaluate a broad range of psychological problems and symptoms of psychopathology. It yields information on nine symptom dimensions (Somatization, Obsessive-Compulsive, Anxiety, Depression, Phobic Anxiety, Hostility, Interpersonal Sensitivity, Paranoid Ideation, Psychoticism and three global indices including a global severity index which measures overall psychological distress (GSI), an index of intensity of symptoms (PSDI) and total number of positive symptoms (PST). The measure was standardized on different groups and has norms for community and psychiatric populations. The instrument has been shown to have strong psychometric properties with internal consistency ranging from .77 to .90 and strong test-re-test reliability yielding coefficients from .80 to .90. The measure used in over 1,000 studies has been found to be valid in its internal structure, have convergent-discriminant validity and factor stability (Derogatis, 1994).

Research design and data analysis

The study used a pre and post test research design to evaluate outcomes. T-tests for paired samples were used to analyze the data for the ‘completers’ group and t-tests for independent samples were used to compare the ‘completers’ and drop-outs’ group. The nonparametric test Chi-Square was employed in examining relationships between categorical variables. All analyses were done using the SPSS statistical package.

Procedure

Participants of the MBTC program were recruited through various means. The program, which was already known amongst service agencies in the region of Peel received referrals from counsellors and therapists from other agencies as well as from within Catholic Family Services. Flyers posted in the agency (and elsewhere) also drew interest from participants some of whom self-referred to the program. Once potential participants made contact with the program they met with the group facilitators for a ‘Pre-Screening’ interview. In this interview participants were explained the nature of the program, the practices that would be used and the level of involvement required from those who would attend. Participants were also assessed for readiness for group counselling at this interview. A total of 55 participants were interviewed for the program. Of this number approximately 12 (21%) dropped out at the pre-screening interview stage. There appeared to be diverse reasons for this attrition. Some participants stated that scheduling problems were a source of difficulty; others reported that they were not ready for a group experience as it would create more anxiety than they could handle. Others stated that their lives at home were too chaotic to follow through with the required mindfulness

practice. A few others felt that this program was not a good fit for them at this time as they were looking for primarily a ‘talk’ therapy group where they would be able to discuss the details of their trauma in depth.

All participants were advised that there would be a research component to the program since it was being evaluated. The program and its evaluation component were explained again in the first session of the group and participants were given further opportunities to ask questions about the same. They were given copies of the Information Form (Appendix B), which explained the purpose of the study as well as the risks and benefits involved. The limits of confidentiality were explained prior to signing consent forms (see Appendix C and D). After obtaining informed consent participants filled out the pre-test battery of measures which took approximately one hour to complete. Participants completed the post-battery in the latter half of the last session of the program. The researcher conducting the study was an independent evaluator and blind to the identity of the participants.

Confidentiality

Every effort was made to ensure that participant’s rights were protected. No identifying information appeared on test forms and individual participants were assigned code numbers, which allowed the researcher to match the individual’s pre-test battery with the post-test battery. The numbering was assigned by group facilitators from a master list of names, which they kept in a secure location. The researcher received only the coded documents (without participant names) from the group facilitators.

Recruitment and attrition.

The size of the sample was influenced by a variety of factors. Forty-three women entered the program of whom 25 (58%) completed the program (and the post-test measures) while eighteen women (42%) in total dropped out from the program. Information obtained from women who dropped out suggest that the reasons for attrition were diverse. For many there were personal reasons (health problems, care giving responsibilities) and for others it was scheduling problems and distance. A few women dropped out without contacting the program and could not be reached despite efforts by the facilitators.

Results

The results are presented in two sections. First, the background information on the sample is presented. Descriptive information include data for the whole sample ($N = 43$) including 18 that subsequently dropped out of the study. (See methods section for a description of full sample and the ‘drop-out’ group). This section is followed by the results of statistical analyses. Data regarding the comparison between the ‘completers’ and ‘drop-outs’ appears in Appendix A.

Table 1

Background information on the sample

Item	% Reporting	(Number)	Total $N = 43$
<hr/>			
<u>Adult experiences</u>			
Partner abuse	56%	(24)	
Sexual assault	49%	(21)	
Abuse by extended family	32%	(14)	
Problems with alcohol or drugs	30%	(13)	
Conflict with law	9%	(4)	

Involvement with psychiatric system	49%	(21)
Chronic physical illness	42%	(18)
Death of a child	5%	(2)
Divorce or separation	53%	(23)
Immigration	12%	(5)
Children in care of State	7%	(3)
Ongoing employment difficulties	28%	(12)
Poverty	21%	(9)
Serious accident	16%	(7)
Hospitalization/Surgeries	44%	(19)
Discrimination on basis of economic status	18%	(8)
Discrimination on basis of sexual orientation	2%	(1)
Discrimination on basis of race	12%	(5)
Discrimination on basis of culture	5%	(2)
Discrimination on basis of religion	5%	(2)
Discrimination on basis of ability	14%	(6)
Discrimination on basis of gender	12%	(5)
Discrimination on basis of language	5%	(2)
Discrimination on basis of education	9%	(4)

Childhood experiences

Raised primarily by both biological parents	74%	(32)
Sexual abuse as a child	67%	(29)
Physical abuse as a child	69%	(30)
Emotional/verbal abuse as a child	77%	(33)
Ritual abuse as a child	18%	(8)
Neglect by caregiver	60%	(26)
Violence between parents	37%	(16)
Abandonment by parents	19%	(8)
Suicide attempts	25%	(11)
Drinking	30%	(13)
Drug use	18%	(8)
Isolation or loneliness	67%	(29)
Discrimination on basis of economic status	18%	(8)
Discrimination on basis of sexual orientation	5%	(2)
Discrimination on basis of race	16%	(7)
Discrimination on basis of culture	9%	(4)
Discrimination on basis of religion	9%	(4)
Discrimination on basis of ability	12%	(5)
Discrimination on basis of gender	14%	(6)
Discrimination on basis of language	5%	(2)
Discrimination on basis of education	14%	(6)

Depression (as per CES-D) 98% (42)

Mental health distress (as per SCL-90) 89% (38)

Alexithymia (as per TAS)

46%

(20)

Mean scores on hopefulness, well-being and ways of coping with stress

Item	Mean	SD	N
Hopefulness of getting relief at time of entry into program (10 point scale from 1 No Hope to - 10 Certain)	6.0	2.1	42
Overall sense of well being at time of entry into program (10 point scale from 1 Very Poor to - 10 Excellent)	4.6	5.0	42
Use of alcohol to deal with stress at time of entry into program (10 point scale from 1 Frequently to - 10 Never)	8.8	1.8	42
Use of drugs to deal with stress at time of entry into program (10 point scale from 1 Frequently to - 10 Never)	9.1	2.1	42
Use of food to deal with stress at time of entry into program (10 point scale from 1 Frequently to - 10 Never)	4.8	2.8	43
Use of shopping to deal with stress at time of entry into program (10 point scale from 1 Frequently to - 10 Never)	6.3	1.0	42
Use of sex to deal with stress at time of entry into program (10 point scale from 1 Frequently to - 10 Never)	8.6	2.4	41
Use of gambling to deal with stress at time of entry into program (10 point scale from 1 Frequently to - 10 Never)	9.3	1.9	42

Table 1 presents the information relating to background information on the participants at the time of entry into the program. Half the women in the sample reported experiences of sexual assault as an adult and over half reported abuse by a partner and experiences of divorce and separation. About one-third also reported that they experienced abuse by their extended family. About 30% of the participants disclosed that they had had problems with drugs and alcohol as adult. However, according to the facilitators who

conducted the pre-screening interviews none were experiencing substance related problems at the time of entering the program. About 44% reported having medical problems involving hospitalization and surgeries for different things. Just under half reported that they had a history of involvement in the psychiatric system. In this study it was not possible to ascertain whether or not this involvement was a direct result of trauma experiences but it reflects the level of distress participants had experienced over the course of their lifetime. A number of participants also reported that they had experienced discrimination or harassment on various grounds over the course of their adult life.

In terms of childhood experiences, a majority (74%) reported that they were raised by biological parents but experienced abandonment (19%), witnessed violence between parents (37%) and neglect (60%). Approximately two-thirds of the participants reported experiencing sexual abuse (67%), physical abuse (69%) and emotional and verbal abuse (77%) as children. Many (67%) described loneliness and isolation as an enduring feature of their young lives and some also described suicide attempts (25%), drinking (30%) and drug use (18%) in childhood. Although by no means common, a number of participants reported that they experienced discrimination or harassment on various grounds while they were growing up.

A majority of participants (89%) reported symptoms of mental health distress and depression (98%) at the time of entry into the program. Just under half the participants (46%) also appeared to be alexithymic indicating difficulties and describing emotions. In response to questions on current coping strategies participants' responses suggested that they were not using alcohol, drugs, sex or gambling as ways of coping with stress.

However, on an average it appeared that many participants used food as a coping strategy.

In general it appears that the participants in this sample had numerous experiences of victimization as children and adults, which, for some were likely compounded by other life difficulties (health problems, unemployment and poverty). On an average, most reported a poor sense of overall well being but at the same time were feeling somewhat hopeful that they would get some relief from the distress they were experiencing by attending this program.

Table 2
Mean differences, t-test results on measures

	Pre-test		Post-test		t	df	p
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>			
Hopefulness of relief from distress	6.2	1.9	7.5	1.9	-2.65	23	.014**
Overall sense of well being	5.0	2.0	6.7	1.8	-3.24	23	.004***
<u>SCL-90</u>							
Global mental distress	70.3	9.2	64.3	9.7	2.74	24	.011**
<u>CES-D</u>							
Depression	34.2	12.4	23.9	10.1	3.11	24	.005**
<u>TSC-40</u>							
Dissociation	9.0	4.9	6.2	3.4	3.67	24	.001***
Anxiety	12.1	5.5	7.5	4.2	4.23	24	.000***
Sexual Abuse Trauma Index	10.1	4.9	7.1	3.9	3.16	24	.004**
Sleep	10.2	4.8	8.8	4.6	1.91	24	.068
Sexual Problems	8.4	5.5	7.3	4.6	1.01	24	.318
<u>TAS</u>							
Alexithymia	56.7	12.7	47.9	10.3	4.69	24	.000***

	Pre-test		Post-test		<u>t</u>	<u>df</u>	<u>p</u>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>			
<u>RSES</u>							
Self-esteem	29.1	8.9	34.6	9.1	-3.47	24	.002*
<u>Self-Compassion Scale</u>							
Self Kindness	12.2	4.5	15.9	4.4	-4.34	24	.000***
Selfjudgment	10.6	3.9	13.9	4.6	-3.49	24	.002**
Common Humanity	11.4	3.6	12.7	4.2	-2.12	24	.044*
Isolation	9.2	3.1	10.8	3.2	-2.10	24	.046*
Mindfulness	10.8	3.0	12.4	3.0	-2.98	24	.006**
Overidentified	8.6	3.7	10.6	3.4	-2.22	24	.036**
Overall self- Compassion	63.0	15.7	76.5	18.4	-4.58	24	.000***
<u>FFMQ</u>							
Observe	26.9	7.0	29.3	6.0	-2.59	24	.016**
Describe	23.5	6.1	27.6	6.1	-4.18	24	.000***
Act with awareness	22.1	6.6	25.9	5.7	-3.96	24	.001***
Non-Judgment	21.8	7.5	26.3	7.8	-4.81	24	.000***
Nonreact	17.9	4.5	21.0	4.6	-4.71	24	.000***

* $p < .05$. ** $p < .01$. *** $p < .001$

A review of Table 2 shows there were significant changes on almost every measure from the start of the program to the time of completion. At the time of program completion participants reported a significantly greater sense of overall well-being and sense of hopefulness. This improvement was also reflected on psychological indicators across different measures. Participants reported significantly less mental health distress at the time of completion than when they began the program. They reported significantly lowered symptoms of depression, dissociation, anxiety and overall sexual abuse trauma symptoms. They reported low alexithymia in comparison to the start of the program indicating greater ability to recognize and describe emotions (lower TAS scores at post-test.). Participants also reported significantly higher self-esteem at the time of program completion. These results suggest that participants experienced significant improvements

in various aspects of mental health functioning as seen on psychological measures used in this study.

Overall, participants reported significant improvement on the capacity for self-compassion, which was reflected on improvements on all sub-scales of the Self-Compassion Scale (kindness, self judgment, common humanity, isolation and mindfulness). Gains were noted in the overidentified sub-scale, which assesses the tendency to ruminate on negative emotions and suffer aversive reactions as a result. One may speculate that with mindfulness training participants developed a better capacity for tolerating unpleasant feelings rather than completely forgetting them. In terms of mindfulness, significant improvements were noted in all five domains (Observe, Describe, Act with awareness, Non-Judgment, Non-React) as measured by the Five Factor Mindfulness Questionnaire.

Discussion

Discussion of findings

Findings from this study showed that participants in the program made significant gains in psychological functioning and in mindfulness practice. The participants who attended the program reported numerous experiences of victimization in childhood and adulthood. They had sought out counselling services seeking help and relief from distress. They were open to learning mindfulness based (meditation) practice and committed to the practice it in its entirety (at least for the duration of the program). The approach to helpseeking and commitment to completion appears to have yielded results in a positive direction for those who completed the program.

In terms of mindfulness practice, significant gains were noted on both mindfulness measures. Participants developed greater capacity for self-observation, attention, compassion and kindness. Participants appeared to have developed mindfulness skills as noted in the significant changes seen on improvements in all five mindfulness domains; the capacity for observation, description, acting with awareness, suspending judgment and nonreaction. Given that emotional, somatic and mental awareness is central to mindfulness practice it was of little surprise to note that significant improvements were also seen on the Alexithymia measure. Alexithymia is the reduced ability to accurately recognize and describe pleasant and unpleasant emotions, which can make it difficult for individuals to modulate and regulate emotion. This can influence an individual's capacity for both, distress tolerance and problem solving. Using mindfulness practice appears to have helped participants make significant gains in their ability to recognize and describe emotions and learn to manage them. Such an ability can impact other areas of psychosocial functioning for example, capacity to handle stress, manage distress and respond effectively to emotional triggers in day-to-day life. However, since these latter functions were not measured in this study such an extrapolation should be considered purely speculative.

Furthermore, mental health distress amongst participants appeared to be affected indicating reduced symptoms across domains. Notably, significantly lowered symptoms of depression were noted among participants at the end of the program. As well, there were significant changes in sexual abuse trauma symptoms and symptoms of dissociation and anxiety by the end of the program. Self-esteem, although not a direct target of the intervention program showed significant improvement. It could be speculated that as

emotional mastery increases, the sense of general self-efficacy and sense of personal control also increase, which in turn can manifest in a sense of enhanced confidence and well-being. It appears that this may be the case given that participants left the program with a greater sense of overall well-being and hopefulness.

The goals of the program were to teach trauma survivors mindfulness practice. As well, the goal of the practice was to help participants get relief from mental and psychological distress through the practice (and application) of mindfulness. Overall, the results indicate that the program was able to accomplish its objectives in both teaching participants mindfulness skills and, through this method, helping them achieve relief from mental suffering.

Limitations and directions for future research

It is important to note that there are several limitations to the current study that need to be considered in interpreting the results. One limitation is that, although there was a lot of heterogeneity in the backgrounds of the participants who entered the program the study is based on a convenience sample and should not be considered representative of trauma survivors, only those who sought out mindfulness based counselling. Broader sampling was beyond the resources and capacity of this project. Furthermore, it was based on a small sample, which limits the possibility of generalizability to samples outside of the one reported in this study. However, it should be noted that in terms of sample size it is a considerable improvement on previous evaluations done by the agency delivering the program (Centre for Research and Education in Human Services, 2005; Yuval, 2006) which were limited by their small sample sizes (one study had nine participants and the

other had ten). At this time discussions are underway to continue to build on the data set that was gathered in this study and improve upon the sample size in the future.

Lastly, lack of longitudinal follow-up poses a limitation in this type of research project. It could be argued that if participants were not followed over time it is difficult to establish the role played by the mindfulness intervention in making changes that are sustainable beyond the immediate gains reported at the end of the study.

Trauma survivors, many of who have lifetime experiences of victimization, often experience mental health problems and seek help from different sources for relief from distress. It would seem appropriate to study the effectiveness of a community based model which is designed specifically to meet their needs and uses a methodology that is both holistic (addresses mind-body as a complete unit) and increases psychological and emotional self-reliance. Cost- benefit analyses comparing this type of model of service to other models would be useful in ascertaining the value of implementing such services in a community setting. It is hoped that future research in this area will continue to grow and, in doing so expand the base of empirical evidence that assesses the efficacy of mindfulness based counselling practices.

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Appendix A

Chi-Square and t-test results of differences between ‘completers’ (n 25) and
‘drop-outs’ (n 18)

	χ^2	df	p
Sexual abuse as a child	3.56	1	.059*
Physical abuse as a child	.94	1	.332
Neglect by parent or caregiver	.31	1	.576
Violence between parents	.69	1	.405
Abandonment by parents	.07	1	.782
Raised primarily by both biological parents	1.01	2	.603
Partner abuse as an adult	1.62	1	.203
Sexual assault as an adult	.017	1	.897
Involvement with psychiatric system as adult	.239	1	.625
Problems with drugs or alcohol as an adult	.088	1	.766
Poverty	.031	1	.860
Divorce or separation	5.05	1	.025*

	Completers		Drop-outs		t	df	p
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>			
Hopefulness of relief from distress	6.2	1.9	5.7	2.3	.64	40	.525
Overall sense of well being	5.0	2.0	4.0	2.2	1.50	40	.142
<u>CES-D</u>							
Depression	34.2	12.4	40.38	14.19	-1.51	41	.138
<u>TSC-40</u>							
Dissociation	9.0	4.9	9.8	5.0	-.48	41	.627
Anxiety	12.1	5.5	11.6	5.9	.31	41	.758
Sexual Abuse Trauma Index	10.1	4.9	10.3	4.1	-.12	41	.904
Sleep	10.2	4.8	13.0	3.9	-1.9	41	.055*
Sexual Problems	8.4	5.5	8.3	5.4	.05	41	.957

<u>TAS</u>							
Alexithymia	57.0	12.5	61.6	16.2	-1.06	41	.293
<hr/>							
	Completers		Drop-outs				
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
<hr/>							
<u>Self-Compassion Scale</u>							
Self Kindness	12.2	4.5	10.4	4.1	1.28	41	.205
Selfjudgment	10.6	3.9	10.3	3.8	.22	41	.825
Common Humanity	11.4	3.6	9.4	2.6	1.93	41	.059*
Isolation	9.2	3.1	8.3	3.0	.91	41	.365
Mindfulness	10.8	3.0	10.0	2.8	.91	41	.364
Overidentified	8.6	3.7	8.8	2.9	-.142	41	.888
Overall self- Compassion	63.0	15.7	57.4	14.0	1.19	41	.240
<u>RSES</u>							
Self-esteem	29.1	8.9	26.6	5.1	1.06	41	.139
<u>FFMQ</u>							
Observe	26.9	7.0	23.5	7.4	1.50	41	.139
Describe	23.5	6.1	23.2	7.2	.14	41	.88
Act with awareness	22.1	6.6	20.2	7.7	.85	41	.397
Non-Judgment	21.8	7.5	29.5	3.7	1.22	41	.228
Nonreact	17.9	4.5	16.3	5.5	1.02	41	.312
<u>SCL-90</u>							
Global mental distress	70.3	9.2	74.7	5.7	-1.75	40	.08

* $p < .05$. ** $p < .01$. *** $p < .001$

Appendix B

Personal History Questionnaire

1. As you were growing up, did you experience any of the following? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Chronic illness in your family |
| <input type="checkbox"/> Frequent moves | <input type="checkbox"/> Leaving your country (as an immigrant or refugee) |
| <input type="checkbox"/> Heated arguments between parents/extended family | <input type="checkbox"/> Serious accident |
| <input type="checkbox"/> Mental health problems in your family | |
| <input type="checkbox"/> Separation or divorce of your parents | |
| <input type="checkbox"/> Remarriage of your parents | |
| <input type="checkbox"/> Parents having affairs | |
| <input type="checkbox"/> Death of a parent/caregiver | |
| <input type="checkbox"/> Sexual Abuse as a child or adolescent | |
| <input type="checkbox"/> Physical abuse as a child or adolescent | |
| <input type="checkbox"/> Emotional/verbal abuse as a child or adolescent | |
| <input type="checkbox"/> Neglect by parent/caregiver | |
| <input type="checkbox"/> Ritual abuse as a child or adolescent | |
| <input type="checkbox"/> Violence between your parents | |
| <input type="checkbox"/> Violence towards siblings by parents | |
| <input type="checkbox"/> Violence between extended family members | |
| <input type="checkbox"/> Alcohol or drug abuse by parent or caregiver | |
| <input type="checkbox"/> Abandonment by parents | |
| <input type="checkbox"/> Chronic physical illness in your family | |
| <input type="checkbox"/> Running away from home | |
| <input type="checkbox"/> Conflict with the law | |
| <input type="checkbox"/> Isolation or loneliness | |
| <input type="checkbox"/> Difficulties learning at school | |
| <input type="checkbox"/> Bullying at school | |
| <input type="checkbox"/> Being cruel to animals | |
| <input type="checkbox"/> Setting fires | |
| <input type="checkbox"/> Suicide attempts | |
| <input type="checkbox"/> Drinking | |
| <input type="checkbox"/> Drug use | |
| <input type="checkbox"/> Bed wetting | |
| <input type="checkbox"/> Serious health concerns | |
| <input type="checkbox"/> Hospitalizations/surgeries | |

- Multiple abusers. In which areas:
- Sexual
 - Physical
 - Emotional/verbal
 - Neglect
 - Catastrophic event such as flood, fire, hurricane, tornado
 - Experience of discrimination or harassment related to: **(Check as many as apply)**
 - Economic status/class/caste
 - Sexual orientation
 - Race
 - Culture
 - Religion
 - Ability
 - Gender
 - Language
 - Educational Level/Credentials
 - Political events in your immediate environment **(Check as many as apply)**
 - War/Civil Unrest
 - Terrorism
 - Political oppression
 - Displaced from home
 - Refugee camp
 - Other significant traumatic event.

Specify: _____

2. Were you brought up by both your biological parents? Yes No

3. If you were not brought up by both your biological parents, were you: **(Check all that apply)**

From Age	To Age		
<input type="checkbox"/>	Brought up by both my biological parents	_____	_____
<input type="checkbox"/>	Brought up by my mother only	_____	_____
<input type="checkbox"/>	Brought up by my father only	_____	_____
<input type="checkbox"/>	Brought up by my mother and stepfather	_____	_____
<input type="checkbox"/>	Brought up by mother and multiple partners	_____	_____
<input type="checkbox"/>	Brought up by my father and stepmother	_____	_____
<input type="checkbox"/>	Brought up by father and multiple partners	_____	_____
<input type="checkbox"/>	Brought up by extended family	_____	_____
<input type="checkbox"/>	Brought up in foster home(s)	_____	_____
	<i>If yes, how many?</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2 <input type="checkbox"/> 3 or more

- Group homes or other institutions _____
If yes, how many? ___1 ___2 ___3 or more
 Legally adopted at age _____

**4. As an adult, did you experience any of the following?
 (check all that apply)**

- Partner abuse
- Sexual assault
- Abused by your extended family
- Problems with alcohol/drugs
- Conflict with the law
- Involvement with the psychiatric system
- Chronic physical illness
- Death of child
- Death of a partner
- Divorce/separation
- Immigration
- Children in care
- Ongoing employment difficulties
- Poverty
- Serious accident
- Hospitalization/surgeries
- Catastrophic event such as flood, fire, hurricane, tornado
- Experience of discrimination or harassment related to:
(Check as many as apply)
 ___Economic status/class/caste
 ___Sexual orientation
 ___Race
 ___Culture
 ___Religion
 ___Ability
 ___Gender
 ___Language
 ___Educational Level/Credentials
- Political events in your immediate environment
(Check as many as apply)
 ___War/Civil Unrest
 ___Terrorism
 ___Political oppression
 ___Displaced from home
 ___Refugee camp
- Other significant traumatic event.

Specify: _____

5. Below is a scale of 1-10.

1 is you have no hope that you will experience relief from your distress. 10 is you are certain you will experience relief from distress. Where would you place yourself now?

1	2	3	4	5	6	7	8	9	10
No hope									Certain

6. Below is a scale of 1-10.

1 is you feel your overall sense of well being is very poor. 10 is you feel it is excellent. Where would you place yourself now?

1	2	3	4	5	6	7	8	9	10
Very Poor									Excellent

Below are some questions relating to alcohol, drug use and/or other behaviours. Do you use any of the following as a way of dealing with life stresses?

7. Alcohol

1	2	3	4	5	6	7	8	9	10
Frequently									Never

8. Drugs

1	2	3	4	5	6	7	8	9	10
Frequently									Never

9. Food

1	2	3	4	5	6	7	8	9	10
Frequently									Never

10. Shopping

1	2	3	4	5	6	7	8	9	10
Frequently									Never

11. Sex

1	2	3	4	5	6	7	8	9	10
Frequently									Never

Appendix C

Participant Information Form

MINDFULNESS BASED TRAUMA COUNSELLING

Participant Information Form

Dear Participant,

You are invited to participate in a research study which is part of the services offered in the Mindfulness Based Trauma Counselling (MBTC) program. The following will provide you with information which will help inform your decision to participate.

Purpose: The purpose of the research study is to explore the effectiveness of Mindfulness Based Trauma Counselling. The study will seek to understand changes women experience following their participation in the program.

Eligibility: You are eligible to participate in this study because you have requested group counselling services for trauma, you are an adult woman and you have expressed an interest in participating in a MBTC program.

Requirements: This research will involve filling out some questionnaires which will take about 45 minutes to complete. These questionnaires will ask you about signs and symptoms related to trauma, support systems, thoughts and feelings about yourself and mindful attention to body and mind. You will complete these questionnaires in the orientation session and then again in the closing session of the group. If you choose to drop out of the program you will be asked to participate in a closing meeting which will include completing the questionnaires.

Research Procedures and Confidentiality: All the information that is gathered in this study will be coded so that no person's answers can be identified on forms or reports. Your confidentiality and identity will be protected by research procedures which will make sure that information you give cannot be linked to you. The questionnaires you fill out will be put in a file with a code number, without your name on it. The group counsellors will keep the list of names and code numbers so the matching post-group questionnaires can be placed in the same file as the pre-group ones. These numbered files will be passed to the researcher who will enter the research data. The researcher will only know individual results through the code numbers. The group counsellors will only see the compiled results, not individual responses. Individual questionnaires will be kept by the researcher under lock and key in a secure place until all results are compiled. At that time the questionnaires will be destroyed.

Benefits and Risks: The results of this study will be used in a number of beneficial ways:

- In understanding changes in women's lives following participation in a MBTC group
- In helping the MBTC program develop greater skillfulness in integrating mindfulness practices with trauma counselling
- In helping counselling programs get a better understanding of how mindfulness works to support women with the impact of trauma
- In helping to develop a base of knowledge in the area of mindfulness and trauma practice

It is possible that some of the questions may make you feel uncomfortable, embarrassed or trigger feelings or memories. If you consent to participate in the study and face any discomfort in answering questions, the counsellors will be available to talk with you.

Voluntary Participation: Your participation in this research is voluntary. You can choose to not participate without giving a reason and it will have no negative impact on your present or future services at this agency. You can withdraw from the study at any time up until one month after you finish the program. If you would like a summary of the results we will be happy to give you a copy when the study is finished. If you require more information about the study please feel free to speak with the group counsellors who will be pleased to answer any questions that you might have.

The Researcher: The research is being conducted by Dr. Smita Vir Tyagi: (vtyagi@oise.utoronto.ca). She is an outside, independent consultant who has been asked to carry out this study at the request of the agency.

If you give your consent to participate in the MBTC research please fill in the attached informed consent form and give the form to your group counsellor.

Thank you.

Appendix D

Consent to participate Form

**MINDFULNESS BASED TRAUMA COUNSELLING RESEARCH
PARTICIPATION
INFORMED CONSENT**

Group Member

I, _____ have read and/or had explained to me the participant information form describing the MBTC research study. I understand the contents of the form, the research procedures and the benefits and risks of participating. I understand that my participation is voluntary and that I can withdraw from the study at any time up until one month after I finish the program.

Group Members Name (*print*)

Signature

Group Counsellor

I, _____ have explained to the group member the contents of the participant information form, the research procedures and the benefits and risks of participating. The group member understands that her participation is voluntary and that she can withdraw from the study at any time up until one month after she finishes the program.

Group Counsellor's Name (*print*)

Signature

Date

Request for a Summary Report

Please circle Yes or No if you would like to receive a written summary of the results of the project when it is completed.

YES: Please send the results to me at the following address:

(Please make sure you can receive confidential mail at this address.)

NO: I do not wish to receive a copy of the results when the study is completed.