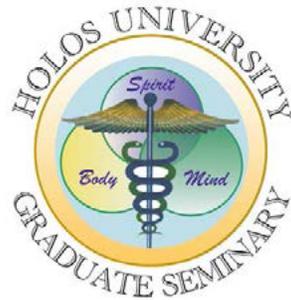


The Inner Counselor Process: An Integral Process to Heal Trauma, Reduce State and Trait Anxiety, and Restore Qualities Associated with Self-Actualization



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DISSERTATION
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The work reported in this thesis is original and carried out by me solely, except for the acknowledged direction and assistance gratefully received from colleagues and mentors.

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ABSTRACT

The Inner Counselor Process: An Integral Process to Heal Trauma, Reduce State and Trait Anxiety, and Restore Qualities Associated with Self-Actualization

Purpose:

To determine if four individual sessions of the Inner Counselor Process™ will statistically reduce State and Trait Anxiety as measured by the State-Trait Anxiety Inventory for Adults and to determine if qualities of a self-actualized person as measured by the Personal Orientation Inventory are also influenced.

Method/Materials:

Seventy participants split evenly into active and control groups participated in measuring the effects of four sessions of the Inner Counselor Process (ICP™) toward reducing State and Trait Anxiety using an experimental pre-test/post-test design. Test instruments included: Adult State – Trait Self Report Anxiety Inventory (STAI) and the Personal Orientation Inventory (POI). Intervention group participants and control group participants completed both tests the STAI and the POI on three occasions, one week prior to the beginning to of the study, one week after the final intervention and one month following the fourth intervention.

Results:

ICP™ Interventions: STAI scores: State Anxiety: The intervention group showed a statistically significant reduction in State Anxiety: $p \leq 0.002$. Trait Anxiety: $p \leq 0.001$. POI scores: Time Competence (TC): $p \leq 0.05$ The intervention group showed substantially lower TC at the pretest, but also showed a statistically significant increase in TC when compared to the control group. Inner directed (I): $p \leq 0.001$ The intervention group showed substantially lower (I) at the pretest, but also showed a statistically significant increase in (I) when compared to the control group.

Spontaneity (S): $p \leq 0.001$). The intervention group showed substantially lower (S) at the pretest, but also showed a statistically significant increase in S when compared to the control group. Self-Regard (SR): $p \leq 0.001$). The intervention group showed substantially lower (SR) at the pretest, but also showed a statistically significant increase in S when compared to the control group. Self-Acceptance (SA): $p \leq 0.004$ The intervention group showed substantially lower SA at the pretest, but also showed a statistically significant increase in SA when compared to the control group. Capacity for Intimate Contact (C): $p \leq 0.003$ The intervention group showed substantially lower C at the pretest, but also showed a statistically significant increase in (C) when compared to the control group.

Discussion:

During the ICP™ sessions it was revealed a high percentage of the participants had history of early trauma, physical or mental abuse, sexual abuse or exposure to domestic violence.

Conclusion:

Four sessions of the Inner Counselor Process™ demonstrated a change in state and trait anxiety at a rate of State Anxiety $p \leq 0.002$, Trait Anxiety: $p \leq 0.001$.

Key Words: Inner Counselor Process™, Trait Anxiety, State Anxiety, Trauma, PTSD, Early Childhood Trauma, Somatic Symptoms, Self-Actualization, Wholeness, Integral, Integration.

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CHAPTER ONE:

Introduction

Introduction

Feeling unequipped to navigate in the adult world can lead to anxiety due to a lack of capacity for mood regulation and the feelings that live on in the body from early childhood experiences (Horwitz and Wakefield, 2007). Research shows the number of adults in the United States suffering with anxiety is approximately 40 million people per year according to the Anxiety and Depression Association of America, and the National Institute of Mental Health (ADDA, 2017; NIMH, 2017). Anxiety disorders are increasingly acknowledged as a global health issue, a 2014 study published on the global distribution of anxiety reported in 2010 there were 272.2 million individuals worldwide with a diagnosable anxiety disorder at any point in time (Baxter et al., 2014). Simultaneously, more people are suffering from medically unexplainable somatic symptoms that are often treated as anxiety based on a collection of physical symptoms (Kujanpaa, 2017; Wittchen, 2002).

The body retains stored memories of all past traumatic emotional experiences. These emotions have a somatic resonance that can easily be re-triggered later in life as physical sensations, emotions, images, smells or sounds associated with the traumatic event (Van der Kolk, 2014). These early retained response patterns are an expression of the reactive attitudes and coping patterns that dictate our choices, characterize our personalities, and condition our relationships with others (Nunley, 2009). These current triggers may seem unrelated, but as Bessel Van der Kolk M. D. writes in *The Body Keeps the Score*, traumatic memories are stored in the body and must be released for healing to occur. As will be described later, the ICP is designed to not only release stored memories, but to transform them.

Background of the Problem

The word psychology derived from the Greek roots meaning the psyche or soul “breath, spirit, soul” and logia meaning “study of” or “research”. The soul/spirit aspect of the psyche has been de-emphasized over recent decades causing a deficit in wholeness and integration. In her book *Wisdom of the Psyche*, Ginette Paris indicates that,

“When a discipline develops as quickly and in as many directions as did psychology, there comes a point where we lose site of the basics; we can’t see the foundations, we forget to examine the solid anchors that are the places of agreement. It may be useful, from time to time, to remind ourselves that all humans, have some perennial values, archetypal principles, spiritual and theoretical cornerstones that sustain the whole edifice.”

The American Psychological Association has recognized the importance of integration of mind-body health in today's society and has committed to a movement in that direction by developing a program called APA’s Mind/Body Health public education campaign in an effort to attract individuals back to psychotherapy to enhance well-being (APA Staff, 2017). The most common mainstream treatments for anxiety are focused on a combination of cognitive behavior therapy and a pharmaceutical management (Olfson, 2010). Cognitive theories of emotional disorders propose that maladaptive thinking styles lead to emotional upset (Hofmann, 2012; Beck, 1976; Ellis, 1962). Anxiety disorders specifically are believed to result from distorted beliefs focused on physical or psychological threat and increased sense of feeling vulnerable (Deacon, 2004; Beck, et al., 1985).

Cognitive-behavioral therapy (CBT) refers to interventions that share a basic premise that psychological stress is maintained by cognitive factors. This model surmises that changing these maladaptive cognitions will lead to changes in emotional distress (Hofmann et al., 2012). The CBT model is aimed at symptom reduction through challenging maladaptive cognitions and to modify maladaptive behavioral patterns (Hofmann et al., 2012). Cognitive and behavioral

therapies have been established as empirically supported treatments for anxiety (Chambers et al., 2001). Research indicates that a cognitive approach is inadequate in reaching the memories stored in the body, and thus inadequate for complete resolution of stored traumas (Van der Kolk, 2014; Porges, 2011). Traumatic experiences from early childhood, or of traumas later in life are often stored in the body out of reach of conscious access inhibiting awareness for cognitive processing (Van der Kolk, 2014). Individuals that have experienced early traumatic events often have difficulty with state regulation, developing a behavioral state of self-protection. This unconscious vulnerability to be defensive may result in difficulties in feeling safe in developing trusting relationships, and in developing social relationships (Porges, 2011).

Those struggling with anxiety are often absorbed with alternate states of consciousness perhaps in rumination or obsession about fears or somatic sensations. Rumination, absorption in the past, or fears and anxieties about the future can pull one away from what is taking place in the present (Brown and Ryan, 2003). Consciousness encompasses a variety of meanings affecting emotions, cognition, sensory perception, awareness, and attention. Each of these types of consciousness can be optimal or in a state of over arousal or under arousal. To be present in the moment we must have access to an optimal state of arousal, awareness and attention (Brown and Ryan 2003).

Another common treatment approach is psychiatric medication which is designed to suppress symptoms. Psychiatric medications are increasingly being prescribed for mental health disorders in the United States. In 2009 there were over three hundred million prescriptions written for psychiatric medications. Benzodiazepines (common names include Xanax, Valium, and Ativan) frequently prescribed for treatment of Anxiety accounted for forty-four million prescriptions written in 2009 (Oldani, 2014). “Benzos”, or “Bennies” common street names for

Benzodiazepines are hypnotics, and muscle relaxants, that work by lowering arousal of the central nervous system (Colman, 2015).

Statement of the Problem

Anxiety is a global issue with no single treatment that appears to effectively address the mind-body-spirit in a cohesive approach. Psychiatric medications which are designed to suppress symptoms are increasingly being prescribed for mental health disorders in the United States. Alternative approaches need to be developed to treat anxiety to effectively resolve these issues.

Purpose of the Study

To determine if four individual sessions of the Inner Counselor Process™ will statistically reduce State and Trait Anxiety as measured by the State-Trait Anxiety Inventory for Adults and to determine if qualities of a self-actualized person as measured by the Personal Orientation Inventory are also influenced.

Specific Aims and Hypothesis

Specific Aim 1: To determine if ICP can statistically decrease State and Trait Anxiety levels.

Hypothesis 1: That four sessions of the ICP statistically decreases ($p \leq 0.05$) State Anxiety as measured by the STAI.

Hypothesis 2: That four sessions of the ICP statistically decreases ($p \leq 0.05$) Trait Anxiety as measured by the STAI.

Specific Aim 2: To determine if the level of the experience of Self Actualization as measured by the Personal Orientation Inventory (POI) can be increased.

Hypothesis 1: That four sessions of the ICP will statistically increase ($p \leq 0.05$) Self-Regard as measured by the POI.

Hypothesis 2: Four sessions of the ICP will statistically increase ($p \leq 0.05$) Self-Acceptance as measured by the POI.

Specific Aim 3: To determine if the ICP will increase the participant's ability to be Time Competent.

Hypothesis 1: That four sessions of the ICP will statistically increase ($p \leq 0.05$) Time Competence as measured by the POI.

Importance of the Study

The Inner Counselor Process™ was developed by transpersonal psychologist Ann Nunley, PhD over a 30-year period. Since its inception the ICP™ has generated a long list of impressive anecdotal stories of how this 15-Step guided process dramatically helps individuals move beyond residual anxiety caused by trauma and unmet needs to create growth towards greater self-actualization. This study is the first of its kind, designed to more clearly illustrate the effects of the ICP™ as measured by the State and Trait Anxiety Inventory (STAI) and, in addition, to ascertain possible changes in Self Actualization as described by Abraham Maslow as measured by the Personal Orientation Inventory (POI).

Definition of Terms

Amygdala. An almond shaped brain structure inside the limbic system, controlling the experience and expression of emotions. Stimulation of the amygdala usually produces intense fear (Colman, 2015, p. 31). In humans, stimulation of the amygdala produces fear or anger often accompanied by “stomach churning” sensation. (Tabers, 2017, p. 105).

Anecdotal. A brief report based on observation (Tabers, 2017, p. 115).

Anonymity. Ensuring that the identity and performance of the subjects in an investigation are not revealed and cannot be identified (Kazdin, 2003, p. 571).

Anxiety. An uneasy feeling of discomfort or dread accompanied by an autonomic response (Tabers, 2017, p. 155)

Anxiety Disorder. Any group of mental conditions that include panic disorder, social phobia, posttraumatic stress disorder, acute stress disorder, generalized anxiety disorder, anxiety caused by a general medical condition and substance-induced anxiety disorder (Tabers, 2017, p. 155).

Assessment. An appraisal or evaluation (Tabers, 2017, p. 201).

Attrition. Loss of subjects in an experiment (Kazdin, 3003, p. 571).

Autonomic Nervous System (ANS). The part of the nervous system that controls involuntary, unconscious, and visceral body functions. The ANS is distributed throughout the body and can produce a wide range of symptoms (Tabers, 2017, p. 223).

Benzodiazepines. Any group of chemically similar psychotropic drugs with potent hypnotic and sedative action, used predominantly as antianxiety and sleep-inducing drugs (Tabers, 2017, p. 257).

Cerebral Cortex. The outer layer of grey matter, largely responsible for sensory, motor, emotional and integrative functions (Coleman, 2015, p. 122).

Clinical Significance. The extent to which the effect of an intervention makes an “important” difference to the clients or has practical or applied value (Kazdin, 2003, p. 572).

Cognition. Thinking skills, reasoning, judgement, learning, intellect (Tabers, 2017, p. 506).

Cognitive Behavior Therapy (CBT). A form of therapy that challenges patients to identify and learn from their ineffective patterns of behavior by consciously choosing to make healthy changes (Tabers, 2017, p. 506).

Confidentiality. Refers to the practice of not disclosing information obtained from a subject in an experiment without the awareness and consent of the participant (Kazdin, 2003, p. 573).

Conscious. Being aware and having perception; awake (Tabers, 2017, p. 543)

Consciousness. The state of being conscious; the normal mental condition of the waking state of humans, characterized by the experience of perception, thoughts, feelings, awareness (Coleman, 2015, p. 161).

Demographics. A quantitative description of a given population, such as age, gender, ethnicity, religion, income, education, employment or other measurable characteristics. (Tabers, 2017, p. 639).

Effectiveness. The impact of treatment in the context of clinical settings and clinical work (Kazdin, 2003, p. 575).

EFT. Emotional freedom technique, also known as tapping, rapidly releases the emotional impact of stressful or traumatic life events from the body-mind system (Craig, 1991).

EMDR. Eye movement desensitization and reprocessing. A form of psychotherapy designed originally for treating PTSD and other anxiety disorders (Coleman, 2015, p. 268).

Emotions. Mental state of feelings such as fear, hate, love, anger, grief or joy that occurs instinctively rather than consciously. Physiologic changes invariably accompany emotions but may not be apparent to the person or the observer. (Tabers, 2017, p. 790).

Ethical. Principles that foster right standards of conduct (Tabers, 2017, p. 853).

Ethics. A system of moral principles or standards governing conduct (Tabers, 2017, p. 853).

Experimental Design. The general plan of an experiment, including the method of assigning research participants or subjects to treatment conditions (Coleman, 2015, p. 263).

Feeling. The conscious experience of emotion. A sensory perception. (Tabers, 2017, p. 906).

Feeling Reactivity. Responsiveness to one's own needs and feelings (Shostrom, 1987, p. 5).

Generalized Anxiety Disorder. Excessive anxiety and worry for at least 6 months (Tabers, 2017, p. 155).

Higher Self. The spiritual self/soul. Synonym: Essential Self, Super-Conscious, Divine Self, True Self, Full-Potential Self, Healer Within, Wisdom Self. (Nunley, 2009, p. 23).

Holism. A philosophy based on the belief that in nature, individual entities function as complete units and cannot be reduced to the sum of their parts. The view of the person in holism encompasses the person's body, mind and spirit (Tabers, 2017, p. 1140).

Holistic Medicine. A patient-centered approach to healing that strives to meet the cognitive, emotional, physical, social, and spiritual needs of patients (Tabers, 2017, p. 1482).

Homeostasis. The state of dynamic equilibrium of the internal environment of the body that is maintained by the constant processes of feedback and regulation in response to internal and external changes (Tabers, 2017, p. 1141).

Hypnagogic State. A transitional state between sleeping and waking (Tabers, 2017, p. 1182).

Hypothesis. A predicted relationship between variables. (Hinton, 1995, p. 298).

Inner Counselor Process™. A 15-Step guided self-awareness process that engages multiple levels of consciousness; the sub-conscious, the conscious and the supra-conscious while engaging body, mind, spirit and emotions creating “whole being” integration (Nunley, 2009).

Inner Directed. The degree to which an individual is independent and self-supportive (Shostrom, 1987, p. 5).

Integration. To make whole. The bringing together of various parts or functions so that they function as a harmonious whole (Tabers, 2017, p. 1278).

Integration Chart. Provides the primary conceptual framework used in the Inner Counselor Process™ to describe movement towards integrative wholeness and balance (Nunley, 2009, p. 11).

Integrative Medicine. Evidence based approach to combine conventional medicine with complementary and alternative medicine (Tabers, 2017, p. 1482).

Intervention. An action taken to modify an effect (Tabers, 2017, p. 1287).

Intrinsic. Belonging to the essential nature of a thing. It is both essential and natural (Tabers, 2017, p. 1294).

Limbic System. A group of brain structures responsible for short term and long-term memories and the emotional response to stimuli, including the autonomic nervous system manifestations of such response (Tabers, 2017, p. 1402).

Locus of Control. An individual's sense of mastery or control over events. Persons with an internal locus of control are more apt to believe that they can influence events, whereas those with an external locus of control tend to believe that events are dictated by fate (Tabers, 2017, p. 1418).

Meditation. The art of contemplative thinking. It is used to control stress and improve relaxation, focus attention, and lower heart rate and blood pressure (Tabers, 2017, p. 1483).

Memory. The mental registration, retention and recollection of past experiences, sensations or thoughts (Tabers, 2017, p. 1494).

Mindfulness. Attentiveness; self-awareness (Tabers, 2017, p.1532).

Neocortex. The most recently evolved portion of the cerebral cortex (Coleman, 2015, p. 497).

Participant. Another name for a subject (research or experimental) or volunteer (Coleman, 2015, p. 552).

Personal Orientation Inventory. The Personal Orientation Inventory (POI) measures the attitudes and values of normal to high functioning adults in terms of the concept of "self-actualizing" (Shostrom, 1987, p. 4).

Personality. The sum total of the behavioral and mental characteristics that are distinctive of an individual (Coleman, 2015, p. 564).

Population. An aggregate of individuals from which a sample may be drawn and to which the results of a research investigation may be generalized (Coleman, 2015, p. 858).

Posttraumatic Stress Disorder (PTSD). Intense psychological distress, marked by horrifying memories, recurring fears, and feelings of helplessness that develop after a psychologically traumatic event such as combat, rape, assault, life-threatening accident or natural disaster (Tabers, 2017, p. 1891).

Pretest-Posttest Control Group Design. An experimental design with a minimum of two groups. Usually, one group receives the experimental condition and the other does not. The essential feature of the design is that subjects are tested before and after the intervention (Kazdin, 2003, p. 580).

Psyche. The human mind or soul. (Coleman, 2015, p. 613).

Psychology. The study of the nature, functions and phenomena of behavior and mental experience (Coleman, 2015, p. 617). The science of dealing with mental processes, both normal and abnormal and their effects upon behavior (Tabers, 2017, p.1953).

Qualitative Research. An approach to research that focuses on narrative accounts, description, interpretation, context, and meaning (Kazdin, 2003, p. 580).

Quantitative Research. The dominant paradigm for empirical research in psychology and the sciences more generally, involving the use of operational definitions, careful control of the subject matter, efforts to isolate variables of interest, quantification of constructs and statistical analyses (Kazdin, 2003, p. 580).

Research Design. The plan or arrangement that is used to examine the question of interest, the manner in which conditions are planned so as to permit valid inferences (Kazdin, 2003, p. 581).

Rumination. An obsessive preoccupation by a single idea or set of thoughts with an inability to dismiss or dislodge them (Tabers, 2017, p. 2083).

Sample of Convenience. Subjects included in an investigation that appear to be selected merely because they are available (Kazdin, 2003, p. 581).

Self-Acceptance. Being realistic about oneself and at the same time comfortable with that personal assessment (Tabers, 2107, p. 2123).

Self-Actualization. Attainment of a person's full potential to be good, to be fully alive, and to find meaning in life after his or her basic needs of food, shelter, warmth, security and sense of community are met (Tabers, 2017, p. 2123).

Self-Esteem. One's personal evaluation or view of self, generally thought to influence feelings and behaviors (Tabers, 2017, p. 2123).

Self-Regard. Self-perception of self-worth (Shostrom, 1987, p. 5).

Self-Report Inventories. Questions and scales in which the subjects report on some facet of their functioning such as personality, cognitions, opinions, behaviors (Kazdin, 2003, p. 581).

Sensation. An awareness of conditions inside or outside the body resulting from stimulating sensory receptors (Tabers, 2017, p. 2126).

Soma. The body as distinct from the mind (Tabers, 2017, p. 2186).

Somatic. Pertaining to the body (Tabers, 2017, p. 2186)

Somatization. The expression of a mental condition as a disturbance in bodily function (Tabers, 2017, p. 2186)

Somatization disorder. A condition of recurrent and multiple somatic complaints of for which medical attention has been sought but no physical basis for the disorder has been found (Tabers, 2017, p. 2186).

Spirit. Soul (Tabers, 2017, p. 2205).

Spiritual distress. A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world or a superior being. Disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychosocial nature (Tabers, 2017, p. 2205).

Spirituality. An awareness of the metaphysical, the religious or the sublime (Tabers, 2017, p. 2205).

State. A mode or condition of being. Status. (Tabers, 2017, p. 2226).

State Anxiety. A temporary form of anxiety (Colman, 2015, p. 725).

Statistical Evaluation. Applying statistical tests to assess whether the obtained results are reliable or can be considered to be sufficient (Kazdin, 2003, p. 582).

Statistical Significance. A criterion used to evaluate the extent to which the results of a are likely to be due to genuine rather than chance effects. A statistically significant difference indicates that the probability level is equal to or below the level of confidence selected (e.g., $p \leq .05$) (Kazdin, 2003, p. 285).

Stress. Any physical, physiological or psychological force that disturbs equilibrium (Tabers, 2017, p. 2249).

Sub-Conscious. The condition in which mental processes take place without the individual's being aware of their occurrence (Tabers, 2017, p. 2259).

Suicide. The act of killing oneself deliberately (Coleman, 2015, p. 742).

Super-Conscious. An expanded awareness beyond consciousness (Nunley, 2009, p. 25).

Suppression. Control but not complete eradication of cause (Tabers, 2017, p. 2273).

Symbol. An object or sign that represents an idea or quality by association (Tabers, 2017, p. 2287).

Thalamus. Relays sensory signals including motor signals to the cerebral cortex (Coleman, 2015, p. 262).

Time Competence. The degree to which an individual identifies with living in the present (Shostrom, 1987, p. 5).

Trait Anxiety. A person's general or characteristic level of anxiety (Colman, 2015, p.775)

Trauma, Traumatic. A psychological shock that has damaging effects (Colman, 2015, p. 780)

Treatment. Any specific procedure used for the cure or the amelioration of a disease or pathological condition (Tabers, 2017, p. 2400).

Triggers. Action of muscles, receptors and neurons in which the stimulus releases energy in an all or nothing fashion (Chaplin, 1985, p. 478).

Unconscious. Lacking in awareness, that part of the mind that consists of unrecognized feelings and drives (Tabers, 2017, p. 2439).

Visualize. To make visible. To imagine or picture something in one's mind (Tabers, 2017, p. 2506).

Volunteer. One who freely participates in a research study without expectation of payment, recognition or reward. Healthy Volunteers often participate in research as control subjects (Tabers, 2017, p. 2513).

Yoga. In the western world, yoga is associated primarily with physical postures and diaphragmatic breathing, many practice yoga for reduction of anxiety, insomnia and other physical conditions (Tabers, 2017, p. 2549).

Chapter Two:

Literature Review

Introduction

This literature review will explore anxiety as a global issue as well as a United States issue. Also discussed is the economic burden of anxiety followed by an explanation of what anxiety is and how it impacts individuals. Further included is a discussion of PTSD and its relationship to anxiety. The literature review explores current methods of treatment and outcomes.

Anxiety Disorders

We live in a culture in which anxiety has become a global issue (Baxter et al., 2014). The prevalence of anxiety and the financial burdens associated with it have been widely studied. Anxiety is increasingly acknowledged, studied and evaluated as a worldwide health issue with attention from the Global Burden of Disease (GBD), the World Health Organization (WHO), and researchers in countries around the world. (Andrews et al., 2000; Baxter et al., 2014; Coppard, 2012). A Global Burden of Disease Study in 2010, reported 272.2 million individuals worldwide had a diagnosable anxiety disorder (Baxter et al., 2014).

According to the National Institute of Mental Health (NIMH 2017), anxiety is the most common mental illness diagnosis in the United States affecting 18.1 % of adults, which is equivalent to approximately 40 million Americans age 18-54 suffering from anxiety disorder (NIMH, 2017). Additional estimates are much higher at 30-40%, this increased estimate is based on data that suggests many people with anxiety do not seek professional help but rather choose to self-medicate with alcohol or drugs (NIMH, 2017). An even more critical note, is found in a

meta-analysis by Kanwar et al., 2013, they describe a three-fold increase in risk of suicidal death connected with anxiety disorders.

A study claiming to be the world's most comprehensive research study of anxiety and depression to date, published by researchers at the University of Queensland (2012) revealed anxiety disorders are more commonly reported in western societies than in non-western societies. According to the Queensland study clinical anxiety affects approximately 10 percent of people in North America, Western Europe, Australia, and New Zealand compared with approximately 8 percent in the Middle East and 6 percent in Asia. (Coppard, 2012)

The economic burden of anxiety disorders has been estimated at \$42 billion annually in the U.S. alone, according to a study commissioned by the Anxiety and Depression Association of America. (ADAA Staff, 2017). The \$42 billion dollars is approximately one third of the total \$148 billion dollars spent annually on mental health, with greater than \$22 billion dollars associated with repeated use of the healthcare system for relief of somatic symptoms (e.g., anxiety) that mimic physical illness or diseases (ADAA Staff, 2017).

Generalized Anxiety Disorder

Many names are given to anxiety disorders: Generalized Anxiety Disorder, Panic Disorder, and Social Anxiety Disorder among a few (DSM-V). Of those suffering approximately 7 million are diagnosed with a non-specific Generalized Anxiety Disorder (GAD) and another 7.7 million have been diagnosed with post-traumatic stress disorder (ADDA Staff, 2017). Wittchen, (2002) writes that Generalized Anxiety Disorder is now considered a severe mental disorder of the anxiety spectrum. GAD is defined as having persistent symptoms (6 months or more) and often characterized by excessive worry, tension, hypervigilance and other somatic symptoms associated with anxiety (DSM-5; Wittchen, 2002).

Anxiety is multifaceted, and the source of anxiety is complex. Anxiety disorders share common features, they often co-occur with other disorders, and they can vary considerably in onset and persistence of symptoms (Baxter et al., 2014). According to *The Neuroscience of Psychotherapy*, Conzolino describes anxiety as a psychological, physiological, and behavioral state induced by a threat to well-being or survival, either perceived, actual or potential. Anxiety can be triggered by countless conscious or unconscious cues, thoughts, feelings and behaviors all of which shape a person's responses, (Conzolino, 2002).

Post-Traumatic Stress Disorder

The National Institute of Mental Health (NIMH, 2017) describes Post Traumatic Stress Disorder (PTSD) as a severe and more serious level of anxiety that develops when someone experiences an intense life event such as being in active military combat, but PTSD can also occur from experiencing non-life-threatening events such as incest, rape, physical or emotional abuse. PTSD may show up immediately or weeks, months or even years later. Women are more likely to be affected than men (ADAA, 2017). A growing body of research is confirming the significance of early childhood abuse and trauma including witnessing domestic violence (Porges, 2011; Van der Kolk, 2014). The early experience of traumatic events and the impact of childhood trauma are associated with impairment of the developmental process, emotional regulation, and a formation of the coherent sense of self (Ogle et al., 2013; Goodman et al. 2010). Childhood exposure to trauma is associated with increased somatic symptoms, which may contribute to diminished capacity for day to day functioning (Kugler et al., 2012). These early life events have a powerful effect on brain development, behavioral and emotional development (Fox et al., 2010). The exposure to complex childhood trauma, has prompted a new diagnostic category of traumatic stress called developmental trauma disorder (Van der Kolk, 2014).

Physiological Correlates of Anxiety

The human body is designed with a primitive rapid response system to recognize immediate threats to safety. This system response operates through the amygdala which senses danger alerted by external stimuli via a direct pathway from the thalamus and sends out alarms directly to the body, bypassing the neocortex, creating fight, flight, or freeze, increased blood pressure and a release of a variety of stress hormones (LeDoux, 1996). If an event occurs such as a physical assault, the body and mind remember, thus a related conditioning occurs which creates sensitivity to similar or familiar conditions (LeDoux, 1996). This contextual conditioning and associated stored memories create a sensitivity to future potential threats of a similar nature. (LeDoux, 1996) This exposure to threats can create anticipatory anxiety common to GAD (Buff, et al., 2017).

Traumatic events are a reality for many. Bessel Van der Kolk M.D., an expert in trauma reports in his book *The Body Keeps the Score*, that twelve million women in the United States have been victims of rape, with more than half of these rapes occurring in girls below the age of fifteen. He also reports three million children each year are victims of abuse and neglect with one third of these cases serious enough to involve child protective services. Dr. Van der Kolk compares these numbers in a profound way, “for every soldier serving in a war zone, ten children are living under conditions where they are endangered in their own home.” (Van der Kolk, B.A., 1993) One can imagine all these statistics may be even higher due to under reporting of events. Such events at an early age for children, is known to impair the ability to develop healthy patterns of self-regulation (Kulkarni, 2013). People that have been abused as children often have physical sensations that have no definable physical cause (Van Der Kolk, 2014; Kulkarni,

2013), children that have experienced sexual abuse have a higher incidence of somatic symptoms (Kugler, et al., 2012)

Physiological characteristics that accompany the primal response to threats create physical arousal (Steimer, 2002) via activation of the autonomic nervous system (ANS). The autonomic nervous system is responsible for regulation of bodily processes such as blood pressure, heart rate, and the respiration rate. The ANS is part of the nervous system that stimulates the supply of blood flow to organs, e.g., bladder, kidney, heart, stomach, and regulates the changes in sweat glands, digestive glands, blood vessels, and pupil dilation (Merck Manual, 2017; Porge, 2011). Under circumstances when a threat is perceived, a number of bodily systems go into an alarm reaction. Although anxiety is a natural adaptive reaction, it can become pathological and interfere with the ability to cope successfully with various challenges and/or stressful events (Steimer, 2002). Suggested possible risk factors for maladaptive anxiety include prolonged stress, and traumatic life events (Porge, 2011; Van der Kolk, 2014). At its core, anxiety is a prolonged or persistent response to stressful situations (Abbass, 2005). Under optimal physiological response, once the threat has passed, in a short while the body should return once again to a normal homeostatic state, accompanied by an ability to relax (Mayo Clinic, 2017).

Somatization

Anxiety disorders are manifested by somatic as well as emotional and cognitive symptoms (Hassan, Ali 2011; Kujanpaa, 2007). Individuals with anxiety present with a higher rate of unexplained physical sensations, symptoms, and healthcare utilization (Kujanpaa, et al., 2017). Anxiety sensitivity creates a hyper vigilance to physical sensations associated with autonomic arousal intensifying the somatic sensation experience, adding to the fear, reinforcing

the cycle (Taylor, 1999). Physical symptoms play a role in the diagnostic criteria for panic disorder, generalized anxiety disorder (GAD), and posttraumatic stress disorder (DSM-V; Crawley, 2014; Caporino, et al).

Anxiety occurs when the normal physiological response becomes persistent and the alarm system fails to turn off (Cassel, 1997; Hassan, 2011). This state of physiological hyper-arousal is felt in the body as somatic sensations, including such symptoms as a pounding heart rate, sweating hands, nausea, or feeling panicky. These somatic symptoms can become intrusive often affecting daily life. It is when these symptoms don't turn off and become intrusive, persistent, and lingering that they become a problem (Mayo Clinic, 2017).

It is well documented, that somatization accounts for a large proportion of office visits to primary care physicians as well as specialists (Abbass, 2005). When feelings are intense, frightening or conflicted, they create anxiety and defense mechanisms to cover the anxiety (Fink, 1999). If these feelings are unconscious to the patient, the subsequent anxiety and defenses may also be outside of awareness (Abbass, 2005). This is common in people who have been traumatized by someone close to them wherein feelings of rage toward a loved one are unacceptable, frightening, and avoided through somatization and other defenses (Katon, Sullivan, Walker, 2001). A great deal of research has linked somatic symptoms to anxiety, and PTSD (Kujanpaa, et al, 2017; Cassel, 1997; Lilly, 2012; Jakupcak, et al 2006). Blocking and inhibiting of emotions, including anger, is a common finding in somatizing patients (Abbass, 2005).

The client with somatic symptoms should be assessed through interview for stored traumatic or emotional events (Abbass, 2005). A recurring somatic complaint is often connected to a prior emotionally charged event causing the memories of the trauma to be stored in the body.

The recurring physical sensations triggered in current experiences, may mimic or echo those experienced in the originally stored event. (Abbass, 2005; Hassaa, 2011; Kujanpaa, et al 2017) When the client denies previous trauma, the original emotionally charged event may have occurred a long time ago and may not be cognitively associated with the symptom presentation today.

Current Treatment Overview

Our mental health care system has become attached to labels of pathology, leaving people feeling broken or damaged, and frequently told they will require and be dependent on pharmaceuticals or poly-pharmaceuticals for life (Healy, 2012, Oldani, 2014). It appears to some that our society is experiencing an epidemic of both over diagnosing and over prescribing for mental health disorders (Whitaker, 2005).

In 2009 there were over three hundred million prescriptions written for psychiatric medication, and of those prescriptions, forty-four million were for Xanax (alprazolam) which is a commonly prescribed treatment for anxiety. One unfortunate outcome for patients today is that polypharmacy, the ingesting of two or more psychiatric medications on a daily basis, has become a social and medical fact for millions of patients. The concept of polypharmacy itself continues to evolve medically and culturally toward greater dependency (Oldani, 2014).

In recent decades, a cognitive behavioral therapeutic approach has been the dominant force in psychotherapy, with many therapists maintaining the belief that dysfunctional thinking is at the core of, if not the cause of psychopathology. Cognitive therapies share a similar approach with the emphasis placed on changing thinking as the key to bringing about changes in patterns of dysfunctional emotional reactions and symptomatic behaviors (Shean, 2003).

While a CBT approach in therapy can be effective, the time required can be lengthy and the cost “over time” can be excessive. In a meta-analysis of 30 years of data on 2400 patients receiving psychotherapy, approximate 50% showed improvement in 8 sessions and another 75% improved in 26 sessions (Howard, 1986). For some this can be cost prohibitive as third-party payers often limit sessions, while costs and co-pays can add up rapidly creating limitations in affordability.

Trends in Treatment

“We have a society that wants a quick fix” says Katherine C. Nordal, PH. D, executive director of APA’s Practice Directorate (Olfson, 2014). A 2010 study published in the *American Journal of Psychology*, indicated the number of people from the general population nationwide utilizing psychotherapy as a treatment remained the same between 1998 and 2007. However, during the same period outpatient mental health care shifted. During the decade studied the use of psychotherapy combined with medication treatment decreased while medication only visits increased. The percentage of clients receiving medication only as a treatment rose from 44% to 57%, while the percentage of clients receiving only psychotherapy as a treatment dropped from 16% to 10.5%, and the percentage of clients receiving the combination treatment of psychotherapy and medication management dropped from 40% to 32% (Olfson, 2010).

Psychotherapy, or cognitive therapy has traditionally focused on making changes by changing thoughts, but this is no longer enough. Neurobiological evidence indicates that emotions can be experienced without cortical interpretations of stimuli, and clinical evidence indicates that experiences can be stored in the body (Shean, 2003). Emotions may be triggered by events or internal cues that trigger reactions that are experienced only as somatic states. (Shean, 2003). People with anxiety are three to five times more likely to seek medical help from

a doctor and six times more likely to be hospitalized than non-sufferers (Abbass, 2005). Those with anxiety have a high propensity to self-medicate through the use of alcohol and drug abuse (Hassan, Ali, 2011; Bolton et al., 2006).

Summary

Clients and therapists are seeking more effective results than those obtained from the current approaches in cognitive behavioral treatments, and the pharmaceutical options in addressing the stored trauma. As a result, techniques are being added to compliment psychotherapy that include more work with the body to enhance the patient's healing experience, as discussed by Bessel Van der Kolk in, *The Body Keeps the Score*, the body holds the physical memory, and these stored memories in the body require release to achieve healing as well as addressing thoughts and the mind. Currently these additional techniques range from meditation, to yoga, EMDR, and EFT (Van der Kolk, 2014).

Anxiety is a costly healthcare issue, affecting over 40 million in the U.S. and over 272 million people globally. Current treatments are focused on cognitive behavioral therapy and pharmaceutical treatments. These approaches fall short by focusing on reduction of anxiety through alteration of cognition and suppression of symptoms through pharmaceuticals. The aspect of the relationship of somatization in anxiety has been a characteristic inadequately explored or addressed as a significant cue of ongoing spiritual distress. Anxiety and trauma, must be seen through the viewpoint that traumatic memories are stored in the body, an important aspect of anxiety becoming recognized. Current treatment modalities are not fully addressing this element of anxiety. A single treatment method is needed that addresses the elements of anxiety, that include somatic symptoms, stored trauma and restoration of internal homeostasis.

CHAPTER THREE:

Research Methods

Introduction

This research study was designed to determine if four individual sessions of the Inner Counselor Process™ will statistically reduce State and Trait Anxiety as measured by the State-Trait Anxiety Inventory for Adults and to determine if qualities of a self-actualized person as measured by the Personal Orientation Inventory are also influenced. The instruments were selected based on the specificity and capacity to measure State and Trait Anxiety and the personality traits of interest to the study.

Study Design

This study used an experimental pretest-posttest design with a sample of convenience. The research study was designed to be completed within a 10-week time frame. Pretests were given to all intervention and control group participants one week prior to the first Inner Counselor Process™ session. Each person in the intervention group was scheduled to have four individual ICP™ sessions that included the closing Integration Exercise. The ICP™ sessions were scheduled one week apart over a four-week period. Posttests were given one week after the fourth Inner Counselor Process™ to all intervention and control group participants, and again one month after the final Inner Counselor Process™. An exit interview was scheduled six weeks after the final ICP™ for all intervention participants completing the study.

Quantitative data was collected from all participants, from pre-tests one week prior to the first ICP™, posttests one week after the fourth ICP™ and one month after the fourth ICP™. Pre-test and post-tests included the State-Trait Anxiety Inventory for Adults (STAI) and the Personal Orientation Inventory (POI). All data was processed by a professional independent statistician.

Qualitative data was gathered in several ways. Demographic data gathered at time on consent, post research exit interviews and personal journaling done by each of the participants after each ICP™ session. All ICP™ sessions were recorded by hand-written notes taken during the session by the primary researcher (See Appendix B).

Human Studies Research Ethics Board Approval

Approval was received from Akamai University Human Studies Research Ethics Review Board on November 23rd, 2016.

Recruitment

A flyer was circulated to attract participants. See Appendix (E) The flyer was emailed to approximately fifty individuals, professional therapists and colleagues, and posted on social media. A total of seventy participants were recruited. Participants were allowed to self-select into the intervention group or control group. The participants, a sample of convenience, were adult volunteers (Age 18 years or older) recruited through word of mouth, social media and referral by other psychotherapists.

Inclusion Criteria

- Adults age 18 or over.
- Diagnosis of anxiety, self-report anxiety or currently in therapy for anxiety.
- A self-report of feelings or emotions that keep them from self-actualizing
- Willingness to participate.

Exclusion Criteria

- Individuals considered high risk, such as self-reported suicidal, or paranoid, or individuals diagnosed with schizophrenia, multiple personality disorder, or a history of violent behavior.

- Individuals with dementia.
- Anyone currently having psychiatric medication changes or adjustments.
- Anyone with a religious conflict related to the spiritual aspects of the process.
- Careful consideration was applied for applicants with a previous diagnosis of PTSD, and those that may be in the Autistic Spectrum Group. Emphasis is placed on protection of the participant and consideration of the abilities to safely access emotions and physical sensations.

Discontinuation Criteria

- Participant chooses to withdraw or to discontinue the protocol before completion date.
- The PI believes the participant is at risk should they continue
- Failure to follow the protocol of pretest, four ICP™ interventions one week apart, posttests as scheduled one week and one month post completion of the ICP™ interventions.

Materials

State-Trait Anxiety Inventory for Adults™ (Forms Y1 and Y2)

The State-Trait Inventory for Adults is self-evaluation questionnaire. First developed in 1964 by Charles D. Spielberger and R.L. Gorsuch, and later revised in 1975. The STAI has been used extensively in research and clinical practice. As of 1983 the STAI has been adapted into more than 30 different languages for cross-cultural research and clinical practice (Spielberger, 1983). The inventory is comprised of two separate twenty question scales that measure state and trait anxiety, both forms are on opposite sides of a single sheet of paper. The S-Anxiety STAI Form Y-1, consists of twenty statements that evaluates how a respondent “feels right now, in this

moment”. The T-Anxiety (STAI Form Y-2) consists of twenty statements that assesses how a respondent “generally” feels.

The S-Anxiety assessment has been found to be a sensitive indicator of transitory changes in anxiety experienced by individuals in psychotherapy and counseling programs. The T-Anxiety assessment has been widely used in assessing clinical anxiety in medical, psychosomatic and psychiatric patients with depressed or psychoneurotic patients generally scoring higher on this scale (Spielberger, 1983).

Norming Information for S-Anxiety and T-Anxiety

Below is the Means, Standard Deviations and Alpha coefficients for
Working with Adults in Three Age Groups. (Spielberger, 1983)

Table 1

	Ages 19-30		Ages 40-49		Ages 50-69	
	M	F	M	F	M	F
S-Anxiety						
Mean	36.54	36.17	35.88	36.03	34.51	32.20
SD	10.22	10.96	10.52	11.07	10.34	8.67
<i>Alpha</i>	.92	.93	.93	.94	.92	.90
T-Anxiety						
Mean	35.55	36.15	35.06	35.03	33.86	31.79
SD	9.76	9.53	8.88	9.31	8.86	7.78
<i>Alpha</i>	.92	.92	.91	.92	.96	.89

The Personal Orientation Inventory (POI)

The POI developed by Everett L. Shostrom, was created to meet the need for an inventory for the measurement of Self-Actualization based on the principles of Abraham Maslow. The POI is a self-administered test of 150 questions in a reusable test booklet, with a separate answer sheet where a response of either A or B is marked. Since its publication in 1963, a great deal of empirical research has been done to study self-actualized people.

In reference to the POI, Maslow stated in 1971:

“In studying healthy people, self-actualizing people, etc., there has been a steady move from the openly normative and frankly personal, step by step, toward more and more descriptive, objective words to the point where there is today a standardized test of self-actualization. Self-actualization can now be defined quite operationally as intelligence used to be defined, i.e., self-actualization is what the test tests” (Shostrom, E., 1987).

Norming Information for the Personal Orientation Inventory

The following POI Scale, Means, Standard Deviations, and Comparisons of Differences Between samples designated as “Self-Actualizing”, “Normal”, and “Non-Self-Actualizing” (Shostrom, E.,1987)

Table 2

POI Scale	Symbol	Self-Actualizing		Normal Adult		Non-Self-Actualizing	
		Mean	SD	Mean	SD	Mean	SD
Time Competence	TC	18.9	2.5	17.7	2.8	15.8	3.6
Inner Directed	I	92.9	11.5	87.2	13.6	75.8	1.2
Self-Actualizing Value	SAV	20.7	3.6	20.2	3.0	18.0	3.7
Existentiality	Ex	24.8	3.8	21.8	5.1	18.9	5.4
Feeling Reactivity	Fr	16.3	2.8	15.7	3.3	14.3	3.8
Spontaneity	S	12.7	2.9	11.6	3.0	9.8	3.4
Self-Regard	Sr	12.9	1.9	12.0	2.7	10.2	3.3
Self-Acceptance	Sa	18.9	3.5	17.1	4.0	14.2	4.0
Nature of Man	Nc	12.3	2.2	12.4	1.9	11.3	2.0
Synergy	Sy	7.6	1.2	7.3	1.2	6.2	1.9
Acceptance of Aggression	A	17.6	3.1	16.6	3.7	14.7	3.5
Capacity for Intimate Contact	C	20.2	3.4	18.8	4.6	16.5	4.3

Inner Counselor Process

The Inner Counselor Process™ is a 15-Step guided self-awareness process that begins by gently guiding the participant into a safe and peaceful place where he/she can fully engage the senses, while feeling safe, strong, and centered. This guided self-awareness process feels as if it takes place in a realm of timelessness while in reality it may take only 30-45 minutes to complete

(Nunley, 2009; See Appendix B). At completion of the 15 steps the Energy Integration exercise is done reinforcing the subtle energy process of integrating the mental, emotional, and physical bodies of the participant (See Appendix C).

Research Personnel

The PI and RA received human studies research ethics training. Only the primary researcher guided participants through the Inner Counselor Process™. The research assistant assembled paperwork, greeted participants, facilitated the scheduling of the participants, assisted with scoring tests and the recording of test scores. A professional statistician was used to provide the statistical analysis of the data.

Consenting

Individual consenting was done, which included review of the consent form and legal rights of the participants. A brief explanation of the research study was offered, as well as an explanation of required time commitments, and the obligations of the pre-test, and post-tests. It was clearly stated to each participant that they could withdraw from the study at any point. Each person was shown the Integration Chart (See Appendix F) and a brief overview of the process was offered. Questions were allowed and a brief trial of the participants ability to access imagery with eyes closed was assessed as this is an integral part of the process. If a desire to continue was indicated the participant was asked to sign the consent forms (See Appendix A-1 and A-2) and to fill out the intake form (See Appendix D), a small Polaroid snapshot was taken for the file.

There was no blinding done for the PI. All intervention participants volunteered to receive four sessions of the ICP™, all control group participants volunteered to provide a baseline for the study. All participants were given a subject number.

Sessions

Thirty-eight volunteer participants self-selected into the intervention group and thirty-two volunteered for the control group. Participants in the intervention group were then scheduled by the research assistant (RA) for four, one-hour appointments one week apart set on the same day at the same time with the Principle Investigator (PI) Rev. Sandra Augustine LIMHP, CPC, M. A., RN, in her private counseling office. Each of the four appointment sessions included a facilitated 15-Step Inner Counselor™ intervention that included the Integration Exercise. Care was taken to ensure that participants felt safe, and that they completed each session in a calm state of mind. Approximately fifteen minutes at the end of the session was set aside for participants to enter a separate and private room to journal their experience. This allowed the individuals time at the end of a session to sit in a safe place and process until they felt calm, and comfortable prior to leaving.

All ICP™ sessions were done in a private office setting with easy accessibility, ample parking, near a bus route. Participants sat in a chair with a back high enough to support the head and a footstool for comfort. A lap blanket was offered for comfort and temperature control if needed. The environment was private, quiet and free from fragrances, distractions or noise, and the lights were dimmed for comfort. Phones were placed on “Do Not Disturb”, and cell phones turned off. An assistant was nearby in an adjacent office if needed for emergency or safety concerns.

Each participant in the intervention was provided quiet time after the intervention to journal in a separate room prior to departure. Each intervention participant had an individual personal journal that consisted of a cover sheet titled “The Inner Counselor Process™ Personal Journal Subject # ___”. The next four pages were plain white lined copy paper, each page

labeled session 1-4, with a date line and directions to “Journal about any thoughts or feelings about today’s session”. The purpose was threefold 1) The participant was allowed time for integration and processing of the ICP™ experience. 2) This period allowed observation and a degree of certainty that each participant was alert, grounded, and calm prior to departure of the research location, 3) The journaling was an opportunity for the PI to get subjective data on the individual experience of each participant. The amount of journaling varied, some participants wrote only a few lines, others wrote a full page and drew an image of their symbol. Journaling allowed the PI another opportunity to assess the participants experience (See Appendix H).

Exit Interviews

A meeting was scheduled with each of the intervention participants six weeks after the final ICP™ sessions were complete. This hour-long post research exit interview was conducted with each of the intervention participants to allow for debriefing for the participant, and to acquire subjective feedback. Interviews were conducted by the PI in a private session, in the private office of the PI, the interview took place in the same office as the interventions took place. The interview began with a series of questions. The following questions were asked;

- 1) Are you aware of any positive or negative changes as a result of the four ICP™ sessions?
- 2) What changes did you notice?
- 3) Do you feel more sessions would have been helpful?
- 4) Were the four sessions worthwhile for you?
- 5) Would you recommend the IC process to others?

All responses were recorded by the PI in hand written notes.

Once the participants answered the five questions, the “issue” from each of the four ICP™ sessions were reviewed individually to determine if the issue remained or was resolved. The question was presented as “In session one, you explored the issue of anger, have you noticed any changes in your anger”? “In session two you explored the feeling of “fear of commitment”

have you noticed any changes in your fear of commitment”? The issue or feeling from each session was reviewed to determine if resolution or a shift in experience had occurred. All responses were recorded by PI in hand written notes.

Once subjective data was collected the PI reviewed the participant’s individual scores from the S-Anxiety pretest, the posttest and the second posttest, followed by the T-Anxiety pretest, the posttest and the second posttest. Next the PI reviewed the participant’s scores from the POI pretest, posttest, and second posttest. The POI scores were presented on a graph with each test designated by color. Test one in pencil, test two in red, and test three in blue, allowing easy visual comparison of the variations of the scores. The POI scores were revealed one category at a time, to allow the participant to see it one score at a time. A brief interpretation of the results was offered, including the category and the shift in results from the beginning to end of the study. Participants were allowed to share feedback related to the scores and correlating personal experience.

Data Collection

Quantitative data was collected from the demographic data collected on all participants prior to the start of the study. Session notes were taken by the PI during each ICP™ and later transcribed by the PI. Journal notes were written after each ICP™ by the intervention participants, and remained part of the subject’s file. Quantitative data was collected from the intervention group and the control group from the STAI and the POI as a pretest one week prior to the first ICP™, a posttest one week after the fourth ICP™, and the second posttest was given one month after the final ICP™.

Data Analysis

Data analysis was obtained by hand scoring the POI using a template purchased from Edits.com, where the test sheets and booklets were purchased for use in the study. The POI tests were scored by the PI and an RA and random checks were done by a second RA and the PI to verify accuracy. All scores were recorded onto an Excel spreadsheet for analysis by an independent professional statistician. Scores were carefully checked and verified for accuracy by two RAs prior to release for analysis.

Scoring of the STAI was done by an RA using a computer scoring tool at www.nrsusa.org a tool approved for use by researchers and their assistants for scoring the STAI, Form Y. All STAI forms were purchase from Mind Garden, Inc.

All hand-written session notes were transcribed and typed for purposes of consolidation, for organization and review of the sessions by the PI after completion of the intervention. Qualitative data was reviewed by PI, including demographic data, ICP™ session notes, journal pages written by intervention participants, and exit interview responses from intervention participants.

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Chapter 4, and the mixed ANOVA results are provided in Chapter 4. The display of mean differences for the groups across time is presented in the profile plot in Chapter 4.

Data Protection

All data that was provided to the statistician was privacy protected by using an assigned subject number for each participant known only to the PI and RA. Any notes acquired from the ICP™ sessions were held in the possession of the PI, and remain locked and secure. No data was

transported between sites except for statistical analysis purposes. Information was then emailed under password protected spreadsheet with participants identified only by subject number. All personal data, demographic data, and all notes, forms and tests remain in the possession of the PI, locked and secured. The data will be maintained under security for 7 years as required by law and then all identifying data will be shredded.

Ethical Considerations

Safety was a high priority, assuring all participants felt safe and secure after each ICP™, allowing time for personal reflection and journaling as they came back into full awareness and the present moment after completing the intervention and prior to leaving and driving. The RA remained available in case assistance was required at any point. Privacy of participants was prioritized and protected. Each participant was assigned a number known only by the investigator and a private assistant. No data will be presented with any individual identifying characteristics.

Summary

This study is the first quantitative research study used to evaluate the effects of the Inner Counselor Process™ in reducing State and Trait Anxiety. The research inventories employed in this study were the State Trait Anxiety Inventory (STAI), which is used to measure changes in State and Trait anxiety, and the Personal Orientation Inventory (POI) instrumentation, which was based on Abraham Maslow's work and used to measure its effectiveness, in terms of Self Actualization. Each individual in the intervention group experienced four ICP™ sessions one week apart for four weeks. The intervention group and the control group were given the STAI and the POI as a pretest one week prior to the first ICP™, and again as a posttest one week after the fourth ICP™, the second posttest was given one month after the final ICP™. The research

study took place over a ten-week period, an exit interview was scheduled for the intervention group participants, approximately six weeks after the final ICP™.

Chapter Four:

Research Results

Introduction

Seventy participants were recruited for participation, fifty-nine participants completed all aspects of the study, eleven participants were eliminated for failure to complete the all aspects of the study within the time frame parameters. Reasons for drop outs occurred when participants failed to comply with completion of the final test, reason given was “I feel I will just answer the questions the same”, and others failed to complete of the fourth and final ICP™ within the allowed timeframe due to illness or family conflict. One participant dropped out at the advice of a therapist early in the study, due to fragility of emotional state with pending divorce. Several others in the control group failed to get the proper paperwork in at the beginning and end of the study in a timely fashion. One intervention participant was eliminated when he was witnessed filling in the POI without reading the questions on the final test.

Results

The results of the ICP™ Interventions are as follows: STAI scores: State Anxiety: The intervention group showed a statistically significant reduction in State Anxiety: $p \leq 0.002$, Trait Anxiety: $p \leq 0.001$. POI scores also showed a statistically significant reduction: Time Competence (TC): $p \leq 0.05$. The intervention group showed substantially lower TC at the pretest, but also showed a statistically significant increase in TC when compared to the control group. Inner directed (I): $p \leq 0.001$ The intervention group showed substantially lower (I) at the pretest,

but also showed a statistically significant increase in (I) when compared to the control group. Spontaneity (S): $p \leq 0.001$). The intervention group showed substantially lower (S) at the pretest, but also showed a statistically significant increase in S when compared to the control group. Self-Regard (SR): $p \leq 0.001$). The intervention group showed substantially lower (SR) at the pretest, but also showed a statistically significant increase in S when compared to the control group. Self-Acceptance (SA): $p \leq 0.004$ The intervention group showed substantially lower SA at the pretest, but also showed a statistically significant increase in SA when compared to the control group. Capacity for Intimate Contact (C): $p \leq 0.003$ The intervention group showed substantially lower C at the pretest, but also showed a statistically significant increase in (C) when compared to the control group.

Demographics

The study attracted seventy participants age eighteen or older, thirty-eight self-selected into the intervention group and thirty-two self-selected into the baseline group. The self-selection process was allowed as a convenience to attract willing participants to accomplish the study. Due to life circumstances both groups had attrition. In the end, a total of fifty-nine participants completed the study, with thirty-three in the intervention group and twenty-six in the baseline/control group.

The demographics in each group were comparable. In several cases a partner, spouse, roommate and fraternal twin were participants. Intervention Group: the age range spanned age 19 to age 66. Control Group: The age range spanned age 19 to age 75. Male to female ratio was approximately two thirds female and one third male in each group. The intervention group had two LGBT participants, the control group had two LGBT participants with one drop out. Intervention Group: Income range from \$10k to \$300K, annually. Control Group: Income range

from \$10k to \$300k annually. Both the intervention and control groups included education from all categories including: a high school diploma, trade school education, some college, associate degree, college degree and master's degree and doctorate degree, and doctor. The intervention group occupations included: Accountant, administrative assistant, bookkeeper, business owner, carpenter, chiropractor, clerical, coach, construction laborer, counselor/advocate, educator, grocery store associate, guest services specialist, hair stylist, IT technician, licensed massage therapist, nurse practitioner, maintenance worker, manager, optician technician, paralegal, photographer, physician, piano teacher, professional tree trimmer, researcher, retail manager, students, teacher, writer. The control group occupations included: Accountant, administrator, administrative assistant, attorney, author, banker, business owner, carpenter, chiropractor, civic volunteer, coach, contractor, cook, dental technician, healthcare sales, maintenance worker, marketing, project manager, psychologist, real estate sales, retired, RN consultant, sales, self-employed, spiritual director, teacher, welder. Religious preference was diverse for each group. The intervention group religious preferences included the following: Anglican, Catholic, Christian, Lutheran, Methodist, no religious preference, and Spiritual. The Control group religious preferences included the following: Armenian Apostolic, Buddhist, Catholic, Christian, Jewish, Lutheran, Methodist, Mystic, Presbyterian, Protestant, no religious preference, and Spiritual.

State-Trait Anxiety Inventory for Adults™ (Forms Y1 and Y2)

The State-Trait Inventory for Adults is a self-evaluation questionnaire that was first developed in 1964 by Charles D. Spielberger and R.L. Gorsuch, and later revised in 1975. The STAI has been used extensively in research and clinical practice. As of 1983 the STAI has been adapted into more than 30 different languages for cross-cultural research and clinical practice

(Spielberger, 1983). The inventory is comprised of two separate twenty question scales that measure state and trait anxiety, both forms are on opposite sides of a single sheet of paper. Each STAI item is given a weighted score from 1-4. Scores from both the S-Anxiety and T-Anxiety can vary from a minimum of 20 to a maximum of 80 (Spielberger, 1983).

State Anxiety

The S-Anxiety STAI Form Y-1, consists of twenty statements that evaluates how a respondent “feels right now, in this moment”. An emotional state exists at a given moment in time and at a particular level of intensity. Anxiety states are characterized by subjective feelings of tension, apprehension, nervousness and worry and by activation or arousal of the autonomic nervous system. The S-Anxiety assessment has been found to be a sensitive indicator of transitory changes in anxiety experienced by individuals in psychotherapy and counseling programs. (Description taken from the State-Trait Anxiety Inventory for Adults Manual).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 3 below, and the mixed ANOVA results are provided in Table 4. The display of mean differences for the groups across time is presented in the profile plot in Figure 1 below.

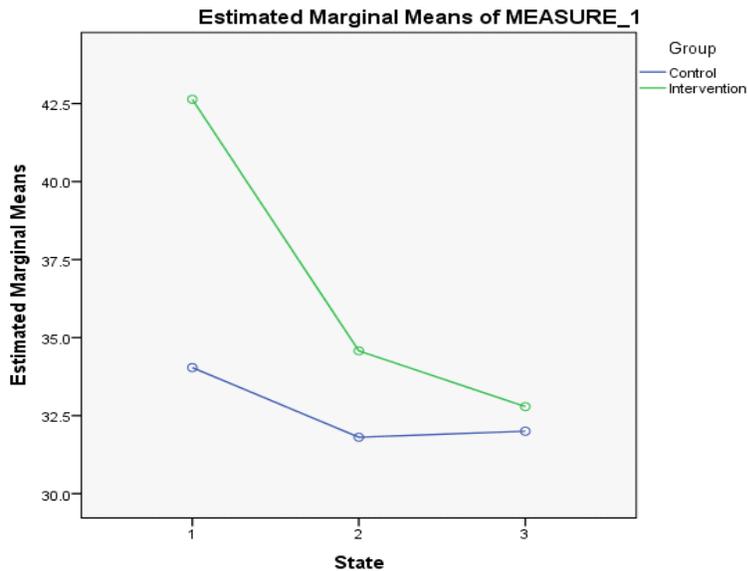
Table 3

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
StatePre	Control	34.038	10.2897	26
	Intervention	42.636	13.1952	33
	Total	38.847	12.6584	59
StatePost 1	Control	31.808	10.3500	26
	Intervention	34.576	9.7437	33
	Total	33.356	10.0237	59
StatePost 2	Control	32.000	9.2952	26
	Intervention	32.788	8.1538	33
	Total	32.441	8.6069	59

Table 4

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
State	Sphericity Assumed	1210.690	2	605.345	17.170	.000
	Greenhouse-Geisser	1210.690	1.773	683.029	17.170	.000
	Huynh-Feldt	1210.690	1.857	651.820	17.170	.000
	Lower-bound	1210.690	1.000	1210.690	17.170	.000
State * Group	Sphericity Assumed	479.436	2	239.718	6.800	.002
	Greenhouse-Geisser	479.436	1.773	270.481	6.800	.003
	Huynh-Feldt	479.436	1.857	258.122	6.800	.002
	Lower-bound	479.436	1.000	479.436	6.800	.012
Error(State)	Sphericity Assumed	4019.084	114	35.255		
	Greenhouse-Geisser	4019.084	101.034	39.779		
	Huynh-Feldt	4019.084	105.872	37.962		
	Lower-bound	4019.084	57.000	70.510		

Figure 1



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=6.8, p=.002$). The intervention group showed substantially higher state anxiety at the pretest, but also showed a disproportionately large decrease in that anxiety when compared to the control group.

Trait Anxiety

Trait Anxiety (T-Anxiety) refers to relatively stable individual personality differences in anxiety proneness. The T-Anxiety Scale (STAI- Form Y-2), consists of twenty statements that assesses how a respondent “generally” feels. The T-Anxiety assessment has been widely used in assessing clinical anxiety in medical, psychosomatic and psychiatric patients with depressed or psychoneurotic patients generally scoring higher on this scale (Spielberger, 1983).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 5 below, and the mixed ANOVA results are provided in Table 6. The display of mean differences for the groups across time is presented in the profile plot in Figure 2 below.

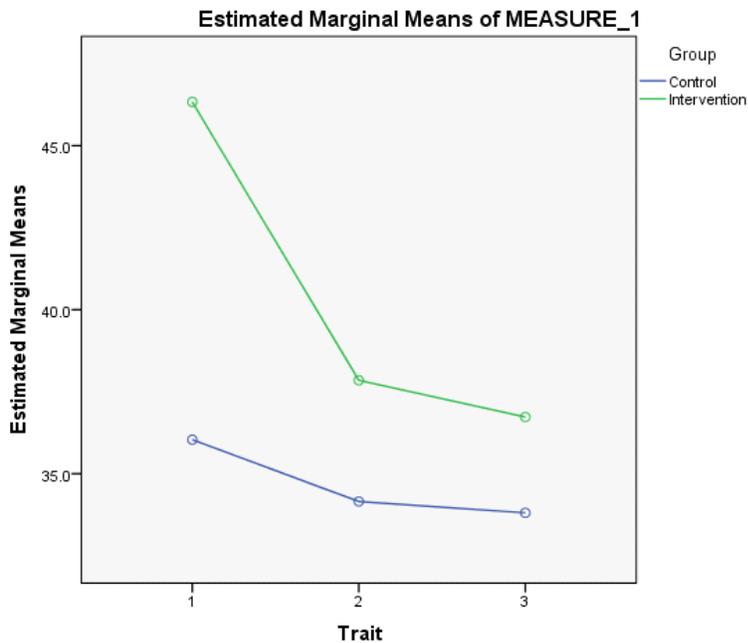
Table 5

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
TraitPre	Control	36.038	9.2021	26
	Intervention	46.333	12.7394	33
	Total	41.797	12.3537	59
1 TraitPost	Control	34.154	9.5276	26
	Intervention	37.848	9.8111	33
	Total	36.220	9.7805	59
2 TraitPost	Control	33.81	8.328	26
	Intervention	36.73	8.658	33
	Total	35.44	8.567	59

Table 6

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
Trait	Sphericity Assumed	1210.844	2	605.422	28.431	.000
	Greenhouse-Geisser	1210.844	1.638	739.297	28.431	.000
	Huynh-Feldt	1210.844	1.709	708.375	28.431	.000
	Lower-bound	1210.844	1.000	1210.844	28.431	.000
Trait * Group	Sphericity Assumed	477.759	2	238.880	11.218	.000
	Greenhouse-Geisser	477.759	1.638	291.702	11.218	.000
	Huynh-Feldt	477.759	1.709	279.501	11.218	.000
	Lower-bound	477.759	1.000	477.759	11.218	.001
Error(Trait)	Sphericity Assumed	2427.597	114	21.295		
	Greenhouse-Geisser	2427.597	93.356	26.004		
	Huynh-Feldt	2427.597	97.432	24.916		
	Lower-bound	2427.597	57.000	42.589		

Figure 2



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=11.22, p \leq .001$). The intervention group showed substantially higher trait anxiety at the pretest, but also showed a disproportionately large decrease in that anxiety when compared to the control group.

Personal Orientation Inventory Scores and Results

Time Competence (TC)

Time Competence or Time Incompetence measures the degree to which one is “present” oriented. A self-actualized person is primarily Time Competent and lives more in the present

moment. Non-self-actualized people are comparatively the most time incompetent. (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 7 below, and the mixed ANOVA results are provided in Table 8. The display of mean differences for the groups across time is presented in the profile plot in Figure 3 below.

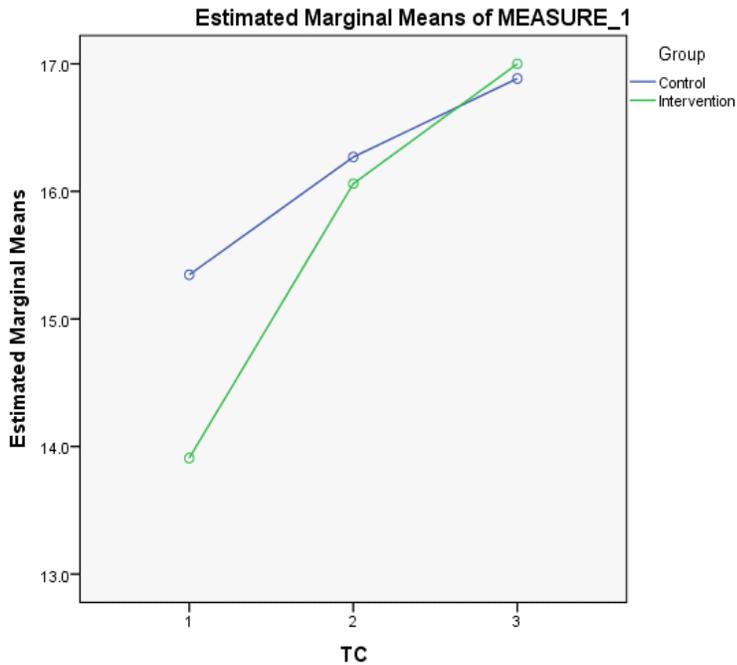
Table 7

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
TCPre	Control	15.346	2.6524	26
	Intervention	13.909	3.3575	33
	Total	14.542	3.1257	59
TCPost 1	Control	16.269	2.5069	26
	Intervention	16.061	3.5876	33
	Total	16.153	3.1339	59
TCPost 2	Control	16.88	2.998	26
	Intervention	17.00	3.657	33
	Total	16.95	3.355	59

Table 8

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
TC	Sphericity Assumed	161.428	2	80.714	25.202	.000
	Greenhouse-Geisser	161.428	1.709	94.445	25.202	.000
	Huynh-Feldt	161.428	1.788	90.298	25.202	.000
	Lower-bound	161.428	1.000	161.428	25.202	.000
TC * Group	Sphericity Assumed	19.507	2	9.753	3.045	.051
	Greenhouse-Geisser	19.507	1.709	11.413	3.045	.060
	Huynh-Feldt	19.507	1.788	10.912	3.045	.058
	Lower-bound	19.507	1.000	19.507	3.045	.086
Error(TC)	Sphericity Assumed	365.103	114	3.203		
	Greenhouse-Geisser	365.103	97.426	3.747		
	Huynh-Feldt	365.103	101.900	3.583		
	Lower-bound	365.103	57.000	6.405		

Figure 3



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=3.04, p=.05$). The intervention group showed substantially lower TC at the pretest, but also showed a disproportionately large increase in TC when compared to the control group.

Inner Directed (I)

The Inner-Director person has an internal “gyroscope” which developed early in life through parental influence. The inner-directed person, operates more independently in life guided by this internal piloting, and guiding principles. The source of direction is an internal motivation rather than external influences, and develops character traits of autonomy, self-support, and freedom (Shostrom, E., 1987).

The Other-Directed person, appears to have developed an early radar system as protection or response to fear or anxiety. Approval from others becomes a higher goal, along with desire to please others, creating social pressure orientation and compulsive conformity (Shostrom, E., 1987).

“A self-actualized person, is sensitive to the opinions of others, tends to be less deficiency oriented, and more inner directed by a more autonomous perspective. Inner-directedness is transcended by critical assimilation and creative expansion of earlier principles of living.” (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 9 below, and the mixed ANOVA results are provided in Table 10. The display of mean differences for the groups across time is presented in the profile plot in Figure 4 below.

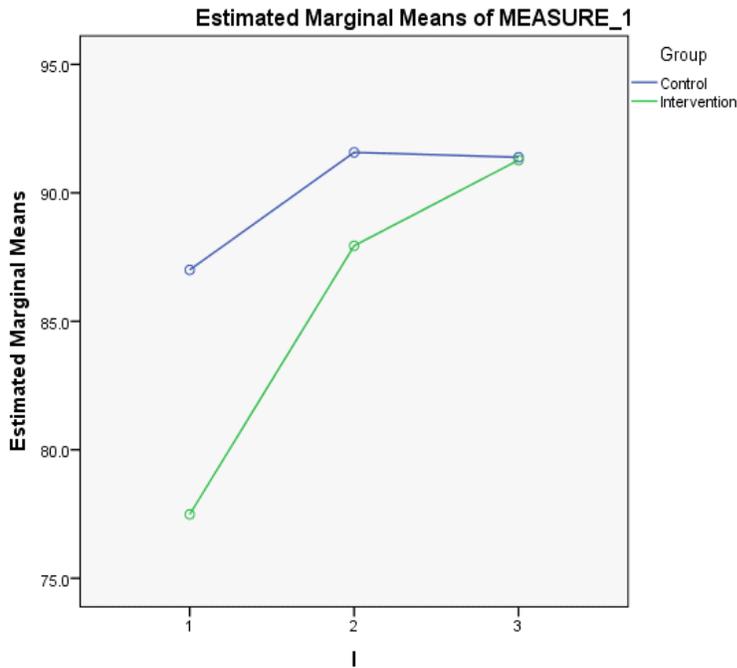
Table 9

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
IPre	Control	87.000	11.7576	26
	Intervention	77.485	14.5003	33
	Total	81.678	14.0816	59
IPost 1	Control	91.577	12.7096	26
	Intervention	87.939	12.1499	33
	Total	89.542	12.4254	59
IPost 2	Control	91.38	13.500	26
	Intervention	91.27	10.468	33
	Total	91.32	11.790	59

Table 10

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
I	Sphericity Assumed	2743.906	2	1371.953	35.607	.000
	Greenhouse-Geisser	2743.906	1.849	1484.162	35.607	.000
	Huynh-Feldt	2743.906	1.942	1413.258	35.607	.000
	Lower-bound	2743.906	1.000	2743.906	35.607	.000
I *	Sphericity Assumed	656.336	2	328.168	8.517	.000
	Greenhouse-Geisser	656.336	1.849	355.008	8.517	.001
	Huynh-Feldt	656.336	1.942	338.048	8.517	.000
	Lower-bound	656.336	1.000	656.336	8.517	.005
Error(I)	Sphericity Assumed	4392.523	114	38.531		
	Greenhouse-Geisser	4392.523	105.381	41.682		
	Huynh-Feldt	4392.523	110.668	39.691		
	Lower-bound	4392.523	57.000	77.062		

Figure 4



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F [2,114]=8.52, p \leq .001$). The intervention group showed substantially lower I at the pretest, but also showed a disproportionately large increase in I when compared to the control group.

Self-Actualizing Values (SAV):

The SAV value was derived from and corresponds to Maslow's concept of self-actualizing people. A high score suggests that an individual hold values of self-actualizing people, a low score suggests the rejection of self-actualizing values (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 11 below,

and the mixed ANOVA results are provided in Table 12. The display of mean differences for the groups across time is presented in the profile plot in Figure 5 below.

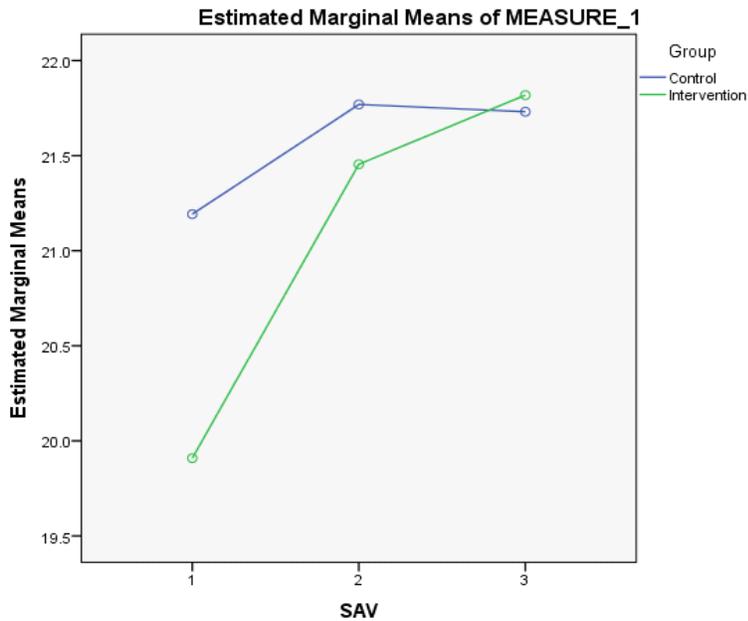
Table 11

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
SAVPre	Control	21.192	2.9123	26
	Intervention	19.909	3.3012	33
	Total	20.475	3.1751	59
1 SAVPost	Control	21.769	2.8609	26
	Intervention	21.455	2.2651	33
	Total	21.593	2.5265	59
2 SAVPost	Control	21.731	2.4093	26
	Intervention	21.818	2.1860	33
	Total	21.780	2.2672	59

Table 12

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
SAV	Sphericity Assumed	51.387	2	25.693	7.774	.001
	Greenhouse-Geisser	51.387	1.917	26.803	7.774	.001
	Huynh-Feldt	51.387	2.000	25.693	7.774	.001
	Lower-bound	51.387	1.000	51.387	7.774	.007
SAV * Group	Sphericity Assumed	14.437	2	7.219	2.184	.117
	Greenhouse-Geisser	14.437	1.917	7.530	2.184	.120
	Huynh-Feldt	14.437	2.000	7.219	2.184	.117
	Lower-bound	14.437	1.000	14.437	2.184	.145
Error(SAV)	Sphericity Assumed	376.772	114	3.305		
	Greenhouse-Geisser	376.772	109.281	3.448		
	Huynh-Feldt	376.772	114.000	3.305		
	Lower-bound	376.772	57.000	6.610		

Figure 5



Examination of the descriptive and inferential statistics reveals that the means of the two showed no statistically significantly different patterns over the three measurement epochs, as evidenced by the F-ratio for the interaction of group X time ($F[2,114]=2.18, p=.12$).

Existentiality (EX)

A compliment to SAV, the Existentiality scale measures one's flexibility in the ability to apply values and principles. Higher scores represent flexibility in application of principles, lower scores are indicative of more rigid values often creating compulsions or becoming dogmatic. (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 13 below, and the mixed ANOVA results are provided in Table 14. The display of mean differences for the groups across time is presented in the profile plot in Figure 6 below.

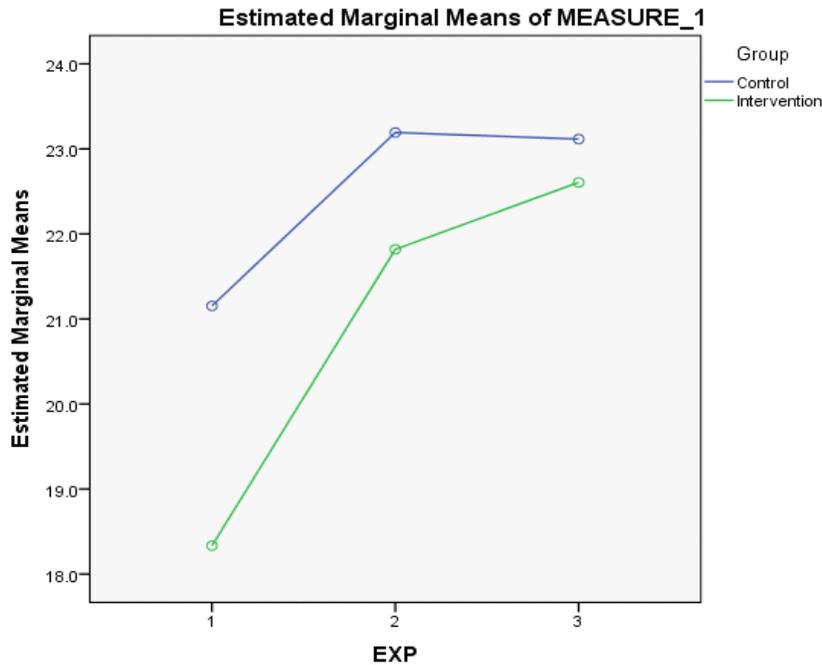
Table 13

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
EXPre	Control	21.154	4.0762	26
	Intervention	18.333	4.6682	33
	Total	19.576	4.6021	59
EXPost 1	Control	23.192	5.2155	26
	Intervention	21.818	5.7198	33
	Total	22.424	5.4999	59
EXPost 2	Control	23.115	5.5232	26
	Intervention	22.606	5.2675	33
	Total	22.831	5.3406	59

Table 14

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	Df	Mean Square	F	Sig.
EXP	Sphericity Assumed	338.733	2	169.366	24.054	.000
	Greenhouse-Geisser	338.733	1.929	175.645	24.054	.000
	Huynh-Feldt	338.733	2.000	169.366	24.054	.000
	Lower-bound	338.733	1.000	338.733	24.054	.000
EXP * Group	Sphericity Assumed	39.660	2	19.830	2.816	.064
	Greenhouse-Geisser	39.660	1.929	20.565	2.816	.066
	Huynh-Feldt	39.660	2.000	19.830	2.816	.064
	Lower-bound	39.660	1.000	39.660	2.816	.099
Error(EXP)	Sphericity Assumed	802.691	114	7.041		
	Greenhouse-Geisser	802.691	109.925	7.302		
	Huynh-Feldt	802.691	114.000	7.041		
	Lower-bound	802.691	57.000	14.082		

Figure 6



Examination of the descriptive and inferential statistics reveals that the means of the two showed no statistically significantly different patterns over the three measurement epochs, as evidenced by the F-ratio for the interaction of group X time ($F[2,114]=2.82, p=.06$).

Feeling Reactivity (FR)

A high score in Feeling Reactive measures one's sensitivity to own needs and feelings, a low score shows insensitivity to one's own needs and feelings (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 15 below, and the mixed ANOVA results are provided in Table 16. The display of mean differences for the groups across time is presented in the profile plot in Figure 7 below.

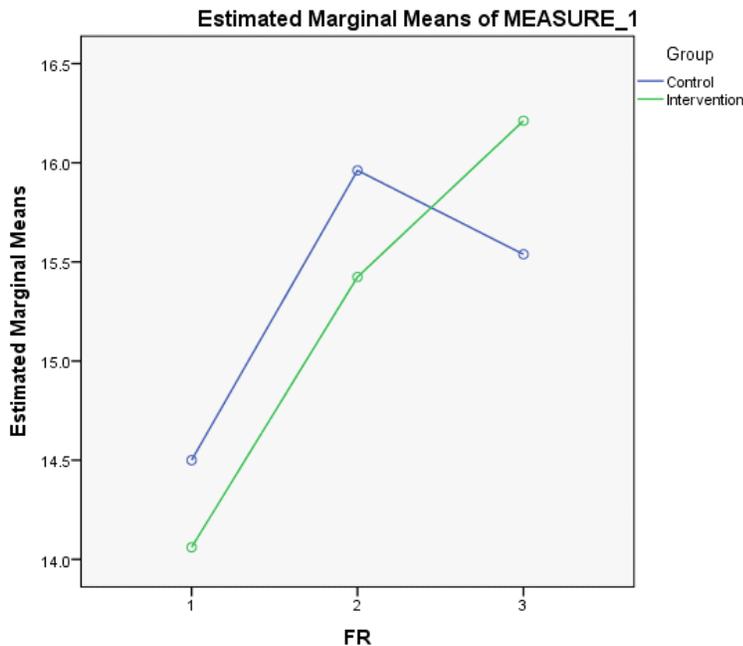
Table 15

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
FRPre	Control	14.500	3.2031	26
	Intervention	14.061	3.2204	33
	Total	14.254	3.1926	59
FRPost 1	Control	15.962	3.0657	26
	Intervention	15.424	2.7503	33
	Total	15.661	2.8804	59
FRPost 2	Control	15.538	3.3850	26
	Intervention	16.212	2.5710	33
	Total	15.915	2.9495	59

Table 16

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
FR	Sphericity Assumed	88.663	2	44.332	15.807	.000
	Greenhouse-Geisser	88.663	1.877	47.237	15.807	.000
	Huynh-Feldt	88.663	1.973	44.945	15.807	.000
	Lower-bound	88.663	1.000	88.663	15.807	.000
FR * Group	Sphericity Assumed	13.160	2	6.580	2.346	.100
	Greenhouse-Geisser	13.160	1.877	7.011	2.346	.104
	Huynh-Feldt	13.160	1.973	6.671	2.346	.101
	Lower-bound	13.160	1.000	13.160	2.346	.131
Error(FR)	Sphericity Assumed	319.721	114	2.805		
	Greenhouse-Geisser	319.721	106.988	2.988		
	Huynh-Feldt	319.721	112.444	2.843		
	Lower-bound	319.721	57.000	5.609		

Figure 7



Examination of the descriptive and inferential statistics reveals that the means of the two showed no statistically significantly different patterns over the three measurement epochs, as evidenced by the F-ratio for the interaction of group X time ($F[2,114]=2.35, p=.10$).

Spontaneity (S):

A high score in Spontaneity measures the ability to express feelings in spontaneous action, a low score indicates that one is fearful of expressing feelings behaviorally (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 17 below, and the mixed ANOVA results are provided in Table 18. The display of mean differences for the groups across time is presented in the profile plot in Figure 8 below.

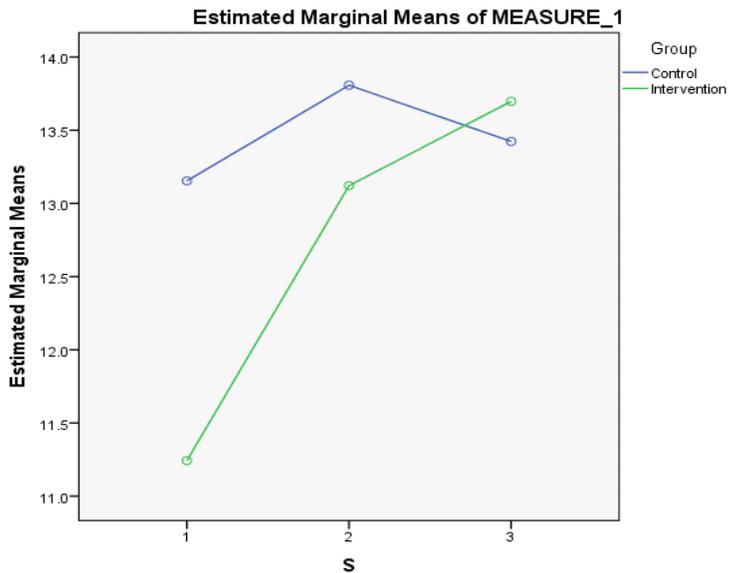
Table 17

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
SPre	Control	13.154	2.3612	26
	Intervention	11.242	3.6745	33
	Total	12.085	3.2815	59
SPost 1	Control	13.808	2.6385	26
	Intervention	13.121	2.2605	33
	Total	13.424	2.4368	59
SPost 2	Control	13.423	3.0222	26
	Intervention	13.697	2.3781	33
	Total	13.576	2.6601	59

Table 18

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	Df	Mean Square	F	Sig.
S	Sphericity Assumed	67.233	2	33.616	15.189	.000
	Greenhouse-Geisser	67.233	1.785	37.669	15.189	.000
	Huynh-Feldt	67.233	1.871	35.935	15.189	.000
	Lower-bound	67.233	1.000	67.233	15.189	.000
S * Group	Sphericity Assumed	34.894	2	17.447	7.883	.001
	Greenhouse-Geisser	34.894	1.785	19.550	7.883	.001
	Huynh-Feldt	34.894	1.871	18.650	7.883	.001
	Lower-bound	34.894	1.000	34.894	7.883	.007
Error(S)	Sphericity Assumed	252.304	114	2.213		
	Greenhouse-Geisser	252.304	101.735	2.480		
	Huynh-Feldt	252.304	106.644	2.366		
	Lower-bound	252.304	57.000	4.426		

Figure 8



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=7.88, p \leq .001$). The intervention group showed substantially lower S at the pretest, but also showed a disproportionately large increase in S when compared to the control group.

Self-Regard (SR):

A high score measures the ability to like one's self because of one's strengths as a person, a low score indicates low self-worth (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 19 below, and the mixed ANOVA results are provided in Table 20. The display of mean differences for the groups across time is presented in the profile plot in Figure 9 below.

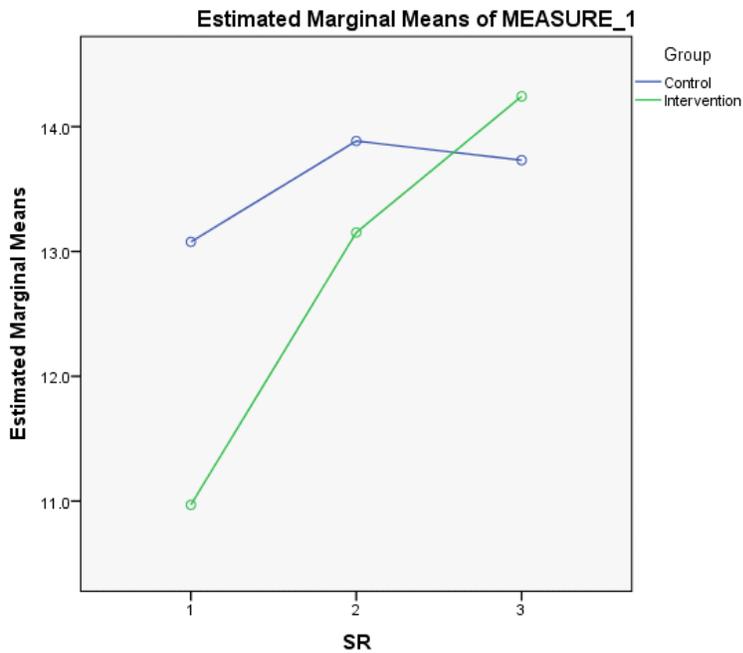
Table 19

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
SRPre	Control	13.077	2.3311	26
	Intervention	10.970	3.3023	33
	Total	11.898	3.0777	59
SRPost 1	Control	13.885	2.0460	26
	Intervention	13.152	1.9059	33
	Total	13.475	1.9858	59
SRPost 2	Control	13.731	2.3248	26
	Intervention	14.242	1.6961	33
	Total	14.017	1.9956	59

Table 20

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
SR	Sphericity Assumed	122.317	2	61.159	25.586	.000
	Greenhouse-Geisser	122.317	1.564	78.231	25.586	.000
	Huynh-Feldt	122.317	1.628	75.135	25.586	.000
	Lower-bound	122.317	1.000	122.317	25.586	.000
SR * Group	Sphericity Assumed	49.910	2	24.955	10.440	.000
	Greenhouse-Geisser	49.910	1.564	31.921	10.440	.000
	Huynh-Feldt	49.910	1.628	30.658	10.440	.000
	Lower-bound	49.910	1.000	49.910	10.440	.002
Error(SR)	Sphericity Assumed	272.497	114	2.390		
	Greenhouse-Geisser	272.497	89.122	3.058		
	Huynh-Feldt	272.497	92.794	2.937		
	Lower-bound	272.497	57.000	4.781		

Figure 9



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=10.44, p \leq .001$). The intervention group showed substantially lower SR at the pretest, but also showed a disproportionately large increase in SR when compared to the control group.

Self-Acceptance (SA)

A high score measures acceptance of one's self in spite of weaknesses or deficiencies. A low score indicates inability of accept one's weaknesses. It is more difficult to achieve self-acceptance than self-regard. Self-actualizing requires both (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 21 below,

and the mixed ANOVA results are provided in Table 22. The display of mean differences for the groups across time is presented in the profile plot in Figure 10 below.

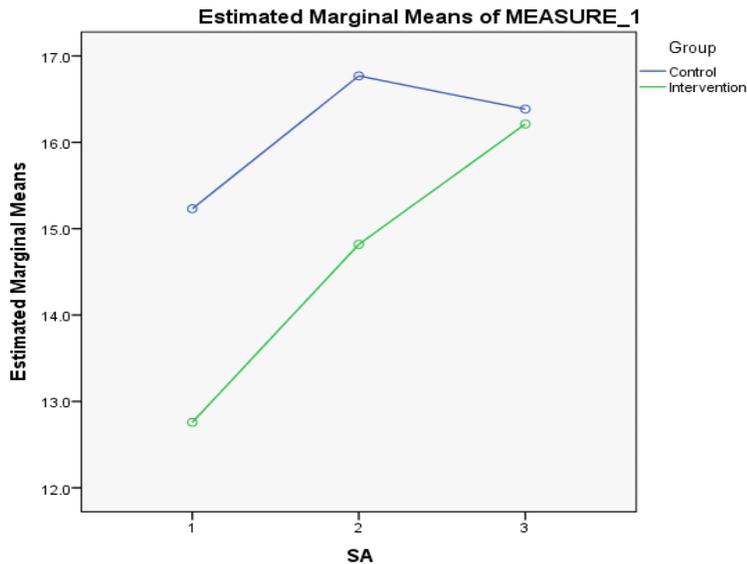
Table 21

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
SAPre	Control	15.231	3.8710	26
	Intervention	12.758	3.7917	33
	Total	13.847	3.9906	59
SAPost 1	Control	16.769	2.9974	26
	Intervention	14.818	4.1114	33
	Total	15.678	3.7621	59
SAPost 2	Control	16.385	3.4650	26
	Intervention	16.212	4.1740	33
	Total	16.288	3.8464	59

Table 22

Tests of Within-Subjects Effects						
Measure: MEASURE_1						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
SA	Sphericity Assumed	170.676	2	85.338	23.128	.000
	Greenhouse-Geisser	170.676	1.926	88.619	23.128	.000
	Huynh-Feldt	170.676	2.000	85.338	23.128	.000
	Lower-bound	170.676	1.000	170.676	23.128	.000
SA * Group	Sphericity Assumed	42.314	2	21.157	5.734	.004
	Greenhouse-Geisser	42.314	1.926	21.970	5.734	.005
	Huynh-Feldt	42.314	2.000	21.157	5.734	.004
	Lower-bound	42.314	1.000	42.314	5.734	.020
Error(SA)	Sphericity Assumed	420.646	114	3.690		
	Greenhouse-Geisser	420.646	109.779	3.832		
	Huynh-Feldt	420.646	114.000	3.690		
	Lower-bound	420.646	57.000	7.380		

Figure 10



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=5.73, p=.004$). The intervention group showed substantially lower SA at the pretest, but also showed a disproportionately large increase in SA when compared to the control group.

Nature of Man Constructive (NC):

A high score means that one sees man as essentially good. He can resolve the goodness-evil, masculine-feminine, selfishness-unselfishness and spirituality dichotomies in the nature of man. A high score, therefore, measures the self-actualizing ability to be synergic in understanding human nature. A low score means that one sees man as essentially evil or bad and is not synergistic (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 23 below,

and the mixed ANOVA results are provided in Table 24. The display of mean differences for the groups across time is presented in the profile plot in Figure 11 below.

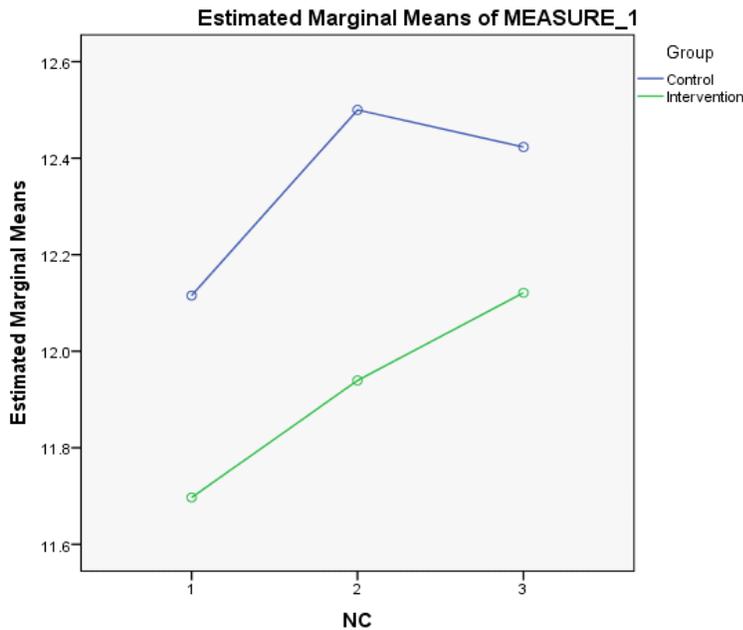
Table 23

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
NCPre	Control	12.115	2.1786	26
	Intervention	11.697	1.8622	33
	Total	11.881	2.0007	59
NCPost 1	Control	12.500	1.9235	26
	Intervention	11.939	1.7128	33
	Total	12.186	1.8144	59
NCPost 2	Control	12.423	1.7245	26
	Intervention	12.121	1.5763	33
	Total	12.254	1.6357	59

Table 24

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	Df	Mean Square	F	Sig.
NC	Sphericity Assumed	4.556	2	2.278	1.216	.300
	Greenhouse-Geisser	4.556	1.859	2.450	1.216	.298
	Huynh-Feldt	4.556	1.953	2.333	1.216	.300
	Lower-bound	4.556	1.000	4.556	1.216	.275
NC * Group	Sphericity Assumed	.488	2	.244	.130	.878
	Greenhouse-Geisser	.488	1.859	.263	.130	.864
	Huynh-Feldt	.488	1.953	.250	.130	.873
	Lower-bound	.488	1.000	.488	.130	.719
Error(NC)	Sphericity Assumed	213.523	114	1.873		
	Greenhouse-Geisser	213.523	105.985	2.015		
	Huynh-Feldt	213.523	111.335	1.918		
	Lower-bound	213.523	57.000	3.746		

Figure 11



Examination of the descriptive and inferential statistics reveals that the means of the two showed no statistically significantly different patterns over the three measurement epochs, as evidenced by the F-ratio for the interaction of group X time ($F[2,114]=0.13, p=.88$).

Results for Synergy (SY):

A high score is a measure of the ability to see opposites of life as meaningfully related. A low score means that one sees opposites of life as antagonistic. When one is synergistic one sees that work and play are not different, that lust and love, selfishness and other dichotomies are not really opposites at all (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 25 below, and the mixed ANOVA results are provided in Table 26. The display of mean differences for the groups across time is presented in the profile plot in Figure 12 below.

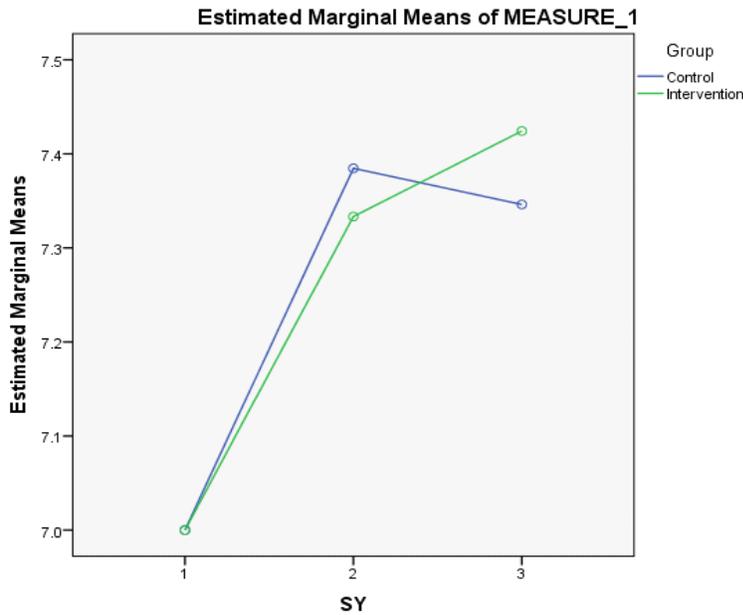
Table 25

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
SYPre	Control	7.000	1.4142	26
	Intervention	7.000	1.4142	33
	Total	7.000	1.4020	59
SYPost 1	Control	7.385	1.0983	26
	Intervention	7.333	1.2416	33
	Total	7.356	1.1710	59
SYPost 2	Control	7.346	1.1642	26
	Intervention	7.424	.9024	33
	Total	7.390	1.0174	59

Table 26

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	Df	Mean Square	F	Sig.
SY	Sphericity Assumed	5.389	2	2.694	3.325	.039
	Greenhouse-Geisser	5.389	1.950	2.764	3.325	.041
	Huynh-Feldt	5.389	2.000	2.694	3.325	.039
	Lower-bound	5.389	1.000	5.389	3.325	.073
SY *	Sphericity Assumed	.123	2	.062	.076	.927
	Greenhouse-Geisser	.123	1.950	.063	.076	.923
	Huynh-Feldt	.123	2.000	.062	.076	.927
	Lower-bound	.123	1.000	.123	.076	.784
Error(SY)	Sphericity Assumed	92.374	114	.810		
	Greenhouse-Geisser	92.374	111.137	.831		
	Huynh-Feldt	92.374	114.000	.810		
	Lower-bound	92.374	57.000	1.621		

Figure 12



Examination of the descriptive and inferential statistics reveals that the means of the two showed no statistically significantly different patterns over the three measurement epochs, as evidenced by the F-ratio for the interaction of group X time ($F[2,114]=0.76, p=.93$).

Acceptance of Aggression (A):

A high score indicates an ability to accept anger or aggression within one's self as natural. A low score means that one denies having such feelings (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 27 below, and the mixed ANOVA results are provided in Table 28. The display of mean differences for the groups across time is presented in the profile plot in Figure 13 below.

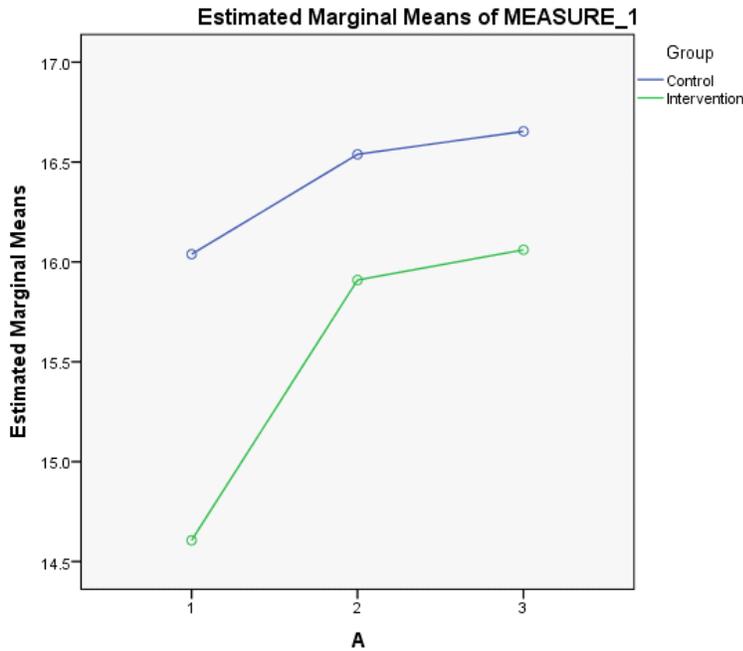
Table 27

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
APre	Control	16.038	3.5942	26
	Intervention	14.606	3.7909	33
	Total	15.237	3.7432	59
APost 1	Control	16.538	3.2891	26
	Intervention	15.909	2.9724	33
	Total	16.186	3.1044	59
APost 2	Control	16.654	3.4979	26
	Intervention	16.061	2.3971	33
	Total	16.322	2.9210	59

Table 28

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
A	Sphericity Assumed	36.873	2	18.437	4.848	.010
	Greenhouse-Geisser	36.873	1.823	20.230	4.848	.012
	Huynh-Feldt	36.873	1.913	19.278	4.848	.011
	Lower-bound	36.873	1.000	36.873	4.848	.032
A * Group	Sphericity Assumed	6.546	2	3.273	.861	.426
	Greenhouse-Geisser	6.546	1.823	3.591	.861	.417
	Huynh-Feldt	6.546	1.913	3.422	.861	.421
	Lower-bound	6.546	1.000	6.546	.861	.357
Error(A)	Sphericity Assumed	433.567	114	3.803		
	Greenhouse-Geisser	433.567	103.894	4.173		
	Huynh-Feldt	433.567	109.026	3.977		
	Lower-bound	433.567	57.000	7.606		

Figure 13



Examination of the descriptive and inferential statistics reveals that the means of the two showed no statistically significantly different patterns over the three measurement epochs, as evidenced by the F-ratio for the interaction of group X time ($F[2,114]=0.86, p=.43$).

Capacity for Intimate Contact (C)

A high score indicates a person's ability to develop meaningful relationships with other human beings. A low score means one has difficulty with warm interpersonal relationships (Shostrom, E., 1987).

The descriptive statistics, broken down by control and intervention groups, and by the three sequential measurements (pretest, posttest, and follow up) are presented in Table 29 below, and the mixed ANOVA results are provided in Table 30. The display of mean differences for the groups across time is presented in the profile plot in Figure 14 below.

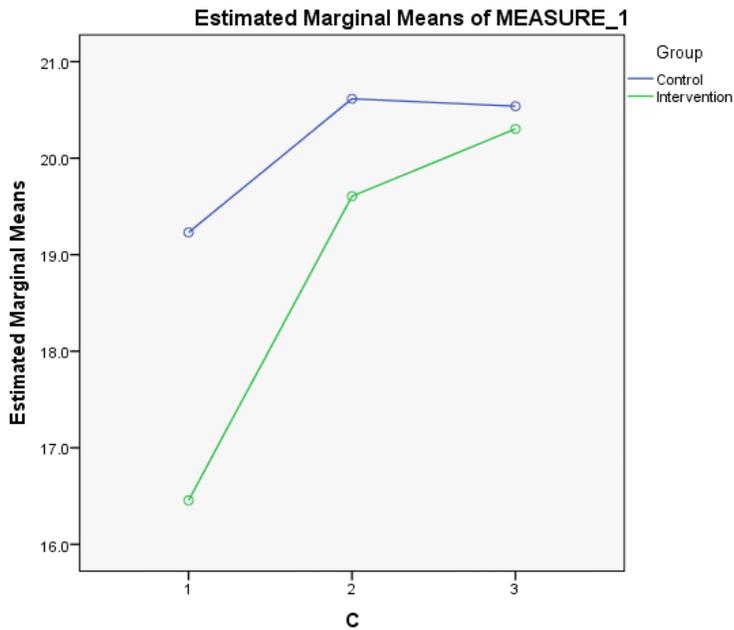
Table 29

Descriptive Statistics				
	Group	Mean	Std. Deviation	N
CPre	Control	19.231	3.9223	26
	Intervention	16.455	4.5558	33
	Total	17.678	4.4738	59
CPost 1	Control	20.615	4.0702	26
	Intervention	19.606	3.8966	33
	Total	20.051	3.9716	59
CPost 2	Control	20.538	4.5187	26
	Intervention	20.303	3.7122	33
	Total	20.407	4.0519	59

Table 30

Tests of Within-Subjects Effects						
Source		Type III Sum of Squares	df	Mean Square	F	Sig.
C	Sphericity Assumed	230.483	2	115.241	28.052	.000
	Greenhouse-Geisser	230.483	1.753	131.448	28.052	.000
	Huynh-Feldt	230.483	1.836	125.512	28.052	.000
	Lower-bound	230.483	1.000	230.483	28.052	.000
C * Group	Sphericity Assumed	49.330	2	24.665	6.004	.003
	Greenhouse-Geisser	49.330	1.753	28.134	6.004	.005
	Huynh-Feldt	49.330	1.836	26.863	6.004	.004
	Lower-bound	49.330	1.000	49.330	6.004	.017
Error(C)	Sphericity Assumed	468.331	114	4.108		
	Greenhouse-Geisser	468.331	99.945	4.686		
	Huynh-Feldt	468.331	104.671	4.474		
	Lower-bound	468.331	57.000	8.216		

Figure 14



Examination of the descriptive and inferential statistics reveals that the means of the two showed a statistically significantly different pattern over the three measurement epochs, as evidenced by the statistically significant F-ratio for the interaction of group X time ($F[2,114]=6.00, p=.003$). The intervention group showed substantially lower C at the pretest, but also showed a disproportionately large increase in C when compared to the control group.

Summary

A number of statistically significant changes were achieved in this research study, below are highlights of the changes that were obtained in four ICPT™ sessions spaced one week apart over a one month period.

State Trait Anxiety Inventory Key Results

State-Anxiety

This research study to determine the effectiveness of the Inner Counselor Process™,

was able to demonstrate reduction in State Anxiety $p=.002$. The level of S-Anxiety was much higher in the pretest in the group receiving the intervention than the control group, with a noticeable reduction in S-Anxiety at the time of the first posttest, and additional reduction in S-Anxiety one month after the fourth intervention. S-Anxiety in the control group began with a mean of 34.038, decreased to a mean of 31.808, and ended with 32.000 in the final posttest. S-Anxiety in the intervention group began with a mean of 42.636, decreasing to a mean of 34.576, and 32.788 in the final posttest.

Trait-Anxiety

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate reduction in Trait Anxiety $p=.001$. The level of T-Anxiety was much higher in the pretest in the group receiving the intervention than the control group, with a noticeable reduction in T-Anxiety at the time of the first posttest, and additional reduction in T-Anxiety one month after the fourth intervention. T-Anxiety in the control group began with a mean of 36.038, decreased to a mean of 34.154, and ended with 33.81 in the final posttest. T-Anxiety in the intervention group began with a mean of 46.333, decreasing to a mean of 37.848, and 36.73 in the final posttest.

Personal Orientation Inventory Key Results

Time Competence (TC)

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate an increase in Time Competence $p=.05$. The level of TC was much lower in the pretest in the group receiving the intervention than the control group, with a noticeable increase in TC at the time of the first posttest, and additional increase in TC one month after the fourth intervention. TC in the control group began with a mean of 15.346,

increased to a mean of 16.269, and ended with 16.88 in the final posttest. TC in the intervention group began with a mean of 13.909, increasing to a mean of 16.061, and 17.00 in the final posttest surpassing the TC of the control group.

Inner Directed (I)

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate an increase in Inner Directed $p=.001$. The level of (I) was much lower in the pretest in the group receiving the intervention than the control group, with a noticeable increase in (I) at the time of the first posttest, and additional increase in (I) one month after the fourth intervention. (I) in the control group began with a mean of 87.000, increased to a mean of 91.577, and ended with 91.38 in the final posttest. (I) in the intervention group began with a mean of 77.485, increasing to a mean of 87.939, and 91.27 in the final posttest surpassing the (I) of the control group.

Spontaneity (S)

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate an increase in Spontaneity (S) $p=.001$. The level of (S) was much lower in the pretest in the group receiving the intervention than the control group, with a noticeable increase in (S) at the time of the first posttest, and additional increase in (S) one month after the fourth intervention. (S) in the control group began with a mean of 13.154, increased to a mean of 13.808, and ended with 13.423 in the final posttest. (S) in the intervention group began with a mean of 11.242, increasing to a mean of 13.121, and 13.697 in the final posttest surpassing the (S) of the control group which decreased in the final posttest.

Self-Regard (SR)

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate an increase in Self-Regard $p=.001$. The level of (SR) was much lower in the pretest in the group receiving the intervention than the control group, with a noticeable increase in (SR) at the time of the first posttest, and additional increase in (SR) one month after the fourth intervention. (SR) in the control group began with a mean of 13.077, increased to a mean of 13.885, and ended with 13.731 in the final posttest. (SR) in the intervention group began with a mean of 10.970, increasing to a mean of 13.152, and 14.242 in the final posttest surpassing the (SR) of the control group which decreased in the final posttest.

Self-Acceptance (SA)

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate an increase in Self-Acceptance $p=.004$. The level of (SA) was much lower in the pretest in the group receiving the intervention than the control group, with a noticeable increase in (SA) at the time of the first posttest, and additional increase in (SA) one month after the fourth intervention. (SA) in the control group began with a mean of 15.231, increased to a mean of 16.769, and decreased ending with 16.385 in the final posttest. (SA) in the intervention group began with a mean of 12.758, increasing to a mean of 14.818, and increasing to 16.212 in the final posttest.

Capacity for Intimate Contact

This research study to determine the effectiveness of the Inner Counselor Process™, was able to demonstrate an increase in Capacity for Intimate Contact $p=.003$. The level of (C) was much lower in the pretest in the group receiving the intervention than the control group, with a noticeable increase in (C) at the time of the first posttest, and additional increase in (C) one

month after the fourth intervention. (C) in the control group began with a mean of 19.231, increased to a mean of 20.615, and ended with 20.538 in the final posttest. (C) in the intervention group began with a mean of 16.455, increasing to a mean of 19.606, and 20.303 in the final posttest.

This study as able to demonstrate four sessions of the Inner Counselor Process™, were able to produce statistically significant reduction in State and Trait Anxiety as measured by the STAI. The four sessions of the ICP™ were also able to produce statistically significant changes in qualities that indicate Self-Actualization as measured by the POI, these qualities include: Time Competence, Inner Directed, Spontaneity, Self-Regard, Self-Acceptance and Capacity for Intimate Contact.

Study Limitations

This is the first study of this kind and as such is essentially a large pilot trial and further studies will need to include phase one, two and three randomized controlled trials for efficacy and effectiveness. Relatively small sample size, sample of convenience and specific age grouping are further limitations. The participants were allowed to self-select into intervention or control group. A limited number of measures were used in this study and further studies might include physiologically based measures and additional psychological test instruments.

Chapter Five:

Discussion

Introduction

This research study was the first such study to evaluate the Inner Counselor Process™, a process that for nearly forty years has relied on anecdotal reports of powerfully positive results. The study was designed to determine if four one hour ICP™ sessions spaced one week apart could statistically reduce State and Trait anxiety as measured by the STAI. The study was also designed to evaluate the capacity for the ICP™ sessions to influence qualities of self-actualization as measured by the POI. Volunteers were recruited for the research that had a diagnosis of anxiety, or self-reported anxiety, and/or experienced feelings or emotions that kept them feeling stuck in life to participate in the intervention. The study, a sample of convenience attracted seventy participants through word of mouth and through social media, fifty-nine participants completed the study.

Discussion

Participants in the intervention group scored noticeably higher on S-Anxiety and T-Anxiety on the pretests than the control group. The results demonstrate statistically significant reduction in State and Trait Anxiety as well as a strong shift in many of the parameters that define self-actualization. These parameters include Time Competence, Inner Directed, Spontaneity, Self-Regard, Self-Acceptance, and Capacity for Intimate Contact. These statistically significant changes were accomplished in four sessions over four weeks.

Unlike Cognitive Behavioral Therapy, the ICP™ is a whole systems approach, that expands conscious awareness in ways that support progressive integration and transformation

(Nunley, 2009). The IC does not employ a cognitive approach, but rather utilizes a hypnagogic state of consciousness that allows the participant

“...to connect with a higher consciousness (through the spiritual/soul/wisdom self) to bring healing and integration to the mental emotional aspects of the personality as well as the physical body. “Within the context of this spiritual orientation, the personality is considered a vehicle of awareness and action through which we can become conscious of and address conflicts of duality as we move towards healthy self-actualization, and transformational awakening”.

(Nunley, 2009)

Guiding the participant to focus on somatic symptoms helps them to travel back in time to a specific moment or event, feel the original pain, and provide information about any unmet intrinsic needs of their younger self. The sessions delved deeply into painful memories and experiences, while simultaneously providing a systematic and highly effective method to visit the painful memories, restore unmet intrinsic needs and help resolve the pain the issue has been causing. All sessions ended with the Integrative Exercise. This exercise is used to complete the experiential metamorphosis into integrative wholeness.

The average length of time for the ICP™ was thirty-five to forty-five minutes, the PI was a guide and a witness to the capacity of the participant’s ability to follow the process utilizing somatic sensations of recent experiences, bypassing cognition and following the somatic sensations back through time. During the process, key emotions were felt in the body, an incident of origin was re-visited, intrinsic needs were identified by the participant, and through the use of symbolic insight, the participant was able to achieve a new level of healing resolution and spiritual integration.

Participants were guided by the wisdom of their own higher-self, directly to the areas of trauma that needed healing. With each session participants were gently guided by their higher self to a different traumatic event to process negative emotions and painful memories, and given opportunity restore previously unmet intrinsic needs. The four sessions seemed to be progressive in depth of pain and trauma with the fourth session being the most profound for many of the participants. By the fourth session, the participants were familiar with the process, and were able to allow themselves to go even deeper into significant trauma in order to create healing.

An Integrative Approach

The effectiveness of the ICP™ provides an integrative approach to treating anxiety and the underlying trauma. The ICP™ begins by engaging the senses in order to utilize somatic sensations as a guide to re-discovering and healing the wounds of the encapsulated trauma that has been stored in the body, in many cases for decades. The ICP™ approach views somatization and physical sensation as a method of expressing emotions from a bodily perspective. It has long been recognized that physical and psychological experiences are closely interwoven during early development and, to some extent throughout life (Rodin, 1984). Candice Pert was able to demonstrate and document emotional receptors throughout the body in her work, as written about in her book *Molecules of Emotion* (Pert, 1997). The ICP™ utilizes the emotional receptors throughout the body to access stored traumatic experience while creating a whole system, symbolically based approach to re-integration of a fragmented psyche.

New Possibilities in Treating Anxiety and Trauma

As a culture, we have been led to believe an external source is the authority and holds the power to fix everything that causes suffering. At present, we are being offered methods for exploring new directions and possibilities to restore an internal locus of control that helps us to maintain or restore mental and emotional health and well-being. The Cognitive Behavioral Therapy model, while effective for cognitive restructuring in some cases, has underestimated and overlooked the significance that our emotions, body memory, and psyche have in terms of revealing important information that can guide us like a compass to truly heal.

This study of the Inner Counselor Process suggests new possibilities in integrative healing. Rather than labeling anxiety, and somatization as pathology, or suppressing symptoms with prescription medications, the ICP™ engages body, mind, emotions and spirit, in a journey of healing through integration, transformation and spiritual awakening (Nunley, 2009). The ICP™ approach views the messages from the body as a compass containing information from our soul, spirit and higher wisdom that indicate a need to move towards mental, emotional, spiritual, and physical homeostasis and into sense of well-being and holism. The ICP™ approach demonstrates that the integration of psyche and soma can reduce anxiety and move an individual toward self-actualization (Nunley, 2009).

Clinical Observations

The PI was a guide and witness to over 150 IC processes over a four-week period. Participants repeatedly reported moments of awareness and clarity after completion of each session, one after another reporting a new understanding of how a present emotional response is linked to a past experience. Often at the end of a process, participants reported “it makes so much sense, but I never would have put it together”. Frequently participants were guided back to

moments in time long ago forgotten that had significant meaning in creating maladaptive coping patterns, and emotional response patterns that no longer served them.

These previous moments in time included a variety of experiences, such as being a young child playing a playful prank and being scolded harshly by adults, creating immense embarrassment and shame which developmentally affected confidence. Or in other situations being a 2-year-old witnessing a father's rage from behind a chair feeling unworthy, powerless, frightened and helpless, or being a young child witnessing domestic violence followed later by living through parents divorcing, feeling unseen, unheard and unloved. Participants were able to go back to the root of fragmentation of the psyche and, through the ICP and supported by their own wisdom, provide for themselves exactly the unmet intrinsic needs they so fervently desired.

In each case, in each process the participating adults were able to go back in time and offer comfort and provide for their younger self the unmet intrinsic needs that were deficient due to traumatic circumstances. They were able to transform the immature coping patterns that had resulted from early unmet needs. Women with sexual abuse were able to go back and address their younger self and offer comfort and reassurance that it wasn't their fault, that they were good little girls who deserved to be loved, and hugged in a healthy way. Each of the women who addressed childhood abuse shared in the exit interview that they now feel free of the experiences, and are no longer asking "why". They are also now able to communicate with the abuser (often a family member) and no longer experience recurring suffering with each interaction. This is remarkable considering that this is the result of only four one hour sessions.

During the ICP sessions, these adults were able to go back in time and say out loud what they could not say back then, finding their personal truth while liberating their ability to communicate openly and honestly going forward. Each session held its own magical moments of

healing and was truly an honor to facilitate and witness. Each session ended in a similar way. The participants, one after another reported feeling lighter, and much freer after the session. Many reported a sense of feeling liberated after each 30-45-minute process. The participants journaled following each session, and the journaling reflected a sense of renewal and hope. Many of the participants eagerly returned the following week excited to share as they continued to recall their “new symbol” and to discuss how it carried them during the week between sessions, reassuring them, comforting them and transforming (and eliminating) old reactive response patterns and behaviors.

Exit Interviews: Debriefing

Each intervention participant that completed the study was scheduled for an exit interview for debriefing. The following questions were asked 1) Are you aware of any positive or negative changes as a result of the four ICPT™? 2) What changes if any have you noticed? 3) Do you feel more sessions would be helpful? 4) Do you feel the four sessions were worthwhile? 5) Would you recommend the IC process to others? Following the previous questions, a review was done of the four sessions and the emotions addressed, to determine resolution, partial resolution or no resolution. A comprehensive list of comments is in Appendix F.

Collective subjective information

Recognizing there may be influencing factors in the responses, such as desire to please the PI, the overall feedback was strongly positive from participants.

Below are the general collective responses:

Q. Are you aware of any positive or negative changes as a result of the four ICPT™?

- All feedback was 100% positive except for 2 individual exceptions. The two individuals expressed they were more aware of and experiencing more emotions, both felt “this

wasn't necessarily a bad thing". PI interpretation is that old memories were stirred up and the lid had come off, both individuals felt more sessions would be helpful and plan to schedule sessions in the future.

Q. Are you aware of any positive or negative changes?

- Other than the comments above 100% positive reports

Q. What changes have you noticed?

- Many were able to specifically identify positive changes (See Appendix F).
- None had negative outcomes to report

Q. Do you feel more sessions would be helpful?

- Some felt more sessions would be helpful, others felt 4 was just right

Q. Were the four sessions worthwhile?

- 100% felt the 4 sessions were worthwhile

Q. Would you recommend the IC process to others?

- 100% said they would recommend the process to others.

Individual Subjective feedback during the debriefing interviews

Participants were open and willing to share their experiences in the debriefing interviews. The following are reports offered by participants during the exit interview, it is important to keep in mind we met on only four occasions with no prior therapeutic relationship. An expanded list of comments is included in Appendix F.

Drug dependency came to light, one individual who had been unemployed, and heavily using meth reported being clean and sober and had become employed, expressing a new level of hope about the future. This same person reported 6 months after the study remaining clean and sober, and is setting boundaries in personal relationships. Another individual who has struggled

with alcohol addiction reported being clean and sober at the debriefing, reported remaining sober at 6 months after the interventions.

Women who had long term sexual abuse by a family member as a child reported they no longer carry the intense feelings and confusion toward the abuser, they are able to move forward with life. One of the individuals can now speak with the family member without the intense somatic experience she carried for decades. Another said she no longer ruminates about “why”, and no longer feels responsible for the long term sexual abuse, she also has been able to set clear boundaries with an abusive relationship.

Several people verbalized they got more out of the four sessions than they had from decades of talk therapy. Referring therapists confirmed positive progress. Many people found domestic relationships improved, and intimate relationships are healthier. Others were able to speak up, and set boundaries as a result of higher self-regard. A couple of women actually left the abusive relationship they were in, shortly after the study. Several people expressed being able to make positive choices that moved them forward in life as a result of feeling more confident and worthy of a better life. One woman with a history of perfectionism, reports she is far less concerned with what others think and better able to relax and just be herself.

There were implications of improved immune system function. Reports of physical symptoms improved such as no further irritable bowel symptoms, and blood pressure had reduced to normal parameters. Another participant that is HIV positive reports being healthier and that lab tests are improved. Many reported a feeling of being more at ease and generally feeling stronger and healthier.

The Future of the Inner Counselor Process™

The individuals from this study continue to report how the process has changed their life in positive ways, removing barriers and opening possibilities. Currently there are limited professionals trained in the ICP™. It is important to develop a method of educating and training professionals to utilize the ICP™ in clinical settings. Future research is essential to develop applications for the ICP™ and demonstrate efficacy utilizing the ICP™ as a primary method of treatment in trauma and in individuals struggling with anxiety and self-actualization.

Recommendations for Future Research

Future research is recommended for specific trauma, such as for victims of domestic violence, victims of sexual abuse, rape victims, developmental trauma or veterans suffering from PTSD. Larger studies are needed to confirm the results of this study. Additional consideration might be to include brain imaging or brain mapping pre-and post ICP™, as well as inventories to measure depression or adverse childhood trauma, to observe a variety of potential types of changes and their level of significance.

Summary

Beneath the elevated levels of S-Anxiety and T-Anxiety, were stored traumatic experiences. During the ICP™ sessions a very high percentage of the participants revealed a history of early childhood traumatic experiences, or a history of significant trauma. These traumatic experiences for some of the individuals began early in life and lasted for many years, such as sexual abuse by a family member, domestic abuse, domestic violence, emotional and physical abuse, living with an alcoholic or drug addicted parent, and early suicide attempts due to the overwhelming pain. The early history of trauma was not known to the PI prior to the start of the research study, yet all participants were gently and safely guided through each process.

Other participants in the intervention group had experienced loss, resulting in grief, or had developed emotional sensitivity to fear. This research study demonstrated the ICP™ is an efficient, safe and effective technique to address and treat early childhood trauma and other significant traumatic experiences with no apparent adverse outcomes.

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APPENDIX A-1:

CONSENT FORM FOR PARTICIPANTS OF THE RESEARCH STUDY:

Holos University Graduate Seminary supports the practice of protecting human subjects participating in research. The following information is provided to help you decide whether you wish to participate in the present study. Please be aware that even if you agree to participate, you are free to withdraw at any time without consequence.

The principal investigator, Rev. Sandra Augustine LIMHP, CPC, RN is interested in studying the effects of the Inner Counselor Process™ (ICP™) on aspects associated with well-being, self-worth and self-acceptance. The ICP™ is a gentle guided self-awareness process where all answers and healing comes from accessing the “healer within” that exists in each of us. This guided self-awareness process is not psychotherapy, and you will not be analyzed. The process is personal, individual and guided allowing for your own wisdom to come forth to support you and help you heal issues that you choose to address.

During the Inner Counselor Process™ you will be invited to sit comfortably, with your eyes closed. You will be asked to fully visualize a place of peace that feels safe to you, in this place you will be asked to fully experience the sights, smells and sounds. From this place of peace, you will be guided to become aware of any feelings or emotions that you wish to address during the process, allowing the answers to come to you safely and easily. During the remainder of the process you will be asked to connect with feelings and sensations in your body that relate to the emotions being explored. Strong emotions may be experienced including anger, sadness or tears. Further guidance from your own inner wisdom will allow these emotions to be replaced with desired intrinsic needs such as love, safety or peace. As the process continues you will be guided safely through a transformational process where all answers, images and symbols will come from your personal expanded state of consciousness. Although you may feel like you are in a state of timelessness, you will recall everything that occurs. Completion of the ICP™ includes a guided imagery integration process.

Those who agree to participate in the study, must be willing to complete two self-report pre-tests, followed by participation in four Inner Counselor Processes™ one week apart followed by the same self-report tests as post-tests one week later and one month later. The self-report tests allow the investigator to determine if changes have occurred and if the results are

lasting. The pre-tests and post-tests will take approximately 30-45 minutes to complete. Each Inner Counselor Process™ will take approximately 30-45 minutes to complete, an hour appointment will be allowed for each session. In addition to your consent to participate in the study we ask your permission to have a “distance reading” pre and post study by a clairvoyant medical intuitive who will read your emotional energy patterns and offer a report post-study of whether there is a change in these patterns. The intuitive will be given your name only; no other personal data or information will be offered or provided.

Your participation in this study is greatly appreciated. While the results of the study will be published, your personal information will remain strictly confidential and your privacy will be protected with the research results individually referred to by use of a random number.

If you have concerns or questions please contact the Principal Investigator Sandra Augustine as listed below. If you have additional concerns about the study or your rights you may contact the Faculty supervisor at Holos University Graduate Seminary as listed below.

Sincerely,

Sandra Augustine, Th.D. Candidate

Appendix A-2

SIGNATURE FORM FOR PARTICIPANTS OF THE RESEARCH STUDY:

Using the Inner Counselor Process™ to reduce anxiety, transform and heal encapsulated trauma in order to increase the sense of self-worth, self-acceptance and sense of well-being.

Principal Investigator:

Sandra Augustine, LIMHP, CPC, RN
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Faculty Supervisor:

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785-863-2176
ann4847@earthlink.net

With my signature, I affirm that I agree to take personal responsibility for my participation in the protocol as described above. I agree I have read the previous pages of the consent form, and have had an opportunity to ask any questions or address concerns. I have been offered a copy of this consent for my records.

Print Name

Signature of person agreeing to participate

Date _____

Appendix B
Inner Counselor Process Recording Document

Date & Time: _____ Session Number: _____

Participant's First Name _____ Session Length: _____

- Close your eyes and be your Place of Peace. Fully sense your surroundings • See the colors • Hear the sounds • Breathe the fragrances • Describe this place. • In this place you feel safe, strong and centered. • Invite your (“Higher Self”) into the center of your heart to be your guide for this journey. • I will invite my Higher Self to be my guide.

P.O.P

- What is the issue and feeling you wish to explore?

- Ask your (“Higher Self”) if it is safe and advisable to address this issue and feeling at this time. (If not, ask to be shown an appropriate issue to address at this time). Are there Additional Guides who would like to be present to help you with this issue? (Have the person describe or name any guides).

- Go to a recent time when you experienced this issue. • Where are you? • What is happening? • What emotions do you feel? What sensations do you feel in your body? Where in your body are these feelings the strongest? (Inquire about core areas: throat, heart, stomach).

- Let these FEELINGS intensify and CARRY YOU to an earlier time when you felt the same. Remember that you are safe. Ride the feelings back through time. • Where are you? • What is happening? • How old are you? • What emotions and sensations do you feel? • Where in your body are the feelings the strongest?

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- What do you truly NEED and WANT to feel inside of yourself? (Dialog to arrive at all the things the person needs to feel INSIDE – freedom, worthiness, love, connection, safety - there may be several needs).

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- Be fully present in that old experience. Feel the (“emotions and sensations”) in your (restate locations). Imagine now you can gather all those feelings and pull them outside of your body and that you can SEE the feelings – Let the feelings take form. Describe the form. • Does this form have an attitude? • This form is a symbol that represents your old coping patterns.

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- This (“Old Symbol”) had a positive intention. How did it help you cope when your needs were not met? Thank the (“Old Symbol”) for helping you when you did not have other options. • Ask the (“Old Symbol”) if it is willing for you to find a better way to cope so that your inner need for (“state needs”) can be fulfilled.

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- Fully sense your need for (state needs) • Ask your (“Higher Self”) to show you a New Symbol that embodies the qualities and values that can protect you and completely fulfill your inner needs.

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- Will this (“New Symbol”) commit to help you with this issue? Are you willing to commit to the qualities and protection of the (New Symbol)?

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- Bring the two symbols together. Have the (“New Symbol”) show the (“Old Symbol”) how its qualities will BOTH protect you and fulfill your needs. • Is the (“Old Symbol”) willing to allow its form and its coping pattern to be absorbed and changed by the (“New Symbol”)?

- Experience the (New Symbol) completely absorbing the (Old Symbol). Is the (Old Symbol) completely absorbed and transformed by the (New Symbol)? (Dialog with the old symbol until this is complete). How does the (New Symbol) look now? • (there may or may not be a change).

- The (New Symbol) has some advice that you need to hear right now? Listen and then speak the advice out loud. Ask (Higher Self and other guides – if there are any) for their advice.

- Be aware of the original issue and feelings • Feel the (New Symbol's) qualities of (name qualities with location of each) • Empower these qualities by asking them to provide you with a specific response to a specific situation in the next 24 hours. • Describe the situation and your response.

15. Give the (New Symbol) a place of honor within yourself and in your Place of Peace. • Thank yourself, your (guides) and your (Higher Self) for participating today. • (Complete the Energy Exercise)

Appendix C:

Energy Exercise

- Together we form a circuit of energy and we experience that flow....
- As the energy flows, imagine a golden light with the special qualities of the (new symbol) entering the crown of your head.
- Visualize and feel the light and power of this light as it fills your head (Pause) filling every cell.
- Feel the light as it moves down to fill your throat (Pause) across your shoulders and down your arms to the tips of your fingers.
- Feel the light filling your heart and lungs (Pause) your solar plexus (Pause) your abdomen (Pause)
- The golden light with the energy of the (new symbol) then moves down to the base of your spine filling your lower body full of healing light (Pause) down your legs to the tips of your toes (Pause)
- As the light fills your body, every cell is full of light (Pause)
- Every cell is changed by the golden light and the qualities of the (new symbol).
- Feel your feet connect with the energy of the earth. (Pause)
- Feel the strength of that energy and draw it up into your body to strengthen the golden light and the qualities it carries. (Pause)
- We will take some deep cleansing breaths together, breathing in through the nose and blowing out through the mouth... Letting go...
- With each cleansing breath, we allow the golden light to move up throughout our bodies, releasing any residual energies that are not part of the light. (Breathe with the participant until you both are calm and full of light.)

AFFIRMATION PRAYER

May every cell in your being forever hold in memory that —
You are created by Divine Light,
You are surrounded by Divine Light,
You are protected by Divine Light,
You are sustained by Divine Light,
You are ever growing into Divine Light.

~Swami Radha, Canada

Quietly open your eyes, and be here in this room
Feeling alert and refreshed, and filled with light.

**Appendix E
Recruitment Flyer**

ARE YOU INTERESTED?

SEEKING ADULTS OVER 18 YEARS OF AGE

With a diagnosis of anxiety, or self-reported anxiety, and/or feelings or emotions that keeps you feeling stuck in your life.

To Participate in a project to explore
“THE EFFECTS OF THE INNER COUNSELOR PROCESS”
ON INCREASING A SENSE OF WELL-BEING

The Inner Counselor Process™ is a holistic process designed to access “the healer within you” and bring forth your inner wisdom. Participation will require a total of approximately seven hours in divided sessions of approximately one hour each.

If you are interested in this opportunity, please contact the researcher at the number below.

There is no fee; the process is free to all participants.

Participation is confidential and Privacy will be protected.

Please contact:

Sandra Augustine LIMHP, CPC, RN

402-904-3663

theaugustineapproach@gmail.com

TO ENROLL OR FOR QUESTIONS

Appendix F

Exit Interviews: A sample comments offered during debriefing.

Physical changes:

- My blood pressure is lower. Before 155/90's, now 120/66.
- My irritable bowel symptoms are gone.
- I feel much better physically, way more energy.
- I am not using Meth. (Update at 6 months remains clean)
- I am sober. (Update at 6 months remains sober).
- My HIV has improved, lab work is better.
- I feel healthier in many ways.
- My whole body is way more relaxed - I feel more peaceful and calm now.
- Sleep is now possible – dreams are pleasant (before unable to sleep even with meds).

Relationship Changes to self and others:

- I have a new realization, I am a gift – I am loved because I am lovable.
- Relationships have changed – I am more confident – people respond to me in positive ways.
- Relationships are more open – no longer feel like a loser – I am proud of myself.
- I can hang out more with myself – I am more at ease.
- I have forgiven my father - we can now talk and laugh, it's pretty amazing.
- I feel more hopeful inside, less need for validation.
- I have more peace.
- I am freer to enjoy life.
- I no longer have to punish myself, I know what happened is not my fault.
- I have goals for myself now, rather than fear holding me back.
- I am totally better, this allowed me to get to the roots and clear the clutter.
- I feel more real, I used to be fake.
- I more freely express myself in many ways.
- For the first time in my life I feel more hope for my future.
- I can now connect with my feelings and calmly communicate, before I was not able to express my feelings, I would panic and freeze.
- I'm more connected Spiritually – I feel more authentic
- I feel more empowered.

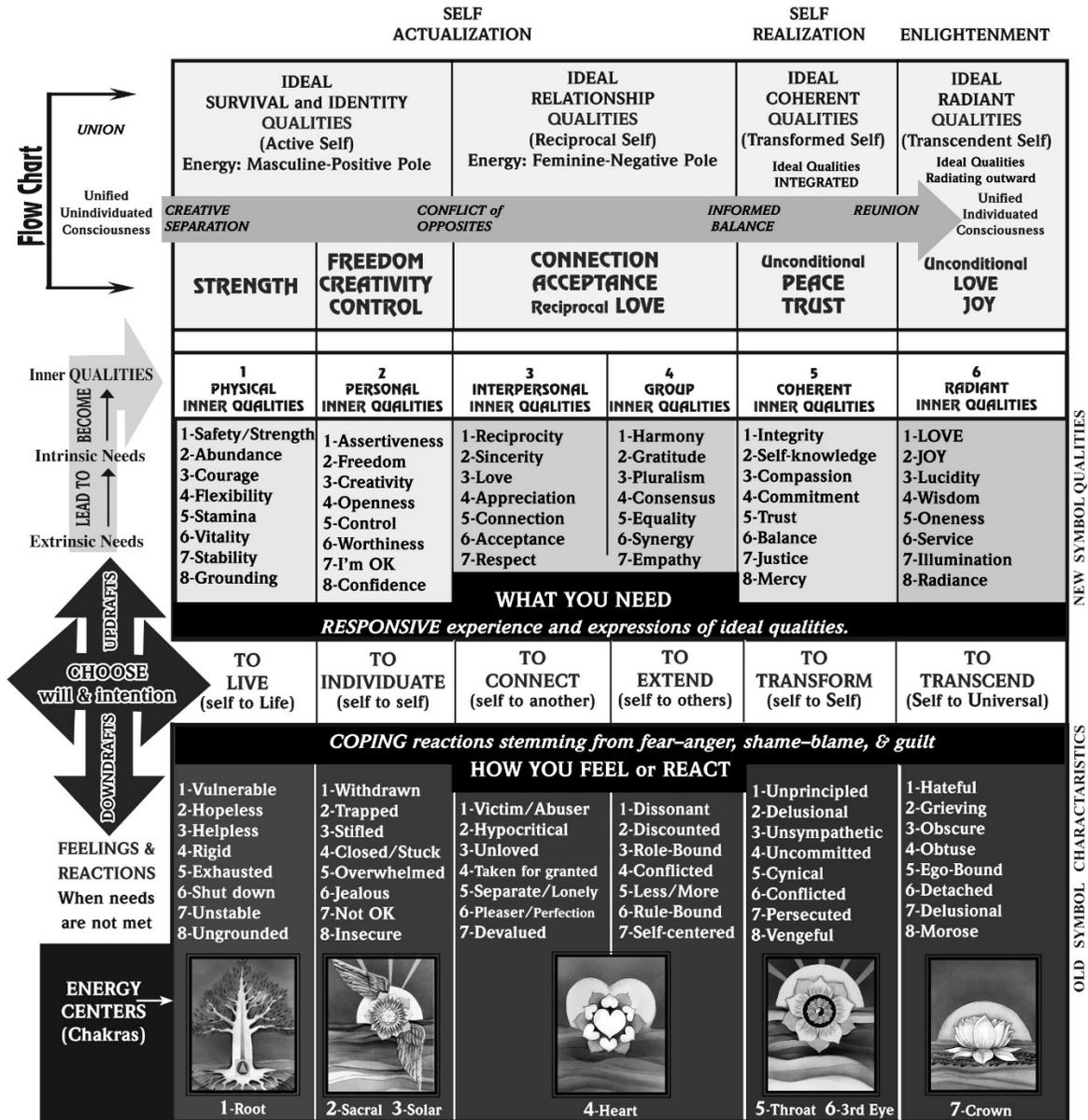
General Comments:

- This was different than I expected, I let myself get vulnerable, felt safe, allowed myself to stay in the space to process.
- I've been in therapy for twenty years and I got more out of these four hours than I did those twenty years.
- I've used a lot of drugs, and I have NEVER felt as good as I did after an ICP™ session, it was the purest high.

APPENDIX G

INTEGRATION CHART

From the INNER COUNSELOR © Ann Nunley



© Ann Nunley, Revised: February, 2007

Appendix H

Notes from the journals of Intervention Participants

- The old symbol for the anger I carried was an open mouth silently screaming, the new symbol of a shield was there to protect me, in the transformation the mouth became part of the shield but it was singing now. I feel at peace leaving today, and the possibility of hope and joy is within my heart.
- Today was an amazing experience. I felt so many different negative emotions but they were swirling outside of me as if voluntarily flowing out into a swirling ball. I saw my soul dancing today with joy and freedom. I'm leaving feeling thankful and blessed.
- I always knew there was something I was blocking out, now that I have seen it I feel so light, free and clear, so present and connected to my body, in such a space of gratitude.
- Today was by far the most powerful of my sessions. The connection of spirit and soul made everything feel complete. The pain I've held onto has limited my life, today's process cut through that and propels me forward. The game has been changed.
- As always, very impressed by the connecting of the dots, the relevance of the content within the session, and the value of visualization and the tools to solve the issues.
- I connected with the energies of guides this week, I had a surprise appearance from my father, it was invaluable to connect to him again.
- Thankful for the trip back to an earlier time to work through being bullied, and the desire for connection and understanding.
- We have found over the last few weeks that communication has flowed better between myself and my spouse. The process has been fascinating, insightful and useful.
- This has been enlightening and encouraging, the process allows me to let go.
- Holy Wow!! I finally feel like I have been able to really access what has been stuck inside of me for so long. I can't fully express the feelings, but I feel energetically and physically like I have been through a re-birthing experience. I have been punishing myself all this time, it is time to shine and glow and share my real self with the world.
- I feel very different right now than I have every felt/remember feeling before. I feel relaxed and vibrant. I purged the shame, anger and self-depreciation.
- I was surprised at the word abandonment coming up, but as we went along the clearer, as we went I could see clearer that feeling during the course of my life.

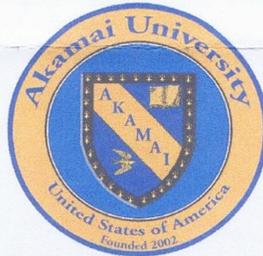
- This is insane, how much I've learned about myself. Powerful stuff! Serenity inducing, wisdom provoking.
- Powerful and intense! I like the idea of going back to give my younger self what he needed, it is helping me become the man I wish to be.
- The session today shined a light into the dark crevice of pain, where I believed I was not enough, and this is what I deserved. I finally feel safe and understand those years.
- I am hopeful again, I feel energized and have a feeling of a new self-image of a younger me dancing around inside me, wanting to get out again, to play and sing and dance without a care in the world!
- No more guilt. Getting my peace of mind back, knowing I have a purpose in life.
- Today's session was "very surprisingly" cleansing. I had a blockage and a wound that was holding me hostage and now I am free.
- It is freeing to let the heaviness go, to let the unworthiness, anger and rage go.
- It was difficult to let go the grief that I have been carrying so long, it was good to give myself permission, then to visualize the feelings leaving my body.
- Today was very freeing, I feel so much lighter.
- I felt transferred into another realm, where it was safe and peaceful and warm.
- I was able to go back to an event that has really affected me, both emotionally and physically, I never understood the impact it had on me, today was enlightening.
- I feel energy all over my body, warm, light and open. My heart feels open, I feel safe, I am love and I am loveable.

Appendix I
IRB Approval Letter

Research with Human Subjects and Live Animals
IRB Approval Form
Akamai University

Sandra Augustine

**Using the Inner Counselor Process™ to Reduce Both State and Trait Anxiety
and to Increase Participants' Ability to Be Time Competent (Live in the
Present) and Inner Directed (Independent and Self-Supportive)**



Affidavit

The Akamai University Institutional Review Board Research with Human Subjects and Live Animals Assessment Team has examined the methods and procedures of the researcher's proposal and has found that the study is in compliance with the Institutional Review Board guidelines relative to research with human subjects and live animals. There is adequate protection of the rights and welfare of the research participants. There are sufficient procedures to guarantee adequate, appropriate, informed consent of the research subjects; and the relative benefits of participation in the project exceed the relative risks.

Approved by:

Douglas Capogrossi

Dr, Douglass Capogrossi
Univesity President

19 November 2016

Date