



Webinar: Q&A

Healing from sexual violence: Innovative approaches for positive mental health

Below are questions from the webinar which speakers were not able to address in session. To view the full webinar, please click [here](#).

1. Do you have particular measures, particularly any quantitative measures, used to capture the particular impact of the embodied aspects of these interventions?

Abbie Shepard Fields:

First and foremost, we need to be aware that most quantitative measures were designed in the West, based on language and conceptions that reflect western ways of experiencing, interpreting and expressing. Their structure limits responses or reactions to a very narrow field of options.

In my own research in this field, I have found that qualitative methods are much more effective in capturing the nuances of changes (both reductions of symptoms and positive growth) that occur through body-focused work (I think this is likely true for more cognitive-focused work as well). What is important is using qualitative measures both prior to and after an intervention (pre-post), to be able to really assess change. And it is important to use a range of well-formulated questions in interviews, for example, to capture the different facets of the impact of body-focused work.

However, I will mention that there are some good quantitative scales for mindfulness, which I used in my own work, and although my sample size was extremely small (and therefore the results of these measures was not significant), I would encourage exploring their use to gauge changes over time. In addition to measuring the extent to which we are present in the moment, mindfulness is a very good indicator of changes in self-awareness and self-acceptance, key elements in healing from trauma. I recommend the Philadelphia Mindfulness Scale. I think it has the right focus on the kinds of changes that occur during recovery from trauma associated with sexual violence.

Daniel Lakin:

Please see the additional resource section for more background. I appreciate the above point regarding the necessity of qualitative measures, particularly as a means of both hypothesis generation and for providing necessary detail in the description of one's subjective experience of a given intervention. Moreover, mental health symptom severity scales (i.e., quantitative measures) can easily/consistently miss culturally specific indications of psychological distress and dedicated qualitative work can be imperative for ensuring accurate depiction of ongoing mental health concerns. The benefit of using an adapted quantitative measure is the possibility of generalising findings and contextualising them within extent research, but for some that is not necessarily the ultimate goal.





2. Are there any literature/interventions from the trauma field of victims of torture in conflict settings that could be adapted to the VAW field?

Daniel Lakin:

Daniel Lakin:

A few things come to mind. One of the most widely studied interventions in humanitarian context, the Common Elements Treatment Approach or CETA, has been used extensively among both victims of torture (Burmese former political prisoners; Bolton et al 2014), and GBV-affected populations (Zambian families in Lusaka; Murray et al., 2020). CETA is decidedly CBT-based but relies on modules that can be configured by the provider depending on the symptoms a given participant presents. I think if you look at the some of the papers above you can get a sense of what, if any, adaptations were made to address the specific needs of these very different populations.

Speaking more broadly, many of the trauma narrative-based interventions that are widely used in humanitarian context do not have specific considerations for GBV-affected groups. One that comes to mind that *does* have such considerations is Cognitive Processing Therapy (CPT), which has been used among former combatants to address posttraumatic stress, while different considerations were used specifically in work among survivors of sexual violence in Eastern Congo.

I think the core principles of most commonly used trauma interventions can feel a bit “one-size-fits-all” for many practitioners, but there are elements of commonality that I think suit the VOT and VAW populations well – issues of stigma, of isolation, and of feeling abandoned by communities and families are both prominent themes in qualitative work from both fields. Many of those themes are in turn prominent in trauma-focused interventions and are often specific intervention points.

3. Do you think yoga, meditation and mindfulness with other treatment way is work more or no?

Abbie Shepard Fields:

This is a great question. I think that treatments for trauma depend a lot on the person and the kinds of symptoms they are experiencing and what they are looking for in terms of support. What research has shown, however, is that there is a very clear relationship between the neurological processing of traumatic experience and the expressions of trauma in the body, and the inability to access traumatic memories cognitively. What is most important is to recognize that trauma affects both people’s minds and bodies, and understand why the rational, cognitive part of our brain is not the only part of our selves that needs to be addressed for healing to take place.

In fact, the trauma informed yoga program I developed together with a Hatha yoga instructor was only “focused” on the body. In other words, none of the women taking part were involved in talk therapy at the time. However, we did meet after the sessions, during a sort of “wind down” period when we talked about how the yoga felt, what it was doing, what was working and what wasn’t. When we realized that the yoga teacher’s words were having a strong impact on the women, we developed different themes for the classes, focusing on key concepts like loving oneself, accepting oneself, letting go of pain, receiving strength, feeling emotions, centering and grounding, etc. And the combination of the yoga postures and the spoken (more cognitive messages) had a powerful impact. I personally



believe that yoga, meditation, and other mindfulness work can be very effective on their own, without being accompanied by psychotherapy (which is the way it is normally used in the US) but should always be offered in conjunction with the backup of a mental health counsellor or psychologist, since a lot of triggering can occur in body work, and it is important for participants in such programs to have support from someone who can help them process their trauma verbally if desired.

4. If we as practitioners would like to refer clients to attended trauma informed yoga, is there an online intervention currently available for suitable candidates to attend?

Sophie Namy:

There are many yoga sessions offered online, especially during the pandemic. Ompowerment has a [Youtube channel](#) with many trauma-informed practices of varying lengths, which are designed to be accessible for practitioners with little to no experience of yoga. There are many other online resources for self/collective care practices, such as [Capacitor's Emergency Response Toolkit](#).

One note is that depending on the individual client and where she/he is in the healing process, more tailored support may be necessary. Moving the body can also be triggering, releasing traumatic memories, and so safety of referring client to online /self- practice platforms need to also be considered.

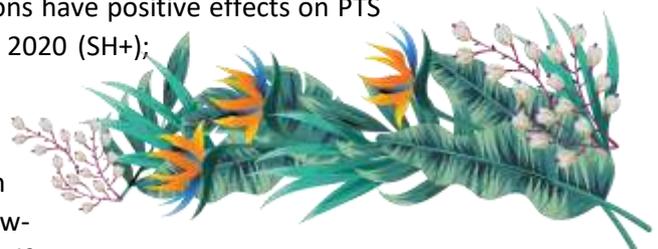
5. Do you think that MHPSS protocol should be adapted to the specific trauma of SGBV survivors, or if a trauma-based protocol should be used (without having to adapt them specifically to SGBV survivors)?

Daniel Lakin:

I think this is actually similar to the question related to VAW and VOT groups – i.e. should MHPSS protocols have specific provisions/considerations for GBV-affected populations. Short answer is “not necessarily, it depends.”

Long answer: It is a delicate balance between what you want to provide and what you have the resources/infrastructure to provide at the desired scale. One of the main points of contention in the field right now is that a majority of the interventions that have been tested are relatively specialised – they require additional training of staff, capacity building, etc., and the interventions themselves are often focused on addressing a specific mental health problem (e.g., depression-focused or PTSD-focused interventions). Programmatically, folks on the ground seem to be advocating for more broad-based community interventions that can serve a diverse group of people, that can be easily folded into an existing infrastructure (e.g., a joint anti-violence and mental health intervention), and that does not require resource-intensive training or specialised providers. There is some evidence that more broad-based, non-trauma specific interventions have positive effects on PTSD symptoms among GBV-affected women (Tol et al 2020 (SH+); Problem Management Plus; etc), for example.

However, there is considerable evidence for trauma-focused interventions and their efficacy in working with SGBV-survivors in humanitarian and low-income context. I know of some research (by myself





and Judy Bass; papers forthcoming) that showed a GBV-focused trauma intervention sustained clinically significant reduction in trauma symptoms more than five years after the initial trial. I don't know that there's been a direct comparison of GBV-adapted trauma interventions to non-adapted though, which is what you'd need to make a claim that one is better than the other. Trauma is by definition a unique individual experience. Culture and context shape both the experience of mental health, mental disorder, traumatic events, etc. In real world circumstances, I think we need to try to strike a balance between what our beneficiaries want, what we can realistically provide, and how well we can meet each other in the middle.

Sophie Namy:

I would also like to emphasise considerations for the ways in which systemic and intergenerational trauma contribute to individual experiences and shape how individuals navigate their own mental health. From an ideological/values-based perspective, I think any work with survivors needs to acknowledge these structural drivers of mental ill-health. This may not be as pressing within general protocols e.g., when working with someone recovering from a more "individual" traumatic event (e.g., loss of a loved one, accident, etc.). This is something we are constantly grappling with at HaRT – finding this balance between appreciating the systemic work that collective wellbeing requires, while at the same supporting more micro/group-based healing for individual women and girls.

Additional resources

- Fields, A., Namy, S. & Dartnall, E. (2020). [SVRI Knowledge Exchange: Healing from sexual violence: Body-focused mental health approaches](#). Sexual Violence Research Initiative: Pretoria.
- [The PSYCHLOPS \(Psychological Outcomes Profile\)](#). Participants/clients can list their own problems (qualitative) and indicate the extent to which it is problematic/hard to deal with using an anchored scale (quantitative). Can be difficult in longitudinal studies, but a really neat way to identify priority problems among the folks you serve.
- [The Acceptance and Action Questionnaire \(AAQ-2\)](#) measures 'psychological flexibility,' a central concept in Acceptance and Commitment Therapy but also a potential analogue for elements of mindfulness practice. The items largely relate to one's ability to delineate between thoughts and feelings and appraise situations as neutral or approachable despite existing anxiety/fear/trauma.
- [WHO-5 Wellbeing Index](#), a great way of 'checking in' with folks on well-being writ large. It's a good way to gauge broad-based impact of an intervention while avoiding overly 'mental healthy' jargon or potentially stigmatizing remarks. Background info can be read [here](#).
- [The DIME Program Research Model: Design, Implementation, Monitoring and Evaluation](#) by Paul Bolton, Judy Bass & colleagues in the Applied Mental Health research group.
- [Profile of Mood States questionnaire](#) (note they also took urine samples to measure cortisol).
- The study "[Effect of Hatha Yoga on anxiety: A meta-analysis](#)" by Hofmann et. al, uses the following scales: State Trait Anxiety Inventory – Trait (STAI; 31): population mean = 36.35 (SD = 11.39; 39), clinical cut-off ≥ 46 (40); Beck Anxiety Inventory (BAI; 30): population mean = 6.16 (SD = 7.16; 39), clinical cut-off ≥ 16 (30); Hospital Anxiety and Depression Scale - anxiety subscale (HADS-A; 32): population mean = 4.7 (SD = 3.5; 41), clinical cut-off ≥ 8 (42); Hamilton Anxiety Rating Scale (HAM-A; 38): ≥ 24 suggests severe anxiety (43); Depression Anxiety and Stress Scales (21 item version).



- Dunphy, K., Jordan, A. & Elton, M. (2014). [Exploring dance/movement therapy in post-conflict Timor-Leste](#), *American Journal of Dance Therapy*, 36(2), 189-208.
- Billings, D., Cohen, R., Coles, J., et al. (2015). [Guidelines for the prevention and management of vicarious trauma among researchers of sexual and intimate partner violence](#). Pretoria: SVRI.
- [HaRT Yoga](#).
- Namy, S. (2020). [Trauma-informed phone interviews on sensitive topics: Learning from the COVID-19 lockdown in Uganda](#). Interview with Sylvia Namakula and Agnes Grace Nabachwa. SVRI Blog.
- Tol, W.A., Leku, M.R., Lakin, D.P., et al. (2020). [Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial](#). *The Lancet Global Health*, 8(2): e254-e263.
- Chigudu, H. (2020). [Healing through rituals: A guide for sustaining wellbeing and activism](#). Kampala: Women's International Peace Centre (The Centre).