THE SIERRA BENDER EMPOWERMENT METHOD® AND ITS EFFECT ON A FEMALE POPULATION

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Dedicated to women and girls around the world.

"When we have mastered observing our emotions and mind in the moment without reaction, we have mastered how to be in our core. We have mastered how to come from a place of self-love and unconditional love for others. This is the foundation of a healthy and vibrant being claiming her space – not just taking up space." – Sierra Bender

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ABSTRACT

The objective of this study, which replicated pilot study findings, was to evaluate the effectiveness of the Sierra Bender Empowerment Method® (SBEM®) and its effects on a female population. To test the SBEM®'s effectiveness, a nonrandomized control group pretest-posttest design was used. The treatment group included fifty women who participated for the SBEM® and fourteen women who participated for the R&R Retreat program at Kripalu Institute for Yoga and Health over the same period of time. Results of a two-way analysis of variance for repeated measures indicated the SBEM® was effective in increasing empowerment and mindfulness as measured by the Empowerment Scale (1997) and Mindful Attention Awareness Scale (2002) and these increases were greater than those seen in the control group. All five-subscales of the Empowerment Scale increased significantly, which include self-esteem, power, autonomy, optimism, and righteous anger.

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CHAPTER 1

INTRODUCTION

Empowerment and Research

Focusing on empowerment can create meaningful assistance for women. Empowerment is a construct shared by many disciplines, including community development, psychology, education, economics, and studies of social movements and organizations (Page & Czuba, 1999). "Women's empowerment is about the process by which those who have been denied the ability to make strategic life choices acquire such an ability," (Kabeer, 1999). Empowerment may be experienced as either a perceived sense of self-control or an actual increase in control over resources (Rapport, 1984; Page & Czuba, 1999). It involves a process of change and helps individuals gain control over their own lives. This process fosters power in people so they may act on issues they define as important in their personal lives, their communities, and in their society (Page & Czuba, 1999).

Empowerment is a major goal within the violence against women movement and the mental health field (Rogers, Chamberlin, Ellison, & Crean, 1997; Kasturirangan, 2008). Only a small amount of systematic research, however, has used empowerment as a health outcome for these areas. A search for women's empowerment programs in the Academic Source Premiere database, which contains indexing and abstracts for more than 8,500 journals, shows 123 results. Only 10 of these results discuss women's empowerment programs in the U.S., and only two of these describe research conducted on the programs, neither conducting a randomized-controlled clinical trial to evaluate the

effects of the empowerment programs (Ross, S. 2003; LaFave, Desportes, & McBride, 2009).

Despite the limited attention in experimental research, statistics show the female gender is suffering (CDCP, 2003; BJS, 2006). Women experience depression nearly two times as much as men in both lifetime and twelve-month prevalence, and surpass men in other areas of poor mental health including suicide attempts, anxiety, panic attacks, eating disorders, and post-traumatic stress disorder (PTSD) (WHO, 2012). Furthermore, the commonness of violence against women is alarmingly high, with one in every four women experiencing domestic violence in her lifetime and 1.3 million women becoming victims of physical assault by an intimate partner each year (Tjaden & Thoennes, 2000; CDCP, 2003). There is undoubtedly a need for further research in women's empowerment and the effectiveness of empowerment programs for women, especially in the area of randomized-controlled clinical trials.

The limited literature surrounding empowerment has been repeatedly identified by Dr. Sally Rogers, the creator of the Empowerment Scale (1997), and others connected to the creation and validation of the scale. Rogers, Chamberlin, Ellison, and Crean (1997) identify empowerment in mental health literature as being connected mainly in relation to the function or mission of self-help programs and how mental health services can promote empowerment. Despite the growing emphasis on empowerment, Rogers et al. (1997) note there are few empirical studies of empowerment as a construct, process, or an outcome. As a result, in 1997 Rogers' objective was to develop a scale that measured the personal construct of empowerment as defined by consumers of mental health services and validate it in the field. Just as the limited literature surrounding

empowerment would point out, Rogers' creation and validation of the empowerment scale exists, with only one additional validation of the scale with an outpatient mental health population. Both articles conclude adequate validity of the scale determined with the same population (Rogers, Chamberlin, Ellison, & Crean, 1997; Wowra & McCarter, 1999).

The effectiveness of empowerment programs for women can be seen in a selection of empirical studies from around the world. Empowerment programs have been implemented and found successful in increasing empowerment for women with illnesses such as cancer and HIV, as well as, women who are divorced (Kinney, Rodgers, Nash & Bray, 2003; Jirapaet, 2000; Chan, Chan & Lou, 2002). None of these studies used the Empowerment Scale (1997), however they all used scales that measured factors negatively and positively associated with empowerment, such as wellbeing, stress, and quality of life (Kinney et al., 2003; Jirapaet, 2000; Chan et al., 2002).

Kinney, Rodgers, Nash & Bray (2003) evaluated an empowerment program for women with breast cancer that focused on mental, emotional, spiritual and physical health. The program followed an integrated and cumulative plan that introduced multiple strategies including meditation, getting in touch and expressing emotions, the healing power within, and experiencing gratitude. They found the women significantly increased their scores in perceived wellness, quality of life, spirituality, and decreased significantly in levels of depression (Kinney et al, 2003).

Chan, Chan & Lou (2002) did develop an empowerment scale to measure changes in the empowerment program for divorced women in Hong Kong; however the validity of this scale has not been demonstrated. Chan focused evaluations on similar aspects of

health as Kinney et al. in the evaluation of an empowerment program for divorced women. Chan's goal was to empower clients' physical, emotional, social, and spiritual health. In this empowerment intervention, women engaged in activities such as physical exercises, imagery, meditation, and short discussions with topics such as, "Growth through pain," and "Love yourself." Participants reported the relaxation and meditation activities to be the most helpful and pre-and post-scores reported significant improvements in their perceived level of stress and sense of empowerment (Chan et al., 2002).

Jirapaet (2000) examined a feedback strategy to implement an empowerment program for HIV-infected mothers in Thailand. This program was conducted in a group setting and relied on the group's reflections on beliefs, values, wishes, and needs of that day. Unlike the two previous studies, Jirapaet also included a Control Group to compare pre- and post-test scores to the Treatment Group. Findings showed the mothers in the empowerment program significantly increased more in levels of coping ability, quality of life, and maternal role adaption when compared to mothers in the Control Group.

The evaluations of the previously described empowerment programs show that multimodal and multifaceted approaches can significantly effect women's empowerment. Yet, there is still a clear need for (1) more research in the area of women's empowerment programs, further validating the use of the Empowerment Scale (1997), (2) further validation of the effectiveness of empowerment programs for women, and (3) evaluation of the utility of empowerment, health, and wellbeing.

Description of the Sierra Bender Empowerment Method®

Sierra Bender, creator of the Sierra Bender Empowerment Method® (SBEM®) has worked with over 1,000 women in her attempt to empower women. Over 600 women have participated in the SBEM®. As an activist, Sierra's mission is to lower statistics of violence against women. She has worked with women all over the globe and has studied alongside highly esteemed scholars, Native American communities, in Indian ashrams, and in the jungle of the Amazon. Sierra Bender has studied health physiology, and is certified as a personal trainer and yoga teacher.

The SBEM® is a multimodal and multifaceted approach to women's empowerment. This method claims to address women's spiritual, mental, physical, and emotional health. Sierra Bender believes that a focus in treating all the different aspects of health most effectively brings about empowerment in women, (Bender, 2009). Key themes of the SBEM® include empowerment of participants and a focus on self-esteem, mindfulness, and overall well-being. The SBEM® includes yoga, meditation and physical and breathing exercises. Research has shown these components have been successful in improving health in various populations and more specifically, in depression, anxiety, and PTSD (Schure, Christopher & Christopher, 2008; Ma & Teasdale, 2004; Teasdale, Williams, Soulsby, Segal, Ridgeway, & Lau, 2000; Brown & Gerbarg, 2005; Brown & Gerbarg, 2005; Ströhle, 2008). The present evaluation of the Sierra Bender Empowerment Method® (SBEM) will both examine the effectiveness of the SBEM® for women, and will contribute to the empirical understanding of empowerment, methodology, and outcome.

CHAPTER 2

METHODS

Design

The objective of this study was to assess the effects of the Sierra Bender Empowerment Method® (SBEM), which is implemented in Sierra Bender's Goddess to the Core® (GTC) program. This method was evaluated using a pre- and post-test design and a non-randomly assigned Control Group who participated in an R&R Retreat program (R&R) at the same site during the same weekend as the Treatment Group. Immediately before and following participation in the program, the Mindful Attention Awareness Scale (MAAS) and Empowerment Scale (ES) were given to SBEM® and R&R participants. Participants' written comments were also collected post program participation to allow for additional insights on the effects of the program.

Pilot data indicated that participation in the SBEM® was effective in increasing mindfulness and empowerment as measured by the MAAS and ES. The purpose of the present study was to determine if these increases were specific to SBEM® participants. By including a Control Group of R&R Retreat participants, further evaluations were made. The hypothesis of this study was that participants of the SBEM® would have greater increases in mindfulness and empowerment scores than those of the control subjects.

Participants

The participants in the treatment SBEM group were individuals who registered to take Sierra Bender's Goddess to the Core® program at Kripalu Center for Yoga and Health during a specific weekend in 2011. The only inclusion criterion was the women

must be completing the GTC® program at that time. Of the 55 women enrolled in the GTC® program, 50 completed the psychological questionnaires at the beginning of the study. Of the 50 women who completed the initial surveys, 42 of these women completed the surveys post participation of the program.

The participants in the control R&R Retreat group were individuals who registered to take the R&R Retreat program at Kripalu Center for Yoga and Health at the same time period of the Treatment Group. The inclusion criteria were the participants must be completing the R&R Retreat program at that time and they must be women, so as to match the Treatment Group. American University's Institutional Review Board approved this exclusion. The R&R Retreat group participated in self-made schedules. They were free to participate in a number of activities provided by Kripalu, including self-directed activities such as kayaking, and educational workshops and exercise classes. Of the 16 R&R women present at the time of the Control Group recruitment, 14 completed the psychological questionnaires at the beginning of the study and all 14 returned to complete the surveys post program participation.

Measures

Two self-report instruments were used to quantify the effects of the Sierra Bender Empowerment Method® through pre- and post-test methods. At the end of the program, participants were also asked to provide written descriptions of any benefits or concerns of the GTC® or R&R Retreat programs.

Empowerment Scale. The Empowerment Scale was chosen due to the focus of the SBEM® program, the goal of the researchers in evaluating the SBEM®'s effect on empowerment, and the need for more research in the area of women's empowerment.

The Empowerment Scale (ES) (Rogers, 1997) was developed to reflect a consensual definition of empowerment by consumers of mental health services. This scale assesses levels of empowerment through five subscales: self-esteem, power/powerlessness, community activism/autonomy, optimism/control over the future, and righteous anger (Rogers et al., 1997). This instrument is a 28-item self-report designed to measure subjective feelings of empowerment, in which respondents answer questions on a four-point scale ranging from Strongly Agree to Strongly Disagree. Higher scores are deemed to reflect higher levels of empowerment (Rogers, 1997).

This ES was hypothesized to successfully evaluate any changes in empowerment in the current study due to its validity in measuring the construct. Wowra and McCarter (1999) showed the utility of this scale through validation in an adult outpatient mental health population. Two thousand consumers of South Carolina's outpatient public mental health system were mailed a survey. Reliability and factor analyses confirmed its five subscales (Wowra & McCarter, 1999).

Mindful Attention Awareness Scale. The MAAS was chosen as an additional wellbeing measurement to the Empowerment Scale. The SBEM®'s use of mindful techniques such as meditation and yoga, and the program's focus on being mindful of four areas of health: spiritual, mental, physical, and emotional, supported the belief that a mindfulness scale would be appropriate as an additional scale in evaluating the effects of the SBEM®.

Brown and Ryan's (2002) Mindful Attention Awareness Scale (MAAS) was designed to assess a core characteristic of dispositional mindfulness, specifically, open or receptive awareness of, and attention to, what is taking place in the present. The

instrument is a 15-item scale that taps a unique quality of consciousness related to, and predictive of, a variety of self-regulation and well-being constructs (Carlson & Brown, 2004). Respondents answer questions on a six-point scale ranging from Almost Always to Almost Never. Higher scores are deemed to reflect higher levels of empowerment. Thirteen different psychological scales claim to measure mindfulness.

Carlson and Brown (2004) evaluated the construct and criterion validity of the MAAS in a cancer outpatient population, using matched community members as the Control Group. Conclusions reported the MAAS to show strong validity with or without the Treatment Group's comparison to the nonclinical Control Group. MacKillop and Anderson (2007) further validated the MAAS in a large university sample. The findings supported the MAAS as showing strong validity for measuring mindfulness. The MAAS was chosen due to its ease in administration and its popularity for measuring the construct. (MacKillop and Anderson, 2007).

Procedure

The pilot study was conducted at both Kripalu Center for Yoga and Health and Omega Institute on two different weekends. After initial registration to Kripalu and Omega, potential participants went to their designated room to await the beginning of their program. During recruitment, as participants walked into the room where the program was held, they received the materials to participate. Every potential participant had the consent form, demographic questionnaire, and two psychology questionnaires in front of her and was allotted 55 minutes to complete the materials and become a part of the Treatment Group. An additional lengthy well-being scale was administered between the two instruments mentioned above. It was dropped from the final study, however, due

to the time required for completion by the participants and its lack of usefulness in evaluating the effect of the program. The participants were also instructed they would fill out the same psychology questionnaires immediately following the conclusion of the program.

The full study was conducted at Kripalu Center for Yoga and Health and began on the first day of SBEM® and R&R Retreat (R&R) programs over the same weekend. After initial registration at Kripalu, (immediately prior to the start of the programs) potential participants went to their designated rooms, one room for the start of SBEM® and another for the R&R. During recruitment, as participants entered the rooms, they received the materials to participate in the program. Every potential participant had the consent form, demographic questionnaire, and two psychological questionnaires in front of her and was allotted 40 minutes to complete the materials and become a part of either the treatment or Control Group. The participants were also instructed that they would fill out the same psychology questionnaires immediately following the conclusion of the program, as well as be provided a blank page to expand on any benefits or concerns of their program.

Sierra Bender Empowerment Method®

Outline

Bender (2012) describes her program as follows:

> Opening night begins with defining and discussing the Sierra Bender Empowerment Method® and its multimodal approach to health (spiritual, mental, emotional, physical). I then mention state statistics of female violence across the U.S. and world to clearly show where women have ended up today. Friday

night's activities include defining terms like feminine, masculine, and power and engaging the group in activities that change perspectives on these terms.

The second day is a full day of activities. It usually begins with a silent hike outdoors and is followed with discussion and education on physical, mental, spiritual, and emotional health. The women are then engaged in a workout to focus on their physical health, as well as, breathwork exercises that assist with both the physical and emotional health. A two-hour break follows for rest, lunch, and reflection. Following, a board breaking activity is conducted to increase emotional intelligence. I have the women learn how to identify victimization, face their fears, and learn their worth as a female.

The third day begins with another silent hike. It is followed by a yoga therapy activity where healing can take place and trauma can be released. Finally, my Goddess to the Core® Thirteen Levels of Empowerment are discussed, and I focus my discussion on how to hold power, recognize when you loose it, and build and sustain it.

CHAPTER 3

RESULTS

Demographic Characteristics for the Pilot Study

An analysis of variance was conducted to evaluate the demographic characteristics of the pilot study using the IBM® SPSS® Statistics Standard GradPack 20 for Windows. All other statistical computations used the same program, as well. The characteristics of the pilot study participants are given in Table 1. There were no significant differences in demographics between the Omega and Kripalu treatment groups.

To assess whether the Mindful Attention Awareness Scale (MAAS) and Empowerment Scale (ES) scores in the pilot study were affected by the demographics of the population statistical tests were conducted. For the pilot study conducted at both Omega Institute and Kripalu Canter, the demographics were not found to significantly impact the results of the tests.

Table 1 - Sample Characteristics of SBEM Pilot Study Participants

Characteristics	Omega	%	Kripalu	%	Total	%
Sample Size	36		48		84	
Age (years)						
M±SD	43±9.2		40±12.8		41.5±11.4	
Range	21 to 58		14 to 62		14 to 62	
Ethnicity						
Caucasian	33	92	45	94	78	93
Latino/Hispanic	1	3	2	4	3	4
Asian/S.E. Asian	0	0	1	2	1	1
Other	2	5	0	0	2	2
Religion						
Catholicism	12	33	14	29	26	31
Protestantism	3	8	7	15	10	12
Judaism	4	11	8	17	12	14
Buddhism	1	3	0	0	1	1

Hinduism	0	0	1	2	1	1
Other	16	45	17	35	33	40
Missing	0	0	1	2	1	1
Marital Status						
Married	11	30	25	52	36	43
Single	15	42	15	31	30	36
Widow	1	3	1	2	2	2
Separated/divorced	9	25	7	15	16	19
Income						
Below $16,000	3	8	6	13	9	11
$17,000-$36,000	4	11	3	6	7	8
$37,000-$56,000	1	3	8	17	9	11
$57,000-$86,000	7	19	3	6	10	12
Above $86,000	20	56	26	54	46	55
Missing	1	3	2	4	3	3
Professional Training						
Health Sciences	2	6	7	15	9	11
Education/ academia	8	22	10	21	18	22
Marketing/ publicity	5	14	7	15	12	14
Yoga/holistic/alt. med.	6	17	6	12	12	14
Business management	3	8	4	8	7	8
Fine arts	0	0	2	4	2	2
Social work /counselor	2	6	3	6	5	6
Homemaker	1	2	0	0	1	1
Lawyer	1	2	1	2	2	2
Other	6	17	7	15	13	16
Health Sciences	2	6	1	2	3	4
Degree of Education						
High school	3	8	9	19	12	14
Bachelor’s degree	22	61	15	31	37	44
Graduate school	9	25	16	33	25	30
Doctorate or higher	2	6	7	15	9	11
Missing	0	0	1	2	1	1
Dealt with eating disorder						
Yes	10	28	11	23	22	25
No	26	72	37	77	63	75
Mental disorder						
Yes	14	39	19	40	33	39
No	22	61	29	60	51	61
Domestic violence						
Yes	21	58	17	36	38	45

No	15	42	28	58	43	51
Missing	0	0	3	6	3	4
Situation of rape						
Yes	11	31	7	15	18	22
No	25	69	38	79	62	74
Missing	0	0	3	6	3	4
Currently in therapy						
Yes	15	42	12	25	27	32
No	21	58	33	69	54	64
Missing	0	0	3	6	3	4
Taking medication						
Yes	9	25	13	27	22	26
No	27	75	35	73	62	74

Outcome Analysis for the Pilot Study

Pre-intervention distributions approximated normal distributions of the dependent variables in the pilot study, which include the MAAS, and the five ES subscales Self-esteem, Power, Autonomy, Optimism, and Righteous Anger. To evaluate the effects of the Sierra Bender Empowerment Method® in the pilot study at the two locations (Omega and Kripalu), a two-way repeated measures ANOVA was conducted and found significant overall effects of time for the MAAS, $F(1, 65) = 18.76$, $p < .001$, and all five ES subscales Self-esteem, $F(1, 67) = 37.98$, $p < .001$, Power, $F(1, 67) = 60.29$, $p < .001$, Autonomy, $F(1, 67) = 39.29$, $p < .001$, Optimism, $F(1, 67) = 16.87$, $p < .001$, and Righteous Anger, $F(1, 67) = 71.33$, $p < .001$. Significant overall effects of time by condition were also found for Power, $F(1, 67) = 6.37$, $p < .05$ and a slight but not significant effect was found for Righteous Anger, , $F(1, 67) = 3.06$, $p = .085$.

Paired *t*-tests were conducted to determine if significant differences existed in the pre- and post-test Mindful Attention Awareness Scale (MAAS) and Empowerment Scale (ES) scores. For the ES, pre- and post-test scores were taken for each individual

subscale: Self-esteem, Power, Autonomy, Optimism, and Righteous Anger. Sample sizes vary across tests due to incomplete pre- or post-test responses by some participants.

In the Treatment Group at Omega Institute, paired *t*-tests showed significant increases in the Treatment Group scores for the MAAS, t(27) = -3.21, $p < .01$, and Empowerment Scale subscales Self-esteem, t(28) = -6.73, $p < .001$, Power, t(28) = -5.5, $p < .001$, Autonomy, t(28) = -5.08, $p < .001$, and Righteous Anger, t(28) = -5.79, $p < .001$. A slight, but not significant increase was seen for the ES subscale Optimism, t(28) = -1.95, p = .06. In the Treatment Group at Kripalu Institute, paired *t*-tests showed significant increases in the Treatment Group scores for the MAAS, t(37) = -2.99, $p < .01$, and all five ES subscales, Self-esteem, t(38) = -3.052, Power, t(38) = -5.12, $p < .001$, Autonomy, t(38) = -3.92, $p < .001$, Optimism, t(38) = -4.05, $p < .001$, and Righteous Anger, t(38) = -5.96, $p < .001$. See Table 2a and Table 2b.

Table 2a - Changes in Mindfulness & Empowerment Over the Treatment Interval in the Pilot Study (at Omega) n = 29

Omega	Pre Mean	Post Mean	t	p
MAAS	3.39	3.83	-1.59	.003
Self-esteem	28.41	31.86	-6.73	.003
Power	23.52	27.24	-5.5	< .001
Autonomy	20.45	22.45	-5.08	< .001
Optimism	12.59	13.31	-1.95	.061
Anger	11.41	13.48	-5.76	< .001

Table 2b - Changes in Mindfulness & Empowerment Over the Treatment Interval in the Pilot Study (at Kripalu) n = 38

Kripalu	Pre Mean	Post Mean	t	p
MAAS	3.38	3.77	-2.98	.001
Self-esteem	28.26	30.28	-3.05	.004
Power	23.46	35.36	-5.12	< .001
Autonomy	20.18	21.67	-3.92	< .001
Optimism	12.38	13.62	-4.05	< .05
Anger	11.44	12.79	-5.96	< .001

Demographic Characteristics for the Full Study

An analysis of variance was conducted to evaluate the demographic characteristics of the full study. The characteristics of the full study participants are given in Table 2. There were no significant differences in demographics between the Treatment and Control Groups in the full study, except when considering domestic violence, $p < .05$. Results show women in the Treatment Group experienced significantly more situations of domestic violence than the Control Group. Income came close to significance, $p < .07$ with a greater number of women with higher incomes in the Treatment Group than in the Control Group. See Table 3.

To assess whether the Mindful Attention Awareness Scale (MAAS) and Empowerment Scale (ES) scores in the full study were affected by the demographics of the population, a univariate analysis of variance was conducted. Results indicated women who had participated in a Sierra Bender program previously, had significantly more mindfulness before, as well as, after their participation in the SBEM®, $p < .05$. Additionally, whether or not a participant had suffered from an eating disorder had a significant impact on the post MAAS score, $p < .01$, and on the difference in the pre- and post-test ES subscale Righteous Anger score, $p < .05$; significance came close for the pre MAAS score, $p = .056$. Marital status also had a significant impact on post MAAS score, $p < .05$; and profession had a slight, but not significant effect for the post MAAS score, $p = .057$. Finally, both pre- and post-test ES subscale Self-esteem scores were positively impacted by whether the participant was currently in counseling/therapy, $p < .05$. An additional analysis of age as a covariate did not show significant results.

Table 3 - Sample Characteristics of SBEM Full Study Participants

Characteristics	TX Group	%	Control Group	%	Total	%	p
Sample Size	50		14		64		
Age (years)							
M±SD	42.9±8.7		41.4±11.8		42.1±9.4		
Range	23 to 58		24 to 67		23 to 67		
Ethnicity							.99
Caucasian	42	84	14	100	56	8715	
African-American	2	4	0	0	2	3	
Latino/Hispanic	5	10	0	0	5	8	
Asian/S.E. Asian	1	2	0	0	1	2	
Religion							.92
Catholicism	15	30	4	29	19	30	
Protestantism	3	6	0	0	3	5	
Judaism	6	12	1	7	7	11	
Other	25	50	9	64	34	53	
Missing	1	2	0	0	1	1	
Marital Status							.77
Married	20	40	10	72	30	47	
Single	18	36	2	14	20	31	
Separated/divorced	12	24	2	14	14	22	
Income							.07
Below $16,000	3	6	1	7	4	6	
$17,000-$36,000	4	8	0	0	4	6	
$37,000-$56,000	4	8	5	36	9	14	
$57,000-$86,000	8	16	3	21	11	17	
Above $86,000	31	62	5	36	36	57	
Professional Training							.1
Health Sciences	11	22	1	7	12	19	
Education/ academia	13	26	5	36	18	28	
Marketing/ publicity	6	12	1	7	7	11	
Yoga/holistic/alt. med.	4	8	1	7	5	8	
Business management	2	4	0	0	2	3	
Fine arts	1	2	0	0	1	2	
Social work /counselor	5	10	1	7	6	9	
Homemaker	1	2	0	0	1	2	
Lawyer	2	4	2	14	4	6	
Other	5	10	3	22	8	12	

Degree of Education							.13
High school	3	6	0	0	3	5	
Bachelor's degree	20	40	6	43	26	41	
Graduate school	23	46	7	50	30	47	
Doctorate or higher	3	6	1	7	4	6	
Missing	1	2	0	0	1	1	
Dealt with eating disorder							.81
Yes	12	24	3	21	15	23	
No	38	76	11	79	49	77	
Mental disorder							.32
Yes	26	52	3	21	29	45	
No	24	48	11	79	35	55	
Domestic violence							.03
Yes	20	40	1	7	21	33	
No	30	60	13	93	43	67	
Rape							.1
Yes	14	28	4	29	18	28	
No	36	72	10	71	46	72	
Currently in therapy							.87
Yes	21	42	2	14	23	36	
No	29	58	12	86	41	64	
Attended SBEM® before							.99
Yes	3	6	0	0	3	5	
No	47	94	14	100	61	95	
Taking medication							
Yes	16	32	3	21	19	30	.23
No	34	68	11	79	45	70	

Treatment Group with Domestic Violence, Treatment Group without Domestic Violence and the Control Group

A chi-square with Yates' corrections showed significantly more women in the Treatment Group experienced situations of domestic violence than in the Control Group, 2 x 2 χ^2 (df = 1) = 3.97, p = .046. As a result, further analyses were conducted to evaluate the Treatment and Control Groups. The subsequent analyses of variance compared pre- and post-weekend scores for Control Group versus Treatment Group

participants with a history of domestic violence and those without a history of domestic violence.

The six graphs in Appendix I suggest a strong, positive effect of the weekend on all measures for all groups, which an analyses of variance for repeated measures for the three groupings found to be positively significant for each of the six dependent variables (MAAS, and the Empowerment Scale subscales Self-esteem, Power, Autonomy, Optimism, and Righteous Anger), $F(1, 54) \geq 20.22$ ps $< .001$.

Not only do the six graphs suggest the change in the six dependent variables was positively affected by pre-weekend values of the variables for the three different groups, but they indicate that the change was more profound for some groups than others, at least on some of the dependent variables. As a result of these findings, the statistical significance of specific differences in post-weekend values of each dependent variable was examined. Pairwise comparisons were conducted using Least Significant Difference (LSD) tests within a MANOVA that treated the pre-weekend assessment of each variable as a covariate for that variable.

The LSD pairwise comparisons of marginal means for the dependent variables (provided in Appendix II) show no significant difference between Mindfulness and Righteous for SBEM® participants who had or had not reported histories of domestic violence, relative to each other or to other participants who were at the retreat, all ps $< .10$.

Self-esteem, did improve for SMEB® participants who had reported histories of domestic violence, relative to R&R participants, however this effect was not significant, $p = .051$. Similar LSD comparisons found the same superior improvement of SBEM®

participants with histories of domestic violence, relative to R&R participants who were at the same retreat, for measures of Power, $p = .011$, and Optimism, $p = .003$, and to some degree for Autonomy, $p = .065$. LSD comparisons of Power and Autonomy also found stronger improvement for SBEM® participants without a history of domestic violence than for R&R, ps = .005 and .028 respectively.

Outcome Analysis for the Full Study

Pre-intervention distributions approximated normal distributions of the dependent variables in the full study, which include the MAAS, and the five ES subscales Self-esteem, Power, Autonomy, Optimism, and Righteous Anger. To evaluate the effects of the Sierra Bender Empowerment Method® in the full study, a two-way, multivariate analysis of variance (MANOVA) for repeated measures was conducted and found that, compared to R&R activities at the same retreat center during the same weekend, the SBEM® produced a significantly more positive overall effect, $F(1, 63) = 2.31$, $p < .05$. Furthermore, the MANOVA conducted showed significant between-subject interactions, with significantly greater increases in scores in the Treatment Group than Control Group for the ES subscales Power, $F(1, 63) = 6.31$, $p < .05$, Autonomy, $F(1,63) = 6.1$ $p < .05$, and Optimism, $F(1, 63) = 7.66$, $p < .01$. A positive effect was found but not significant for the ES subscale Self-esteem, $F(1,63) = 3.84$ $p < .05$.

A two-way repeated measure ANOVA found a positive significant overall effects of time for all five ES subscales Self-esteem, $F(1, 56) = 22.77$, $p < .001$, Power, $F(1, 56) = 9.82$, $p < .01$, Autonomy, $F(1, 56) = 8.83$, $p < .01$, Optimism, $F(1, 56) = 16.5$, $p < .001$, and Righteous Anger, $F(1, 56) = 32.22$, $p < .01$. A slight overall positive effect of time was found for the MAAS, but was not significant, $F(1, 55) = 3.53$, $p = .07$. Positive

significant overall effects were also found for time by condition for Self-esteem, $F(1, 56) = 4.08$, $p < .05$, Power, $F(1,56) = 6.78$, $p < .05$, Autonomy, $F(1, 56) = 6.52$, $p < .01$ and Optimism, $F(1, 56) = 8.12$, $p < .01$. See Table 4a.

Paired *t*-tests showed positive significant increases in the Treatment Group scores for Self-esteem, t(42) = -6.22, $p < .001$, Power, t(42) = -5.46, $p < .001$, Autonomy, t(42) = -5.34, $p < .001$, Optimism, t(42) = -6.99, $p < .001$, Righteous Anger, t(42) = -5.87, $p < .001$, and the MAAS, t(41) = -2.27, $p < .05$. For the Control Group, paired *t*-tests only showed positive significant differences in Self-esteem, t(13) = -2.85, $p < .05$ and Righteous Anger, t(13) = -4.01, $p < .01$. See Tables 4a, 4b and 4c.

Table 4 - Changes in Mindfulness and Empowerment Over the Treatment and Control Intervals in the Full Study

	Pre Mean	Post Mean	d	Between	TimexControl	Time
MAAS						
Tx	3.53	3.83	.3*	.634	.634	.066
C	3.38	3.56	.18			
Self-esteem						
Tx	27.44	30.79	3.35***	.055	.048*	< .001***
C	29	30.36	1.36**			
Power						
Tx	23.47	25.79	2.32***	.015*	.012*	.003**
C	23.43	23.64	.21			
Autonomy						
Tx	19.74	21.63	1.89***	.017*	.013*	.004**
C	20.64	20.79	.15			
Optimism						
Tx	11.58	13.21	1.63***	.008**	.006**	< .001***
C	12.43	12.71	.28			
Righteous A						
Tx	10.86	12.67	1.81***	.705	.593	< .001***
C	10	11.5	1.5**			

<.05 = *; <.01 = **; <.001 = ***

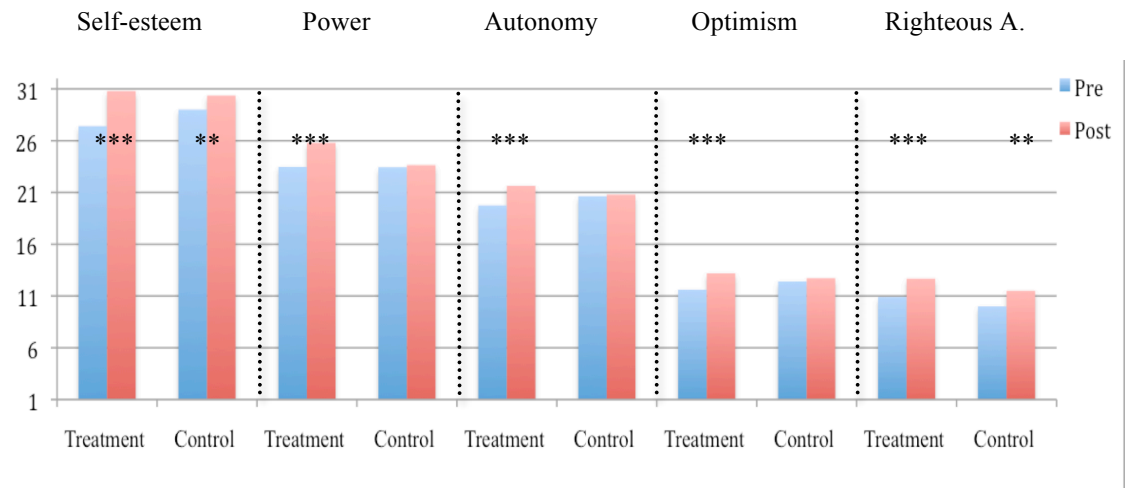

Figure 1. Changes in Empowerment Over the Treatment and Control Intervals in the Full Study

<.05 = *; <.01 = **; <.001 = ***

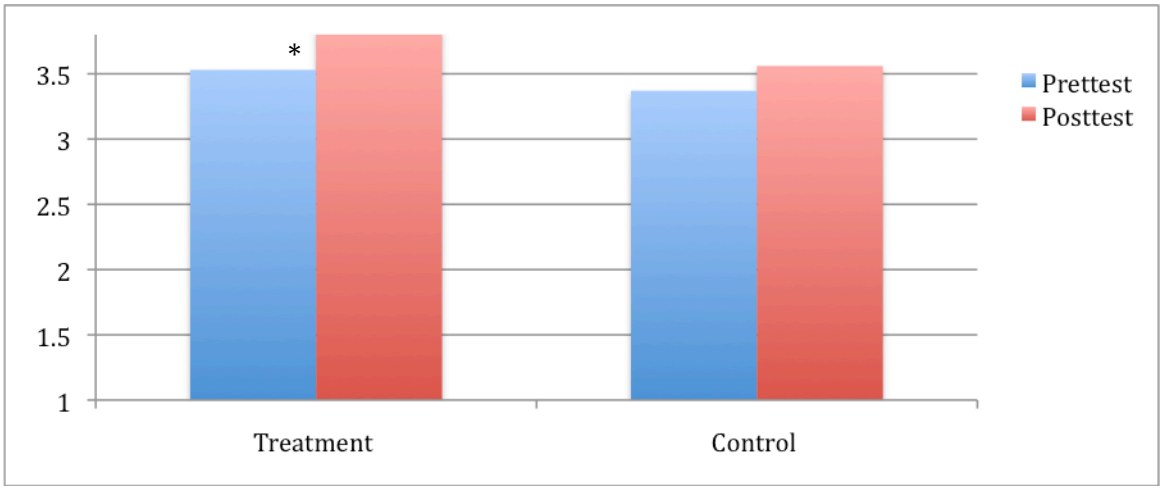

Figure 2. Changes in Mindfulness Over the Treatment and Control Intervals in the Full Study

<.05 = *; <.01 = **; <.001 = ***

CHAPTER 4

DISCUSSION

Results of the full study show both the Treatment Group, which participated in the SBEM®, and Control Group, which participated in the R&R Retreat, improved in mindfulness and in all five subscales of empowerment. A two-way multivariate analysis of variance (MANOVA) for repeated measures found that, compared to the R&R Control Group, the SBEM® Treatment Group showed a significantly more positive overall effect when assessed at the retreat site during the same weekend.

When evaluating the demographic characteristic of the Treatment and Control Groups, an analysis of variance indicated the Treatment Group reported more situations of domestic violence than the Control Group. This difference can be explained when considering the target audience of the SBEM®. While the SBEM® reaches out to a wide variety of women, it points out its usefulness in helping women increase in empowerment, and even more specifically, assisting women who have experienced domestic violence. The difference in income that came close to significance, with more women in the SBEM® group than in the R&R group having higher incomes, may be explained by the fact that participation in the SBEM® can in some cases cost more than participating in the R&R Retreat program.

The subsequent analyses of variance that were conducted in response to the conclusion that significantly more women in the Treatment Group suffered from situations of domestic violence than in the Control Group resulted in six graphs (one for each measurement) indicating a variety of relationships between the three groups (Treatment Group with situations of domestic violence, Treatment Group without

situations of domestic violence and Control Group) and the dependent variables (MAAS and ES subscales: Self-esteem, Power, Autonomy, Optimism, and Righteous Anger).

The figure in Appendix I shows that each group had the lowest score in at least one of the dependent variables during the pre-test evaluations. One of the Treatment Groups, however, always ended up with the highest mean in the post-test evaluations. Furthermore, the two Treatment Groups post-test scores were nearly identical in two of the post-test scores, Self-esteem and Autonomy; scores were very close for Righteous Anger and Power post-test scores. This finding is important as it suggests that the SBEM® works effectively for both individuals who have and those who have not experienced situations of domestic violence. Taken together, the results support the generalizability of the SBEM® to successfully increase empowerment in the female population.

Paired *t*-tests indicated which increases in scores were significant for the Treatment Group and Control Group, individually. The Treatment Group showed significant increases in mindfulness, and all five Empowerment Scale subscales, self-esteem, power, autonomy, optimism, and righteous anger. The Control Group showed significant increases in the Empowerment Scale subscales self-esteem and righteous anger. The MANOVA also indicated the Treatment Group increases in the ES subscales power, autonomy, and optimism to be significantly greater than the increases in those subscales by the Control Group. These conclusions suggest that the SBEM® successfully serves as an intervention for empowering women.

Results show there was some improvement in mindfulness in the Treatment Group, but also reveal more positive change in empowerment. This is most likely due to

the fact that although the SBEM® incorporates mindfulness in its multimodal approach, its main focus remains with empowerment. Because the Control Group was only participating in relaxing and restful activities, it follows that the R&R subjects did not increase significantly in mindfulness or the ES subscales power, autonomy, and optimism. Additionally, the choice of using a mindfulness scale to evaluate the effects of the SBEM® may be reevaluated, as it did not detect a significant difference between effects in the Treatment and Control Groups.

The significant increase in self-esteem by the Control Group suggests that the retreat-like nature of the Control Groups' weekend is a relevant factor influencing self-esteem. The significant increase in righteous anger in the Control Group, however, is difficult to interpret and further validity in this area would be of interest.

The written comments provided by participants in the treatment and Control Groups when asked to describe any benefits and/or concerns associated with their program provided additional insight into the effects of the programs. Twenty-one out of fifty women from the Treatment Group and nine out of fourteen women from the Control Group completed the additional comments form. The following excerpts reflect the scope of the comments received by the Treatment Group.

> I loved this program and this weekend will be a pivotal point in my life. I'm not the only one and Sierra has created the program to carry us and all future generations of women forward into our rightful space in this world.
>
> - SBEM® participant

There was not enough time allowed to express specific personal concerns or questions. A lot of great material was presented, but little time for questions.

- SBEM® participant

Benefits: People felt comfortable, including myself to speak about what brought them here. Very interesting and helpful to learn that we all have similar situations and we are not alone. Concerns: I felt deeply for the few that really broke down.

- SBEM® participant

The Goddess to the Core workshop provided me so much that no other "help" has offered. A true sense of love, community, and empowerment radiated the whole weekend.

- SBEM® participant

These comments and others suggested the SBEM® created a sense of empowerment, health, and enlightenment in the group. Women identified the program as a turning point in their lives, which helped them feel more empowered and happier than they had ever felt before. The multimodal approach may be responsible for the spectrum of feelings brought about, including individual empowerment yet a sense of community, and acknowledgement that the program forced them to own their struggles, but also identification of the program as being nurturing. Furthermore, many women acknowledged that it was important to spread Sierra Bender's message to other women, including young girls. Most of the concerns with the SBEM® revolved around not

having enough time to ask questions given all the new information they were taught, as well as, individual expectations, such as having anticipated more yoga or meditation activities. These concerns, however, were minimal and minor when compared to the breadth of benefits listed by the Treatment Group.

The following excerpts reflect the scope of the comments received by the Control Group.

> Concerns: Only that I can't stay here longer. Benefits: The beauty of having time for self-reflection, restoration, and relaxation. A great opportunity to really explore, expand yoga, and my personal practice.
>
> - R&R participant

> This weekend allowed me to slow down and enjoy what life is really about. It allowed me to rest and relax in a way that was right for my body. I am hoping to bring what I have learned this weekend home so I can continue to slow my life style pace down and appreciate the beauty around.
>
> - R&R participant

These comments and others suggested the R&R Retreat program gave participants an awareness of their surroundings and themselves and a greater appreciation of life. The program allowed the women to slow down, relax, and listen to what they needed physically and mentally. Of the nine comments given, only one indicated a concern, which was that Kripalu Center felt more commercialized than the last time the

individual had attended. This can possibly be accounted for by the fact that Kripalu has grown in size and opportunities for activities over the years.

It is clear that both the SBEM® and R&R Retreat created positive effects in the women who participated in the programs. The comments and statistics clearly indicate that the changes in empowerment are created through the SBEM® and not just by attending Kripalu Center. There was only one main limitation in this study and it was that the controlled trial was not randomized. Although random assignment did not seem possible for this study, the study found that Control Group subjects had similar baseline levels of mindfulness and empowerment as the Treatment Group at the outset of the study. By recruiting women for the Control Group who chose to participate in a program at the same retreat center as the Treatment Group, it was presumed that the groups could be well matched. Because of the focus of Kripalu Center for Yoga and Health, attendees are likely to have similar general interests such as wellness and fitness. Additionally, it was hoped that by conducting the study over the same weekend for the Treatment and Control Groups, time and weather would not be factors.

Because the study was not randomized, the MANOVA conducted on the Treatment and Control Groups' demographics was able to point out one significant difference between their populations. Forty percent of the women in the Treatment Group reported having experienced a situation of domestic violence either as a child or an adult, versus seven percent of the women in the Control Group. The statistic that one in four women will experience domestic violence in her lifetime, shows that the Treatment Group experienced almost twice that, at one in two women, and the Control Group experienced three and a half times less than this reported average, (NCADV, 2007).

These major differences in rates of abuse may be due to the stated individual goals of the programs and therefore, the different women they attract. The R&R Retreat program is geared towards anyone, male or female, who wants time to relax and rejuvenate themselves, whereas the SBEM® is geared towards women and specifically women with issues such as domestic violence and situations surrounding women disempowerment.

Income was not a significant difference between the Treatment Group and Control Group, though the Treatment Group individuals had slightly higher paid incomes than those of the Control Group. This can possibly be due to the cost difference in the programs, the R&R Retreat having the option of costing less than the SBEM® depending on what housing and paid activities are chosen. Although two pilot studies without Control Groups were conducted prior to the full study, future studies with a Control Group are needed to improve the reliabilities of the outcome measures and to continue to evaluate randomized Treatment and Control Groups.

The primary conclusion from this study is that the Sierra Bender Empowerment Method® is effective in increasing empowerment in women. Though research on women's empowerment programs is limited and in need of considerably more attention, the current data provide a major step forward in understanding the type of programming that effectively empowers women.

Considering the violence against women and the significantly greater mental health issues faced by women mentioned in the beginning of this paper, it is absolutely necessary that more research be conducted to identify and validate solutions to these societal concerns. Future analyses have the potential to create a randomized sample, as well as, evaluate long-term effects of the Sierra Bender Empowerment Method® and

fully validate the Sierra Bender Empowerment Method® as a successful treatment for women.

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APPENDIX I

Key: Purple = TX w/DV
Green = TX without DV
Yellow = Control

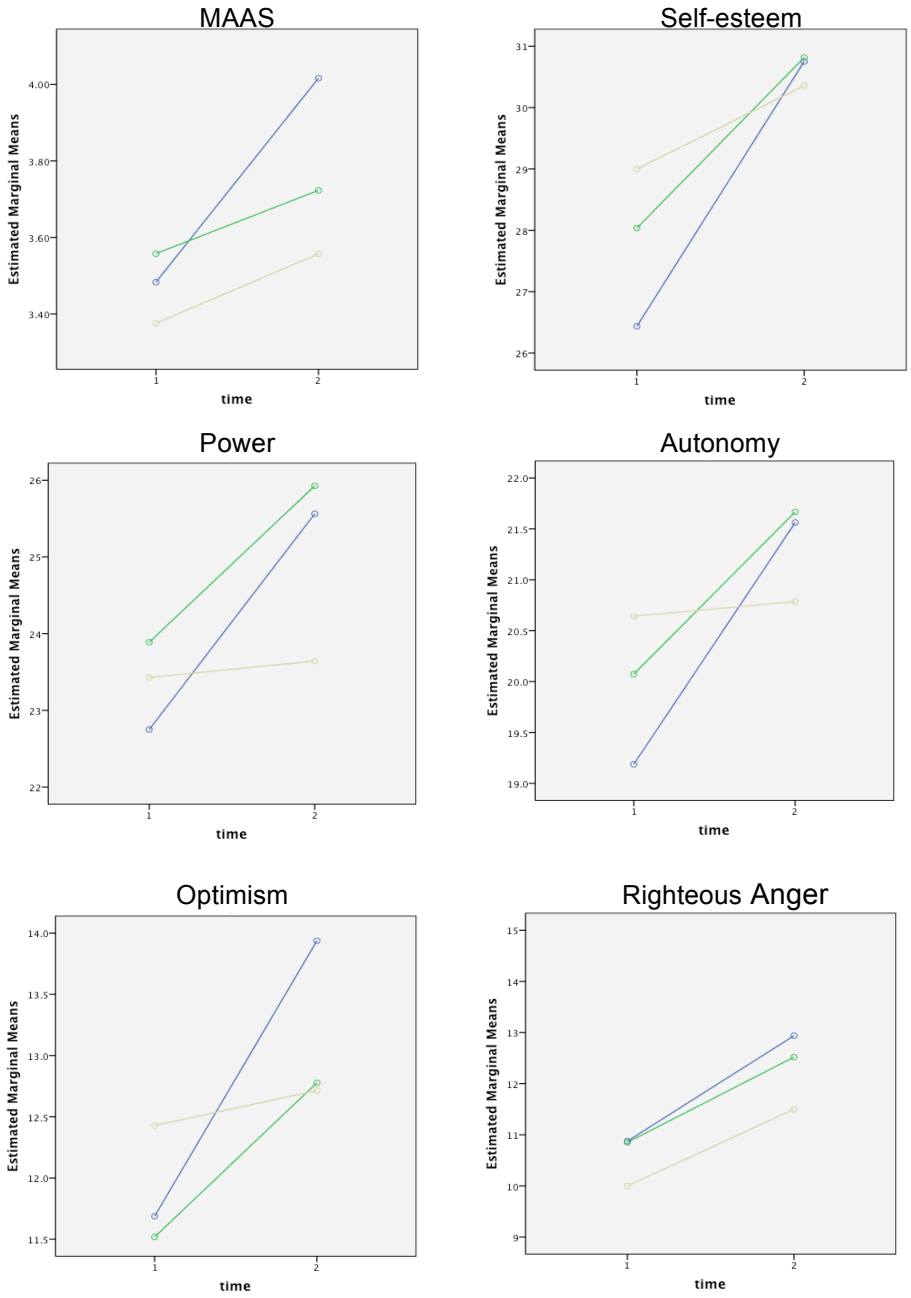

Figure 3. Changes in Mindfulness and Empowerment Over Time - Treatment Group w/Domestic Violence, Treatment Group w/out Domestic Violence, and Control Group

APPENDIX II

Key: 1 = TX w/DV
2 = TX without/DV
3 = Control

Dependent Variable	Condition	Condition	Mean Difference	Std. Error	Sig.
Post MAAS	1	2	.138	.246	.578
		3	.463	.280	.105
	2	1	-.138	.246	.578
		3	.325	.253	.205
	3	1	-.463	.280	.105
		2	-.325	.253	.205
Post Self-esteem	1	2	.683	1.020	.506
		3	2.328	1.161	.051
	2	1	-.683	1.020	.506
		3	1.644	1.048	.123
	3	1	-2.328	1.161	.051
		2	-1.644	1.048	.123
Post Power	1	2	-.035	.798	.965
		3	2.411*	.908	.011
	2	1	.035	.798	.965
		3	2.446*	.820	.005
	3	1	-2.411*	.908	.011
		2	-2.446*	.820	.005
Post Autonomy	1	2	-.112	.650	.864
		3	1.400	.740	.065
	2	1	.112	.650	.864
		3	1.511*	.668	.028
	3	1	-1.400	.740	.065
		2	-1.511*	.668	.028
Post Optimism	1	2	.922	.496	.069
		3	1.761*	.564	.003
	2	1	-.922	.496	.069
		3	.840	.510	.106
	3	1	-1.761*	.564	.003
		2	-.840	.510	.106

Post Righteous Anger	1	2	.383	.603	.529
		3	.749	.686	.281
	2	1	-.383	.603	.529
		3	.366	.620	.558
	3	1	-.749	.686	.281
		2	-.366	.620	.558

Figure 4. Least Significant Difference Pairwise Comparisons - Treatment Group w/Domestic Violence, Treatment Group w/out Domestic Violence, and Control Group