A QUANTITATIVE STUDY EXPLORING THE EFFECTS OF FOCUSING-ORIENTED ARTS THERAPY – INTERNET PROTOCOL (FOAT-IP) ON STRESS, ANXIETY, DEPRESSION, AND POSITIVE STATES OF MIND IN SOUTH ASIAN WOMEN

by

Rashmi Chidanand

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I certify that I have read and approved the content and presentation of this dissertation:

_____	_____
Glenn Hartelius, Ph.D., Committee Chairperson	Date
_____	_____
Ron Pilato, Psy.D., Committee Member	Date
_____	_____
Laury Rappaport, Ph.D., ATR-BC, REAT, Committee Member	Date

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Abstract

A Quantitative Study Exploring the Effects of Focusing-Oriented Arts Therapy – Internet Protocol (FOAT-IP) on Stress, Anxiety, Depression, and Positive States of Mind in South Asian Women

by

Rashmi Chidanand

Two in 5 South Asian women experience intimate partner violence (IPV) within the context of their marital relationship that results in PTSD precursors such as stress, depression, and anxiety. However, South Asians may not be as receptive to traditional talk therapy as some other ethnic groups due to stigmas around psychotherapy held by this population. Because South Asians are hesitant to talk openly to anyone, such as a therapist, outside their family circles, adjunct approaches that draw on aspects of Gendlin's Focusing-oriented therapy and the expressive arts (i.e., art, movement, poetry, etc.) can help facilitate meaning-making in a nonverbal manner that also respects their need for privacy. Therefore, Rappaport's *Focusing-Oriented Arts Therapy* (FOAT) was adapted to the Internet (FOAT-IP) and explored as an integrative well-being adjunct tool in working with clients who have not been acculturated to psychotherapy. The main question investigated was: Does FOAT-IP lessen PTSD symptoms such as stress, anxiety, and depression in a population at risk for IPV? It was hypothesized that FOAT-IP would reduce the symptoms of stress, anxiety, and depression.

A pre-and-posttest quantitative design was utilized in this 4-week pilot study for a Web-based intervention. Participants ($N = 16$) were South Asian women who completed 4 quantitative measures (Perceived Stress Scale, State Trait Anxiety Inventory, Beck Depression Inventory, and Positive State Of Mind) at the beginning and end of the study. SPSS software was used to

analyze quantitative data. The depression measure was the only one to yield significant results; 47% of the participants' improvement may be attributed to the FOAT-IP intervention. However, the other measures' findings were limited by a small sample size to be conclusively attributed to the intervention. Therefore, it is worthwhile for future studies to explore the FOAT-IP intervention with a larger sample size. Initial results suggest that FOAT-IP is feasible and potentially efficacious as a Web-based adjunct tool for depression in South Asian Women.

Dedication

This metamorphic, self-actualizing journey
would not have been possible without the support of:
my truly unconditionally loving-compassionate parents,
Shamala and Chidananda,
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Eat.Taste.Heal.

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Preface

This study was inspired by the researcher's own personal experience with somatization of stress, anxiety, and depression, of which she had little awareness due to life stressors. Her health rapidly started to deteriorate, ranging from digestive problems and stomach pains escalating to spinal back pain and vertigo. Despite being born and raised in the United States, the South Asian cultural stigmas around mental health were prevalent all around her with South Asians' tendency to dismiss physical health symptoms as "psychosomatic" and the way to fix it is to go to a doctor and get medicine. Psychotherapy or going to see a therapist is not an option to manage stressful life events. It was through the researcher's own journey of FOAT that she discovered a private way to process life stressors to alleviate somatic symptoms. The researcher had witnessed how her relatives and friends, like many other South Asian women, were raised with the belief that divorce was not an option under any circumstance because "family comes first." Fearing being ostracized and shamed, South Asian women remained in unhealthy marriages (often involving IPV), suffering silently frequently to the extent of PTSD. This researcher wanted to help bridge the gap not only in South Asian mental health research but also with the introduction of a *nonverbal* alternative technique to traditional "talk therapy." As a bridge between "no therapy" to "therapy," this researcher explored FOAT-IP as a segue well-being tool to initiate the healing process in South Asian women.

Table of Contents

List of Tables

Chapter 1: Introduction

South Asian women residing in the United States (US) who are survivors of *intimate partner violence* (IPV) may not be receptive to conventional verbal therapy due to familial, cultural, and societally imposed stigmas surrounding psychotherapy. Focusing-Oriented Arts Therapy – Internet Protocol (FOAT-IP) might be used as an adjunct method to clinical work to help manage *post-traumatic stress disorder (*PTSD) precursors such as stress, anxiety, and depression in South Asian IPV survivors. This is important because two in five South Asian women experience IPV within the context of their marital relationship (Raj, Liu, McCleary-Sills, & Silverman, 2005). This statistic is disproportionately higher than other ethnic groups, including Asian and Pacific Islander. Yet, as a subset of Asians or Asian Americans, South Asian women are one of the less studied populations; practically the only examination of this group consists of a limited amount of research on South Asian IPV (Hurwitz, Gupta, Liu, Silverman, & Raj, 2006). More importantly, South Asians' healing model is based on Ayurvedic medicine, a holistic mind-body-spirit treatment approach in which emotional distress is handled in very different ways than the approaches used within Western culture. For example, South Asians do not view the analysis of one's intrapsychic conflicts and the recreation of childhood patterns in adulthood as necessarily related to each other (Prathikanti, 1997).

However, it is also possible that South Asian IPV survivors are mainly concerned with the privacy factor and do not want to experience guilt and shame that may be evoked in talking to a therapist. Raj and Silverman's (2002a) pioneering study concluded that further research needs to be conducted on the experiences of South Asian immigrants in the US, which is a challenge due to the secrecy surrounding IPV amongst the community members (Ahmed, Riaz, Barata, & Stewart, 2004). Therefore, a supplemental technique was explored to help with PTSD-

related conditions, which integrates the above-mentioned factors into a potentially holistic, meaning-making modality. Specifically, Rappaport's (2008, 2009, 2010, 2014) Focusing-Oriented Arts Therapy (FOAT), which integrates Gendlin's (1978, 1996) *Focusing-oriented therapy* (FOT) with *expressive arts therapy* (EAT), was adapted by the researcher as an Internet Protocol (FOAT-IP). In this study, FOAT-IP was utilized to reduce stress, anxiety, and depression in South Asian women, a population at risk for IPV. The main question investigated was: Does FOAT-IP reduce symptoms of stress, anxiety, and depression in South Asian women, who are at risk for IPV?

South Asians

South Asians*,* those comprising Indian, Pakistani, Nepali, Sri Lankan, Bangladeshi, Bhutanese, and Maldivian heritage, are the fastest growing and third largest Asian American population in the US (Hurwitz et al., 2006; Raj et al., 2005). Even though a majority of the working-aged South Asian adults are medical professionals, the community as a whole minimizes the use of any mental health services (Ahmed, Mohan, & Bhugra, 2007; Prathikanti, 1997). The cultural and religious framework of traditional South Asian values is founded in family structures and community life. According to Das and Kemp (1997, as cited in Prathikanti, 1997) and Jayakar (1994, as cited in Prathikanti, 1997), psychotherapy is underutilized due to cultural stigmas on bringing shame to the entire family and to one's ethnic group. The South Asian concept of family generally refers to the large and dynamic entity that is composed of several households dispersed all over the world, yet manages to function as a single unit. Exposing personal conflicts outside a family not only undermines family honor but also compromises the South Asian community's image of being the model minority in the US.

Consequently, mental illness is considered a sign of instability or weakness, and thus, hidden from the public eye (Prathikanti, 1997; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003).

The responsibility of family obligations outweighs any beliefs to fulfill individual desires of a family member (Venkataramani-Kothari, 2007). Even if South Asians participated in therapy, the individual may resist any goals that focus on helping oneself (Maker, Mittal, & Rastogi, 2005; Prathikanti, 1997). South Asian women are often raised to fulfill the duties of a daughter, wife, and mother (Prathikanti, 1997), which means one's dharma (duty) within the family outweighs individual desires. Because of their "family comes first" perspective, a South Asian woman often sacrifices personal autonomy, health, and safety to remain loyal to her family (Hurwitz et al., 2006; Prathikanti, 1997; Yoshioka et al., 2003). The failure to make such sacrifices results in women being blamed for any hardships, shame, and/or results in being socially ostracized. Most South Asian women describe marriage as merging of two families and not solely the union of two individuals (Maker et al., 2005; Prathikanti, 1997). Often the entire family collectively convinces the woman to uphold her duty by utilizing guilt, shame, and a sense of moral obligation to the family. Even if found in an abusive relationship, the elder family members urge the daughter to make adjustments and accommodate to any differences surfacing in the marital relationship. To cite a cultural practice that illustrates the family dynamics of South Asian households: The main house door is closed to the exterior world, but the interior doors in the house are expected to be open. This practice, which discourages privacy within the house, is communicating metaphorically to family members that there are no secrets in a family, but that anyone residing outside the family household will have no access to these family "secrets" (e.g., health, psychological, marital, financial, or any other challenges the family is experiencing).

Alternatively, traditionally oriented South Asian women have come to the US through arranged marriages in hope of financially helping their families back in their homeland (Yoshioka et al., 2003). Krishnan, Baig-Amin, Gilbert, El-Bassel, and Waters stated that newly immigrated South Asians "often lack social and structural supports, knowledge of support systems available in the community, [and] the facility with English language" (as cited in Yoshioka et al., 2003, p. 172) to escape intimate partner violence.

Intimate Partner Violence (IPV)

IPVis a specific subset of domestic violence that is characterized by physical, mental, sexual, and spiritual abuse by a survivor's significant other, such as a spouse (Center for Disease Control and Prevention, 2009; Raj & Silverman, 2002b). According to EndAbuse (2010), a family violence prevention organization, "nearly one-third of American women experience IPV at some time in their lives" (p. 1). IPV is one of the leading causes of "female homicides and injury-related deaths during pregnancy, [and] . . . accounts for a significant proportion of injuries and emergency room visits for women" (EndAbuse, 2010, p. 5). As stated by the US Department of Justice, "37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend, or girlfriend" (EndAbuse, 2010, p. 5). This is in line with the findings of the Center for Disease Control and Prevention (2009): "Each year . . . about 4.8 million [women] experience . . . intimate partner-related physical assaults and rapes" in the US (p. 1). This statistic represents about 20% of all nonfatal violent crime experienced by American women.

Post Traumatic Stress Disorder (PTSD)

Many survivors of IPV, including South Asians, experience psychological trauma that may result in PTSD, which is:

> A syndrome of intrusive re-experiencing, avoidance and emotional numbing, and hyperarousal symptoms that occurs in some individuals in the aftermath of a traumatic event. A *traumatic event* is defined as experiencing or witnessing an event involving threat to life or physical integrity that results in feelings of fear, helplessness, or horror. (DeJongHe, Bogat, Levendosky, & Eye, 2008, p. 294)

In the context of prevention and management of PTSD in IPV survivors, there are some effective psychotherapeutic tools such as *Cognitive Behavioral Therapy* (CBT) and *Traumatic Incident Reduction* (TIR). However, FOAT is a psychotherapeutic method that integrates focusing with expressive arts therapy involving the art forms of poetry, movement, and drawing to facilitate emotional and spiritual healing around a traumatic event (Boone, 2006; Fox, 1997; Rappaport, 1993, 1998, 2006, 2009, 2010, 2014, in press). Research in expressive arts therapy has been found to help trauma survivors process stress resulting from a traumatic event.

Focusing-Oriented Therapy (FOT)

FOT involves getting in touch with one's *felt sense*, which is the direct experience that is *something* in its preverbal form residing within an individual. It encompasses the internal processes of engaging the zone of the unconscious and the conscious (Gendlin, 1996). Simply stated, it is a bodily sensation that has meaning. The felt sense is an embodied experience utilized in the process of *clearing a space* and identifying a *handle* that sometimes arise in the forms of an image, gesture, word, or sound. The first step of the six-step Focusing method, clearing a space, involves sensing inwardly what is in the way of feeling fine. The process welcomes each concern to surface, be acknowledged by the client, and then gently placed aside for the present moment to allow another concern to arise. This process may be repeated a few more times before an issue is selected from one of the concerns set aside to focus upon or the client may choose to remain in this space as a place where everything is fine for the moment.

Handle or *symbol* is a word, phrase, gesture, movement, sound, or an image (Gendlin, 1996). It is meant to capture or express the experience of the client's felt sense. The handle

specifically helps the client stay present with the felt sense as well as allows the felt sense to remain open for something more to emerge. The handle serves to express what the source has to say. Even though there are limited studies on FOT, there are a number of books on the subject matter published in the past two decades (e.g., Amodeo, 2001; Cornell, 1996; Stapert & Verliefde, 2008).

Focusing-Oriented Expressive Arts Therapy (FOAT)

FOAT is an umbrella term for *Focusing-Oriented Expressive Arts* and includes both clinical and nonclinical applications. There are four main approaches: FOAT Basic Step; Clearing a Space with Arts (CAS-Arts); Theme-Directed FOAT; and FOAT-Psychotherapy (Rappaport, 2009, 2014). FOAT Basic Step consists of bringing the Focusing Attitude of "being friendly" to the bodily felt sense, seeing if there is a symbol or handle that matches the felt sense—such as a word, phrase, image, gesture or sound—and then externalizing the handle through expressive arts (Rappaport, 2009, p. 27). For example, a word or phrase may be expressed through writing; an image through art; gesture into movement or dance; and sound into music or sound expression. Laury Rappaport (2009) defined the approaches as follows: In *Clearing a Space with the Arts* (CAS-Arts), the client uses the imagination and the arts to symbolically place stressors and issues in the way of feeling "All Fine" and also to express the "All Fine Place" (an inherent place of well-being; p. 37). Rappaport developed CAS-Arts after Gendlin's (1978, 1996) method for Clearing a Space in which the Focuser accesses the felt sense and imagines placing the issues in the way of feeling fine outside of the body, and also then gets a felt place that is separate from those stressors (a place of well-being). The arts help to place the issues outside of the body, as well as provide a concretization of the issues and "All Fine Place." CAS-Arts is "beneficial for centering, stress reduction, clarifying and dis-identifying with issues,

and helping clients to have an experiential knowing of their intrinsic wholeness" (Rappaport, 2009, p. 92).

FOAT-Psychotherapy is "primarily applied to individuals and couples where the orientation is toward authenticity, congruence, empathy, depth-oriented insight, communication skills, and change" (Rappaport, 2009, p. 92). In FOAT Psychotherapy, the therapist follows the client's experiential unfolding moment-to-moment and then responds with listening, Focusing, and expressive arts in a carefully attuned manner.

A *Theme-Directed* FOAT approach is most often used in groups, and can also be used with individuals and couples. A theme, such as fear, trust, strengths, is selected that matches the client or group needs. Although FOAT is "primarily a *Person-Centered Approach*, it is applicable to all orientations, including, psychodynamic, cognitive, behavioral, etc." (Rappaport, 2009, p. 92).

Focusing-Oriented Arts Therapy – Internet Protocol (FOAT-IP) is the researcher's adaptation of FOAT to a Web-based protocol to be used in this study. The FOAT-IP for this research includes a Theme-Directed FOAT approach on well-being/empowerment that also includes FOAT Basic Step and CAS-Arts. FOAT-IP integrates FOT and expressive arts to facilitate emotional and spiritual healing (Rappaport, 2009; 2014; in press). FOAT-IP offers a direct way of working through central emotions without any self-disclosure, and consequently may perhaps be more accessible to South Asian clients who are not acculturated to traditional talk-therapy (Maker et al., 2005). South Asian women communicate unhappiness by behaving in a subdued manner (Prathikanti, 1997). Because explicit expression of anger is considered a shameful act of impatience and lack of self-control, an outlet for expressing any negative emotions may be found through the expressive arts. Because South Asians are hesitant to talk

openly to anyone outside their family circles, such as a therapist, adjunct approaches such as Gendlin's FOT and Rappaport's FOAT that integrate Focusing with the expressive arts (i.e., art, movement, poetry, etc.) may help facilitate meaning-making in a nonverbal manner that also respects their need for privacy.

Moreover, research in this population is significantly deficient, which includes research on the effects of alternative psychotherapeutic interventions to augment conventional talk therapy. Therefore, FOAT-IP was explored as a potentially promising well-being technique to manage stress to reduce anxiety and depression symptomology in South Asian IPV women survivors.

Client-Centered Psychotherapy Theoretical Model

Gendlin's FOT evolved from his research with Carl Rogers and is categorized as client-centered psychotherapy (Gendlin, 1996). Carl Roger's client-centered psychotherapy (CCP) is based on self-theory, where a client has failed to develop a healthy sense of self. *Self-theory* strives for *congruence* between the self and the entire realm of an individual's experience. CCP is a form of humanistic therapy "that enable[s] the client to access feelings, strengthen reliance on inner resources, develop self-esteem, and become less dependent on the approval of others" (Ingram, 2006, p. 327). CCP also incorporates an existential therapeutic approach "in which the therapist self-discloses, offers honest feedback, and presents a model of healthy interpersonal functioning" (Ingram, 2006, p. 327).

CCP therapists adopt and convey a particular attitude toward a client before displaying any skills. Specifically, they experience and express congruence, unconditional positive self-regard, and accurate empathy for the client (Flannagan & Flannagan, 2004). The *congruent* therapist is authentic, open, and honest, and able to express both positive and negative feelings

present in the therapeutic relationship with a client. *Unconditional positive regard* for a client is evident by the therapist openly accepting and valuing the entire being of a client. In this safe and trustful container, clients explore what they really want and who they really are, which leads to clients accepting themselves. In conjunction with congruence and unconditional positive regard, *accurate empathy* is a powerful component in therapy that promotes insight for the therapist to see and feel a client's world from the client's point of view. Contemporary CCP therapists are more active and directive than traditional CCP therapists. For example, Rappaport's (2008, 2009) integration of the expressive arts with Gendlin's (1978, 1996) FOT represents the variation of the nondirective stance of CCP. In essence, CCP therapists come across to clients as "I am listening and doing my best to understand your life experiences and how you are experiencing them in life and in yourself."

Theoretical Worldview

Different worldviews and theoretical lenses are integrated into this study. However, the predominant worldview for this study falls under postpositivism. The components of this worldview include (a) the researcher rejecting or accepting the hypotheses; (b) data being objectively collected; (c) unbiased measures being used; (d) the researcher testing an intervention; and (e) the study being written in a scholarly, scientific manner. The study also shares the aspects of pragmatism, such as (a) the researcher including both biased (qualitative measures such as the journals) and unbiased (quantitative self-report measures), and (b) the researcher combining both quantitative and qualitative data and integrating them. The constructivist elements may also be incorporated because (a) the researcher will visit participants' site to collect data, and (b) the researcher will work with the participants to implement the intervention and to collect the data.

As for the theoretical lens, this study can be seen as both social science and as advocacy. Through a social science lens, FOAT-IP serves as an intervention around which questions are asked and answered in the current study. Through the advocacy lens, this study is an invitation to further research with a South Asian population who are an underrepresented group in psychological research, and this research can be viewed as a call for change regarding the social and cultural stigma that exists in this population around seeking psychotherapy.

Chapter 2: Literature Review

In addition to presenting the limited research on South Asian women and IPV, this section provides an overview of the available research literature on (a) the current conventional and holistic PTSD therapeutic modalities, including existing research on FOAT; and (b) existing research on expressive arts and therapy. Specifically, an overview of FOAT-IP's handle-modalities and foundational mechanisms are presented in the context of its applicability to the South Asian women population. Lastly, the section presents the transpersonal aspect of FOAT. This section is not an exhaustive literature review on expressive arts therapy, focusing-oriented therapy, and/or current PTSD therapeutic modalities. It is rather an attempt to present existing research in the context of how FOAT integrates the benefits of current conventional and holistic PTSD therapeutic modalities and expressive arts addressing trauma. There is no research that explores a clinical intervention for PTSD in South Asian women. However, the limited research on South Asian women, which is in the context of medical health issues and/or IPV, will be presented. It is important to note that there is a gap in the area of South Asian research and mental health. This study is an attempt to address that research gap.

Current Treatments in PTSD

The most common therapies currently in use for PTSD are Cognitive Behavioral Therapy (CBT) and Traumatic Incident Reduction (TIR). Specifically, while TIR is primarily utilized with more stable clients (Gerbode, 2006), *eye movement desensitization and reprocessing* (EMDR) and exposure therapy, which are subsets of CBT, are more commonly implemented for treating PTSD in clinical settings. However, researchers Van Emmerik, Kamphuis, and Emmelkamp (2008) found *structured writing therapy* (SWT), which is based on structured

writing assignments such as journaling, to be an effective holistic alternative to CBT in treating PTSD.

Structured Writing Therapy (SWT). SWT is "a medium for disclosing one's innermost feelings and gaining clarity regarding traumatic experiences, and has been found to have a curative effect" (Barrett & Wolfer, 2001, p. 356). Both Van Emmerik et al. (2008) and Barrett and Wolfer's (2001) studies suggested the importance of writing to reorganize fragmented traumatic events and rebuild an individual's sense of identity to expedite the coping process in survivors. Barret and Wolfer (2001) demonstrated writing as a self-administered and supplemental intervention to clinical treatment for anxiety.

Smyth and Pennebaker (1999) described SWT as (a) 20 minutes of writing three to four times a week with 10 minutes to regroup oneself after the writing episode; (b) uncensored journaling reflecting any topic or emotion, weighing heavily on the person in that present moment; and (c) following the reflective journaling, exploring how the subject matter is related to different issues in one's life such as in childhood, relationships, self-identity, dreams, and so forth. FOAT-IP might be viewed in one sense as an extension of SWT, but with the flexibility to be structured (like SWT journaling) or unstructured (as in poetry therapy), making it more adaptable to the processing needs of trauma survivors.

Cognitive Behavioral Therapy (CBT). According to the National Center for PTSD (2007), the most effective form of treatment for PTSD is CBT, where the therapist helps the survivor understand how thinking about the trauma induces stress and how altering the dysfunctional thought process alleviates PTSD symptoms. CBT is based on the beliefs that personal thoughts affect moods and emotional states, and psychopathology is a result of skill deficits in a person. CBT treatment techniques are empirically supported by quantitative research

(Flanagan & Flanagan, 2004). CBT includes therapy modalities such as exposure therapy, TIR (Art of Healing, 2004; Gerbode, 2006), and EMDR (National Center for PTSD, 2007; Wilson, Becker, & Tinker, 1995). The goal of exposure therapy is to diminish fear associated with the memories of the traumatic event by repeatedly talking to a therapist about it (National Center for PTSD, 2007). This repeated exposure to replaying the trauma will condition the survivor to gain control over any negative reactions through desensitization to the stressful event (National Center for PTSD, 2007).

Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a fairly new therapy that "focuses on distractions like eye movements, hand taps, and sounds" (National Center for PTSD, 2007; Wilson et al., 1995) to condition more positive reactions to traumatic memories in PTSD survivors. An example of EMDR is where the therapist usually waves the fingers back and forth as the client tracks the finger with his/her eyes, going back and forth, while the survivor discusses the traumatic memories, and "this visual tracking desensitizes the client's feelings of anxiety, allowing a new awareness to emerge" (Valentine & Smith, 2002, p. 192). This is a more complex approach than the example demonstrates, but a noteworthy therapeutic approach in the context of current PTSD treatments. In essence, while EMDR addresses the cognitive aspect of CBT, exposure therapy addresses the behavioral aspects.

Traumatic Incident Reduction (TIR). The previously mentioned stress-reducing CBT approaches fall into two categories: coping methods and cathartic techniques (Art of Healing, 2004). Although coping methods and cathartic techniques provide temporary relief from PTSD symptoms, TIR is a preventive technique that focuses on resolving the trauma (Art of Healing, 2004; Gerbode, 2006). TIR is based on Freud's theory of *anamnesis* (i.e., recovery of repressed memory), which concentrates on reducing the troublesome symptoms often experienced by

trauma survivors (Valentine & Smith, 2002). TIR is a therapist-directed therapeutic invention that is centered on the survivor and the memory (Valentine & Smith, 2002). Similar to exposure therapy, the survivor is "asked to repeatedly 'view' the incident until it is understood differently" (Valentine & Smith, 2002, p. 193). This process desensitizes the traumatic event into a "boring incident" with an end point (Gerbode, 2006; Valentine & Smith, 2002). TIR is primarily effective with trauma clients who are stable and capable of focusing on the traumatic event for a specific duration (Gerbode, 2006; Valentine & Smith, 2002). TIR has been effective with treating trauma ranging from a single event (e.g., accident) to reoccurring events such as IPV (Gerbode, 2006; Valentine & Smith, 2002).

There are three ways TIR is different from other techniques: "(1) length of session, (2) absence of the therapist's interpretation, evaluation, or commentary, and (3) reliance on the survivor's choice regarding which prior traumatic event the individual wants to review" (Valentine & Smith, 2002, p. 193). Specifically, TIR usually can yield end-point results (i.e., resolution around the trauma is reached) after a single session, but it is dependent on the nature of the trauma. For example, a current trauma may be dependent on a past trauma from childhood, which needs to be resolved prior to obtaining resolution of current trauma. As a result, the therapist is a guide for the client, who is in control of the pacing in therapy as well as which traumatic content to review in a session (Gerbode, 2006). Client insight is at the core of the resolution process in TIR.

Somatic psychology approach. An underlining thread to these current therapies is their holistic approach to healing the body, mind, and spirit (Aposhyan, 2004). The field of somatic psychology also aims to bridge the mind-body dichotomy, which is a prevalent split in the Western healing model. This section aims to provide a brief overview on the benefits of holistic

approaches in the context of somatic psychology. This is noteworthy for two reasons: (a) FOAT/FOAT-IP is a subtype of somatic psychology; and (b) it may also be considered a holistic approach that shares components of body-mind psychotherapy, Reichian therapy, Feldenkrais, Alexander technique, and Hakomi. The South Asian research presented after this section is primarily focused on medically related health problems as a result of IPV stressors. It is suggested these medically related health problems may be a somatic response to stressors, which result in PTSD-related symptoms (Hurwitz et al., 2006; Raj et al., 2005; Reavey, Ahmed, & Majumdar, 2006). A part of this study is to address these possible somatic responses to stressors resulting in stress, anxiety, and depression in South Asians.

Body-mind psychotherapy (BMP). Somatic-oriented therapies include body-mind psychotherapy (BMP), Reichian, Feldenkrais, Alexander Techniques, Hakomi, and mindfulness-based practices (Aposhyan, 2004; Dunleavy & Slowik, 2012; Kurtz & Minton, 1997). Even though experimental research literature is limited on these specific somatic methods, there are numerous published books on the subject matter. BMP utilizes techniques that bring bodily awareness to the client by engaging in touch, breathwork, and movement (Aposhyan, 2004). The primary goal is to work with the body and the mind as inseparable rather than as separate entities. FOAT-IP also aims to work with the body and mind as an integrated entity as opposed to individual components of a person's health.

Reichian therapy. Similar to BMP, Reichian therapy, based on William Reich's work, combines breathing, yoga-type movements, sound, and touch (i.e., pressure points) to treat psychological issues that manifest as physical bodily ailments. The idea is to physically free up *blocked* energetic points to link the body and the mind (Aposhyan, 2004). FOAT-IP may

possibly relieve somatic, physical bodily ailments by addressing stress, anxiety, and depression (i.e., psychological issues).

Feldenkrais and Alexander Technique. Resembling Reichian, two other well-known somatic methods are Feldenkrais and Alexander Technique, which both encourage bodily awareness, active participation, and regular practice to obtain results (Dunleavy & Slowik, 2012). Feldenkrais method is better fit for an individual who is more self-directed, while Alexander Technique is more beneficial for contemplative individuals who prefer seeking guidance from a teacher. FOAT-IP encompasses a contemplative component through the FOT activities, followed by actively engaging in the expressive arts on a regular basis.

Hakomi. Hakomi, developed by Ron Kurtz, is another body-centered method that integrates Western psychology with Eastern philosophies of mindfulness and nonviolence (Aposhyan, 2004; Kurtz, 2007; Kurtz & Minton, 1997). Specifically, it is grounded in principles such as mindfulness, nonviolence, organicity, unity, and body-mind holism (Kurtz, 2007). Hakomi works with body sensations, memories, and emotions. FOAT-IP also works with body sensations and emotions through FOT and connecting with one's felt sense, which will be discussed further later in the literature review.

EMDR, Focusing, and expressive arts therapy are specific subjects that fall under somatic psychotherapy, which all attempt to connect the body with the mind and its spirit. EMDR, BMP, Reichian, Feldenkrais, and Alexander Technique approach the body-mind healing from the outside-in perspective (or moving from the physical body to connect with the mental state of mind to facilitate healing; Aposhyan, 2004; Dunleavy & Slowik, 2012); Hakomi, expressive arts, and Focusing approach healing from the inside-out perspective (or moving from the mind/spirit center to eventually experience healing on the physical body level) of a client. Specifically with

Focusing, the client directs the process by simply engaging with his/her intuitive self, or in Focusing terms, the felt sense.

Focusing's nonlanguage approach. Focusing is a process model that can help to create meaning out of a stressful and anxiety-provoking experience such as trauma, where language may emerge from nonlanguage (Gendlin, 1997b; Thombre, Sherman, & Simonton, 2010). The human body is an environment in which many processes occur on different levels, and making implicit meaning out of experiences is one such process (Gendlin, 1997a). Basically, how a person makes sense out of something is an implicit process. Recently, meaning-making has turned into a focal point for empirical research on PTSD and therapeutic interventions (Park & Ai, 2006). Meaning-making model refers to restoring general life meaning after it has been violated through a traumatic event. The process involves reframing and reintegrating the negative experience in a manner to facilitate a positive association with the trauma-inducing stimulus. Engaging the client with not only making logical deductions with regard to the significance of a traumatic experience, but also taking into account the importance of allowing meaning to emerge from an experience, is also necessary when processing a traumatic event (Gendlin, 1997b). In other words, therapists utilizing FOT facilitate the client in working with the implicit (abstract) along with the fully formed concept (concrete).

Focusing is primarily client-based, where the therapist serves more as a witness or a guide during the therapeutic process. In this therapeutic relationship, the client controls the pace of the unfolding of the process that helps with regaining control, which the client may have lost when traumatized (Koch & Weidinger-von der Recke, 2009). Moreover, a secure space needs to be obtained to begin the healing process of the mind and body, which is similar to the first step in focusing, called Clearing a Space (CAS). As described earlier, CAS guides the client to a place

within oneself that feels safe and grounded (Rappaport, 2009). This is achieved by having the client identify issues that are preventing oneself from feeling "All Fine" in that moment (Rappaport, 2009, p. 37). Then, the therapist guides the client to place those issues at a comfortable distance away from or outside one's body through imagination. For example, the client may be invited to imagine placing the issues one by one in different colored suitcases on a baggage carousel, or imagine tying the issues to a balloon and letting it float up into the sky. Therefore, unlike TIR, Focusing enables clients, who still have not been able to focus on a traumatic event, to first feel safe and grounded prior to focusing on and attempting to make sense out of a trauma.

Focusing and expressive arts. Expressive arts may provide a vehicle for expressing what may surface through focusing-oriented therapy. FOAT-IP is derived from Laury Rappaport (2008), who coined the term "Focusing-Oriented Arts Therapy (FOAT)" (p. 139) to describe a method of psychotherapy that integrated art and focusing. As mentioned in the Introduction chapter, FOAT is an umbrella term that includes Focusing and art therapy (i.e., Focusing-Oriented Art Therapy); Focusing and expressive arts (i.e., Focusing-Oriented Expressive Arts Therapy); as well as nonclinical applications, such as in education, organizations, coaching, spirituality, and so on. In particular, the FOAT Basic Step, CAS-Arts, and Theme-Directed FOAT are all utilized in nonclinical settings (L. Rappaport, personal communications, May, 2014).

Klagsbrun et al. (2005) explored Focusing and EAT as an intervention on the quality of life for 18 women with breast cancer. In this pilot study, the investigation was conducted over a 2-day intensive retreat, lasting 7 hours a day. The multimodal expressive arts intervention consisted of complementary treatments (i.e., Focusing, writing, art, and movement) and

administering pre- and posttests measuring the participants' qualities of life. The study included a semi-structured interview for each of the participants prior to the start of the retreat and concluded with a follow-up phone interview 6 weeks after the study's conclusion to explore the participants' personal experiences of the complementary treatments.

The quality of life measures utilized were the following questionnaires: Experiencing Scale (EXP), or the ability of a person to connect with one's felt sense; Clearing a Space Checklist (i.e., a way to measure the Focusing intervention); Grindler Body Attitude Scale; Functional Assessment of Cancer Therapy for breast cancer (FACT-B); and Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-sp-12; Klagsbrun et al., 2005). The questionnaires were intended to measure quality of life or well-being by studying these dimensions: spiritual, physical, emotional, cognitive, creative, and social. Brief definitions of these dimensions are: spiritual (i.e., connection with a source of strength, hope, and faith); physical (i.e., positive body attitude); emotional (i.e., ability to express feelings through the arts); cognitive (i.e., goal-oriented and having purpose or meaning); creative (i.e., participation in self-expression and the arts); and social (i.e., interaction between group members).

As for the results, three out of five measures demonstrated significant differences from pre- to posttests (Klagsbrun et al., 2005). The Clearing a Space Scale results suggested that the participants were able to connect with their bodily experiences and also set aside negative issues to center themselves in an "All Fine Place" (Rappaport, 2009, p. 37). The FACT-B and FACIT-sp results suggested improvement in physical, social, emotional, and spiritual well-being. The high-rating participants on the EXP scale demonstrated higher likelihood of completing the Clearing a Space exercises than the low- or moderate-scoring participants, as well as a significant improvement in their body self-image.

One of the limitations of the study was that the demographics of the women were not included other than that they were all fluent in English (Klagsbrun et al., 2005). Another limitation was that the participants were all breast cancer women from the same treatment center, which can limit the generalizability of the results to other women with breast cancer. Speaking of the treatment center, the location may also have been a limiting factor, as the researcher mentioned, "10 acres of beautifully landscaped gardens. It is possible that some of the benefits reported by the participants were at least partly attributable to the natural surroundings" (Klagsbrun et al., 2005, p. 134). In addition, the breast cancer women were at varying stages of their illness, which may impact the mental state of an individual and how she reports herself on the measures. Even though the study had a pre-and-post design, there was no control group, and consequently, the participants served as their own control. Another limitation was that the research design did not differentiate whether it was the Focusing or expressive arts or both parts put together that had an impact as an intervention.

However, the qualitative results from the case study and interviews (Klagsbrun et al., 2005) further demonstrated the personal experience and positive impact the complementary treatments had on the participants. Moreover, the research study demonstrated the positive impact that Focusing and the expressive arts can have on its participants. Despite it being a 2-day intensive retreat, both the quantitative and qualitative data suggested the powerful influence Focusing and the expressive arts had on its participants' overall well-being.

Even though empirical research is limited in FOAT, there has been FOAT research that explored FOAT's effect on cultivating resiliency, quality of life, self-compassion, and stress-reduction. In the current study, FOAT-IP as a well-being technique included exercises on improving resiliency, quality of life, and self-compassion, while attempting to lessen the

symptoms of the PTSD precursors (i.e., stress, anxiety, and depression). The next part is not an exhaustive overview of FOAT research and literature but rather a brief overview of FOAT literature exploring mindfulness, resiliency, self-compassion and stress-reduction.

FOAT and mindfulness, compassion, inner wisdom. FOAT is considered a mindfulness-approach consisting of foundational pillars "presence, grounding, Focusing Attitude [i.e. friendly attitude], listening and reflection, and clinical sensitivity – [which] serve to establish mindfulness and are designed to ensure the respect and safety of clients throughout all phases of treatment" (Rappaport, 2014, p. 194). As mentioned earlier, FOAT-IP utilizes FOAT Check-In (i.e., Basic Step), CAS-Arts, and Theme-Directed FOAT, thereby establishing mindfulness by cultivating mindful awareness, compassion, and insight (wisdom), as well as naming feelings and experiences without identification attachments. FOAT-IP attempts to honor what Thich Nhat Hanh affirmed: "'When you have enough energy of mindfulness you can look deeply into any emotion and discover the true nature of that emotion. If you can do that, you will be able to transform that emotion' (Hanh, 2012, p. 89)" (as cited in Rappaport, 2014, p. 206).

FOAT and resiliency. According to Levine (2010), resiliency is an important consideration in the context of trauma recovery process. In the context of Focusing and trauma, FOAT has demonstrated the potential for promoting resilience. For example, Lee (2011) conducted a mixed-method study to explore the effects of FOAT on promoting resiliency in four children residing in a homeless shelter. The format of the FOAT intervention was in the context of bookmaking. The intervention was implemented over four sessions in 1 week, and two measurements were administered at the beginning and end of each session. The measurements were Social-Emotional Assets and Resilience Scale (SEARS-C) and Draw-a-Person-in-the-Rain

(DAPR) art-based assessment. Overall, there was a positive change from pre-to-posttest in assessment, and the artwork seemed to indicated an increase in resiliency.

One limitation of the study was the small sample size ($N = 4$) consisting of participants from the same homeless shelter (Lee, 2011). This may affect the generalizability of the findings to other homeless-shelter children. Another limitation was that the study had no control group, where the participants served as their own control. As a result, the positive impact of the intervention on the participants may possibly be due to other factors.

Despite the duration of the study being 1 week, the positive change in results suggested the FOAT intervention having a promising impact on fostering resiliency in its participants (Lee, 2011). Moreover, the qualitative results further demonstrated the personal experience and positive impact the FOAT intervention had on the participants.

FOAT and stress-reduction. Weiland (2012) conducted a mixed-method study to explore the effects of FOAT on stress and self-compassion in nine female graduate students. The intervention was implemented over two sessions, and two measurements were administered at the beginning and end of each session. A self-report developed by the researcher was giving at the beginning and end of the study. The two measurements were the Self-Compassion Scale (SCS) and the Stress Arousal Checklist (SACL). Overall, there was a decrease in both stress and self-compassion.

One limitation of the study was the small sample size ($N = 9$) consisting of only females, as well as being a sample of convenience by consisting of participants from the researcher's Art Therapy Psychology department of her university (Weiland, 2012). This affects the generalizability of the findings to other graduate students and women of diverse backgrounds. Another limitation was that the study had no control group, where the participants served as their

own control. As a result, the positive impact of the intervention on the participants may possibly be due to other factors.

However, the qualitative results from qualitative questionnaires further demonstrated the personal experience and positive impact the FOAT intervention had on the participants (Weiland, 2012). Despite the duration of the study consisting of two 90-minute sessions, the research study demonstrated the positive impact of FOAT as a stress-reduction tool.

While the Weiland (2012) study explored FOAT as a stress-reduction intervention, the next two studies looked at CAS-Arts in the context of stress management. McGrath (2013) conducted a mixed-methods study to see the effect of CAS-Arts on stress, anxiety, and depression as well as pain in 8 female participants with chronic pain. The intervention was implemented over three 90-minute sessions, and three measurements were administered at the beginning and end of the study. The three measurements were the Depression Anxiety Stress Scale (DASS), the Mindful Attention and Awareness Scale (MAAS), and the Chronic Pain Intrusion and Accommodation Scale (CPIAS). Overall, there was a significant decrease in depression and pain, while decrease in anxiety and stress were not supported by the quantitative data. On the other hand, the qualitative results supported CAS-Arts as a promising pain-management and relaxing intervention for chronic pain.

One limitation of the study was the small sample size ($N = 8$) consisting of only females, as well as being a sample of convenience by consisting of participants from the researcher's practicum site (i.e., mental health clinic; McGrath, 2013). The demographics did not mention the ethnicities of the women who participated in the study. This affects the generalizability of the findings to be extended to other chronic pain sufferers and possibly women of diverse backgrounds. Another limitation was that the study had no control group, where the participants

served as their own control. As a result, the positive impact of the intervention on the participants may possibly be due to other factors.

However, the qualitative results from the case study, body maps, and self-reported written responses further demonstrated the personal experience and positive impact the CAS-Arts had on the participants (McGrath, 2013). Moreover, the research study demonstrated the positive impact of CAS-Arts as a pain-management tool. Despite the study duration being three sessions long, both the quantitative and qualitative data suggested the beneficial positive influence CAS-Arts has on its participants' overall well-being.

While McGrath (2013) explored the effects of CAS-Arts with chronic pain in women, Castalia (2010) explored the effects of CAS-Arts with reducing stress in sign-language interpreters. The 9 participants consisted of 5 women and 4 men, and 8 out of 10 were trained sign-language interpreters. The intervention was implemented over three sessions utilizing three variations of CAS-Arts, and one measurement (i.e., State-Train Anxiety Inventory [STAI]) was administered at the beginning and end of the study. Overall, there was a measurable decrease in stress. On the other hand, the qualitative results supported CAS-Arts as a promising stress-reducing intervention for sign-language interpreters.

One limitation of the study was the small sample size ($N = 9$) and the demographics did not mention the ethnicities of the participants in the study (Castalia, 2010). This affects the generalizability of the findings to other populations. Another limitation was that the study had no control group, where the participants served as their own control. As a result, the positive impact of the intervention on the participants may possibly be due to other factors. In addition, the results on the STAI may have been limited by the low pretest level of anxiety in the participants.

The STAI measure may have been a limiting factor in that STAI may not have been sensitive enough to detect changes in stress.

However, the qualitative results from body maps and written reflections further demonstrated the personal experience and positive impact the CAS-Arts had on the participants (Castalia, 2010). Moreover, the research study demonstrated the positive impact of CAS-Arts as a stress-management tool. Despite the study duration being three sessions long, both the quantitative and qualitative data suggested the beneficial positive influence CAS-Arts has on its participants' overall well-being. In addition, any of the inconclusive results in the study may provide groundwork for future (larger) studies.

FOAT and FOAT-IP. The assumption of this study is that FOAT-IP encapsulates the body-mind integrative aspect of psychotherapy on which somatic psychology is based. Specifically, the process involved in FOAT-IP covers three main FOAT approaches: (a) FOAT Basic Step; (b) Clearing a Space with Arts (CAS-Arts); and (c) Theme-Directed FOAT. In any of these approaches, the client identifies a handle that develops into a creative expression depending on the type of handle that arises. There are four main types of handle forms: a handle *image* expressed through a visual art such as a painting; a handle *word* expressed as a poem or a narrative story; a handle *sound* translated into a musical sound experience; and a handle *gesture* expressed through a dance movement (Rappaport, 2008). In FOAT/FOAT-IP, the handle can be expressed in any form that feels right to the client.

The FOAT process has many potential benefits for the therapist as well as the client. One benefit is that the empathic understanding fostered between the therapist and client through concrete mediums (art, words, movement/dance, or sound/music) may help the therapist to witness the client's felt sense experience with greater clarity (Rappaport, 2008, 2009). In turn,

this may help the client to pace and track her inner experience more effectively to facilitate healing (Rappaport, 2008, 2009). A positive benefit of FOAT is that the process progresses at the pace that is most fitting to the client due to the "back and forth checking in with the body, image, art materials, body, image and so forth. It is similar to the 'zigzag' that Gendlin (2004) discusses, with the addition of the art work" (Rappaport, 2008, p. 153). The *zig-zag* process involves the client checking in with the felt-sense in a back-and-forth process until what the client thinks matches what the body feels. This client-based pacing may allow the therapist to track the client more effectively by reminding the client to pause and notice the changes that are happening within. Then, the therapist may invite the client to express what emerged from her or his felt sense through a form of expressive art. More importantly, the FOAT process of externally expressing the handle may result in a *felt shift*, which may be cathartic in itself (Rappaport, 2008). The felt shift refers to the felt movement that may allow a client to gain insight and/or take possible action to move beyond a *stuck* place. In other words, FOAT may be a gentle approach through its zigzagging component to work with trauma survivors who are not yet ready to consciously confront or acknowledge their trauma but suffer from posttraumatic stress.

Another aspect of FOAT in FOAT-IP that is particularly beneficial for trauma survivors may be in the management of PTSD stress, as Rappaport's (1998) article illustrates with a clinical case example of a client working through posttraumatic stress from child sexual abuse. According to Rappaport (1998),

> Focusing and art therapy are both tools and processes that can stand by themselves as helpful approaches to working with PTSD. . . . FOAT provides a safe container to hold and facilitate forward movement, or felt shift of the posttraumatic stress response (p. 36).

In other words,

> Focusing offers a way of listening to the inner self, to the felt sense, that helps the client to be the author of her or his own recovery. Art therapy provides concrete expression of the focusing process that serves as a visual guide and reminder of where to go on the

> journey of recovery. The art making provides a safe container to hold the felt experience; the art image serves to document the felt sense. The action of focusing with art therapy serves to help the experience to move forward, marked by the felt shift. (Rappaport, 1998, p. 36)

In this article, Rappaport equated Judith Herman's (1992) trauma recovery stages with Gendlin's Focusing steps as follows: Stage 1 of *creating safety* uses the focusing step of clearing space, which provides a safe place and space to address trauma via creating some distance between the survivor and trauma memory. Stage 2 of *remembrance and mourning* is similar to the Gendlin steps of listening to a felt sense, finding a handle, and resonating; and, lastly, Stage 3 of *reconnection with ordinary life* is basically the focusing steps of listening to the felt sense, finding a handle, resonating, asking and receiving (Rappaport, 1998). In essence, focusing is a way to be attentive to the client while simultaneously giving space and respecting the client/survivor's privacy (Rappaport, 1998, 2010). Rappaport (2014) recently modified Herman's stages of recovery to a Focusing-oriented trauma-informed model. This is further explained later in the literature review (see section "FOAT and Trauma"). FOAT-IP is primarily focused on Stage 1: establishing safety, and will be discussed further later.

South Asians

FOAT for chronic health problems in South Asian IPV survivors. Focusing may work with the South Asian population because research has shown that this group seems to suffer from psychosomatic health issues due to pen-up stress in their bodies, which may indicate that on some level South Asians translate their psychological stressors into physical bodily symptoms (Hurwitz et al., 2006; Raj et al., 2005; Reavey et al., 2006). South Asian IPV women specifically experience greater emotional and physical repercussions from IPV victimization when compared with other immigrant survivors (Dasgupta, 2007). IPV has emerged as a significant risk factor for many chronic health problems and health risk behaviors with South

Asian IPV survivors being more susceptible to a range of physical and mental health conditions, which include frequent headaches, gastrointestinal problems, depression, anxiety, sleep problems, and PTSD (EndAbuse, 2010; Hurwitz et al., 2006).

Hurwitz et al. (2006) conducted one of the few studies available on South Asian IPV survivors presenting with health problems. The study consisted of both quantitative and qualitative analyses that surveyed South Asian women in their current heterosexual relationships and administered in-depth interviews to IPV survivors. The participants were recruited through community outreach approaches, such as snowball sampling, fliers, and referrals. A majority (91%) of the participants were Indian, a third of the participants were US citizens, and a quarter of them had immigrated to the US within the last 2 years. Because the participants were not randomly selected and not representative of the South Asian population as a whole, the results of the study may not be generalized to the broader South Asian population. However, research has found that Indian Asians comprise the majority of the South Asian populations, and hence the results may be generally applicable to the Indian Asians (U. S. Bureau of Census, 2010). The 208-person sample in the quantitative study was surveyed to understand more about the South Asian women's health and IPV histories, and the researchers found 21% of the sample reported IPV in the current relationship (Hurwitz et al., 2006). Ninety-five percent of the abused women with IPV histories suffered from depression, anxiety, and suicidal ideation, and were more likely to report health problems (Hurwitz et al., 2006).

Hurwitz et al. (2006) and Reavey, Ahmed, and Majumdar's (2006) findings demonstrated the links among mind, body, and spirit resulting from IPV victimization of South Asian women. Reavey et al. analyzed data collected through semi-structured interviews and two focus groups consisting of 37 psychologists and 18 South Asian women, who were survivors of sexual assault.

Reavey et al. discussed how the survivor's inability to verbalize her trauma resulted in somatic health problems.

FOAT as a non-language-based process for ESL South Asians. When a trauma is experienced and the trauma survivor is unable to make sense of it, the new memories are "stored initially as sensory fragments that have no linguistic components" (van der Kolk, McFarlane, & Weisaeth, 1996, p. 289). FOAT-IP may allow a trauma survivor to process such fragmented nonlinguistic components, especially nonnative English-speaking South Asians. Another study by Semin, Gorts, Nandram, and Semin-Goossens (2002) involved 84 participants speaking either Dutch (European) or Hindustani (South Asian). The Hindustani sample members utilized more emotion-terms linked to their interpersonal relationships compared with the Dutch sample, which may suggest that the "linguistic construction of emotional events may vary systematically between cultures" (Semin, Gorts, Nandram, & Semin-Goossens, 2002, p. 21).

Both Reavey et al. (2006) and Semin et al.'s (2002) studies suggest that a less linguistically determined process such as FOAT-IP may allow South Asians with limited English-speaking skills or English-as-a-Second-Language (ESL) to effortlessly express themselves without being weighed down by words. Currently, the inaccurate translations from their native language to English further isolates these South Asian women from their families and allows them to be dismissed by the South Asian community as having medical health problems as opposed to embodied expressions of mental distress (Reavey et al., 2006). Reavey et al. also found that South Asian women were more receptive to acknowledging a mental illness if it is presented in the context of a medical disorder. Thus, FOAT-IP, as a complement to standard medicinal therapy, may offer a broader scope of healing for South Asian IPV survivors by treating the mind, body, and spirit as a whole.

FOAT potentially a socioculturally sensitive intervention for South Asians. As has been noted, the South Asian population is extremely reluctant to seek traditional talk therapy, which is partially due to the cultural stigma surrounding psychotherapy and its demeaning association with being dysfunctional and abnormal (Maker et al., 2005; Prathikanti, 1997; Yoshioka et al., 2003). Because half of the South Asian IPV survivors reported having knowledge of IPV services, the Raj and Silverman (2002a) findings support the need for developing more socioculturally sensitive interventions, potentially like FOAT-IP, to encourage South Asian IPV survivors to protect themselves (Ahmed et al., 2007). Raj and Silverman (2002a) surveyed 160 South Asian women in Boston, who were recruited through various community outreach methods such as fliers, referrals, and snowball sampling. The predominantly Indian immigrant (83.1%) participants, who were between the ages of 18 and 62, provided data through self-administered questionnaires and anonymous surveys that focused on demographics, intimate partner violence, and sexual health concerns. Raj and Silverman (2002a) reported that 40.8% of these immigrant women experienced IPV with their current partners, which was higher than the general population. Because the participants were not randomly selected, the results did not proportionately represent all South Asians to yield generalizations concerning this population.

The FOAT-IP process may serve as an empowering experience for South Asian women, like the participants in the Raj and Silverman (2002a) study, as well as a private way of seeking psychological assistance in processing trauma that might also be perceived as fun and supportive when conducted in a theme-directed format. For example, in context of one group FOAT exercise, the following steps encompass the FOAT process: (a) Focusing, (b) identifying bodily

tension, (c) drawing the felt sense, (d) group sharing, (e) second drawing, (f) comparing, (g) final sharing (Rappaport, 1993). These steps seem to show that the:

> Drawings go from a state of blocked tension to a greater flow of energy. In other words, clients who felt "stuck" in a felt sense experienced a release that allowed them to get "unstuck" in their therapeutic process. Clients reported having fun, learning to relax, and feeling empowered to do something to relieve their stress, tension, and anxiety. (Rappaport, 1993, p. 3)

It is an assumption of this study that through FOAT-IP, South Asian women could connect with their felt sense to bring awareness to what is in an abstract, nonverbal feeling of stress, anxiety, and/or depression within oneself and express externally in a more concrete, verbal format through the expressive arts. This process would be paced at the rate that is most suitable to the survivor via Focusing's zigzagging process. The possible ways FOAT-IP may be utilized with this process are (a) identifying handles and expressing in some creative form such as collecting word handles to eventually create a poem or narration over time; or (b) utilizing the clearing space step as a place of safety, stress-free, blissful region, which could be a source of creative expression until a handle surfaces. The clearing a space step may serve as a stepping stone in the interim to accessing the felt sense by being a grounding point to return to during the zigzagging process. Specifically, the survivor experiences the zigzagging process by delving deeper within oneself to uncover and process one's felt sense when the survivor is ready to access it.

Thus far, this section has provided a brief overview of the current PTSD treatments that include somatic psychology. Focusing is a subset of somatic psychology, which is a component of FOAT-IP. Focusing was discussed in the context of facilitating meaning-making from a nonlanguage approach or felt sense level. For the purpose of this study, Focusing was integrated with expressive arts, and FOAT-IP was discussed in the context of Rappaport's FOAT research. The potential benefits of FOAT-IP was highlighted in context to the South Asian population.

The next section is a limited overview of the available literature in the context of FOAT and trauma. As a result, the different Focusing handles will be discussed in the context of some expressive arts research specific to trauma. This section is not meant to be a comprehensive literature review in expressive arts and trauma, but to strengthen the foundational pillars of FOAT with some research.

FOAT and Trauma

FOAT as a phased treatment. Rappaport (in press) delineated a phased treatment in her case study research "Focusing-Oriented Expressive Arts Therapy: A Trauma-Informed Approach with Children and Adolescents." The trauma-informed approach "integrates neuroscience and neurodevelopment, somatic approaches, mindfulness practices, and resilience enhancement, using art making as the core approach" (Malchiodi, 2014). Specifically, the approach involves (a) grounding the body through expressive arts; (b) assessing and diagnosing the body's response to stressful events/memories through expressive arts; (c) using somatic and sensory approaches the body learns to self-regulate in response to the traumatic experience; (d) establishing a sense of safety; and (e) normalizing and enhancing resilience through the arts (Malchiodi, 2008, 2014). Malchiodi's trauma-informed approach incorporates concepts of sensorimotor psychotherapy, which is a method that treats trauma utilizing sensorimotor, cognitive, and emotional processing (Ogden & Minton, 2000).

Rappaport (1998, 2014) incorporated the trauma-informed components with Judith Herman's (1992) stages for trauma recovery. The three phases are based on Herman's stages for trauma recovery: (a) establishing safety; (b) remembrance and mourning (i.e., processing trauma); (c) reconnection with ordinary life. Rappaport's FOAT Phased-Treatment consists of Phase I: establishing safety and cultivating resilience; Phase II: processing trauma and accessing

the body's wisdom; and, Phase III: integration and life forward direction. FOAT Phased-Treatment Phase I includes Theme-Directed and Clearing a Space with Arts (CAS-A) activities to establish safety through the foundational principles of FOAT (i.e., safety, presence, listening and reflecting, grounding the Focusing Attitude, and clinical safety).

Once FOAT Phased-Treatment Phase I is established, Phase II draws upon FOAT Psychotherapy to titrate and pace the trauma processing work that is appropriately attuned to the client's experience. This customization and pacing to the client's needs "delicately addresses the safety, relational, somatic, and sensory levels necessary for trauma-informed work" (Rappaport, in press, p. 16). In Phase II, the therapist guides the client to zigzag between safely connecting with the felt sense to process the traumatic experience and pausing to simply witness the experience as needed by the client. In Phase II, the following Focusing steps are utilized: (a) connecting with a felt sense; (b) having a handle/symbol emerge; (c) checking to see if the handle *resonates* with the felt sense; (d) dialoguing internally to *ask* the felt sense a question (e.g., "What does it need?"); and (e) simply being friendly *receiving* or hearing to whatever that comes up from that inner dialogue.

In Phase III: integration and life forward direction, the client:

> focuses on the integration of self before and after the trauma . . . with an emphasis on living fully in the present with an eye toward the future. . . . [This is accomplished by focusing] on themes of: What I want in my future; dreams and wishes; and a toolbox of resources of what I learned through therapy that I want to take with me. (Rappaport, in press, p. 20)

In this way, the last phase of trauma treatment strengthens a trauma survivor's splintered sense of self and facilitates closure to move forward in life.

In the context of FOAT-IP, the primary aim is to accomplish Phase I by establishing safety, resiliency, and self-compassion for overall well-being and empowerment of self

(Rappaport, in press). Once safety is established, the client may move through Phases II and III through psychotherapy.

An important component of FOAT-IP is that FOAT is one expressive intervention that integrates other expressive arts modalities used with trauma, such as art therapy (image handle), dance movement therapy (movement handle), poetry therapy (words handle), and music therapy (sound handle; Rappaport, 2009). In the next section, the FOAT handles are briefly discussed in context with existing research for art, dance movement, poetry, and music therapy and their positive influence in processing trauma. Following the section on the handle-modalities contributing to FOAT, the basic mechanisms providing the framework for FOAT-IP (i.e., Focusing-Oriented Arts Therapy – Internet Protocol) are presented. The possible mechanisms incorporated in FOAT are (a) making meaning out of a trauma, and (b) maintaining privacy. These mechanisms are supported by research that suggest the positive benefits in posttraumatic growth work for trauma survivors (Thombre et al., 2010) as well as the importance of privacy, which is particularly important to the South Asian population (Prathikanti, 1997; Yoshioka et al., 2003).

Handle-modalities contributing to FOAT. There are four modalities that contribute to FOAT-IP: image, gesture, sound, and word handles derived from Focusing (Rappaport, 2009). The image handle results in a visual art piece; the gesture handle results in a movement piece; the sound handle results in music or exploring sound; and the word handle results in a writing piece, such as poetry or journaling.

Image handle in the form of art therapy. The focusing handle in the form of an image could result in art therapy. Qualitative and quantitative empirical studies found positive effects of expressive arts therapies as a treatment for traumatized individuals and supported the

effectiveness of body psychotherapies along with expressive arts therapies on traumatized individuals (Carey, 2006; Dokter, 1998; Gantt & Tinnin, 2007; Harris, 2007a, 2007b; Johnson, 1987; Koch & Weidinger-von der Recke, 2009; Penelope, 2007). Moreover, research has found that for processing and coping with trauma, nonverbal approaches such as art and movement are preferred and less intimidating than verbal therapies (Koch, 2009). In addition, expressive arts therapies can be cross-cultural approaches (Chang, 2006). It is the researcher's assumption that secrets can be more easily expressed through symbolization or gestures that may be externalized in expressive arts modalities than articulated through words. The themes and stories emerging from the creative pieces are intended to slowly encourage clients to transform the sense of loss of control to a source of empowerment. Engaging in groups and narrating their expressive art pieces can further facilitate meaning making (Haas-Cohen, 2009).

Word handle in the form of poetry therapy. The focusing handle in the form of a word could result in poetry therapy in the context of Expressive Arts Therapy (EAT). According to Fox (1997), one of the pioneers of poetry therapy, "poetry is a natural medicine; it is like a homeopathic tincture derived from the stuff of life – your experience" (p. 3). While there are no evidence-based research studies on poetry therapy as a clinical intervention, the following study by Tegner, Fox, Philipp, and Thorne (2009) is relevant in the context of well-being and fostering resiliency. Tegner et al. (2009) conducted a pilot study to assess the efficacy of poetry therapy as a psychotherapeutic technique to cultivate resilience with cancer patients in a group setting. The participants consisted of 12 female cancer patients attending a cancer support center, who were randomly placed into an intervention group (experimental) or a delayed intervention group (control). They participated in 1 1/2-hour poetry sessions on a weekly basis for 6 weeks. Both groups took self-report questionnaires before and after the 6-week period, which measured

deliberate controlling of one's emotions, posttraumatic positive personal growth, hospital-induced anxiety and depression, and cognitive-behavioral reactions to being diagnosed and treated for cancer. Poetry groups were facilitated in accordance with most poetry therapy practices: (a) in a private room, participants are seated in a circle for easy eye contact with all group members; (b) poems are selected based on accessibility and imagery that matches the developmental phase (beginning, interim, or closing) of the group; (c) sessions begin with a warm-up task associated with that day's poem to serve as a catalyst for participants to talk and interact with other group members; (d) the poem chosen for the day is read twice and discussed as a group focusing on any personal meanings or associations derived from a word, theme, or image based on the poem; (e) after the group discussion, the participants are invited to write for 5 minutes based on a prompt that came up during the discussion; and (f) each session ends with a closing ritual that highlights their personal experience and denotes the transition back into daily life. The crux of group poetry therapy intervention is affording the participants the opportunity to engage in the simple act of being heard by group members.

In this study, poetry therapy was found to improve emotional resilience and overall quality of life through the expression of emotions (Tegner et al., 2009). Specifically, the study suggested "a decrease in suppression of emotions . . . improve[d] emotional resilience and experience of anxiety," (p. 121) in the experimental group but not in the control group as evidenced by the nonparametric statistical measures that were utilized. The specific measures used were Courtauld Emotional Control Scale (CECS), Post-traumatic Growth Scale (PTGI), and Hospital Anxiety and Depression Scale (HADS). In addition, the decreased suppression of anger implied that "discussing their common situation within the framework created by the poem followed by reflective writing gives people a means of expressing their anger, a commonly found

reaction to having cancer, which was not available to them before" (Tegner et al., 2009, p. 127). However, because the participants were part of a support center, the group consisted of self-selected members, who were all female. Consequently, this limitation restricts the results from being generalized to a population of cancer patients who are men. Even though the unreplicated pilot study of 12 cancer patients was too small to generalize even to women cancer patients, the study proposed the potential positive influence poetry has on the human spirit and in decreasing anger, stress, and anxiety that are common conditions associated with PTSD. The study further suggested that the process of healing begins when the patient leaves the hospital bed and attempts to resume normalcy in life.

Gesture handle in the form of Dance/Movement Therapy (DMT). Even though there is no research on poetry therapy in the context of domestic violence and PTSD, research in the expressive arts therapies, such as *dance/movement therapy* (DMT) and music therapy, have demonstrated therapeutic benefits experienced by domestic violence survivors (Devereaux, 2008). As the primary therapeutic intervention, DMT has been shown "to address the physical and emotional patterns of immobilization and also, as a reparative tool, it assists survivors in integrating healthy self-regulatory capacities that have been stunted by trauma experienced through the body" (Devereaux, 2008, p. 58). Combining the musical component of DMT with the writing element of song writing, the study by Teague, Hahna, and McKinney (2006) researched effects of music therapy mixed with other expressive arts modalities in women IPV survivors.

Sound handle in the form of music therapy. Teague et al. (2006) utilized repeated measures design and post hoc analyses to investigate the effects of the creative interventions on the levels of anxiety, depression, and self-esteem in the IPV women. The 7 participants, who

were all residing at the same transitional housing setting, completed a *visual analogue scale* (VAS) at three points in time: in the first session, in the last session, and in a 3-week follow-up after the final session. The research design included no control group that the researchers presented, with the participants serving as their own control, which is a limiting factor to the generalizability of the study's results. A board-certified music therapist facilitated the group, with each session lasting about 1–1.5 hours a week for 12 weeks. The researchers hypothesized that the participants would experience decreased anxiety and depression while reporting increased self-esteem. Even though results showed that there was no significant increase in self-esteem, significant decrease in depression and marginally significant decrease in anxiety were found at the end of the study.

One of the limitations to this study was the small sample size ($N = 7$) with nonrandomized, all female (who were of European descent except for 1 Chinese woman; Teague et al., 2006) participants, thereby preventing any conclusions generalizable to general populations. The use of a single measure (VAS) for each dependent variable was another limitation, which may have not captured the potential efficacy of the intervention in showing improvement in self-esteem, anxiety, and depression. Despite the limitations, the study offers preliminary evidence for creative arts therapies as an efficacious intervention in addressing the psychological needs of IPV women survivors.

It is an assumption of this study that FOAT-IP may assist trauma survivors such as IPV survivors in a way similar to dance and music therapy (Teague et al., 2006). Despite the paucity of research in FOT, EAT, and FOAT, the researcher believes that by combining the creativity expressed in movement therapy with the therapeutic benefits of words and writing as in music therapy, FOAT-IP may be a viable form of supplemental psychotherapy for trauma survivors.

Mechanisms contributing to FOAT. FOAT-IP draws on FOAT, which seems to incorporate the following mechanisms: (a) making meaning out of a trauma, and (b) maintaining privacy.

The previous section's four modalities of expressive arts or FOAT handles/symbols may contribute to ways trauma survivors can make meaning out of their trauma and pain that result from a fear reaction to a threat, which may elicit a short-term stress response (Haas-Cohen & Findlay, 2009), when the survivors have entered phase 2 or phase 3 of the FOAT Trauma-Informed Approach. Research has found that making meaning out of pain is a bridge between physical and emotional psychological functions (Haas-Cohen & Findlay, 2009), and expressive arts have been used successfully as an adjunct to medical treatments and CBT approaches to achieve positive meaning making, mindfulness, and interpersonal attunement managing pain-related issues (Haas-Cohen, 2009; Nanis et al., 2006). Even though FOAT-IP is focused primarily on phase 1 of the trauma-informed approach, it serves as an adjunct tool preparing survivors for phases 2 and 3. Hence, it is beneficial to note the importance of meaning-making in the context of processing trauma in phases 2 and 3.

Meaning-making mechanism. Research in focusing and expressive arts therapies modalities suggest there is an association with positive posttraumatic growth through meaning-focused coping (sense-making, benefit-finding), and simply through finding general meaning in life (Park & Ai, 2006; Thombre et al., 2010). Empirical research studying the role of meaning on such issues as life satisfaction, PTSD, and therapeutic interventions (Park & Ai, 2006; Silberman, 2005) has recently provided support for the meaning-making model, including how negative meaning-making results in distress, anxiety, depression, and PTSD symptomatology (Ali, Dunmore, Clark, & Ehlers, 2002; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Park & Ai,

2006). Several different theoretical models have been proposed with regard to stress-related growth, ranging from repeated exposures and coping techniques to the integration of shattered core beliefs due to traumatic stress (Park & Ai, 2006; Park & Folkman, 1997). Most of the recent research findings, which reported most people experiencing positive changes in highly stress-inducing situations, are presented in the context of health, specifically cancer. Particularly, Thombre, Sherman, and Simonton (2010) found that meaning-making process resulted in posttraumatic growth regarding cancer patients in India.

Thombre et al. (2010) investigated the correlation between posttraumatic growth and cognitive processes such as meaning-focused coping, illness appraisals, and reevaluation of core beliefs among Indian cancer patients in a Pune, India clinic. Questionnaires were administered to collect data from the 61 patients with nonmetastatic cancer who were recruited for the study. Specifically, the male and female participants were measured utilizing the following scales to measure subjective appraisals: PTGI (Posttraumatic Growth Inventory), Core Beliefs Inventory (worldviews), two items drawn from a previous meaning-making study, and Fear of Recurrence scale along with another scale drawn from a previous study. A bivariate analysis supported the hypothesis that greater meaning-focused coping (i.e., sense-making, benefit-finding) and theoretically important cognitive processes influence perceived growth in cancer patients. The reevaluation of worldviews was found "the strongest concurrent predictor of posttraumatic growth" as suggested by the findings in multivariate analyses (Thombre et al., 2010, p. 15). However, growth was not significantly associated with illness appraisals and stressfulness. Results from this cross-sectional study supported that active cognitive processes may warrant further study.

One of the strengths of Thombre et al.'s (2010) study is its consolidation of pieces of previous studies on posttraumatic growth into one study, which included the presentation of theoretical models that have proposed numerous factors influencing growth. Specifically, the study measured illness appraisals, meaning-making, and core beliefs/worldview, which were individual areas of focus for research predating this study. Moreover, the strongest contributing factor of this study is filling the gap in terms of empirical research as well as being one of the first studies to evaluate posttraumatic growth in the Indian cancer population. In addition, the sample size was representative at 61 participants, and diverse with regard to gender (50% females, 49% males), education (31% greater than high school level, 48% less than high school level), and income (36% greater than 20,000 Rps, 32% less than 15,000 Rps, and 32% between 15,000-20,000 Rps).

However, the sample size may not be generalizable to other cancer populations because the study focused on Indian cancer patients attending a specific clinic (Thombre et al., 2010). In addition, the patients were of nonmetastatic (i.e., stages 1–3) breast, lung, or head and neck cancer, thereby consisting of a heterogeneous sample. Even though the researchers did not find their results significantly affected, future studies focusing on a more medically homogenous sample with a greater number of participants may yield more representative results on which to draw generalizable conclusions. Continuing along the same line, the study focused on measuring perceived growth at the early phase of treatment care rather than different phases of treatment. Considering different phases may demonstrate how participants' tendency to be optimistic is greater in the initial phases rather than later may impact the process of meaning-making (i.e., sense-making vs. benefit-finding) for cancer patients.

FOAT-IP has potential to be another meaning-making model for trauma survivors to utilize in the assimilation process on transforming the meaning of the trauma to alignment with the pre-trauma meaning the survivor once held, especially for South Asian IPV survivors. Specifically, FOAT-IP has potential to prepare the IPV survivors for phases 2 and 3 by first establishing safety (phase 1). After that safety is established, FOAT can be implemented for phases 2 and 3, to eventually make sense out of their traumatic experience and accept what has happened to them.

Maintaining privacy. Even though South Asians may be reluctant to speak in a group therapy format, they may be more receptive to sharing their traumas through the private process of focusing followed by the guise of an EAT modality. Through the hidden identity of the artist, dancer, or writer, a reluctant trauma survivor may feel safer discussing personal issues when the focus is not on the survivor's own life (Boone, 2006). Conversely, group therapy and traditional "talk therapy" may not work for South Asians (Du & Lu, 1997; Maker et al., 2005). Even though South Asians may be hesitant to speak in a group setting, they may be more receptive to sharing their traumas through the guise of the expressive arts' handle forms of FOAT-IP. Anonymity is crucial to South Asian psychotherapy, whose culture discourages openly talking about a personal family problem (Prathikanti, 1997; Yoshioko et al., 2003). In essence, FOAT-IP may help South Asians establish safety by utilizing anonymity as part of phase 1 (establishing safety) to eventually work towards possibly accessing memories of traumatic experiences, and work through them to facilitate meaning-making and healing as part of phase 2 (remembrance and mourning) and phase 3 (reconnection to ordinary life).

The next section will discuss FOAT-IP as a transpersonal modality by first establishing how South Asians have a tendency toward holistic models like ayurvedic medicine, which will

be defined and discussed in the context of some literature. Then, FOAT-IP will be discussed in the context of how it fits the definition of transpersonal through three themes: (a) content, (b) context, and (c) catalyst. The section suggests how FOAT-IP may be viewed as a transpersonal and potentially a holistic (i.e., socioculturally sensitive) intervention for South Asians.

FOAT as a Transpersonal Modality

South Asians and ayurveda. Because ayurvedic medicine heals by integrating the mind, body, and spirit, many South Asians tend to consult physicians for many somatic problems resulting from emotional pain. For South Asians, ayurveda states, "the person is always a whole simultaneously existing" (Prathikanti, 1997, p. 91) as a body, mind, and spiritual soul where ayurveda "offers a holistic guidemap for awakening [a person's] healing potential" (Yarema, Rhoda, & Brannigan, 2006, p. 20). Ayurveda is a 5,000-year-old comprehensive Vedic system of natural health focused on the unity of the mind, body, and spirit. From an ayurvedic framework, "Health is a continuous and participatory process that embraces all aspects of life: physical, mental, emotional, behavioral, spiritual, familial, social, and universal. Achieving balance on all levels of being is the true measure of vibrant health" (Yarema et al., 2006, p. 20). South Asians also associate ayurveda with Hindu philosophy similar to the way in which Western medicine (allopathy) is connected to philosophy, ethics, and basic life sciences (Weiss, 2003).

Halliburton's (2004) research demonstrated the South Asian preference for ayurvedic therapy over allopathy, which may provide another reason South Asians in the US are reluctant to seek psychotherapy as a result of IPV. Halliburton's research examined three modes of psychiatry—ayurvedic (indigenous), allopathic (Western), and religious healing (performed at a temple, mosque, or church)—for patients in South India. The research found that developing countries have more therapeutic options for local patients, resulting in greater improvement in

mental disorders than in developed countries. As a result, in ayurveda "psychological distress or mental illness is primarily a reflection of the overall imbalance" in a person's constitution, or *dosha* (Prathikanti, 1997, p. 91). Ayurvedic medicine does not specify a psychological treatment process to address mental distress because mental illness stems:

> from physical illness, social disruptions, or karmic tendencies of the reincarnating soul. The remedies for [dosha] imbalances involve prayers, purification rituals, soothing ointments, dietary instructions, and behavioral changes; the remedies are designed to mitigate karmic influences and restore harmony to the suffering person. (Prathikanti, 1997, p. 91)

Consequently, by the time South Asian IPV survivors are able to seek help, many are most likely suffering from PTSD or other physical and somatic ailments.

Healing the physical body of South Asian IPV survivors through medical treatments may be considered a short-term healing of external wounds and bodily breakage, and medical treatments may not address the long-lasting psychological scars that may reside in the survivor's mind and spirit (Babcock, Roseman, Green, & Ross, 2008). Moreover, research has shown that if an individual decreases the psychological experience of PTSD then the person can simultaneously reduce or eliminate systemic sequelae. According to Kendall-Tackett (2009):

> People who have experienced traumatic events have higher rates than the general population of a wide range of serious and life-threatening illness including cardiovascular, diabetes, gastrointestinal disorders, and cancer. . . . The question of trauma's impact and health is at the junction of mind-body medicine. It has important implications for not only healthcare costs, but also for trauma practice, and how we can best meet the needs of people who have experienced trauma. (p. 35)

Taft, Vogt, Mechanic, and Resnick (2007) suggested "that PTSD is pivotal with respect to explaining the effects of trauma on health" (p. 354). Their study showed that women who sought assistance for intimate partner aggression had a greater tendency to suffer from PTSD, and were also afflicted with physical health issues (Taft et al., 2007). By treating an individual's acute

physical health concerns and long-term psychological and spiritual health, FOAT-IP may be used as a holistic modality to heal the mind, body, and spirit.

FOAT and transpersonal psychology. This is important because the FOAT-IP method may be designed to compliment or integrate the mind-body-spirit components of ayurvedic holistic healing, which are also components of *transpersonal* psychological healing, where "transpersonal means optimal health and well-being, holistic development of self, and psychology of transformation" (Hastings, 1999, p. 198). More recently, Hartelius, Caplan, and Rardin (2007) proposed a definition for transpersonal psychology as:

> an approach to psychology that 1) studies phenomena beyond the ego as context for 2) an integrative/holistic psychology; this provides a framework for 3) understanding and cultivating human transformation. . . . [In other words] transpersonal psychology studies human transcendence, wholeness, and transformation. (p. 145)

Their definition intended to highlight the "future potential of humanity" while acknowledging "human meaning in the present" (Hartelius, Caplan, & Rardin, 2007, p. 142). They categorized transpersonal experience into three themes: (a) content (i.e., where trans in transpersonal means *beyond*-ego unfolding on an individual basis); (b) context (i.e., trans means *pervading* to create an integrative/holistic personhood); and (c) catalyst (i.e., trans means *changing* humanity or transformation). Consideration of the characteristics and experiences of FOAT-IP shows it to fit well with these definitions. First, FOAT-IP is an intervention, which allows individuals to uncover human meaning in the present moment by taking the "here-and-now homecomings to a deeper self [i.e., the felt sense] that is always present (often unnoticed)" (Hartelius et al., 2007, p. 142). Second, FOAT-IP involves the focuser as an active participant, and is a path designed to cultivate the beyond-ego unfolding by engaging with the individual's felt sense. FOAT-IP includes a focuser and a listener (guide), where the somatic presence of therapist in relationship to client's ego is not separate but part of a greater whole. Hartelius et al. (2007) indicated

practicing meditation, compassion, and altruism as possible ways to facilitate beyond-ego unfolding, which is aligned with their content-theme transpersonal definition. The application of FOAT-IP as a form of meditation to heal psychological wounds can be seen as one such path, especially for those with fragile ego structures who need a nonconfrontational way of processing wounds. In addition, FOAT-IP takes into consideration culture-specific psychologies that facilitate human transcendence and wholeness (e.g., ayurveda's holistic healing perspective on mind-body-spirit levels). The felt shifts experienced in the body through the FOAT-IP process may lead to personal as well as social transformations. Lastly, FOAT-IP may serve as a "catalyst for human transformation" (Hartelius et al., 2007, p. 144) by potentially changing the perspectives of South Asians with regard to seeking therapy and/or helping IPV survivors manage PTSD.

FOAT-IP may alter an individual's perception of the mundane and transcendental by attaining deeper appreciation, understanding, and comfort in a person's place in the world. Even though mainstream practice of meditation is rooted in South Asian culture (Du & Lu, 1997), Boorstein stated, "awareness practice may be difficult for individuals with a fragile ego structure. . . . [and thereby] direct confrontation with strong emotions may be stressful and destabilizing" (as cited in Scotton, Chinen, & Battista, 1996, p. 347). Similar to spiritual practices such as yoga, meditation, and mantra chanting, which are quite familiar to South Asians (Du & Lu, 1997), FOAT-IP may be a medium for meditation whereby emotion, intellect, and the body merge to form a deeper presence in the world by giving new meaning to the chaos in people's lives.

The next and final section briefly presents some of the limited literature supporting Web-based interventions and the validity of online assessments. The section concludes with the importance of FOAT-IP in the context of reaching a population not acculturated to

psychotherapy and/or a population that would otherwise be excluded from research and mental health services.

FOAT as a Web-Based Intervention

FOAT-IP being accessible by Web is an important component of consideration when working with populations not acculturated to psychotherapy and who value privacy, anonymity, and confidentiality such as South Asians. Even though there are no Web-based studies for FOT or EAT, there are studies that have reported successful behavior change through Web-based interventions using cognitive-behavioral therapy (CBT) addressing depression, insomnia (i.e., anxiety), weight loss (i.e., stress), and irritable bowl syndrome (i.e., stress, anxiety, depression; Ljotsson et al., 2010; Ritterband & Tate, 2009; Ritterband, Thorndike, Cox, et al, 2009.; Ritterband, Thorndike, Gonder-Frederick, et al., 2009; Sheeber et al., 2012).

Web-based CBT (with mindfulness) for somatic symptoms (IBS) and anxiety. Ljotsson et al. (2010) utilized CBT with a mindfulness component, where the connection with mind to body is explored. The pilot study included 85 participants suffering from irritable bowel syndrome (IBS), who received CBT and mindfulness exercises delivered through the Web. The follow-up study included 75 of their original 85 participants submitting self-reported responses 15–18 months after the conclusion of both the treatment and wait-listed crossover groups had received treatment. The physical somatic symptoms, quality of life, and anxiety self-report measures demonstrated that the therapeutic gains were maintained from the pilot study. Specifically, 50 participants reported adequate improvement in symptoms to suggest that Internet-based CBT and mindfulness has long-term benefits to participants suffering from IBS. The CBT intervention utilized was exposure therapy (which is a titrated body-based, experiential intervention) to help alleviate bodily IBS and anxiety symptoms. A secondary focus was

accepting the symptoms through mindfulness exercises rather than avoiding or controlling the negative symptoms. In turn, the participants are alleviated from the burden of physically and mentally experiencing the somatic bodily symptoms. The researchers found that alleviating the symptoms led to improved quality of life. Limitations included the power of this study and it being a follow-up to a pilot study. To establish significant results, the study would need to be replicated with a larger population to yield significant statistical results generalizable to the population of IBS sufferers. Nevertheless, the study demonstrated the potential and effectiveness of Internet-based therapeutic intervention with a mindfulness component similar to FOAT-IP.

Web-based CBT for insomnia. Ritterband, Thorndike, Gonder-Frederick, et al. (2009) studied the effects of Web-based CBT intervention for addressing insomnia in adults. Forty-five participants, who suffered from insomnia for at least a decade, were randomly assigned into experimental ($N = 22$) and wait-listed control groups ($N = 23$). An evidence-based CBT approach for addressing insomnia was implemented through the Internet. Findings supported the positive efficacy on facilitating sleep; however, the homogenous, small sample size limited this study. Nevertheless, the study showed promising long-term insomnia relapse prevention. Specifically, the 6-month follow-up with the Internet group yielded the maintenance of the positive effects gained from the intervention. This study demonstrated the potential of combating insomnia, which is a symptom of anxiety and depression, through a Web-based intervention similar to FOAT-IP.

Web-based CBT for depression. Sheeber et al. (2012) utilized Internet-based CBT to treat maternal depression. In this feasibility study, the participants ($N = 70$) were randomly assigned into the experimental group (Internet CBT) or the wait-listed control group. Several outcome measures were used to assess various aspects of the mother's lifestyle, including the

Beck Depression Inventory (BDI-II) and Parent Behavior Inventory (PBI). Despite the small sample size to yield weak power analysis, the intervention yielded significant decrease in depression. Therefore, the study demonstrated the potential and efficacious of Internet-based therapeutic intervention to address mental disorders such as depression similar to FOAT-IP.

Internet model for effective behavior change and symptom improvement. Ritterband, Thorndike, Cox, et al. (2009) created an Internet model for achieving effective behavior change and symptom improvement. The model took into consideration how a person's environmental factors (e.g., bedroom, café, laptop, tablet, etc.) influence how an individual utilizes a Website. In addition to Website use, the specific characteristics of a Website also helped create and establish a sense of support for an Internet user. In turn, these Website characteristics created an environment of support that determined how successfully an Internet user will adhere to an online behavior change program. Through various mechanisms of change, the Website use of an Internet user resulted in changes in behavior and improvement in symptoms of an individual. To maintain these behavioral changes and symptom improvements in an Internet user, the Internet treatment model also included a way to maintain the benefits established by an online treatment program in order to prevent relapse in an individual's recovery process. Moreover, there is growing literature to further support and highlight the advantages of Web-based interventions (Ritterband & Tate, 2009). The benefits of Internet interventions include scalability, cost-effectiveness, and reaching populations that would not have access to treatments.

Validity of online assessments. Online assessments are considered an acceptable and a validated means of self-assessment administration to participants (Ritter, Lorig, Laurent, & Matthews, 2004). In a randomized comparison study, Ritter et al. (2004) compared Web-based questionnaires with standard pencil-and-paper questionnaires, which were mailed to the

participants. The study recruited participants online ($N = 397$) and randomly assigned them into either the Web-based group or the mailed pencil-and-paper group. A total of 16 self-report instruments were utilized and none were found to be significantly different from either group. The study found participants completed more and required less follow-up when the questionnaires were Internet-based than mailed. The study also found the questionnaires to be reliable irrespective of being Web-based or mailed questionnaires. Therefore, online implementation of self-assessments was found an equally appropriate mode of data collection for a Web-based study.

FOAT-IP contributing to the evolving research on Web-based interventions. Similar to the Ljotsson et al. (2010) studies, the present study of FOAT-IP explored mind-to-body connection, where the mindfulness element (i.e., FOAT-IP activity) led to the cognitive component (i.e., journaling). Unlike Ljotsson et al. (2010), FOAT-IP is a nonclinical application of FOAT, and not therapy being conducted online like the CBT being implemented over the Internet to treat IBS. FOAT-IP is suggested as an adjunct tool to provide a self-help or homework aspect to psychotherapy, thereby contributing to the well-being and empowerment of the client. Ritterband, Thorndike, Gonder-Frederick, et al.'s (2009) research on insomnia and Sheeber et al.'s (2012) research on depression both suggested the potential success for addressing stress, anxiety, and depression through FOAT-IP. Ritter et al.'s (2004) research validated the implementation of online assessments utilized in FOAT-IP. In this manner, FOAT-IP was implemented online, which is important when trying to reach a population that would otherwise be excluded from research and mental health services. However, it is important to note that there is limited research to solidly affirm the success of online interventions. Further research on a larger scale, with more powerful sample sizes and robust data sets, would need to

be conducted. Nevertheless, this current study could also be contributing to this evolving area of Web-based interventions in the realm of psychotherapy.

Conclusion

In summary, even though Web-based interventions are relatively recent and limited in research, the online format of FOAT-IP seems promising, especially in the context of reaching populations not acculturated to psychotherapy like South Asians. Specifically, the components of Focusing, expressive arts, and internet-implementation provide a way for more privacy. FOAT-IP addresses nonclinical, well-being, and empowerment issues as a means to create safety and to provide a vehicle for expression in a more private setting. FOAT-IP may be the first step for establishing privacy and safety; then, further therapeutic processing and work for trauma survivors may be possible. Specifically, South Asian IPV survivors potentially may be able to gain insight and understanding from traumatic experiences to ultimately be able to move on in life. In other words, South Asian women may reveal their traumatic selves to cultivate resiliency and well-being, which may result in the transpersonal healing of the individual. Therefore, to assist populations like South Asian IPV survivors in the US, FOAT-IP is proposed as an adjunct psychotherapeutic technique to help reduce the symptoms of stress, anxiety, and depression in this population that is at risk for IPV.

Chapter 3: Methods

This quantitative study explored the effectiveness of FOAT-IP as an online intervention to potentially assist South Asian women suffering from stress, anxiety, and depression. The quantitative aspect tested and measured the hypothesis, specifically, that FOAT-IP would reduce stress, anxiety, and depression in South Asian women at risk for IPV. In this study, questionnaires were used to test and predict that the FOAT-IP intervention would reduce stress, anxiety, and depression for the South Asian women participants in the Bay Area, as well as throughout the nation.

The quantitative method employed was a pretest-posttest wait-list control group experimental design, where participants were randomly assigned to one stimulus condition (FOAT-IP). The quantitative method provided concrete empirically based data to potentially draw significant conclusions regarding the effect of FOAT-IP on PTSD-related conditions. A pretest-posttest wait-list control group cross-over design experimental approach was administered in which one experimental group experienced FOAT-IP, while the control group was wait-listed for 4 weeks. At the conclusion of the 4-week waiting period, the wait-listed participants were offered the opportunity to engage in FOAT-IP for 4 weeks.

Due to the importance of anonymity amongst South Asians, recruiting individuals to overtly participate in research studies was extremely difficult. As a result, a Web-based intervention was designed with the intention to more effectively reach this population. As a Web-based intervention, the participants received the assistance they needed from the privacy of their own homes. The framework for Web implementation was as follows: First, the participants needed computer/Internet access along with supplying their own art materials. Then, an e-mail was sent out with a link to the week's online FOAT-IP activities. Each week's link remained

active only for 1 week, forcing participants to complete all assigned activities on a weekly basis. The FOAT-IP activity was delivered through .mp3 audio files streamed online so they could listen and engage in the FOAT-IP exercise. Participants submitted their creative pieces by uploading a photo/video of the expressive art component. Following the FOAT-IP activity, the participants were prompted to journal about their personal experiences with engaging in FOAT-IP.

Recruitment

The participants ($N = 25$, with 12 participants in the experimental group and 13 participants in the control group) were recruited through community outreach efforts such as fliers, referrals, and snowball sampling, as well as online popular social media platforms such as Facebook (see Appendix A). An incentive of $500 was offered in the form of a gratitude-gift card, and awarded through a raffle to those participants who had completed the study in its entirety. Ultimately, the sample size was a randomly assigned convenience sample consisting primarily of participants, who were networked either through acquaintances of the researcher, the researcher's family, or friends of friends.

FOAT-IP was presented as "Focusing Expressive Arts Technique (FEAT)" to establish clarity to the participants that it was not therapy, but a well-being, empowerment technique derived from FOAT. It was important to the researcher to make this clear to the participants because of the cultural stigmas around mental health and therapy in the South Asian community. By presenting the FOAT-IP exercises as FEAT, they would be better received within the South Asian culture given their openness to learning techniques (e.g., dance, art, music, singing, etc.).

Participants

The participants were restricted to the following criteria due to the specificity of the population at study: (a) ages: 18–65; (b) ethnicity: South Asian; (c) gender: women; (d) primarily English-speaking, even though utilization of their native language was supported during FOAT-IP activities. Since prescreening this population was difficult, the pretest results were screened to ensure the participants were appropriate and safe to participate in the study.

Data Collection

In this study, quantitative data was obtained through a pretest and posttest design, whereby the participants were administered questionnaires to measure depression (BDI-2), anxiety (STAI), stress (PSS), and positivity (PSOMS). These measures are explained further in the next section, Instrumentation. The data were collected utilizing the SurveyGizmo Website.

For accountability purposes, the researcher had the participants submit their creative pieces for the FOAT-IP exercises in which they engaged on a weekly basis. To ensure confidentiality and anonymity, the participants uploaded the images or word documents of their creative pieces onto the SurveyGizmo Website with no identifying information other than their participant ID number. For the purpose of this study, the qualitative data was not analyzed.

Instrumentation

Three quantitative measures were utilized for assessing participants' stress, anxiety, and depression: Perceived Stress Scale (PSS; Cohen, 1994); State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983); and Beck Depression Inventory-II (BDI-II). One measure, Positive States Of Mind scale (PSOMS; Horowitz, Adler, & Kegeles, 1988), was administered to note any positive effects the intervention may have, which were not evident in the PSS, STAI, or BDI-II instruments.

Perceived Stress Scale (PSS; Cohen, 1994) is a widely utilized psychological instrument to measure an individual's perception of stress in one's life. It measures one's ability to do things to have a happy life (Cohen, Kamarck, & Mermelstein, 1983; Cohen & Williamson, 1988). The measure is meant for community samples consisting of junior high school education level or higher. The items consider the participants' experiences of unpredictability, uncontrollability, and being overloaded in their life over the last month, including current levels of experienced stress. Specifically, the questions are easy to understand and the response choices are simple to grasp, which is an important consideration when working with participants whose English capacity may be limited. According to Cohen, Kamarck, and Mermelstein (1983), the questions are designed in a generic manner so that the content is free from being specific to any subpopulation group. PSS scores are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1, & 4 = 0) to the four positively stated items (items 4, 5, 7, and 8) and then summing across all scale items. A short 4-item scale can be made from questions 2, 4, 5, and 10 of the PSS 10-item scale. Construct validity of the PSS was evidenced in its moderate correlations with other measures of appraised stress and negative life events (Cohen et al., 1983). Cohen et al. (1983) reported Cronbach's alphas of .84 and .85 for two college samples and .86 for a smoking cessation sample. The PSS had a 2-day test-retest reliability coefficient of .95 and a coefficient of .55 after 6 weeks. The data yielded a coefficient alpha of .85. PSS is not a diagnostic tool.

State Trait Anxiety Inventory (STAI; Spielberger et al., 1983) is the leading measure for distinguishing anxiety from depression in adults. The STAI Form Y assesses anxiety symptoms, where the first subscale measures the temporary state of anxiety, while the second subscale measures the ongoing trait of anxiety. Despite having to reverse-score the questions on the absence of anxiety, scoring the measure is simple and straightforward, adding up the points that

fall in the range of 20–80, where the higher score indicates greater anxiety (Spielberger et al., 1983; Tilton, 2008). For STAI, internal consistency coefficients for the scale have ranged from .86 to .95; test-retest reliability coefficients have ranged from .65 to .75 over a 2-month interval (Spielberger et al., 1983). For validity purposes, if less than three questions were answered, an alternative means of scoring is included. STAI can be administered due to its adaptability across diverse ethnic and cultural groups. More importantly, the STAI results can be utilized for clinical assessment and diagnosis and for medical and psychological research (Tilton, 2008).

Beck Depression Inventory (BDI-II), one of the most commonly administered depression screening measure for adults (Sharp & Lipsky, 2002), was modified from its original to integrate the DSM-IV criteria. Taking participants approximately 5 to 10 minutes to complete the measure, the questions are designed to consider the symptoms over a timeframe of the recent 2 weeks prior to test date. Scoring the measure is simple and straightforward, adding up the points assigned to each response item. BDI-II can be administered due to its adaptability across diverse ethnic and cultural groups. Research had found with BDI-II a high internal consistency ranging from .89 to .94 even when utilized on diverse populations. Over a 1-week interval, the test-retest reliability was .93.

Positive States Of Mind (PSOMS; Horowitz et al., 1988) scale measures the capacity to experience positive states such as focused attention, productivity, responsible caretaking, restful repose, sharing, nonsexual pleasure and intimacy, when experiencing stressful life events. It indicates the current life satisfaction of an individual. Research found that there was no statistically significant difference when utilized with diverse ethnic groups. Horowitz, Adler, and Kegeles (1988) reported a Cronbach's alpha of 0.77 for the six areas that people have difficulty experiencing positively when enduring stress. The PSOMS was "found to be internally

consistent, sensitive to degrees of life stress, well accepted, quick to administer, and amenable to use as a repeated measure in longitudinal studies" (Horowitz et al., 1988, p. 477).

The assessments were administered directly online. Online assessments are considered an acceptable and a validated means of self-assessment administration to participants (Ritter et al., 2004).

Procedure

The researcher conducted the sessions in a period of 4 weeks. There was a total of two groups: (a) FOAT-IP experimental group, and (b) wait-list (WL) control group. The experimental groups were assessed two times during the course of the study (pretest and posttest). The participants concluded each session by journaling at the end of their session, reflecting on their online experience.

FOAT-IP manual and recordings. The researcher created a manual (see Appendix B) that delineated the weekly activities, which were in collaboration with Laury Rappaport (2009) and derived from her *Focusing-Oriented Art Therapy* book. The researcher recorded the FOAT-IP activities from the manual using a digital-voice recorder, while playing music in the background. The researcher uploaded the recordings onto SurveyGizmo.

FOAT-IP process. The online FOAT-IP process included the following elements: (a) Focusing-check-in, (b) felt sense, (c) symbolizing the felt sense, (d) FOAT-IP theme-directed exercise, (e) symbolizing the felt sense now, (f) journal for after exercises and end of session for 15 minutes. The participants had a whole week to complete each week's activities (see Appendixes C and D). FOAT-IP materials included drawing utensils, such as pens, markers, crayons, and oil pastels; paint; assorted color papers; magazines photos/words; scarves (*dupattas/chunnis*) for movement; and music.

Each group either engaged in the technique or were wait-listed for 4 weeks. The quantitative assessments were administered to the control group at the beginning and conclusion of the waiting period. Prior to the first day of the study, participants were randomly assigned to participate in FOAT-IP or WL conditions and signed consent forms and completed baseline questionnaires (see Appendixes E and F).

Specifically, during the 4-week period of the study, the participants engaged in a weekly Web-based study for approximately 30 minutes. On a weekly basis, the participants were e-mailed links to access the weekly FOAT-IP activities on the SurveyGizmo Website (see Appendix G). The weekly links were open to the participants only for a week before the link closed. During this period, the participants listened to a FOAT-IP recording and engaged in activities that included art, movement, music, writing, and/or journaling process. The participants were asked to submit their creative pieces by uploading a digital photo format or Microsoft Word .doc format with their assigned participant number to maintain anonymity. This was to ensure the activities were completed on a weekly basis. These materials were not subject to analysis in this study.

During weeks 0 and 4, the participant's involvement consisted of taking online surveys on SurveyGizmo took approximately 5 minutes to complete. The surveys consisted of questions about stress, anxiety, depression, and positive states of mind. Their identity and responses were kept confidential. Their responses were aggregated with the responses from other participants and the participant as an individual was not identified in any way in the final project. Survey Gizmo provided a secure platform for data collection and shared the information with only the primary researcher to protect participants' privacy. The participants were also directed to the

SurveyGizmo Website as follows: “For more information on the Survey Gizmo privacy policy, please visit http://www.surveygizmo.com/privacy/” (see Consent Forms, Appendix E).

Treatment of Data

To maintain confidentiality, participant surveys, interviews, and demographic information were provided with a unique identification number that encoded each response. The key to the code was stored separately from material directly supplied by the respondent, and the researcher was the only person who had access to that storage location and/or saved in a password-protected file on a secured laptop. Only the researcher could access the online data. All data was saved to a private laptop, which was password protected.

The participants had utilized participant identification numbers with all submissions to preserve anonymity. This permitted the researcher to directly download the data from SurveyGizmo into an Excel spreadsheet file format. The researcher organized the file by manually scoring the pretest and posttest measures (i.e., BDI-II, STAI, PSS, and PSOMS) for each participant. The quantitative data was organized into a Microsoft Excel file that was then exported into a file format compatible with the statistical analysis program, the Statistical Package for the Social Sciences (SPSS), which was utilized. Descriptive statistics were acquired first, and then one-way analysis of covariance (ANCOVA) was applied due to the small sample size utilized in this feasibility study. A statistician was consulted to review the results.

Risks. Potential risks for participating in the 4-week online study included the possibility that working with negative stressors may bring up uncomfortable feelings. The risk may be slightly higher with unpleasant stressors surfacing because this was an online technique. By participating in this study, risks included but were not limited to increased stress, anxiety, or depression due to recognizing what was in the way of feeling fine. However, this study was

designed to reduce anxiety and promote feelings of well-being. The researcher safeguarded against feelings of stress, anxiety, and discomfort by conducting the study online to establish a safe environment for the population. The researcher was available during the study to help participants process any discomfort that may have arisen and/or had a list of local mental health resources to provide to any participant needing the extra support.

Benefits. The possible benefits of participating in this study were many. Participants may have experienced a reduction in perceived anxiety, depression, and stress, and they may have experienced an increase in positive states of mind. In addition, they may have found it fun and relaxing to work with art materials or discover a new means of expression not previously used. They may have experienced personal growth and self-knowledge. Additionally, they may have experienced a sense of fulfillment by contributing to a scientific body of knowledge in a nascent field of research. Furthermore, potential benefits may have included gaining a deeper understanding and awareness of how an individual experiences negative daily stressors on mind, body, and spirit levels. Participants may have discovered new tools for working through those emotions, which may have fit the individual's personality better and also been considered more appropriate by the participant's family and the South Asian culture. Lastly, the FOAT-IP activities may cultivate into a lifelong self-care practice for well-being, if the participant chose to continue practicing with the FOAT-IP tools even after completing the study.

Implications. The results of this study could further the field of art therapy and South Asian clinical/mental health research. Research into the benefits of art therapy is growing, especially in terms of improving psychological well-being. More research is needed into the mind-body benefits of art therapy, especially in the context of South Asians. Little research has been done on the effects of Focusing-Oriented Art Therapy on South Asians. The results of this

study may suggest that FOAT for depression is a beneficial adjunct treatment. This study is the first to design and implement FOAT in an online format.

Chapter 4: Results

This study measured the effect of FOAT-IP between an experimental group and wait-listed control group, and the variables of stress, anxiety, depression, and positive states of mind. It was hypothesized that there would be significant improvements in stress, anxiety, depression, and positive mindset. Eight South Asian (i.e., Indian) women participated in the 8-week-long Web-based intervention. Stress scores were measured using the Perceived Stress Scale (PSS) at the beginning of the first week and at the end of the fourth week in order to measure change in the stress levels over the course of the study. Anxiety scores were measured using the State Trait Anxiety Inventory (STAI-S, STAI-T) at the beginning of the first week and end of the fourth week in order to measure change in anxiety levels during the course of the study. Depression scores were measured using the Beck Depression Inventory (BDI-II) at the beginning of the first week and at the end of the fourth week in order to measure change in depression levels over the course of the study. The Positive States of Mind Scale (PSOMS) was used at the beginning of the first week and at the end of the fourth week in order to measure the changes in positive mindset during the study.

Participant Demographics

Sixteen individuals participated in the study. Originally, 40 participants were recruited for the FOAT-IP 8-week study; however, by the time the study started, the total dropped down to 25 participants (12 in the experimental, 13 in the control). After 25 participants signed the consent forms, only 16 out of the 25 completed the 4-week long study. Eight out of the 12 experimental participants participated in the intervention and completed the study, while 4 experimental participants did not complete the study.

The descriptive statistics for the participants' discrete and continuous demographics are listed in Tables 1 and 2, respectively. All participants were of South Asian descent (Indian) descent. The sample was highly educated. Three (18.8%) participants had a Bachelor's degree, 7 (43.8%) had a Master's degree, 3 (18.8%) had a professional degree, and 3 (18.8%) were doctorates. The average participant was 35.81 (SD = 9.70) years of age. Approximately half (56.3%) the individuals were single and never married. Half (50.0%) the participants were employed for wages, 4 (25.0%) were homemakers, 2 (12.5%) were self-employed, and 2 (12.5%) were students. The participants' yearly household incomes were reported as follows: 2 (12.5%) less than $25,000; 5 (31.3%) $75,000–$99,999; 3 (18.8%) $100,000–$149,000; 3 (18.8%) $150,000–$199,999; and 3 (18.8%) $200,000 or more.

Approximately half (7; 43.8%) the participants reported their native language was English, 6 (37.5%) Indian, and 3 (18.8%) indicated that English and Indian were their native languages. Nine (56.3%) participants were born in India, and 7 (43.7%) were born in the United States. Among the participants were 4 with primary Indian mother-tongue languages, with Kannada (5; 31.3%) being the most prevalent. The single (6.3%) participant who indicated not having an Indian mother-tongue language was presumably English-speaking in the household. A majority (12; 75.0%) of participants indicated Hinduism as their religious affiliation.

Table 1

Descriptive Statistics for Participants' Discrete Demographics

Variable	*N*	*%*
Education		
Bachelor's Degree	3	18.8
Master's Degree	7	43.8
Professional Degree	3	18.8
Doctorate Degree	3	18.8
Marital Status		
Single, Never Married	9	56.3
Married or Domestic Partnership	6	37.5
Separated	1	6.3
Employment Status		
Employed for Wages	8	50.0
Homemaker	4	25.0
Self-Employed	2	12.5
Student	2	12.5
Yearly Household Income		
Less than $25,000	2	12.5
$75,000 - $99,999	5	31.3
$100,000 - $149,000	3	18.8
$150,000 - $199,999	3	18.8
$200,000 or More	3	18.8
Native Language		
English	7	43.8
Indian	6	37.5
Both English and Indian	3	18.8
Primary Indian Mother-Tongue Language		
Gujarati	3	18.8
Hindi	3	18.8
Kannada	5	31.3
Telugu	3	18.8
Tamil	1	6.3
Not Applicable	1	6.3
Country Born		
India	9	56.3
United States	7	43.7
Religion		
Buddhism	1	6.3
Hinduism	12	75.0
Jainism	1	6.3
Sikhism	1	6.3
Zoroastrianism	1	6.3

Note. Some additive percentages do not equal 100 due to rounding error.

Table 2

Descriptive Statistics for Participants' Continuous Demographics

Variable	*n*	*Min.*	*Max.*	*M*	*SD*
Age	16	25.00	62.00	35.81	9.70

The respondents were also asked about their interests, hobbies, and other relaxation outlets in which they participate. The descriptive statistics for these responses are listed in Table 3. The participants' interests and hobbies were reported as follows: 8 (50.0%) art; 8 (50.0%) dance; 7 (43.8%) writing; 5 (31.3%) singing; 3 (18.8%) musical instruments; and 12 (75.0%) other. Among the participants' reported relaxation outlets were the following: 6 (37.5%) meditation; 5 (31.3%) yoga; 4 (creative/expressive arts); 4 (25.0%) other; and 4 (25.0%) none.

Table 3

Descriptive Statistics for Participants' Interests, Hobbies, and Relaxation Outlets

Variable	*N*	*%*
Interests & Hobbies		
Art	8	50.0
Dance	8	50.0
Writing	7	43.8
Singing	5	31.3
Musical Instruments	3	18.8
Other	12	75.0
Relaxation Outlets		
Meditation	6	37.5
Yoga	5	31.3
Creative/Expressive Arts	4	25.0
Other	4	25.0
None	3	18.8

Note. Additive percentages do not equal 100 because responses were not mutually exclusive.

Hypothesis Testing

The following section details the analytical process utilized to assess the study's hypotheses. All inferential tests were conducted at $\alpha = .05$.

Research Question 1: Is there a statistically significant difference between the experimental and control groups on posttest PSOMS (Positive States of Mind) scores after statistically controlling for participants' pretest scores?

H_0: There will not be a statistically significant difference between the experimental and control groups on posttest PSOMS (Positive States of Mind) scores after statistically controlling for participants' PSOMS pretest scores.

H_A: There will be a statistically significant difference between the experimental and control groups on posttest PSOMS (Positive States of Mind) scores after statistically controlling for participants' PSOMS pretest scores.

A one-way ANCOVA (analysis of covariance) was conducted to determine if there were significant differences between the experimental and control groups on posttest PSOMS scores after controlling for pretest PSOMS scores. The ANCOVA is appropriate when comparing two or more groups on a continuous dependent variable while controlling for a continuous variable (Stevens, 2002; Tabachnick & Fidell, 2007). Treatment group (experimental vs. control) was the between-subjects independent variable, posttest PSOMS scores was the dependent variable, and pretest PSOMS scores was the covariate (i.e., control variable).

The purpose of the ANCOVA is to assess differences on posttest PSOMS scores while statistically controlling for participants' preexisting differences on PSOMS. This strategy will allow the researcher to assess the impact of the treatment on PSOMS while eliminating

participants' preexisting differences on PSOMS, thus eliminating it as a potential confounding variable in the statistical model.

The following ANCOVA testing procedures were utilized (Stevens, 2002; Tabachnick & Fidell, 2007). First, the data were screened for outliers. The participants' posttest PSOMS scores were standardized by group, and the resulting scores were utilized to identify outliers in the data. A data point was considered an outlier when the |standardized score| was greater than 3. This process failed to reveal any outliers.

The next step in the analysis was to assess the statistical assumptions. The small sample size in each group ($n = 8$) precluded the use of the central limit theorem or histograms to diagnose the normality assumption. Therefore, the Kolmogorov-Smirnov test was utilized to assess normality. The tests indicated the distributions for the control group and experimental group were approximately normal, $z = 0.88$, $p = .415$ and $z = 0.77$, $p = .599$, respectively.

Levene's test was not significant, indicating the two groups had equal error variances (i.e., homogeneity of variances) on posttest PSOMS scores, $F(1, 14) = 0.00$, $p = .995$. Lastly, the final assumption of ANCOVA is homogeneity of regression slopes which is assessed with an F test on the independent variable X covariate interaction term. The term was significant, indicating the inequality of regression slopes, $F(2, 4) = 8.56$, $p = .036$. This indicates the relationships between pretest and posttest PSOMS scores were inconsistent for the two between-subjects groups.

The unadjusted and adjusted means are listed in Tables 4 and 5, respectively. The ANCOVA test statistics are listed in Table 6. The ANCOVA failed to reveal a significant difference between the control ($M = 14.29$, $SE = 0.81$) and experimental ($M = 14.97$, $SE = 0.81$) groups on posttest PSOMS after controlling for participants' pretest PSOMS scores, $F(1, 13) =$

0.35, $p = .565$ ($\eta^2 = .03$, power = .09). The difference between the group means increased slightly after controlling for preexisting differences on PSOMS scores. However, only 3% of the variability in the participants' posttest PSOMS scores can be attributed to the treatment after controlling for pretest PSOMS scores. Thus, the researcher fails to reject the null hypothesis.

Table 4

Unadjusted Post-Test PSOMS Scores

Group	*N*	*M*	*SD*
Control	8	14.38	2.39
Experimental	8	14.88	2.36

Table 5

Adjusted Post-Test PSOMS Scores

Group	*N*	*M*	*SE*
Control	8	14.29	0.81
Experimental	8	14.97	0.81

Table 6

One-Way ANCOVA on Post-Test PSOMS

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Pre-test PSOMS	10.70	1	10.70	2.04	.176
Group	1.83	1	1.83	0.35	.565
Error	68.05	13	5.24		
Total	79.75	15			

Research Question 2: *Is there a statistically significant difference between the experimental and control groups on posttest PSS (Stress) scores after statistically controlling for participants' pretest scores?*

H_0: There will not be a statistically significant difference between the experimental and control groups on posttest PSS (Stress) scores after statistically controlling for participants' PSS pretest scores.

H_A: There will be a statistically significant difference between the experimental and control groups on posttest PSS (Stress) scores after statistically controlling for participants' PSS pretest scores.

A one-way ANCOVA (analysis of covariance) was conducted to determine if there were significant differences between the experimental and control groups on posttest PSS scores after controlling for pretest PSS scores. Treatment group (experimental vs. control) was the between-subjects independent variable, posttest PSS scores was the dependent variable, and pretest PSS scores was the covariate (i.e., control variable).

The strategy will allow the researcher to assess the impact of the treatment on PSS while eliminating participants' preexisting differences on PSS, thus eliminating it as a potential confounding variable in the statistical model. The ANCOVA testing procedures described above were utilized (Stevens, 2002; Tabachnick & Fidell, 2007) for this analysis. The data screening process failed to reveal any outliers.

The small sample size in each group ($n = 8$) again precluded the use of the central limit theorem or histograms to diagnose the normality assumption. Therefore, the Kolmogorov-Smirnov test was utilized to assess normality. The tests indicated the distributions for the control group and experimental group were approximately normal, $z = 0.80$, $p = .540$ and $z = 0.71$, $p = .699$, respectively.

Levene's test was not significant, indicating the two groups had equal error variances (i.e., homogeneity of variances) on posttest PSS scores, $F\ (1, 14) = 0.07$, $p = .798$. The homogeneity of regression slopes F test on the independent variable X covariate interaction term was not significant, indicating the equality of regression slopes, $F\ (2, 4) = 0.00$, $p = 1.00$. This indicates the relationships between pretest and posttest PSS scores were consistent for the two between-subjects groups.

The unadjusted and adjusted means are listed in Tables 7 and 8, respectively. The ANCOVA test statistics are listed in Table 9. The ANCOVA failed to reveal a significant difference between the control ($M = 33.66$, $SE = 1.46$) and experimental ($M = 31.46$, $SE = 1.46$) groups on posttest PSS after controlling for participants' pretest PSS scores, $F\ (1, 13) = 1.08$, $p = .318$ ($\eta^2 = .08$, power = .16). The difference between the group means increased after controlling for preexisting differences on PSS scores. Eight percent of the variability in the participants'

posttest PSS scores can be attributed to the treatment after controlling for pretest PSS scores. Thus, the researcher fails to reject the null hypothesis.

Table 7

Unadjusted Post-Test PSS Scores

Group	*N*	*M*	*SD*
Control	8	33.13	4.58
Experimental	8	32.00	3.78

Table 8

Adjusted Post-Test PSS Scores

Group	*N*	*M*	*SE*
Control	8	33.66	1.46
Experimental	8	31.46	1.46

Table 9

One-Way ANCOVA on Post-Test PSS

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Pre-test PSS	38.41	1	38.41	2.40	.146
Group	17.31	1	17.31	1.08	.318
Error	208.46	13	16.04		
Total	251.94	15			

Research Question 3: Is there a statistically significant difference between the experimental and control groups on posttest BDI-II (Depression) scores after statistically controlling for participants' pretest scores?

H_0: There will not be a statistically significant difference between the experimental and control groups on posttest BDI-II (Depression) scores after statistically controlling for participants' BDI-II pretest scores.

H_A: There will be a statistically significant difference between the experimental and control groups on posttest BDI-II (Depression) scores after statistically controlling for participants' DBI-II pretest scores.

A one-way ANCOVA (analysis of covariance) was conducted to determine if there were significant differences between the experimental and control groups on posttest BDI-II scores after controlling for pretest BDI-II scores. Treatment group (experimental vs. control) was the between-subjects independent variable, posttest BDI-II scores was the dependent variable, and pretest BDI-II scores was the covariate (i.e., control variable).

The data screening process failed to reveal any outliers. The Kolmogorov-Smirnov tests indicated the distributions for the control group and experimental group were approximately normal, $z = 0.43$, $p = .992$ and $z = 0.57$, $p = .906$, respectively. Levene's test was not significant, indicating the two groups had equal error variances (i.e., homogeneity of variances) on posttest BDI-II scores, $F\ (1, 14) = 1.13$, $p = .306$. The homogeneity of regression slopes F test on the independent variable X covariate interaction term was not significant, indicating the equality of regression slopes, $F\ (3, 3) = 1.12$, $p = .465$. This indicates the relationships between pretest and posttest BDI-II scores were consistent for the two between-subjects groups.

The unadjusted and adjusted means are listed in Tables 10 and 11, respectively. The ANCOVA test statistics are listed in Table 12. The ANCOVA revealed that the control group (M = 11.46, SE = 1.31) scored significantly higher than the experimental group (M = 4.80, SE = 1.31) on posttest BDI-II scores after controlling for participants' pretest BDI-II scores, F (1, 13) = 11.48, p = .005 (η^2 = .47, power = .88). The difference between the group means increased drastically after controlling for pre-existing differences on BDI-II scores. Forty-seven percent of the variability in the participants' posttest BDI-II scores can be attributed to the treatment after controlling for pretest BDI-II scores. Thus, the researcher rejects the null hypothesis.

Table 10

Unadjusted Post-Test BDI-II Scores

Group	*N*	*M*	*SD*
Control	8	8.50	6.35
Experimental	8	7.75	7.15

Table 11

Adjusted Post-Test BDI-II Scores

Group	*N*	*M*	*SE*
Control	8	11.46	1.31
Experimental	8	4.80	1.31

Table 12

One-Way ANCOVA on Post-Test BDI-II

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Pre-test BDI-II	483.55	1	483.55	40.31	.000
Group	137.68	1	137.68	11.48	.005
Error	155.95	13	12.00		
Total	641.75	15			

Research Question 4: *Is there a statistically significant difference between the experimental and control groups on posttest STAI-State (Anxiety) scores after statistically controlling for participants' pretest scores?*

H_0: There will not be a statistically significant difference between the experimental and control groups on posttest STAI-State (Anxiety) scores after statistically controlling for participants' STAI-State pretest scores.

H_A: There will be a statistically significant difference between the experimental and control groups on posttest STAI-State (Anxiety) scores after statistically controlling for participants' STAI-State pretest scores.

A one-way ANCOVA (analysis of covariance) was conducted to determine if there were significant differences between the experimental and control groups on posttest STAI-State scores after controlling for pretest STAI-State scores. Treatment group (experimental vs. control) was the between-subjects independent variable, posttest STAI-State scores was the dependent variable, and pretest STAI-State scores was the covariate (i.e., control variable).

The data screening process failed to reveal any outliers. The Kolmogorov-Smirnov tests indicated the distributions for the control group and experimental group were approximately normal, $z = 0.45$, $p = .998$ and $z = 0.46$, $p = .985$, respectively. Levene's test was not significant, indicating the two groups had equal error variances (i.e., homogeneity of variances) on posttest STAI-State scores, F (1, 14) = 0.66, $p = .431$. The homogeneity of regression slopes F test on the independent variable X covariate interaction term was not significant, indicating the equality of regression slopes, F (2, 4) = 12.37, $p = .019$. This indicates the relationship between pretest and posttest STAI-State scores was inconsistent for the two between-subjects groups.

The unadjusted and adjusted means are listed in Tables 13 and 14, respectively. The ANCOVA test statistics are listed in Table 15. The ANCOVA failed to reveal a significant difference between the control group ($M = 51.17$, $SE = 1.20$) and the experimental group ($M = 50.96$, $SE = 1.20$) on posttest STAI-State scores after controlling for participants' pretest STAI-State, F (1, 13) = 0.02, $p = .904$ ($\eta^2 = .00$, power = .05). The difference between the group means increased slightly after controlling for preexisting differences on STAI-State scores. Less than 1% of the variability in the participants' posttest STAI-State scores can be attributed to the treatment after controlling for pretest STAI-State scores. Thus, the researcher fails to reject the null hypothesis.

Table 13

Unadjusted Post-Test STAI-State Scores

Group	*N*	*M*	*SD*
Control	8	51.13	2.75
Experimental	8	51.00	3.70

Table 14

Adjusted Post-Test STAI-State Scores

Group	*N*	*M*	*SE*
Control	8	51.17	1.20
Experimental	8	50.96	1.20

Table 15

One-Way ANCOVA on Post-Test STAI-State

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Pre-test STAI-State	1.35	1	1.35	0.12	.736
Group	0.17	1	0.17	0.01	.904
Error	147.53	13	11.34		
Total	148.94	15			

Research Question 5: Is there a statistically significant difference between the experimental and control groups on posttest STAI-Trait (Anxiety) scores after statistically controlling for participants' pretest scores?

H_0: There will not be a statistically significant difference between the experimental and control groups on posttest STAI-Trait (Anxiety) scores after statistically controlling for participants' STAI-Trait pretest scores.

H_A: There will be a statistically significant difference between the experimental and control groups on posttest STAI-Trait (Anxiety) scores after statistically controlling for participants' STAI-Trait pretest scores.

A one-way ANCOVA (analysis of covariance) was conducted to determine if there were significant differences between the experimental and control groups on posttest STAI-Trait scores after controlling for pretest STAI-Trait scores. Treatment group (experimental vs. control) was the between-subjects independent variable, posttest STAI-Trait scores was the dependent variable, and pretest STAI-Trait scores was the covariate (i.e., control variable).

The data screening process failed to reveal any outliers. The Kolmogorov-Smirnov tests indicated the distributions for the control group and experimental group were approximately normal, $z = 0.41$, $p = 1.00$ and $z = 0.61$, $p = .854$, respectively. Levene's test was not significant, indicating the two groups had equal error variances (i.e., homogeneity of variances) on posttest STAI-Trait scores, $F\ (1, 14) = 0.27$, $p = .614$.

The unadjusted and adjusted means are listed in Tables 16 and 17, respectively. The ANCOVA test statistics are listed in Table 18. The ANCOVA failed to reveal a significant difference between the control group ($M = 37.73$, $SE = 2.90$) and the experimental group ($M = 35.77$, $SE = 2.90$) on posttest STAI-Trait scores after controlling for participants' pretest STAI-

Trait, F (1, 13) = 0.20, p = .660 (η^2 = .02, power = .07). The difference between the group means decreased after controlling for preexisting differences on STAI-Trait scores. Only 2% of the variability in the participants' posttest STAI-Trait scores can be attributed to the treatment after controlling for pretest STAI-Trait scores. Thus, the researcher fails to reject the null hypothesis.

Table 16

Unadjusted Post-Test STAI-Trait Scores

Group	*N*	*M*	*SD*
Control	8	34.13	10.47
Experimental	8	39.38	9.91

Table 17

Adjusted Post-Test STAI-Trait Scores

Group	*N*	*M*	*SE*
Control	8	37.73	2.90
Experimental	8	35.77	2.90

Table 18

One-Way ANCOVA on Post-Test STAI-Trait

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Pre-test STAI-Trait	695.00	1	695.00	11.89	.004
Group	11.84	1	11.84	0.20	.660
Error	759.75	13	58.44		
Total	1,565.00	15			

Conclusion

In summary, participants experienced a statistically significant decrease in symptoms of depression as a result of FOAT-IP intervention, but the negative results on stress, anxiety, or positive states of mind were found inconclusive. BDI-II: 47% of the variability in the participants' posttest BDI-II scores can be attributed to the treatment after controlling for pretest BDI-II scores. PSS: 8% of the variability in the participants' posttest PSS scores can be attributed to the treatment after controlling for pretest PSS scores. STAI-Trait: only 2% of the variability in the participants' posttest STAI-Trait scores can be attributed to the treatment after controlling for pretest STAI-Trait scores. STAI-State: less than 1% of the variability in the participants' posttest STAI-State scores can be attributed to the treatment after controlling for pretest STAI-State scores. PSOMS: only 3% of the variability in the participants' posttest PSOMS scores can be attributed to the treatment after controlling for pretest PSOMS scores.

Chapter 5: Discussion

This study measured the effect of FOAT-IP on stress, anxiety, depression, and positive states of mind in an experimental group and compared these with outcomes for a wait-listed control group. Participants experienced a statistically significant decrease in symptoms of depression as a result of FOAT-IP intervention, but the negative results on anxiety, stress, or positive states of mind were found inconclusive due to the small sample size. As a feasibility study, this project demonstrated that FOAT-IP shows potential to positively benefit the target population in the mitigation of symptoms of depression. Future studies should be conducted to further test these initially promising findings with a larger and more diverse South Asian sample, as findings with greater validity and generalizability are needed to strengthen the case for wider use of this intervention.

In order to examine the study results more closely, ANCOVA was used to assess the impact of FOAT-IP on PSOMS, BDI-II, PSS, and STAI on participants. ANCOVA measures the differences between the experimental FOAT-IP and control groups in posttest results while eliminating the preexisting differences as a potential confounding variable in the statistical model—thereby allowing for enhanced statistical analysis even when limited by a small sample. The following sections (a) examine the study's findings in the context of their statistical significance, (b) provide possible explanations for these findings based on relevant literature, (c) discuss the limitations and delimitations, and (d) offer the researcher's own interpretations as part of the context for proposing future research with this population.

The participants in this study were demographically representative of the predominant South Asian population residing in the US. That is, all participants were Indians, in keeping with the fact that a majority of South Asians in the US are Indians (Hurwitz et al., 2006; Raj et al.,

2005); in addition, these participants were typically highly educated and affluent, reflecting what is typical of South Asians residing in the US (Ahmed et al., 2007; Prathikanti, 1997). The participants in other South Asian studies of IPV survivors have been either limited to Indians residing in India or to immigrant IPV women survivors residing in the Boston, Massachusetts area (Hurwitz et al., 2006; Raj et al., 2005; Raj & Silverman, 2002a; Reavey et al., 2006). In those studies the participants were therefore less representative of the mainstream Indians residing in the US, in some cases because they did not live in the US, and in all cases due to lower education levels and socioeconomic status.

It has been noted that researching South Asian women is challenging due to the social stigma of exposing personal or family matters in any context outside of the family. Participants who contributed to this study had an average age of 35 (range was 25–62) and their willingness to participate may be reflective of younger generations' greater openness to modern thinking around psychology as compared to a traditional mindset that harbors stigmas and shame around any mental health issue. It can be noted that despite being born in either India or the US, the Indian women in this study were either bilingual (English and Indian) or spoke English as a primary language, so that language barriers were not an issue in data collection for the study. Participants resided in California, Texas, or New York; this geographical diversity, while possibly beneficial to the construction of a good sample, simply reflected the researcher's communities and the results of snowball sampling.

Implications of the Findings

Depression (BDI-II). Overall, symptoms of depression as measured by the BDI-II significantly decreased for participants over the course of the 4-week study (mean change = 6.66). With a large effect size ($\eta^2 = .47$, power = .88) taken into consideration and after

controlling for pretest BDI-II scores, 47% of the variability in the participants' posttest BDI-II scores can be attributed to the treatment. This finding appears to be quite significant since the intervention was short, and depression is a dynamic variable that has other probable contributing factors (e.g., income, health, self-worth, career, family, etc.). In other words, it is noteworthy that the results were statistically significant despite the complexity of factors contributing to symptoms of depression and the limitations in sample size and study duration. These results strongly suggest FOAT-IP's potential value as an effective therapeutic technique for this potentially highly resistant and stigmatized population.

As stated in the literature review section, meaning-making is important to positive health (Park & Ai, 2006; Silberman, 2005; Thombre et al., 2010). In this study, the researcher speculates that engaging in the FOAT-IP activities facilitated meaning-making for the participants to the extent that their state of mind significantly improved on the depression scale. Depression is a dynamic variable that has numerous causes; however, it may also be one of the most challenging to treat in South Asians due to the cultural stigmas, denial, and secrecy (Ahmad et al., 2004; MySahana, 2011a, 2011b, 2011c; PAMF, 2012a, 2012b, 2012c). The researcher speculates that in this study, FOAT-IP seems to have crossed cultural barriers and allowed improvement in feeling depressed by creating meaning from one's felt sense to create a more positive mindset.

In addition, this study may have reflected culturally familiar practices, which may have helped facilitate engagement with felt sense handles in FOAT-IP. The demographics of the participants suggest that the majority of the participants engaged in meditation ($N = 6$), yoga ($N = 5$), art ($N = 8$), dance ($N = 8$), writing ($N = 7$), singing ($N = 5$), and/or musical instruments ($N = 3$) as part of their existing self-care practices. Given that a majority of the South Asian

participants also identified themselves as Hindu, and that meditation, yoga, and the arts are all part of the practice of Hinduism, FOAT-IP seemingly created a natural bridge for these women to utilize practices with which they are already familiar to facilitate improvements in their mental health.

As a side note, it may be significant that all participants who started the intervention saw it through to completion; that is, 8 out of 12 participants in the experimental group started Week 1 and consistently did every week until Week 4. Coming from a more collectivist culture, expectation to help family and friends is greater with Indian adults than US adults in general (Miller, Das, & Chakravarthy, 2011). It may be that participants felt a sense of obligation and expectation to complete the study given the fact that they were friends or friends-of-friends of the researcher's family. This dynamic should be considered in future studies, both with respect to any potential for favorable-outcome bias, and for its utility in promoting participant retention. In any case, future studies with a larger sample size are highly recommended to further explore and validate these preliminary findings.

Positive States of Mind (PSOMS), Stress (PSS), and Anxiety (STAI-State, STAI-Trait). As discussed in the results section, positive states of mind, stress, and anxiety measures yielded *no statistically significant* results that can be attributed to the intervention due to the small sample size. Attempting to measure a dynamic variable like states of mind, it is important to take into consideration factors other than small sample size that contributed to the lack of findings in the areas represented by these measures. Due to the paucity of research on this population, many of the researcher's speculations on possible factors and/or tendencies among South Asian populations, as presented below, cannot be supported with empirical literature. However, there are articles that offer indirect support to these suggested factors, but future

studies would need to validate these popular factors accepted as accurate depictions by the South Asian community (MySahana, 2011a, 2011b, 2011c; PAMF, 2012a, 2012b, 2012c).

The researcher speculates that one major factor contributing to the absence of findings with respect to beneficial changes in stress, anxiety, and positive states of mind may be attributable to the South Asian tendency towards emotional suppression (MySahana, 2011e). Commonly presented with the cultural ethos of thinking, "I'm fine," South Asians consequently may repress stress, anxiety, and depression because it is considered a sign of instability or weakness and thus, should be hidden from the public eye (Prathikanti, 1997; Yoshioka et al., 2003). Such repression may eventually result in strong somatic responses within the physical body as chronic health issues nonresponsive to medical treatments (Hurwitz et al., 2006; Reavey et al., 2006).

In addition to the potential for emotional suppression to influence the results, the researcher speculates that South Asians may have a tendency towards perfectionism, perhaps leading to procrastination when perfection does not seem attainable in the present moment (MySahana, 2012b). Even though there is no direct literature on South Asians examining the relationship between perfectionism and procrastination, there is some research concerning this subject matter. For example, Rice, Richardson, and Clark's (2012) study strongly associated perfectionism and procrastination with psychological distress in college students. Similarly, the researcher observed that participants in this study waited until the deadline day to complete FOAT-IP activities. This was noteworthy because despite having an entire week to complete activities, along with having the benefit of e-mail reminders during the week from the researcher to encourage timely submissions of FOAT-IP activity reports, the participants repeatedly chose to procrastinate. The researcher acknowledges that it may also be that personal lifestyles, career

obligations, family responsibilities, cultural, and societal duties may all take priority over stress management (Hurwitz et al., 2006; Prathikanti, 1997; Yoshioka et al., 2003).

Moreover, this population has a tendency towards intellectualizing and minimalizing, as noted earlier under the context of emotional suppression. From a South Asian perspective, mental illness is considered a sign of instability or weakness, and thus hidden from the public eye (Prathikanti, 1997; Yoshioka et al., 2003). The researcher speculates there may be a *social desirability* to conform to a false exterior appearance of contentment when the interior reality is otherwise. In this study, participants may therefore have been motivated to appear more favorably in their pretest and posttest responses than a careful and transparent report might have reflected.

The researcher speculates that another contributing factor to the lack of findings may be a lack of body awareness in South Asian populations. For example, the researcher has observed that a group of South Asians learning to ski approached the process from a technical (intellect in the head) approach rather than experiential (feel in body). Consistent with such a stance, a study on aging and mental health using participants from India suggests that this population may not be disposed toward the recognition of affective disorders. Patel and Prince (2001) investigated the manner in which elder people hold the concepts of late-life mental health conditions (i.e., dementia and depression). The study demonstrated that dementia was accepted as a normal part of aging and the South Asian community did not seek medical care around it. However, depression frequently went undiagnosed. This researcher speculates that South Asians can see mental deterioration as tangible evidence for the existence of dementia and therefore can intellectually accept that dementia is a real condition. In contrast, it may be that depression is not diagnosed because it is an affective condition not manifest in any way other than behaviorally—

and that such related behaviors are actively suppressed as socially unacceptable. The dismissal of an affective condition is consistent with the speculated intellectual and anti-affective stance of this South Asian community.

In the current study, the researcher speculates that an initial lack of bodily awareness at pretest may have shifted toward greater awareness developed after undergoing FOAT-IP experiential activities. In such a case, increased discovery of uncomfortable somatic sensations may have balanced out any mitigation in the emotional dynamics of stress or anxiety. In this study, the researcher further speculates that FOAT-IP seemed to help South Asians go from body-to-head (somatic strategy) rather than what may be a more familiar head-to-body (intellectual) strategy. Future studies might fruitfully explore this *heady* tendency in South Asian people, which may lead to more effective interventions that connect body to mind as a means to facilitate therapeutic healing.

In summary, statistical significance on the depression measure suggests that FOAT-IP may be a worthwhile intervention for addressing symptoms of depression in South Asian women. The raw scores for the other measures showed numerical increases, although after statistical analysis, significance was not found. However, these raw score increases suggest that repeating the study with a larger sample size might produce statistically significant improvements in stress, anxiety, and positive states of mind. If further study replicates the initial positive findings regarding the efficacy of the FOAT-IP intervention for symptoms of depression, and especially if significant results are obtained for the mitigation of other conditions such as stress, anxiety, and negative states of mind, FOAT-IP might be utilized as a well-being tool to potentially bring mental health services to the South Asian community, which currently underutilizes these services (Ahmed et al., 2007; Prathikanti, 1997). However, future studies

would need to utilize a significantly larger sample size to solidly validate the preliminary findings of this study while also taking into consideration the numerous limitations in this study.

Delimitations and Limitations

As with any research, a number of limitations and delimitations exist for this study. The following section discusses the researcher bias limitations, methodological delimitation and limitations, the small sample size delimitation and limitations, the measures limitations, South Asian perspective limitation, and the attrition limitation.

Researcher bias limitation. The potential biases and belief systems the researcher may bring into this dissertation as an American-born South Asian woman is a limitation in itself. Another limitation is that the researcher is not certified in FOAT (and there is no FOAT-IP certification available because it is a derivative of FOAT). However, the researcher is certified in FOT and has a creative expression specialization at the Master's level.

Methodological delimitation and limitations. The researcher opted to implement FOAT-IP through the Internet to facilitate participation within what appears to be a highly reluctant population, which served as a primary delimitation in this study. Even though there are growing studies on Web-based interventions, especially working with mental disorders, there are some limitations as well as advantages to Internet-delivered interventions. First, studies have found Internet interventions effective for mild-to-moderate mental issues, while efficacy with more severe mental disorders (e.g., bipolar, schizophrenia, etc.) still needs to be explored (Anderson, Carlbring, Ljotsson, & Hedman, 2013). Second, there is the challenge to establish a consistent model for Internet implementation as technology evolves, and the Internet is more commonly being accessed through smart phones than a computer. Future studies would have to investigate various models that would take into consideration the different environments of

implementation (e.g., computer, smart phone, tablet, etc.). Yet, the likelihood of adherence to treatment and relapse prevention may be improved with such open accessibility to users. Web-based interventions augment conventional psychotherapy, which may accelerate therapeutic healing between clinical sessions. Future studies may conduct a comparison study to research the efficacy between conventional therapy and conventional study augmented by online intervention. Even though the majority of literature for Internet-delivered interventions was for CBT, FOAT-IP's initial results suggested that FOAT-IP intervention was feasible and has the potential to be efficacious as a Web-based intervention to augment treatment modalities for depression in South Asian women, who are at risk for IPV.

The implementation of the study online is a methodological limitation when it comes to uniformity; in other words, ensuring that the participants opted to do the FOAT-IP activities in one sitting versus over a week did not influence the outcomes. In this study, the researcher noted that all participants consistently did the FOAT-IP activities in one sitting at approximately the same time each week. However, future studies should note this as a possible methodological limitation, which is harder to control with larger, heterogeneous sample sizes.

Small sample size delimitation. In this study, the largest delimitation was the small sample size, which may have underrepresented the statistical significance of the FOAT-IP intervention's effectiveness on South Asian women. The researcher opted for a small sample size due to recruiting challenges and time constraints to complete the study. In consideration for future studies, most important would be to get a larger sample size that can provide a strong power analysis. A sample size of approximately $N = 128$ would significantly strengthen the preliminary findings of this feasibility study. In addition to a larger sample size, a more diverse South Asian sample size would improve generalizability of the findings for the population.

Also, due to recruiting challenges, the sample was a randomly assigned convenience sample consisting of participants mostly networked with the researcher's family, friends, and friends-of-friends. Even though Indians comprise the majority of South Asians in the US, it is still a limitation that the South Asian participants in this study were all Indian and failed to include other South Asians (e.g., Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives, Bhutan). In other words, the homogenous sample size, consisting of Indian women, was a delimitation. Most importantly and probably most challenging, future studies would need to investigate FOAT-IP's effectiveness as a well-being tool to supplement existing PTSD therapy with South Asian women who are IPV survivors.

Measures limitations. The lack of measures validated on a South Asian community utilized in this study is a limitation because it may not integrate the cultural component of South Asians, when assessing for stress, anxiety, and depression.

Small sample size limitation. Moreover, the research amongst this population is limited, and the significance of this study's contribution may be limited due to its sample size. Because research on the South Asian population is limited, the presentation of stress, anxiety, and depression symptoms may differ from that of other ethnicities. Hence the results from the scales may potentially be inflated or underrepresented in regard to the severity of posttraumatic stress symptomology. Moreover, the participants used self-report measures, which is a limitation, thus possibly minimizing or repressing their true experience of stress, anxiety, and depression in the assessment results.

South Asian perspective limitation. Recruitment of South Asian women was one of the most challenging phases and the South Asian community's attitude is the greatest limitation that impacted recruitment in this study. The researcher was aware that culturally there would be a

barrier potentially due to stigmas and upholding family values. However, the extent of the reluctance was unexpected. For example, the researcher attended a large South Asian fundraising walkathon event in the Bay Area. The walkathon was aimed to set the standard as the largest social and service platform of its kind. It recognized, supported, and nurtured the spirit of giving by empowering individuals of diverse backgrounds to unite and strengthen their communities. The researcher had also read that it had one the largest gatherings of all the various South Asian organizations in the Bay Area.

Lack of participation by the South Asian population was grossly underestimated by the researcher. There is no statistical information available for this population to explain the possible reasons for this except through the following anecdotal data. As the researcher approached the vendor booths holding flyers in hand, the South Asian volunteers at the booths were skeptical, hesitant, and uncooperative. Despite explaining the purpose of the research workshop, the flyers were repeatedly placed under the table pending approval by the organization's manager (offsite).

The researcher also encountered the "business mindset" of the South Asian community; "business mindset" in this community means there is an expectation of a quid pro quo or reciprocation for any services rendered. For example, the researcher approached the spiritual organization that her family has been an active member of since 1990. However, they were not members of the San Jose chapter. The booth representatives handed the researcher the schedules of classes, workshops, and events at the spiritual center, encouraged her to first invest time in attending and building relationships with the members, and said, "Then we can see how we can help you with your research workshop." This spiritual organization is supposed to be founded on helping the community and humanity in a gracious, generous manner. Yet, here were representatives from her own spiritual organization asking her to invest time and money she did

not have, to attend classes and workshops before they would volunteer any assistance in recruiting. This experience suggests a possible set of limitations that would need to be addressed, mentioned below in the Future Studies section.

The researcher consulted about different recruiting attempts with her family, and was surprised by her parents' and sisters' responses: "What were you thinking wanting to recruit our people? *Desis* [South Asians] don't help each other like that. You know that. In fact, have your friends help you recruit. They are more responsive to non-Desis than their own kind. That's just how they are." The Indian supervisor at the researcher's internship site also concurred with what her parents had shared. The Indian supervisor mentioned how the South Asians who seek counseling insist on working only with non-South Asian therapists. The researcher speculates that the reason behind seeking non-South Asian therapists is to not feel guilt or shame associated with seeking psychotherapy. Further speculating, the chances of the non-South Asian therapists running into other South Asians in the area, and potentially "outing" them to their community, may be slightly less risky compared to seeking therapy with a South Asian.

At the next recruiting event, the researcher took her Caucasian male friend with her. He managed to distribute nearly 80% of the flyers within 2 hours by simply saying, "Help South Asian women," while the researcher took longer with more dialogue effort. Another future study would be to examine this preference for non-South Asian therapists by conducting a survey for the preference between a non-South Asian therapist versus a South Asian therapist.

As part of the recruiting efforts, the flyer underwent different modifications (see Appendix A). Originally, the study was designed to be marketed in the San Francisco Bay Area only as a women's group (i.e., no online format). The researcher created the first flyer using words "Stress . . . Anxiety . . . Depressed" having heard South Asians (especially in the Silicon

Valley) express such sentiments on numerous occasions. However, through the distribution process, it was found South Asians quickly took offense to the word "stress," which is perceived as a benign and common experience in the workplace by Americans. To illustrate, when one of the researcher's Caucasian female friends approached her South Asian coworker, "Would you be willing to help my friend with her dissertation research?" the coworker took one glance down at the flyer and took offense, "*You* think I'm stressed?" The friend remarked, confused by the defensiveness, "Who isn't? We all work for big hi-tech companies with high demanding jobs." This type of response from South Asian women was commonly encountered during the recruitment phase. As mentioned in the literature, the South Asian population is extremely reluctant to seek traditional talk therapy, which is partially due to the cultural stigma surrounding psychotherapy and its demeaning association with being dysfunctional and abnormal (Maker et al., 2005; Prathikanti, 1997; Yoshioka et al., 2003).

In this study, the first flyer was eventually modified into a more achievement-oriented empowerment workshop and used catch phrases such as "work and home balance" and "burn-out prevention." The researcher extended this workshop to volunteers at domestic violence shelters in the Bay Area as a way to work through secondary traumatization and burn-out prevention. Flyers were also marketed online through social media platforms such as Facebook. In addition, the assistance of students belonging to South Asian organizations at local universities such as Stanford University and other colleges/universities in the Bay Area were recruited in marketing the flyers through their mailing lists. The South Asian students were quite open to promoting the flyers; however, despite these diverse modes of marketing and distributing flyers, recruiting efforts still yielded zero participants. Transforming the FOAT-IP into a Web-based intervention made it accessible to more people while creating the convenience for participation from the

privacy of their homes. In addition, when the study was modified from an 8-week empowerment group Bay Area workshop into an 8-week Web-based workshop, the recruiting efforts started to yield some participants ($N = 40$). However, by the time the workshop started, the potential participants withdrew, and the researcher had to reduce the study to 4 weeks and reduce the number of participants ($N = 25$).

To expedite the recruiting process for the shorter study, the researcher enlisted her family and friends to reach out to their South Asian friends all over the US. In summary, for the purpose of yielding significant results to demonstrate the effects of FOAT-IP on this population, the study originally was designed to be an 8-week study. However, as a result of recruiting challenges and limited time to complete the study, the design was reduced to 4 weeks to facilitate participation, which ultimately yielded participants. The study's duration was a delimitation because the researcher speculates larger impact of FOAT-IP may have resulted with a longer study, thereby potentially resulting in statistically significant numbers. Future studies may benefit from a longitudinal study to demonstrate the effectiveness of FOAT-IP over a longer duration than 4 weeks. Future studies may also benefit in exploring this recruitment limitation by investigating how to motivate South Asians to participate in workshops and research.

The researcher also observed the participants' lowest priority was emotional self-care practices by how the participants, especially in the control group, had difficulty finding 30 minutes out of an entire week to complete the posttests. Some participants agreed to participate but a week later ended up dropping out because "too busy." The researcher speculates that the items that the South Asian woman prioritizes ahead of her own health and well-being on her "to-do" list may come into balance if she made taking care of her mental and spiritual self a priority. However, the culture and societal message of "family comes first" seems to force self-care

practices at the bottom of their unbalanced lifestyles (Hurwitz et al., 2006; Prathikanti, 1997; Yoshioka et al., 2003). The responsibility of family obligations outweighs any beliefs to fulfill individual desires of a family member (Venkataramani-Kothari, 2007).

Expounding on the above concept of putting family ahead of self, especially in the context of IPV, a question surfaced: Are South Asian women viewing marriages as a *black hole*? In this context, the researcher is defining a black hole as a concept of whatever goes in, it does not come out. Similarly, the researcher speculates the South Asian IPV women may feel stuck in unhealthy relationships because of cultural stigmas and fears of guilt and shame in dishonoring their families. As a result, they may view outside help such as couples therapy as hopeless because there is no motivation for compromise and change in a black-hole marriage. Both parties may believe that divorce is unlikely, especially for immigrant South Asian women who are dependent on their husbands for livelihood and support. The researcher further speculates the power dynamic may be skewed to the extent that South Asian women endure whatever marital problems and sometimes abuse because they cannot go outside for help. Even if help was sought, the marriages would remain unchanged behind closed doors. Perhaps it is this fear that is preventing these women from seeking help and feeling unstuck in these unhealthy marriages.

The researcher speculates that unless South Asian women feel empowered and as independent equals to their spouses, the problems and abuse will continue to get sucked into the black hole. Until South Asian women give their husbands a reason for change, such as the possibility of leaving him, compromise and change will not occur. However, the researcher speculates that South Asian IPV survivors would need to realize that such abusive relationships will not change and that the only way to take care of herself is through empowerment and eventually leaving the husband to start a new life. Future studies with South Asian IPV survivors

would need to explore this concept through a qualitative study after building strong rapport with the participants.

Attrition limitation. Another limitation consideration is minimizing, if not eliminating, attrition when studying this population. Recruiting South Asians was extremely challenging, let alone reducing attrition in this population. A total of 25 participants (experimental group = 12, control group = 13) had been recruited, but only a total of 16 participants completed the study. The control group incurred attrition because of participants unexpectedly taking a trip to India and unable to complete the posttests until their return to the US. Other participants in the control group reported simply being "too busy" and "forgetting" despite the multiple e-mail reminders. These reasons could also be further evidence of the South Asian's resistance and reluctance to participate in research. Four of the participants, randomly assigned into the experimental group, signed the consent forms to participate but chose not to participate for the entire duration of the study. Two of the four, who were students who would have found the $500 raffle gift card incentive appealing, also chose not to participate. The other participants were quite representative of the South Asian community, consisting of affluent, well-educated working professionals. How to motivate an affluent population to participate and remain an active participant throughout the entire study? One possibility is to individually pay each participant a weekly amount that accrues with each week's submission to encourage weekly compliance. However, it would have to be in a manner to prevent introducing research bias and validity issues into the research design and implementation.

South Asians are achievement-oriented and money-minded; if research participation can be presented in a manner that answers, "What can I gain or get out of this?" then perhaps research participation would increase and/or attrition be reduced when conducting studies with

this population. Another option is building an alliance with South Asian organizations by being an active member for a couple of years, and utilizing this relationship to run the research study as a workshop within the organization.

Future Studies

Future studies should explore a more heterogeneous sample of South Asians, as well as validating these preliminary findings with a larger sample. Without this, the findings of such a study may not be generalizable to the broader South Asian population residing in the US. In addition, future studies might benefit from explicitly examining whether there is any measurable South Asian tendency toward emotional suppression and the possible relationship of such behavior to states of mind and/or somatization. This is an important consideration because the literature indicates that this group seems to suffer disproportionately from psychosomatic health issues, which may indicate that South Asians tend to translate their psychological stressors into physical bodily symptoms (Hurwitz et al., 2006; Raj et al., 2005; Reavey et al., 2006). Future studies might also include a somatic symptoms inventory to assess for somaticized issues. Other future studies might explore the presentation of stress, anxiety, and depression in South Asians and compare symptomology with the diagnostic criterion of the DSM-5 to determine whether these conditions show cultural variation within a South Asian population. It would also be worthwhile for future studies to investigate whether there are demonstrable South Asian tendencies toward perfectionism and procrastination that may influence states of mind, depression, anxiety, and stress.

With regard to recruitment and minimization of attrition, future studies involving South Asians should consider the need to build strong relationships with local organizations for an extended period of time—perhaps a year or more—before expecting any collaboration in

recruiting and/or participation in research. Future studies may also want to consider a comparison study between a Web-based intervention and a non-Web-based group intervention, examining the effectiveness of each in mitigating attrition and motivating participation within this highly reluctant and private population. Moreover, future studies would have to address questions such as how to encourage emotional self-health over family and self-materialistic professional gains.

In this study, several cultural inquiries surfaced that future studies should investigate further. Even though meditation, yoga, and Eastern philosophies are becoming more popular in mainstream culture in Western countries, people in India are moving away from traditions and towards a materialistic mindset. One way traditionalism may manifest is in a reluctance to participate. By being set in their cultural ways, South Asians most likely are not ready to take risks such as volunteering for a stranger's research study. These ways are a result of the cultural wiring under which younger generations were raised, in which they blindly do as their parents did. This is also an important consideration when assessing the likelihood of South Asians' willingness to help strangers or openness to change in the context of self-actualization.

The unspoken need for any intervention, let alone a well-being tool like FOAT-IP, is the openness for new experiences and allowing change to evolve from the felt sense level through bodily awareness. Atkinson and Gim's (1989) study on "Asian-American cultural identity and attitudes toward mental health services" (p. 209) suggested a possible acculturation factor influencing the decision-making of Asian American seeking mental health assistance. In other words, the more acculturated the Asian American was in adapting to Western thinking, the more likely the Asian American was open to psychotherapy. Similarly, this researcher speculates that South Asians who are younger, more educated, and modern (i.e., Western) in worldview

perspectives are more likely inclined to new experiences to facilitate change, especially self-change. Therefore, future studies exploring South Asian upbringing, worldviews, and openness to change would be informative for future research designs, recruitment approaches, and attrition reduction.

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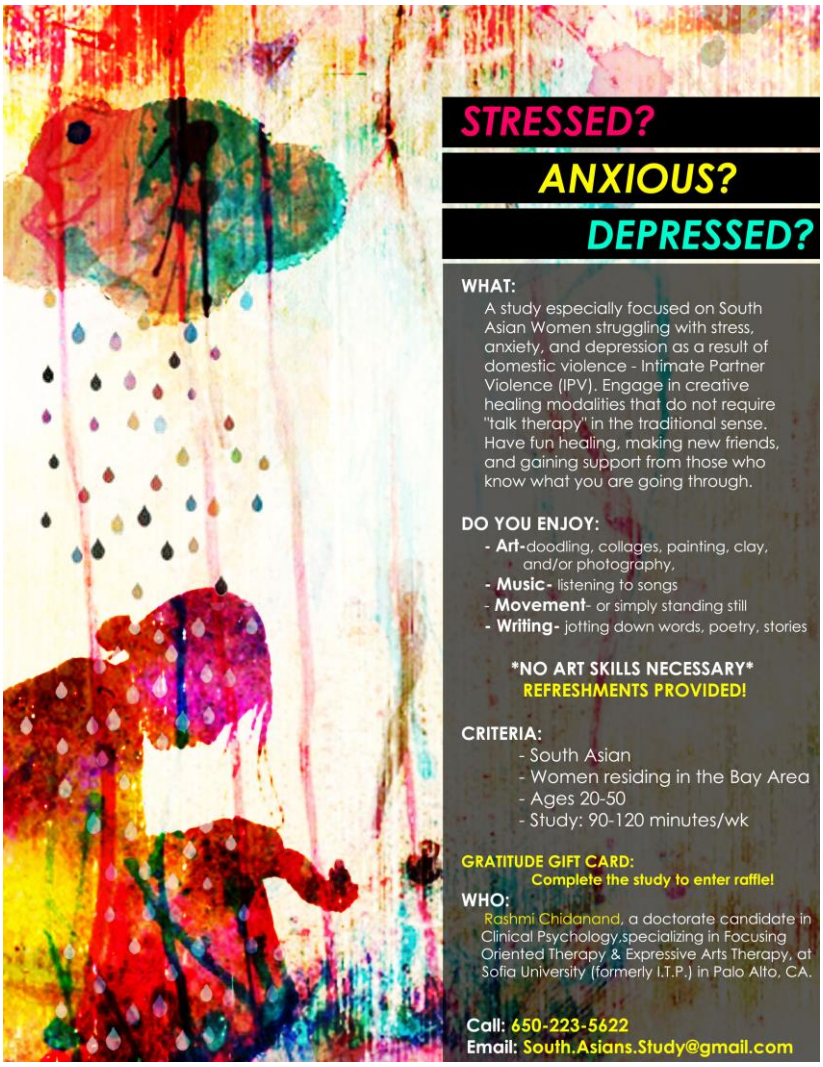
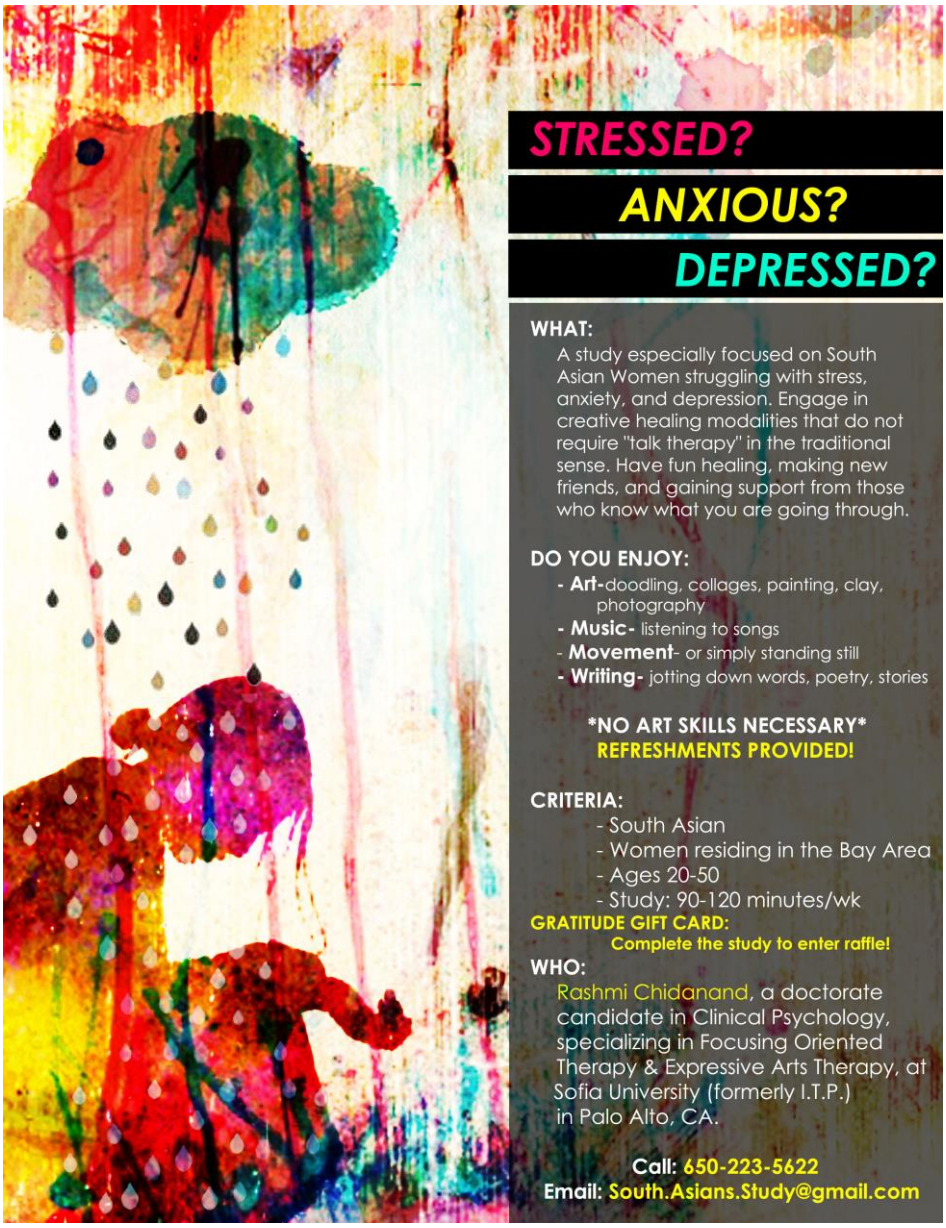
Appendix A: Recruitment Flyers

ORIGINAL – IPV South Asian Women



ORIGINAL – Not IPV South Asian Women



SECOND VERSION – Empowerment Workshop

FINAL VERSION – Empowerment/Well-Being Workshop

Calling All South Asian ladies:

Unleash your highest potential through creative modes of expression that will empower you for life success & achieve greater productivity at work & home.

Facilitated by:
Rashmi Chidanand, M.A., Ph.D (c)

A 8-WEEK ONLINE EMPOWERMENT and SELF ACTUALIZATION WORKSHOP - *FREE!*

Are you experiencing:

- **Stuck** in a job that drains your energy?
- **Body aches and pain** preventing you from climbing the corporate ladder?
- **Poor Memory or Concentration** compromising your job performance?
- **Difficulties with** sleep, weight, relationships, relocation, worrying/ loneliness decreased your motivation for self-growth?
- **Craving** excitement, fun in your monotonous daily routine?
- **Desire** TOOLS and on-going support to better manage life's demands and practice unconditional self-acceptance and compassion?

If you said 'Yes' to any of the above, **WE WANT YOU!**

Be a part of a new online research study that focuses on improving your quality of life and overall well-being. **Awaken your optimal self** through creative ways (i.e., art, movement, writing, music) and learn how to be the best you can at work and at home - all within a safe and supported environment. Your online participation is 100% confidential & anonymous, and can be done at the convenience & privacy of your home!

All completed participants stand a chance to win a $500 Gratitude Gift Card via raffle.

CRITERIA:

- South Asian descent
  (i.e. India, Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives, Bhutan, & Afghanistan)
- Females aged between 18-65 yrs old
- Duration: 1 hour / wk

FOR MORE INFO, CALL: 650.223.5622 or EMAIL: South.Asians.Study@gmail.com

Appendix B: FOAT-IP MANUAL

Exercises are from Laury Rappaport's book: Rappaport, L. (2009). Focusing-Oriented Art Therapy: Accessing the Body's Wisdom and Creative Intelligence. London, England: Jessica Kingsley.

Summary of Weekly Meetings

Week 0 Orientation

- Check In
- Exercise 0.0 FEAT Grounding Exercise and Mindful Breathing
- Exercise 0.1 Focusing Attitude and Felt Sense *(Rappaport, 2009, p. 31)*
- Optional: Choose 1:
    - Exercise 0.2 Exploring the Language of Artmaking. *(Rappaport, 2009, p. 81) OR*
    - Exercise 0.3 Name Drawings *(Rappaport, 2009, p. 149)*
- Journal

Week 1 Stress Reduction for Mind, Body, Spirit: Clearing Space

- Exercise 1.0 FEAT Self Check-In *(Rappaport, 2009, p. 97)*
- CHOOSE 1:
    - Exercise 1.1 Clearing a Space with Art I (Concrete Imagery) OR
    - Exercise 1.2. Art II (Directive Imagery) *(Rappaport, 2009, p. 121)*
- Exercise 1.3:Well-Being Self-Care(FOAT Self-Care Exercise © Laury Rappaport, 2012)

Journal

Week 2 Stress Management for Mind, Body, Spirit

- Exercise 2.0 Peaceful Place *(Rappaport, 2009, p.141)*
- Exercise 2.1 Accessing Inner Wisdom: *(Rappaport, 2009, p. 141)*
- Journal

Week 3 Accessing Acceptance, Compassion, and Inner Strength

- Exercise 3.0 Acceptance and Compassion *(Rappaport, 2009, p. 95)*
- Exercise 3.1 Strengths *(Rappaport, 2009, p.174)*
- CHOOSE 1:
    - Exercise 3.2 Walking meditation *(Rappaport, 2009, p. 232) OR*
    - Exercise 3.3 Exploring Movement to Music
- Journal

Week 4 Spirituality

- Exercise 4.0 Where I am now/ where I'd like to be spiritually *(Rappaport, 2009, p. 231)*
- Exercise 4.1 Pebble Meditation *(Rappaport, 2009, p. 208)*
- Exercise 4.2 What I want to carry with me? *(Rappaport, 2009, p. 175)*
- Journal

Week 0– Orientation

Orientation

Overview

I would like to welcome you to the South Asian Women's Study, and I appreciate your time and participation in this study. This program attempts to integrate a therapeutic approach called Focusing with Expressive Arts (i.e., art, dance, music, poetry). Laury Rappaport calls this approach Focusing-Oriented Arts Therapy (FOAT). Basically, it's listening to your body in a slightly different way, which results in an image, a gesture, a sound, or word, come to mind. In this workshop, we'll be using a technique rooted in FOAT to facilitate overall well-being called Focusing Expressive Arts Technique, or FEAT.

Have you ever just felt stuck? Have you ever felt like you had a word at the tip of your tongue and couldn't think of it, but felt it in your body? Have you ever found yourself saying like "I can't find the word, but it's like something"? Have you ever gotten lost and totally found your way back by listening to your gut? What you are doing is focusing on what we call your felt sense. When you listen to your felt sense, and give it a moment to inform you of the word at the tip of your tongue or give you an image to turn at the next stop sign, you are basically starting to practice focusing. The more attuned you get with listening to your felt sense, the more it will start communicating to you by having an image, movement, gesture, sound or word. The attractive piece of FEAT for me, being a shy and private person, is FEAT is a private way of processing anything that we are struggling with that is causing us stress, anxiety, and/or depression. In this approach, it is not solely dependent on "talk therapy" to help us through an issue, which is hard to talk about when the issue is something that you're just experiencing and feeling, and not yet found its way into words.

Before we get started, I would first like to invite everyone to take the pretest.
[Pause.]

Ground Rules and Attendance Expectations

Before we start, let's review some basic ground rules, go over confidentiality, and expectations that I ask you to adhere to, in order to optimize your personal experience.

1. Confidentiality: Please use your participant number with any submissions to preserve confidentiality and anonymity.
2. Attendance: I would greatly appreciate if you could do every weekly session in order to facilitate the best experience for you. If for any reason you can't complete a particular week's session, please try to notify me as soon as possible. In addition, because this is a research study, we will be asking you to fill out various measures and questionnaires along the way in order to help us modify and change the protocol for the better. Because this is a small group, each person's feedback is very important, and I value each of yours opinions very seriously.

3. Journals: Also, you will maintain a word document as a journal for your personal use. After any activity we engage in, you will be given a few minutes to quickly capture your personal experience of the activity. However, I encourage everyone to journal after being moved by a specific activity. These journals will only be read by you and no one else.
4. Submissions: Weekly submissions of creative pieces and/or journal entries is completely voluntary. Anything submitted, please use your assigned participant numbers and not your names.

Exercise 0.0: FEAT GROUNDING

Let's take a moment now to get more grounded and connected to our body in a safe way. I encourage each of you to attend to your physical, energetic, and emotional needs for boundaries such as whether you would like to keep your eyes open or closed. Also, it is important to feel empowered and comfortable to choose whether or not to participate in experiential parts that we will be engaging in during the course of this workshop.

Mindful breathing: Presence and Calmness

If you feel comfortable, I invite you to close your eyes now, but you don't have to. And, if you do close your eyes, know that it's ok to open them anytime, and don't have to wait until I suggest you open them. As you settle in, with your eyes closed or open, gently bring your awareness to your body. Feel your feet flat on the floor; the chair supporting your upper legs and back; feel your shoulders – how are they being supported? Your arms and hands? Maybe they are crossed in your lap or resting at your side. Be aware of your breath coming into your body and moving out. In and out. As you breath in, repeat silently to yourself, "Breathing in, I feel safe." And as you breathe out, repeat silently to yourself, "Breathing out, I feel calm." Gently and compassionately, say this a couple more times to yourself. (pause.) Momentarily, I will hit the chime 3 times: when I hit the chime once, gently bring your awareness back to the room; when I hit the chime again, gently open your eyes if you have them closed. On the last chime, stand up and stretch your bodies.

I hope you are feeling a bit more grounded, present, and safe enough to introduce yourself to the group. At any time you feel ungrounded or unsafe, try to bring your attention back to this exercise we just did – the Mindful Breathing. The simplest thing to do is bring your awareness to your breathing.

[Pause for a moment]

Once again, Welcome to the South Asian Women's Study. I appreciate your time and participation in this study. Specifically, FEAT is a technique rooted in Laury Rappaport's FOAT (Focusing Oriented Arts Therapy, which involves Focusing-oriented therapy integrated with Expressive Arts Therapy). In a nutshell, it is following your "gut" or "intuition," and listening

to your body speak to you when trying to figure out an answer to a question or simply wanting to gain insight on a matter. The best way to understand FEAT is to do a sampling of it.

But first, let's warm up by getting comfortable to connecting with our feelings in our bodies (i.e, the felt sense) and artmaking.

Exercise 0.1 Focusing Attitude and Felt Sense *(Rappaport, 2009, p. 31)*
Goal: An important part of FEAT and cultivating empowerment is learning to be accepting of our inner experience, as it is. This helps to build greater self-acceptance, which helps us to listen to and hear the wisdom inside of our bodies. This exercise teaches how to "bring our awareness into the body and to bring a "friendly" or accepting quality to whatever is there. Sometimes the mind might come in a judge it or criticize the inner experience. If that happens, just notice that and invite that judging or critical mind to take a seat outside of the room, or imagine it somewhere distant from you that feels right.

Take a few deep breaths down inside to your body. Let yourself feel the support of the chair that you're sitting on, the floor and earth beneath your feet, and sitting here in this room. Follow your breath down inside to your body and imagine that there is a searchlight that illuminates everything on the inside. Let yourself notice how it is in the inside – is it tense, or jumpy, tight, relaxed… or something else? [Awareness]. See if you can *be friendly or welcoming* to whatever you find there [Creating a welcoming space]. Take your time… to just notice…and see what's there [pause]. Imagine sitting down next to whatever you find…being friendly to it and keeping it company.

I invite you to take a moment and jot down anything that comes up for you in your Journal.

FOR THOSE OF YOU NOT FAMILIAR WITH "ART" on a regular basis, I would encourage practicing the next two exercises in preparation for Week 1.

Exercise 0.2: Exploring the language of artmaking. *(Rappaport, 2009, p. 81)*
Goal: This exercise helps to learn how lines, shapes and colors are our natural language before words. We all began drawing before we could talk. The goal is to relax and fun. Most people find this exploration is fun and relaxing, once they do it for a little while.
Set a sheet of paper in front of you. We're going to begin with exploring all the different possibilities of making lines and how they feel. Don't judge what the line looks like – just explore the making of lines. To begin, we're going to explore what it is like to make a wavy line. Let yourself be drawn to a medium that you'd like to use first –the oil pastel, chalk pastel, or marker. When you're ready, begin making a wavy line on your paper. Continue to exploring different wavy lines, perhaps making them at a medium pace, a slow pace, and fast pace. Switch

hands and make a wavy line with your nondominant hand. Make a few wavy lines with that hand. Notice how it feels to make wavy lines. Notice how it feels making it with different hands.

Now make a jagged line – one that goes up and down and up and down. Keep exploring the jagged line. Feel free to change colors at any point. After a few moments, notice how it feels to make a jagged line.

Now make a light line. Continue making light lines. Notice the difference between light and heavy.

Exercise 0.3: Name Drawings *(Rappaport, 2009, p. 149)*
Goal: This is a great beginning exercise for creative expression. It's called a "Name Drawing" where I'll guide you in an exercise to become aware of your name. Then you'll be drawing or creating your name in a way that expresses something about you. You may want to draw your name big or small…or in a corner or in the middle. Use whatever colors and materials you feel drawn to. Then you can also add things around your name to express what is important or meaningful to you. You can express it through symbols-shapes, colors or images-whatever is comfortable for you.

Take a few deep breaths down inside to your body. Just greet and be accepting to whatever you find there in this moment. Take a few moments and say your name yourself. Hear your name on the inside. Ask inside, "How would I like to create my name in a way that expresses something about me…Am I bold , or quiet… What do I enjoy?... What or who is important to me?" Just wait and let yourself have time for the answers to arise from within. When you're ready, ask inside, "So what's the whole feel of all of that [who I am and what I'd like people to know about me]?" See if there's an image (or word, phrase, gesture, or sound) that matches or acts like a handle for inner felt sense…check it against your body for a sense of rightness. If it's not right, let it go and invite a new image (or word, phrase, gesture, or sound) to come. Perhaps the name feels big, or small, is certain colors, or thicknesses. See if there are any other symbols, shapes, colors, or images that go with your name. Sense that in your body. When you're ready, gently stretch your body and open your eyes, if they were closed. Notice which art materials you feel drawn to, and use them to create your Name Drawing that matches your felt sense.

We will conclude today with practicing writing in our journals. For today, I invite you to list words to describe feelings in the moment around the experiential parts we did today and/or simply being here today. You may also journal about anything else that is more present for you right now. I ask that you journal for about 15 minutes at the end of each week's class, jotting down whatever comes up for you. Journaling is an important part of the workshop process that helps to optimize your overall personal experience.

As we wrap up, I would like to appreciate you for being here today, and look forward to sharing your journey over the next few weeks. Namaste. See you next week!

Week 1 – Stress Reduction for Mind, Body, Spirit: Clearing Space

Exercise 1.0: FEAT Check-In *(Rappaport, 2009, p. 97)*
Hi, welcome. Let us do a FEAT Check-in on "How am I right now?" or "How is it on the inside right now?"

Like we did last week to get grounded and settle into our group, let yourself sit in a comfortable position. Take a few deep breaths, noticing the breath moving in and out of the body. Feel free to close your eyes or keep them open…whichever is most comfortable to you. Feel the support of the chair, the floor where your feet touch, the ground, and being here. Gently follow your breath inside your body and just notice how it is right now. Ask "How am I on the inside right now?" See if you can be friendly to whatever you find. Notice if it's tight, or jumpy, or warm, or some other quality. (Pause.) See if there's an image (or word, phrase, gesture, or sound) that matches or acts like a handle for inner felt sense…check it against your body for a sense of rightness. If it's not right, let it go and invite a new image (or word, phrase, gesture, or sound) to come. When you're ready, gently stretch your body and open your eyes, if they were closed. Notice which art materials you feel drawn to, and use them to create an artistic expression that matches your felt sense. If you rather move or write instead of draw, feel free to engage in any expressive art form that resonates with you. (pause). When you finish, you may journal about the piece and what came up in this check-in.

[Pause to do the expressive art part.]

Take a moment to jot down anything that comes up for you in your journal.

Choose one of the two Clearing Spaces Exercises:

EXERCISE 1.1 Art I: Clearing a Space (Concrete Imagery) *(Rappaport, 2009, p. 121)*
Goal: In times of feeling unsafe, we are stressed. When we are confronted with issues that are out of our control in life, we're stress. What are some stressors in your life? (Pause). *In order to help to de-stress and detach momentarily from all the heavy-weighing worries in our life, there is a tool to help clear space in our mind and body. It is also a wonderful way to escape to a place of calm and control. It is your own zen spot or swarga. We will try Clearing a Space in different ways today so you can see which way fits you the best. In Focusing, Clearing a Space is a wonderful method for stress reduction and for accessing greater wellbeing.*

Exercise: See if you can notice what's in the way of feeling "All Fine" or "okay" or "present" right now. Like in meditation, as each thought comes to mind and you let it go. Write a list of those things in your journal. Create a symbol for each issue or concern that you identified through writing, and draw it somewhere on the page as a way to get some distance from it. The symbol can be a color, shape, texture, or image that matches your felt sense of the concern.

Create a symbol for each of your concerns. Once you have written down your issues or concerns on pieces of paper (make use of the colored construction paper, index cards, etc) and place them inside the *chombu* (pot). After placing the concerns inside the chombu, I invite you to use the art materials, writing materials or the space to do any movement to represent the "All Fine Place" which is the part of the self that is separate from all the concerns you placed in the chombu.
If this way of Clearing Space does not resonate with you and you prefer a guided imagery way of clearing space, I invite you to try the next exercise instead. Otherwise you may skip to Exercise 1.3.

EXERCISE 1.2. ART II: Clearing a Space with Directive Imagery: *(Rappaport, 2009, p. 120)*

Goal: This is a similar exercise to the Clearing a Space with Concrete Imagery. The difference is that this exercise includes a guided Focusing of listening inwardly (more like guided imagery or meditation). This exercise is also useful for centering and stress reduction.

First, find a comfortable position in your chairs or on the floor, and take a few deep breaths, inviting your body to relax…If you feel like it, you may close your eyes…or keep them open…whichever is more comfortable to you. When you're ready, ask, "How am I from the inside right now?" …Turn your attention like a searchlight inside to your body, just noticing whatever you find there, without judgment…Now imagine yourself in some peaceful place…It may be a place you know already or it may be one you create in your imagination. Imagine you have a beautiful kite to which you can attach all the things between you and feeling "All Fine." Or you may imagine tying each issue or concern you have to a balloon, and imagine that the string lets the balloon float at just the right distance from you. Or, check to see if you'd like the balloon to just float off into the sky. If the kite and balloon images don't resonate with you, imagine someone from your life, (friend, therapist, family member, teacher, spiritual figure) who can hold each issue or concern for you. Or, imagine putting each concern or issue in a different colored suitcase and putting it on baggage claim carousel to set at some distance from yourself. You can go claim it anytime you are ready to. With each issue or concern, check in with yourself and ask, "Except for all that, I'm "All Fine," right?"…If more comes up, continue to tie it to a balloon or set in a suitcase for the baggage carousel. Keep a comfortable distance from you and your kite, balloon, or suitcase.
Keeping everything at a distance, now, I'd like to invite you to bring your attention to this "All Fine Place" …See if there is an image that matches or acts like a "handle" for the "All Fine Place"…Check it against your body to make sure it's right. If not, invite a new image that matches or acts like a "handle" for the "All Fine Place" to come…If what comes is a word or phrase, that's fine…Be accepting of that. I invite you to mark this "All Fine Place" in a meaningful way for you, so you can return to this cleared space of feeling All Fine during times

of stress and ungroundedness. When you are ready, use the art materials, music, gesture, movement, and/or words to create something expressing your felt sense of the "All Fine Place."

EXERCISE 1.3 Well-Being Self-Care *(FOAT Self-Care Exercise © Laury Rappaport, 2012)*

GOAL:. This exercise facilitates overall balance by maintaining one's sense of center and preventing stress build-up. Having a regular self-care practice to guide stress out of our body can help maintain our center and feel balanced, even during the most stressful periods of our life.

Find a comfortable position…take a few deep breaths… noticing your breath come in your body and move out of your body…feel the support of the ground and the earth…the sky and heavens. If you have any thoughts on your mind, notice them and let them pass by like clouds in the sky. As you breathe, turn your attention inside to your body…just notice what is there in this moment…and be accepting to whatever you find…When you're ready, just ask,

"So what am I needing most in my life now to care for myself?" Your mind may answer quickly but just wait…take the question down inside to your body…just wait…and listen… It may be time for yourself, nature, talking with someone, taking a bubble bath…or something else. Be friendly to what comes. It may be something new.

Imagine that you have this in your life now…imagine what it would look like and feel like in your body to have this thing in your life now…(pause)…see if there's an image, word, phrase, gesture or sound that would match that sense…of having it in your life now. If you'd like, you can move your body in the position of what it would look like or feel like to have that in your life now?

When you're ready, ask, ***"So, what's in the way?"*** …(pause)…listen inside to the body…and be friendly to whatever comes.

Now ask to the inner felt sense, ***What's needed? What's needed to bring this into my life?***

And now ask from the inside, ***"And what's a good, <u>small</u> step in the right direction (to bring that into your life).***

Take however long or short as you need. When you are ready, gently stretch, open your eyes if they were closed, and see if you would like to express whatever was significant for you in the Focusing in an arts modality…art, movement, sound, music, writing.

JOURNAL

Please indicate in your journaling today if you opted for Exercise 1.1 or 1.2. It will benefit you later when you refer back. Thank you.

Week 2 – Stress Management for Mind, Body, Spirit

EXERCISE 2.0 Peaceful Place *(Rappaport, 2009, p.141)*
Goal: The goal of finding a peaceful place to teach that we can call on a peaceful place—either one that we know or make up in our imagination, to become more peaceful. It is helpful for deepening feelings of peacefulness and safety, and is useful for stress reduction.
Imagine that you are somewhere peaceful. It may be a place that you know or one that you make up in your imagination. Sense how it feels in your body…being friendly to what you find…(Pause). Now see if there's an image, gesture, movement, word, or sound that matches the felt sense. When you're ready, draw, move, or journal about the felt sense image.

EXERCISE 2.1: Accessing our Inner Wisdom *(Rappaport, 2009, p. 141)*

Goal: This exercise is useful for teaching stress reduction, and dialoguing with our felt sense since it provides access to our body's wisdom for wellness. It's amazing that if we listen inside, we can ask questions and our bodies can provide answers that will be helpful..

Take a few deep breaths into your body. Follow your breath down inside to your body and notice any places that feel tense or stressed. See if you can be friendly to whatever is there. Now, see if there's an image, gesture, movement, word, or sound, that act like a handle for the inner felt sense of the stress or tension. Check it for a sense of rightness. When you're ready: draw, move, or journal about the felt sense image.
Next, take a moment to go back inside to your body (Focusing). Take a few deep breaths, noticing the breath as it comes into your body and moves out of your body. Now imagine what it would feel like for your body to feel all healed—free from stress (pause)…your body and mind free from stress…(pause). Now see if there's an image, colors, shapes…or a word, phrase image, gesture or sound that matches the felt sense of being free from stress and all healed.
Once you have it, we're going to ask the felt sense 3 questions. If any question isn't right, you can let it go:

a. in a gentle and friendly way, ask inside, "What's in the way of the felt sense of being free from the stress?" Just wait…and be friendly to what comes.

b. What's needed to get to the second felt sense—of being free from the stress.

Just wait and allow the body to answer.

c. When you're ready, ask,"What's one small step in the right direction? Notice the word "small."…a small step. It may be something like taking a walk; breathing different; exercise; talking to someone. Just wait, and see what comes to you.

JOURNAL *After you are done, take like 10 minutes to Journal about your experience and anything else that may have come up for you.*

Week 3 – Accessing Acceptance, Compassion, and Inner Strength

Goal: Have you ever felt like there is this voice inside of you that is really good at putting you down? Well, you know what they say: you're your own worst critic. It is that voice inside of you that we call "the inner critic" that does an excellent job of making sure you don't like all parts of yourself, and makes you feel like you're not good enough.

To facilitate harmony with our Inner Critic, we're going to do an activity that focuses on Acceptance and compassion, and how that feels in your body. This way, you can return to this place of self-acceptance and self-compassion whenever your inner critic comes up.

EXERCISE 3.0 Acceptance and Compassion *(Rappaport, 2009, p. 95)*
Let yourself sit in a comfortable position. Take a few deep breaths, noticing the breath moving in and out of the body. Feel free to close your eyes or keep them open…whichever is most comfortable to you. Feel the support of the chair, the floor where your feet touch, the ground, and here. I'd like to invite you to become aware of someone or something that transmits the qualities of acceptance…gentleness…kindness…compassion. It could be someone you know, or a place, something from nature, a spiritual presence…anything. Begin to sense these qualities…bringing them right here into the room. (Pause). Now imagine that these qualities –of acceptance, kindness, and compassion— are here for you. …Sense in your body what it would feel like to have these qualities for you. (Pause). Be friendly to what you receive. See if there's an image that matches the inner felt sense… Check it against your body to see if it is right. If it's not, let go and invite another image to come. (If image doesn't come, that's okay, it may come as a word, phrase, gesture, or sound). When you have the image (handle/symbol) for the felt sense, express it using the art materials.

EXERCISE 3.1 Source of Strength *(Rappaport, 2009, p. 174)*
Take a few deep breaths down into your body…breathing in…breathing out. Become aware of your body where it meets the chair, of your feet touching the floor. Feel how your body is supported. Whatever thoughts are on your mind, notice them and let them pass by like clouds in the sky. I'd like to invite you to become aware of something in your life that has been a source of strength. It may be a person in your life, something from nature, a spiritual source, or something else. Describe this source of strength to yourself…Turn your attention inside to your body and notice how it feels inside as you focus on this source of strength. (Pause). See if there's an image that matches or acts like a "handle" for the inner felt sense. (Pause). Check it against your body for a sense of rightness. If it's not right, let it go and invite a new image (or word, phrase, gesture, or sound) to come. (Pause). When you're ready, bring your attention to being in this room, stretch, and gently open your eyes. Using the art materials, create the image of your source of strength.

The next activity you may choose to do outdoors and/or in a park, while tuning in from your smartphone. Movement is a nice way to move something that feels stuck inside you. The following walking meditation helps facilitate such mindful movement.

Choose one of the two Exercises below:

EXERCISE 3.2 Walking meditation *(Rappaport, 2009, p. 232)*

Standing on your feet, gently draw your attention to your breath. As you focus on your breathing, I am going to chime the bell at various times. When you hear the chime, bring your awareness to what thought/feeling you're experiencing in that moment. Simply notice. Then, I will lead you into a walking meditation. For now, simply notice your breathing, thoughts, feelings, and being present with the bell chime. (Pause for a couple minutes, cueing different bell chimes).

As you breathe in and out, bring awareness to your breath and to each foot as it lifts up, travels through space, and makes contact with the ground." The pace is Slow. Short *mantras,* or phrases, are silently repeated in coordination with the breath and a particular foot:

Left foot: Breathing in, I am aware of breathing in.
Right foot: Breathing out, I am aware of breathing out.

[After a few repetitions, you can shorten the phrases]
Left foot: In, aware of breathing in
Right foot: Out, aware of breathing out

[Repeat for a few repetitions]

Notice if there are any negative feelings or thoughts coming up within you. Be friendly with whatever is coming up. If a certain emotion like anger or fear or loneliness, etc, modify your mantra to address that. For example,

Left foot: Breathing in, I'm aware of that anger is in me.
Right foot: Breathing out, I'm aware of anger leaving me.

Repeat this slowly for another 5-10 repetitions. Then, change the mantra to:
Left foot: Breathing in, I feel calm
Right foot: Breathing out, I feel peace.
Repeat this slowly for 5 repetitions. Then, shorten the mantra to:
Left foot: In, calm.
Right foot: Out, peace.

Repeat this slowly for another 5-10 repetitions. I'm going to invite you to continue on your own until you feel complete with the walking meditation. If you want music, you can tune into www.pandora.com, and select station: "Yoga" radio.

EXERCISE 3.3: Exploring Movement with Music

Now I invite you to turn on your favorite song or go to: www.pandora.com (enter at 'New Station': "Bollywood" radio). Listen for a few moments and notice how the music feels in your body. Be friendly to whatever you are feeling. If you feel like moving to the music, you may do so. If you rather stand still, that is also a form of movement. Pause this stream, and try that for a minute to see how it feels to move in your body. When ready, you may unpause and continue with the stream.

Take a moment to reflect on the experience in your Journal. What was your experience of moving with music? Did you feel comfortable or uncomfortable? Anything else?

JOURNAL

Please indicate in your journaling today if you opted for Exercise 3.2 or 3.3. It will benefit you later when you refer back. Thank you.

Week 4 – Spirituality

We have arrived at our final meeting for this study. Over the weeks we've focused on ways to handle our stressors and achieving a balance, while gaining insights about our true, authentic Self within us. At the core of feeling imbalance, is how our spirit is negatively affected.

EXERCISE 4.0 Where I am now/ where I'd like to be spiritually *(Rappaport, 2009, p. 231)*
Take a few deep breaths down inside you to your body. Feel the support of the floor and the chair that you are sitting on. If you feel comfortable, close your eyes, otherwise gently lower your gaze in front of you. We're going to take some time to reflect on where you are at in your life spiritually right now and where you'd like to be. Follow your breath inside. Begin to become aware of your spirituality and how it is expressed in your life now…how you nourish or nurture your spirituality…whether it is through prayer, going to church or temple, spending time in nature, doing art, practicing sitting meditation or moving meditation. Or maybe your spirituality is feeling undernourished. However it is, just notice…and be accepting to how it is. Sense in your body how your spirituality feels right now. Check it for a sense of rightness. Take another deep breath, inhaling new life…Now imagine living your life in a way that nourishes your spirituality the way you would like. Describe that to yourself…See yourself doing those things right now…Turn your attention inside to your body and ask, "What's the whole feel of that, of life nourishing my spirituality the way I'd like it to be?" See if there's an image, colors, shapes that match or act as a symbol for the inner felt sense. Continue checking until you have the right image…and then ask inside, "So what's between these two felt images…my spirituality now and the way I'd like it to be?" Give time for the answer to form. Ask inside, "What 's needed to get from the first image to the second?" (Pause). You might want to ask another question: "What's a good small step in the right direction?" …Just listen for an answer. Be friendly to whatever may come up. When you're ready, bring your attention back here…stretch out and allow your eyes to gently open if they have been closed. Use the art materials to create the two images with what's needed to get from one to other, including the step.

Whenever the spirit is feeling low and needing a way to recharge itself, this simple spiritual practice can be utilized. This meditation, called the "Pebble Meditation," comes from the Buddhist faith and has been effective in rekindling a fraying spirit with continued practice.

EXERCISE 4.1 Pebble Meditation *(Rappaport, 2009, p. 208)*
Materials: 4 rocks (or flower petals, leaves, coins, marbles, meditation balls, anything that feels good to hold in hand)
Please set 4 "rocks" in front of you. You may use anything else that feels good to hold in your hand such as flower petals, leaves, coins, marbles, meditation balls, etc. Each "rock" represents a different element: flower, mountain, water, and space. As I read each line twice, repeat the line

silently to yourself. If you feel comfortable, I invite you to close your eyes, and take your first rock in your dominant hand, and repeat silently to yourself:

Breathing in, I see myself as a flower.
Breathing out, I feel fresh.
Now place that "rock" aside. Take the next "rock" in your hand.

Breathing in, I see myself as a mountain.
Breathing out, I feel solid.
Now place that "rock" aside. Take the next "rock" in your hand.

Breathing in, I see myself as still water in a pond.
Breathing out, I see clearly.
Now place that "rock" aside. Take the next "rock" in your hand.

Breathing in, I see myself as space.
Breathing out, I feel free.

Take a few breaths inside to your body. Feel the support of the chair, the earth, the sky. Breathing in … breathing out… Take a friendly attitude toward how you are right now…Take a moment to check inside, asking, "How am I right now?"

See if there's a word, phrase, image, gesture or sound that matches or acts like a handle for the inner felt sense. Check it for a sense of rightness. When you're ready, gently open eyes (if you have them closed) and create an artistic expression of your felt sense image, words, or movement.

EXERCISE 4.2 Journal Meditation: What I want to carry with me? *(Rappaport, 2009, p. 175)*
Take a few deep breaths inside to your body. Feel the support of the chair, the earth, the sky. Breathing in…breathing out…take a friendly attitude toward how you are right now… take a moment to check inside, asking, "How am I right now?" See if there's a word, phrase, image, gesture, or sound that matches or acts like a handle for the inner felt sense. Check it for a sense of rightness.

Now we're going to go back in time and recall some of your experiences in this workshop…remember when you first decided to participate in this workshop…Bring your awareness to what drew you here…and what you were looking for.

Now remember some of your experiences…learning the "clearing a space" tool, focusing on a source of strength, accessing acceptance and compassion, self-care, and …Remember your creative pieces…. What stands out as highlights? Sense in your body how that feels. Ask inside, "What do I want to take with me after this workshop, into my life?" Just listen…and wait. (Pause). What's the whole feel in your body of what you want to take with you? See if there's an image (or words, or a gesture, or a sound) of against your body for a sense of rightness. If it's not right, let it go and invite a new image (or word, phrase, gesture, movement, or sound) to come. (Pause). When you're ready, bring your attention to being in this room, stretch, and gently open your eyes. Use the art materials to create the image of what you wish to take with you from the workshop into your life in your Journals.

JOURNAL

CLOSING

As we conclude our workshop, I would like to express my gratitude for your time and participation for the last 4 weeks. My hope is that you have found an additional self-care practice with the integration of FEAT into your life.

To conclude, please make sure to complete the Post-Test survey/questionnaires to ensure your eligibility for the gift card raffle. For those of you who would like to voluntarily submit your creative works and/or your journals for the study, please contact me. As always, I appreciate you being here weekly, and hope your journey over the past weeks have been an insightful and empowering experience for you. Namaste!

Appendix C: Weekly Outline

Below is the basic structure of each online FOAT-IP session. The participants have a whole week to complete each week's activities. The activities are based on the exercises given in Focusing-Oriented Art Therapy book by Laury Rappaport.

Source: Rappaport, L. (2009). Focusing-Oriented Art Therapy: Accessing the Body's Wisdom and Creative Intelligence. London, England: Jessica Kingsley.

1) Opening
2) Check In
3) Theme Directed exercises
4) Symbolize
5) Journaling
6) Closing

Appendix D: Themes of Each Group Meeting for FOAT-IP

Below are the themes of each group meeting taught in the FOAT group intervention for the 4-week research study. Please contact the primary researcher, Rashmi Chidanand, if you wish to inquire about training for research replication purposes: South.Asians.Study@gmail.com.

Source: Rappaport, L. (2009). Focusing-Oriented Art Therapy: Accessing the Body's Wisdom and Creative Intelligence. London, England: Jessica Kingsley.

Week Zero: Orientation

Week One: Stress Reduction for Mind, Body, Spirit: Clearing Space

Week Two: Stress Management for Mind, Body, Spirit

Week Three: Accessing Acceptance, Compassion, and Inner Strengths

Week Four: Spirituality

Appendix E: Consent Forms

Consent Form: Quantitative Data

To: Research Study Participant

From: Rashmi Chidanand, Primary Researcher
Sofia University (formerly Institute of Transpersonal Psychology)
1069 East Meadow Circle, Palo Alto, CA 94303

You are invited to participate in a Sofia University (formerly I.T.P) student's Clinical Psychology 4-week South Asian Women's Ph.D. dissertation study. In this research, we will look at the effect of an expressive arts process has on **stress, anxiety, and depression**. In this research, you will participate in a women's empowerment group created for the South Asian Women's Study research team.

During the 4-week period of the study, you will engage in a weekly Web-based study for approximately 60 minutes. During this period, you will listen to a recording and engage in exercises that include art, movement, music, writing, and/or journaling process. You will be asked to submit your creative pieces by uploading a digital photo format or word doc format with your assigned participant number to maintain anonymity. This is to ensure the activities are completed on a weekly basis. These materials will not be subject to analysis in this study, and only upon your consent will any future analysis of the materials be conducted.

During weeks 0 and 4, your involvement will consist of taking online surveys on Survey Gizmo that will take approximately 30 minutes each to complete. The surveys consist of questions about stress, anxiety, depression and positivity. Your identity and responses will be kept confidential. Your responses will be aggregated with the responses from other participants and you as an individual will not be identified in any way in the final project. Survey Gizmo provides a secure platform for data collection and will not share your information with anyone but the primary researcher to protect your privacy. For more information on the Survey Gizmo privacy policy, please visit http://www.surveygizmo.com/privacy/.

If any transcribing is done, it will either be transcribed directly by the primary researcher to protect participant confidentiality, and/or a transcriber, who will be required to sign a transcriber confidentiality agreement. As an added precaution, I will alter any information that might otherwise identify you as a participant in this research study. Please feel comfortable asking any questions that might come up before, during, or after your participation in this study.

All the information gleaned from this research will be protected for your privacy. All information will be kept confidential and your identity will be protected. Electronic records (such as survey responses, audio/video recordings, notes on the computer, etc.) will be stored in a password-protected, encrypted, non-internet, and non-network connected external computer hard drive; no one besides the researcher will be able to access it. To assure your privacy and the confidentiality of your artwork and writing pieces, you will be assigned a participant number. I will be the only person to know your name, and the only person to have access to the key for the

cabinet that holds your information. My dissertation chairperson, committee members, research assistants, and statisticians will only know you by your **participant number**.

Potential benefits may include gaining a deeper understanding and awareness of how you experience negative daily stressors on mind, body, and spirit levels. You may also discover new tools for working through those emotions, which may fit your personality and be considered more appropriate by your family and culture. This may cultivate into a lifelong self-care practice for you and your well-being.

Potential risks for participating in the 4-week South Asian Women's Study include the possibility that working with your negative stressors may bring up uncomfortable feelings. The risk may be slightly higher of unpleasant stressors surfacing because this is an online technique. If at any time you have concerns or questions during the course of the study, I will make every effort to discuss them with you and inform you of various options to resolve your concerns.

You may request, for any reason, to be withdrawn from the study at any time without penalty or prejudice. There will be no penalty to you for wishing to be withdrawn from the study, and, you may still continue to complete the 4-week period without having your data collected.

Participation is entirely voluntary and no pressure will be applied to encourage participation. From the start of the 4-week study period, I will explicitly make clear that it is completely voluntary to have your information be a part of the overall data collection.

At the start of the 4-week study period, I will explain in detail the method and purpose of the study, and answer any questions you might have. Therefore, after signing this form, you are agreeing that I, the researcher, will have explained the study to each participant (you) and answered questions.

You will have the opportunity to contact me for the study's results. You may request a summary of the results of the study. You will not receive individual results or the results of another participant. To request results, or to ask questions, please call me, Rashmi Chidanand, at 650.223.5622 or email: South.Asians.Study@gmail.com. You can also contact Glenn Hartelius, Ph.D., my committee chairperson at 650-493-4430, or Fred Luskin, Ph.D., (Chairperson for the Research Ethics Committee) at Sofia University (formerly I.T.P.) at 650-493-4430.

I attest that I have read and understand this consent form. Any questions I have about this study and my participation have been answered to my satisfaction. I understand that my participation is entirely voluntary and that no pressure has been applied to encourage participation. My name and clicking 'yes' indicates my willingness to participate in this research study and to have the results published.

Participant's Name: _____ Date: _____

By clicking Yes below, you have given consent to participate in this study.

- o Yes

- No

Please send me a written summary of the study's pertinent findings: ___ yes ___ no

Contact Information (Please Print):

Name: _____

Address: _____

Phone: _____ Email: _____

Consent Form: Qualitative Data

To: Research Study Participant

From: Rashmi Chidanand, Primary Researcher
Sofia University (formerly Institute of Transpersonal Psychology)
1069 East Meadow Circle, Palo Alto, CA 94303

Thank you for your participation in the 4-week South Asian Women's Ph.D. dissertation study and women's empowerment online group. We explored the effect of an expressive arts process (FEAT) has on **stress, anxiety, and depression**.

At this time, would you be willing to:

- Submit your creative pieces from the workshop? Yes/No
- Submit your journals from the workshop? Yes/No
- Participate in a Post-study interview (45 minutes) to share your personal experience of the workshop? Yes/No

These materials as research data may be used for many different purposes: it may be processed using new analysis techniques to gain new insight into a phenomena, analyzed to address a new or related research question, incorporated into a meta-analysis study to identify common trends, or used as a teaching resource.

Specifically, creative artwork, journals, and post-study interviews will be subject to a qualitative data analysis to capture the personal, human experience of the FEAT tool, which is not captured by the quantitative analysis. This qualitative study will be conducted separately within 5 years after the completion of the quantitative dissertation study for purposes of new research study and/or publication.

Submissions will be made on Survey Gizmo by utilizing your participant number to maintain anonymity and confidentiality. As an added precaution, I will alter any information that might otherwise identify you as a participant in this research study.

Survey Gizmo provides a secure platform for data collection and will not share your information with anyone but the primary researcher to protect your privacy. For more information on the Survey Gizmo privacy policy, please visit http://www.surveygizmo.com/privacy/.

If any transcribing is done, it will either be transcribed directly by the primary researcher to protect participant confidentiality, and/or a transcriber, who will be required to sign a transcriber confidentiality agreement. Please feel comfortable asking any questions that might come up before, during, or after your participation in this study.

All the information gleaned from this research will be protected for your privacy. All information will be kept confidential and your identity will be protected. Electronic records (such as survey responses, audio/video recordings, notes on the computer, etc.) will be stored in a password-protected, encrypted, non-internet, and non-network connected external computer hard drive; no one besides the researcher will be able to access it. To assure your privacy and the confidentiality of your artwork and writing pieces, you will be assigned a participant number. I will be the only person to know your name, and the only person to have access to the key for the cabinet that holds your information. My dissertation chairperson, committee members, research assistants, and statisticians will only know you by your **participant number**.

You will have the opportunity to contact me for the study's results. You may request a summary of the results of the study. You will not receive individual results or the results of another participant. To request results, or to ask questions, please call me, Rashmi Chidanand, at 650.223.5622 or email: South.Asians.Study@gmail.com. You can also contact Glenn Hartelius, Ph.D., my committee chairperson at 650-493-4430, or Fred Luskin, Ph.D., (Chairperson for the Research Ethics Committee) at Sofia University (formerly I.T.P.) at 650-493-4430.

I attest that I have read and understand this consent form. Any questions I have about this study and my participation have been answered to my satisfaction. I understand that my participation is entirely voluntary and that no pressure has been applied to encourage participation. My name and clicking 'yes' indicates my willingness to grant permission for the researcher to utilize my creative artwork and journals, and participate in a post-study interview. I understand and grant permission also to have the results be subject to a qualitative analysis as part of a future research study and/or published.

Participant's Name: _____ Date: _____

By clicking Yes below, you have given consent to participate in this qualitative study and willing to submit creative artwork, journals, and participate in a post-study interview.

- o Yes
- o No

Quantitative Data Analyst Confidentiality Agreement

To: Quantitative Data Analyst
From: Rashmi Chidanand, MA, PhD Candidate, Primary Researcher

South Asian Women's FEAT: A Quantitative Study Exploring the Effects of Focusing Expressive Arts Technique (FEAT) on Stress, Anxiety, and Depression in South Asian Women

Rashmi Chidanand, MA, PhD candidate in Clinical Psychology at Sofia University (formerly I.T.P.), Palo Alto, CA, is undertaking this research. The purpose of the research is to explore the effect of an expressive arts process has on stress, anxiety, and depression on South Asian Women.

As the quantitative data analyst of this research, I understand that I will be reading responses to psychological assessments. Respondents who agreed to participate in this research on the condition that their interviews would remain strictly confidential have revealed the information in their responses to online surveys. I understand that I have a responsibility to honor this confidentially agreement.

I agree not to share any information from these responses, about any party, with anyone except the primary researcher of this project. Any violation of this and the terms detailed below would constitute a serious breach of ethical standards and I confirm that I will adhere to the agreement in full.

I, _____ agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the content of the responses to online surveys in any form or format (e.g. Excel files, SPSS uploads, etc.) with anyone other than the primary researcher.

2. Keep all research information in any form or format (e.g. Excel files, SPSS uploads, etc.) secure while it is in my possession.

3. Return all research information in any form or format (e.g. Excel files, SPSS uploads, etc.) to the primary researcher when I have completed the data analysis tasks.

4. After consulting with the primary researcher, erase or destroy all research information in any form or format regarding this research project that is not returnable to the primary researcher (e.g. information stored on my computer hard drive).

_____ _____
Quantitative Data Analyst's Signature Date

_____ _____
Primary Researcher's Signature Date

Appendix F: Demographic Questions

Age : _____

Ethnicity: Are you of South Asian descent? If so, which country?

- India
- Pakistan
- Nepal
- Bangladesh
- Sri Lanka
- Afghanistan
- Maldives
- Bhutan

If India, which City and State in India are you and/or your family heritage from?
Which country were you born in (e.g. U.S., India, etc)?

Language: Is English your native-language?

- Yes
- No
- Both English and Indian were my native languages

What is your primary Indian mother-tongue?

Education: What is the highest degree or level of school you have completed? *If currently enrolled, highest degree received.*

- No schooling completed
- Nursery school to 8th grade
- Some high school, no diploma
- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Marital Status: What is your marital status?

- Single, never married
- Married or domestic partnership
- Widowed
- Divorced
- Separated

Employment Status: Are you currently…?

- Employed for wages
- Self-employed
- Out of work and looking for work
- Out of work but not currently looking for work
- A homemaker
- A student
- Military
- Retired
- Unable to work

Income: What was your total household income before taxes during the past 12 months?

- Less than $25,000
- $25,000 to $34,999
- $35,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 to $199,999
- $200,000 or more

Religion: What religion were you raised in and/or currently practicing?

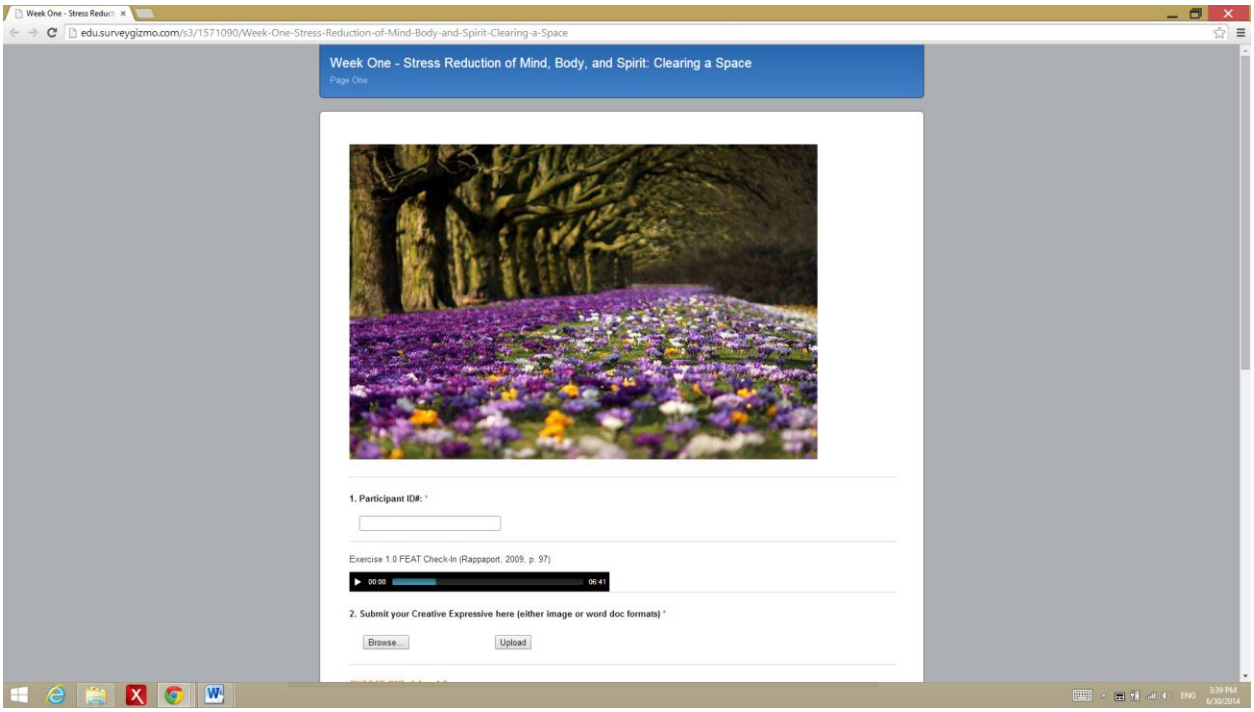
- Hinduism
- Buddhism
- Islam
- Sikhism
- Zorastrianism
- Jainism
- Christianity
- Judaism
- Atheist/Agnostic
- Other

Practices: Which of the following do you practice on a regular basis?

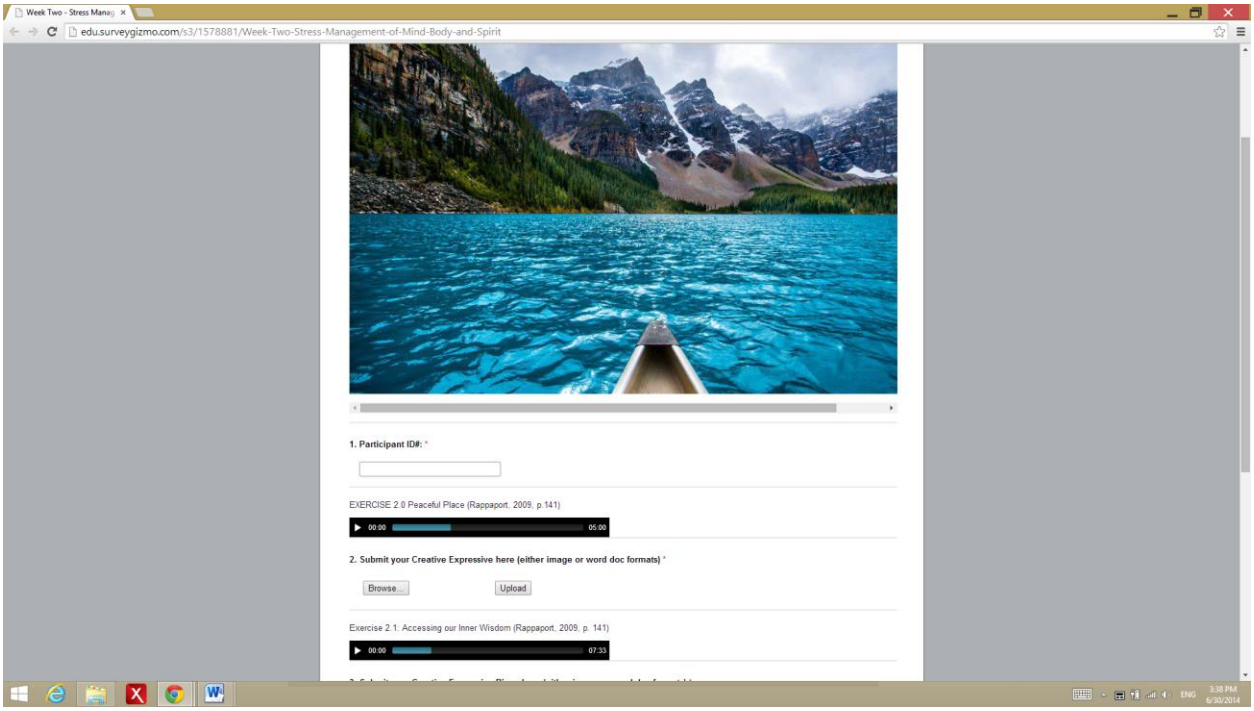
- Meditation
- Yoga
- Creative/Expressive Arts
- None
- Other

Appendix G: Screenshots of FOAT-IP Web Pages

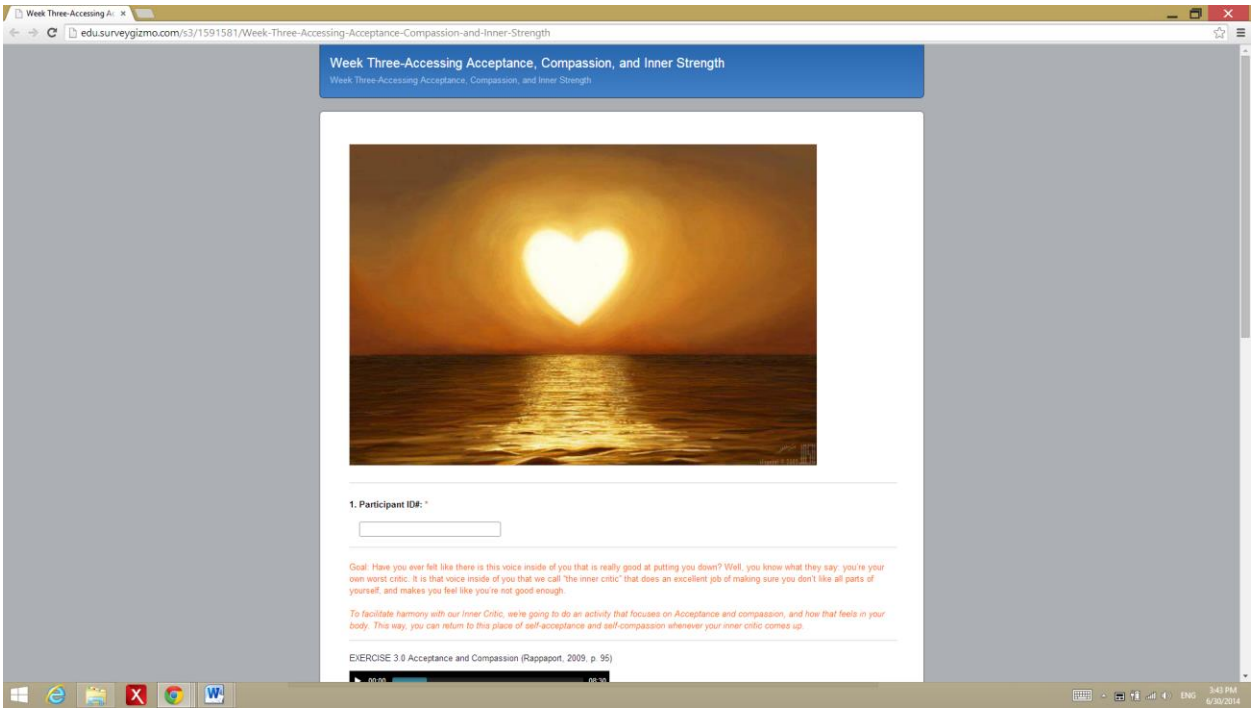
Week 1


edu.surveygizmo.com/s3/1571090/Week-One-Stress-Reduction-of-Mind-Body-and-Spirit-Clearing-a-Space
Week One - Stress Reduction of Mind, Body, and Spirit: Clearing a Space
Page One
1. Participant ID#: *
Exercise 1.0 FEAT Check-In (Rappaport, 2009, p. 97)
00:00
06:41
2. Submit your Creative Expressive here (either image or word doc formats) *
Browse...
Upload

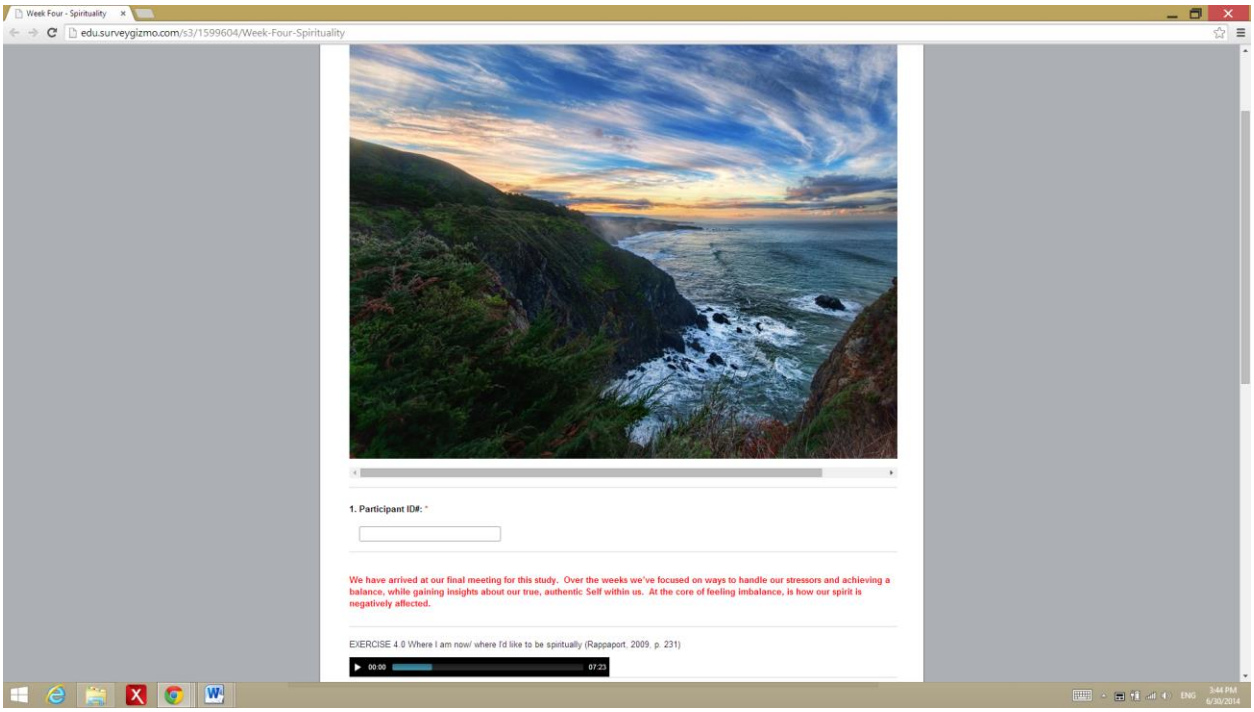
Week 2


Week Two - Stress Manag
edu.surveygizmo.com/s3/1578881/Week-Two-Stress-Management-of-Mind-Body-and-Spirit
1. Participant ID#: *
EXERCISE 2.0 Peaceful Place (Rappaport, 2009, p.141)
00:00
05:00
2. Submit your Creative Expressive here (either image or word doc formats) *
Browse...
Upload
Exercise 2.1: Accessing our Inner Wisdom (Rappaport, 2009, p. 141)
00:00
07:33

Week 3


edu.surveygizmo.com/s3/1591581/Week-Three-Accessing-Acceptance-Compassion-and-Inner-Strength
Week Three-Accessing Acceptance, Compassion, and Inner Strength
Week Three-Accessing Acceptance, Compassion, and Inner Strength
1. Participant ID#: *
Goal: Have you ever felt like there is this voice inside of you that is really good at putting you down? Well, you know what they say: you're your own worst critic. It is that voice inside of you that we call "the inner critic" that does an excellent job of making sure you don't like all parts of yourself, and makes you feel like you're not good enough.
To facilitate harmony with our Inner Critic, we're going to do an activity that focuses on Acceptance and compassion, and how that feels in your body. This way, you can return to this place of self-acceptance and self-compassion whenever your inner critic comes up.
EXERCISE 3.0 Acceptance and Compassion (Rappaport, 2009, p. 95)

Week 4


Week Four - Spirituality
edu.surveygizmo.com/s3/1599604/Week-Four-Spirituality
1. Participant ID#: *
We have arrived at our final meeting for this study. Over the weeks we've focused on ways to handle our stressors and achieving a balance, while gaining insights about our true, authentic Self within us. At the core of feeling imbalance, is how our spirit is negatively affected.
EXERCISE 4.0 Where I am now/ where I'd like to be spiritually (Rappaport, 2009, p. 231)
00:00
07:23