ABSTRACT

A MINDFULNESS PROGRAM FOR FEMALE SURVIVORS OF SEXUAL VIOLENCE: A GRANT PROPOSAL

By

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May 2015

The purpose of this project was to locate a potential funding source and write a grant to create a mindfulness program for female survivors of sexual violence. The program will be hosted by the Long Beach Trauma Recovery Center, an agency which treats trauma survivors exclusively and is committed to the use of evidence-based interventions. The Ahmanson Foundation was selected as the potential funder.

The mindfulness program will aim to decrease trauma symptoms, improve coping skills, and increase mindfulness in survivors through mindfulness-based stress reduction courses in both English and Spanish. The program will be evaluated through the use of reliable and valid scales using a pre-test/post-test design. If funded, this program would give up to 200 survivors an opportunity to learn a practice that has been proven to improve quality of life and promote healing.

A MINDFULNESS PROGRAM FOR FEMALE SURVIVORS OF SEXUAL VIOLENCE: A GRANT PROPOSAL

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CHAPTER 1

INTRODUCTION

Statement of Purpose

The purpose of this project was to write a grant to incorporate mindfulness-based interventions into the treatment of female survivors of sexual violence with the goal of reducing trauma symptoms. Sexual violence is both a social and public health problem in the United States. Sexual violence encompasses rape, attempted rape, sexual coercion, and sexual assault. According to the findings of the National Intimate Partner and Sexual Violence Survey, conducted by the Centers for Disease Control and Prevention, sexual violence affects a large percentage of women (Black et al., 2011). In the United States, 1 in 5 women, or 18.3%, has been raped at some point in her life. An estimated 13% have experienced sexual coercion. Over 50% of these rapes were perpetrated by an intimate partner and over 40% by an acquaintance. Sexual violence affects women of all ages, but most female survivors of completed rape, or 79.6%, experienced their first rape before the age of 25 (Black et al., 2011). The National Violence Against Women Survey (NVAWS) found that 21.6% of rape survivors experienced their first rape before the age of 12, while 32.4% experienced their first rape between the ages of 12 and 17 (Tjaden & Thoennes, 2006).

A woman's response to sexual violence is complex. It is affected by several factors such as the nature of the trauma, environmental conditions, availability of support

systems, access to resources, and individual attributes (Yuan, Koss, & Stone, 2006). Although each woman is different, Black et al. (2011) noted that sexual violence has several negative implications for survivors. Survivors of sexual trauma experience a range of mental health issues such as depression, anxiety, posttraumatic stress disorder (PTSD), and substance use. Survivors of sexual violence are also more likely to experience poor physical health than women who do not experience sexual violence. Survivors often report problems such as chronic pain, headaches, difficulty sleeping, and gastrointestinal disorders (Black et al., 2011).

The practice of mindfulness and mindfulness-based interventions offer several benefits for survivors of sexual trauma such as decreased anxiety, stress, and depression, as well as increased compassion (Shapiro & Carlson, 2009). Mindfulness originates from Eastern spiritual and philosophical teachings and is the practice of focusing attention (Follette, Palm, & Pearson, 2006). Kabat-Zinn (1994), one of the earliest scholars of the mindfulness movement, described mindfulness as nonjudgmental awareness and attention to the present moment. Mindfulness principles have been integrated into psychotherapeutic interventions. Mindfulness-based stress reduction and mindfulness-based cognitive therapy are two interventions stemming from the principles of mindfulness (A. P. Brown, Marquis, & Guiffrida, 2013).

Definition of Terms

Adulthood sexual violence: Contact and non-contact sexual acts performed without the survivor's consent, when the survivor is age 18 and older (Yuan et al., 2006).

Childhood sexual abuse: Contact abuse of a minor ranging from fondling to rape and non-contact abuse such as modeling inappropriate sexual behavior or forced involvement in child pornography (Yuan et al., 2006).

Mindfulness: The practice of nonjudgmental awareness of the present moment, as well as accepting whatever arises in that moment (A. P. Brown et al., 2013).

PTSD: Characterized by exposure to a traumatic event, distressing memories or nightmares about the trauma, psychological or physical distress upon exposure to reminders of the trauma, avoidance, negative changes in cognition and mood, and changes in arousal and reactivity (American Psychiatric Association, 2013).

Sexual violence: Any sexual act that is perpetrated against someone's will, including a completed nonconsensual sex act such as rape, an attempted nonconsensual sex act, an abusive sexual contact such as unwanted touching, sexual coercion, and non-contact sexual abuse (for example, threatened sexual violence, exhibitionism, and verbal sexual harassment). Sexual violence is nonconsensual or committed against someone who is unable to provide consent (Basile & Saltzman, 2002).

Multicultural Relevance

Sexual violence is a cross-cultural issue that can affect any woman despite her ethnic, cultural, or racial background. Prevalence rates among races and ethnicities do not vary greatly, but American Indian and Native Alaskan women are at a slightly higher risk when compared to other specific ethnic or racial groups (Black et al., 2011). According to the National Intimate Partner and Sexual Violence Survey findings, approximately 22% of Black women have experienced rape while 41% have experienced other forms of sexual violence. Among White women, 18.8% experienced rape with

47.6% experiencing other forms of sexual violence. In the Hispanic population, 14.6% of women have been raped in their lifetime, while 36.1% have experienced other forms of sexual violence. More than a quarter of women, or 26.9%, who identified as American Indian or Alaskan Native have experienced rape. Almost half of American Indian or Native Alaskan women, or 49%, have experienced other forms of sexual violence. In the Asian or Pacific Islander population, 29.5% have experienced sexual violence other than rape. Of women identifying as multiracial, 33.5% experienced rape and 58% experienced sexual violence other than rape (Black et al., 2011).

Importance to Social Work

Sexual violence is a widespread issue for women in the United States, one that should be studied and understood by those who serve this population. Social workers in a variety of settings will face the issue of sexual violence, as they help clients cope with and overcome both mental and physical consequences of sexual trauma. The consequences of sexual trauma can be complex, long-lasting, and affect the survivor's intrapersonal and interpersonal functioning. Social workers must understand the complexities of sexual trauma, as well as understand the range of evidence-based practices available to meet the needs of survivors.

CHAPTER 2

LITERATURE REVIEW

Introduction

The Impact of Sexual Violence -- An Ecological Perspective

Sexual violence is a profound issue in the United States that affects women across age, culture, and economic status groups. The impact of sexual violence on women's mental and physical health has been extensively studied with several negative implications found to be associated with sexual victimization (Campbell, Dworkin, & Cabral, 2009). Several studies have documented poor mental and physical health outcomes for survivors of sexual violence (Black et al., 2011; Dube et al., 2005; Spataro, Mullen, Burgess, Wells, & Moss, 2004). However, each survivor is unique, and his or her response to his or her experience will be unique as well (Briere & Jordan, 2004). Response to trauma can be influenced by a variety of factors including individual characteristics, previous victimization history, assault characteristics, and sociocultural factors (Briere & Jordan, 2004). The research has shown there to be a myriad of possibilities in outcomes. An ecological theory of human development explains these differences among survivors of sexual trauma.

Bronfenbrenner (1979) developed the ecological theory of human development, which can be utilized to explain how factors at multiple levels affect a survivor's response to sexual trauma. Bronfenbrenner described the theory as "development in

context" (p. 12). The theory describes the relationship between individuals and their immediate environment as being mediated by forces coming from more remote parts of their environment. A person's environment is made up of microsystems, mesosystems, exosystems, and macrosysytems. The individual and each interconnected system constantly interact (Bronfenbrenner, 1979).

Campbell et al. (2009) reviewed empirical studies on adult sexual assault to analyze the impact of sexual violence on mental health from the ecological theory perspective. Understanding the impact of various systems and factors in a survivor's response to victimization is helpful in organizing the complex and interrelated outcomes associated with sexual violence (Campbell et al., 2009).

Along with systemic environmental factors, survivors have individual characteristics that also affect outcomes. The survivor's individual attributes include biological or genetic factors, sociodemographic factors, assault characteristics, coping styles, and alcohol use (Campbell et al., 2009). Campbell et al. (2009) found that individual attributes such as an avoidant coping style and poor mental health prior to the assault were associated with negative outcomes.

A survivor's microsystem is made up of interactions with family and friends and the survivor's perceptions of these interactions (Bronfenbrenner, 1979). Campbell et al. (2009) found that positive social reactions and support from those within the microsystem were linked to less mental distress after a sexual assault. Negative social reactions were linked to increased distress.

A survivor's mesosystem encompasses links between the individual and systems such as rape crisis centers and legal, medical, and mental health systems (Campbell et al.,

2009). Victim blaming or absence of help from legal and medical systems predicts negative outcomes, but these can be mitigated by supportive rape crisis center and community mental health centers (Campbell et al., 2009).

The macrosystem consists of societal norms and beliefs that shape the comprehensive social environment, including beliefs and attitudes towards rape (Campbell et al., 2009). Buchwald, Fletcher, and Roth (2005) describe American culture as one that provides an environment conducive to rape by encouraging male sexual aggression, and supporting violence against women while condoning and celebrating rape through our beliefs and values. The pervasiveness of rape culture, institutionalized discrimination towards women, and the acceptance of rape myths create a difficult sociocultural environment for survivors in terms of their recovery (Campbell et al., 2009). Each of these systems interact with the survivor, and with each other, shaping the survivor's unique response to the trauma.

Childhood Sexual Abuse

Childhood Sexual Abuse (CSA) is a considerable problem in the United States, rife with negative social and psychological consequences for survivors (National Sexual Violence Resource Center, 2012). Many women in the United States were raped as children and adolescents. The NVAWS found that 21.6% of rape survivors experienced their first rape before the age of 12 (Tjaden & Thoennes, 2006). Additionally, this survey also suggested that the risk of CSA has risen steadily for the past 50 years (Tjaden & Thoennes, 2006). This is especially concerning as women who have been sexually assaulted as children are twice as likely to be raped as adults (Tjaden & Thoennes, 2006).

According to the U.S. Department of Health and Human Services (HHS, 2013),

there were 62,936 national cases of childhood sexual abuse reported to child protective services in 2012. Of these cases, 4,240 were in California. Although these numbers are alarming, CSA is a heavily under-reported crime, and the actual prevalence of CSA is likely to be much higher (National Sexual Violence Resource Center, 2012). For example, in a national sample of 4,503 children it was found that 34.9% of females ages 1 month to 17 years had experienced sexual victimization (Finkelhor, Turner, Shattuck, & Hamby, 2013). This number represents a much higher percentage of female child victims of CSA than represented in reported cases.

Social Consequences of Childhood Sexual Abuse

CSA is a particularly traumatic stressor associated with several negative social consequences for survivors. CSA typically impacts a survivor's development, self-view, and relationships with others (Cohen, 2008). CSA disrupts childhood development, as well as the development of healthy sexuality by forcing a child to engage in behavior that he or she cannot understand or consent to (Cohen, 2008). The child often experiences feelings of betrayal, helplessness, and develops a negative self-view. A study by McAlpine and Shanks (2010) found that women with a history of CSA held more negative self-views than both women not under treatment for a mental health condition and women with depression. Aspelmeier, Elliott, and Smith (2007), in a study of 324 undergraduate women, found that CSA survivors were more likely than other women to report self-harming behaviors and negative thoughts and feelings about themselves and their sexuality. Survivors were also more likely to engage in negative sexual and interpersonal behaviors. A negative self-view may contribute to the fact that women with a history of CSA are twice as likely to attempt suicide than those who did not experience

CSA (Dube et al., 2005).

CSA frequently affects the survivor's attachment style and interpersonal relationships as children are often abused by those they were taught to trust or obey (Cohen, 2008). Aspelmeier et al. (2007) found that survivors of CSA had lower levels of attachment security, which includes trust and communication in relationships, and higher levels of alienation in their relationships with peers, parents, and other close adults than non-survivors. Dube et al. (2005) found that survivors of CSA had an increased likelihood of marrying an alcoholic and were more likely to report experiencing current marital and family problems.

Survivors of CSA are also more likely to engage in high-risk sexual behaviors (D. L. Lang et., 2011). Yuan, Koss, and Stone (2006) posited that this may be due to survivors modeling some of the behaviors learned from the perpetrator. For example, a longitudinal study of African-American adolescents found that over time girls with a history of rape victimization (RV) were more likely to engage in risky sexual behaviors (D. L. Lang et al., 2011). Those with a history of RV had fewer occurrences of condom protected sex, higher frequencies of sex while intoxicated, and more sexual partners than girls without a history of RV (D. L. Lang et al., 2011). These behaviors can lead to negative physical consequences for survivors such as sexually transmitted infections. Wingood, Seth, DiClemente, and Robinson (2009) found exposure to sexual abuse to be a predictor for human papilloma virus, the most common sexually transmitted infection in the United States, in young African American women.

Psychological Consequences of Childhood Sexual Abuse

Survivors of CSA often experience a range of negative psychological

consequences. Yuan et al. (2006) explored these consequences and found that survivors are at a high risk for PTSD, depression, suicide, and other mental health problems. In a prospective cohort study of 1,612 children Spataro et al. (2004) found that survivors of CSA had higher rates of childhood mental disorders, personality disorders, anxiety disorders, and major mood disorders than the general population. Spinhoven, Penninx, van Hemert, de Rooij, and Elzinga (2014) found that CSA was a prominent risk factor in predicting comorbidity involving PTSD, anxiety, and/or depressive disorders.

Extreme experiences of CSA are also associated with symptoms of borderline personality disorder (Yuan et al., 2006). Borderline personality disorder symptomology includes instability in interpersonal relationships, self-image, and affect as well as high impulsivity (American Psychiatric Association [APA], 2013). Substance use has also been associated with CSA. Dube et al. (2005) found that survivors of CSA had a higher risk of alcohol and substance use. In a longitudinal study of 892 childhood abuse survivors, Spatz Widom, Marmorstein, and Raskin White (2006) found a history of childhood victimization to be associated with higher levels of current drug use and drug-related problems than found in a matched comparison group.

Childhood Sexual Abuse and Revictimization

Experiencing CSA has been established as a risk factor for revictimization in adulthood with CSA survivors being twice as likely to experience rape as an adult (Tjaden & Thoennes, 2006). Black et al. (2011) found that among female respondents who reported experiencing a completed rape before the age of 18, 35.2% also experienced a completed rape as an adult, compared to 14.2% of women who did not have such an experience. Filipas, Ullman, and Najdowski (2009) conducted a

longitudinal study of 555 adult sexual assault survivors and found that CSA was associated with revictimization. CSA was also found to be a predictor of PTSD symptoms, especially re-experiencing the traumatic event, avoidance, and hyperarousal. These PTSD symptoms were a predictor for problem drinking, which in turn predicted revictimization.

Balsam, Lehavot, and Beadnell (2011) compared revictimization in lesbians, gay men, and heterosexual women. Although the study found that lesbian women had the highest rates of both CSA and adult rape, the differences between the groups were not significant. However, there were significant associations between CSA and revictimization. Nearly 20% of those who reported CSA also experienced adult rape. These participants were more likely to report suicidality, self-harm, and psychological distress than those who had experienced only CSA or only adult rape (Balsam et al., 2011). These findings suggest that CSA is not only associated with a higher likelihood of revictimization, but that experiencing both CSA and adult rape will increase vulnerability to negative psychological outcomes.

Adult Sexual Trauma

Psychological Consequences of Adult Sexual Trauma

Women who are sexually victimized as adults typically experience negative psychological consequences. A survivor may immediately begin to experience PTSD symptoms such as heightened fear, emotional detachment, flashbacks, and difficulty sleeping after her sexual assault (Yuan et al., 2006). Acute Stress Disorder may be diagnosed if a survivor experiences intrusive distressing memories, negative mood, dissociative symptoms, avoidance, or arousal symptoms within a month of the sexual

assault (APA, 2013). However, there are a variety of both individual and external factors that affect how a survivor copes with the traumatic experience and the symptomology that may emerge (Fanflik, 2007).

The mental health outcome of sexual violence that has received the most attention in the literature is PTSD (Nickerson et al., 2013). After 1 month, an ongoing Acute Stress Disorder diagnosis will be changed to PTSD (APA, 2013). Women and survivors of sexual violence independently are among the groups with the highest rates of PTSD, making female survivors of sexual violence especially likely to develop PTSD (APA, 2013). Pineles et al. (2011) linked avoidant coping styles (e.g., the avoidance of trauma reminders to prevent distress) to increased severity of PTSD, especially the symptoms of increased numbing and re-experiencing the event.

PTSD rates differ between genders and types of trauma. Women are twice as likely as men to meet the criteria for PTSD, although women were found to experience less potentially traumatic events (Tolin & Foa, 2006). Tolin and Foa (2006) attributed this gender difference to the fact that women are more likely to experience CSA as well as adult sexual assault. Campbell et al. (2009) postulated that rape is the most severe of all traumas. The severity of sexual violence is evidenced by the fact that the highest rates of PTSD are found in survivors of rape, along with combat veterans and those who experienced ethnically or politically motivated internment or genocide (APA, 2013).

Survivors of sexual violence frequently experience a range of psychological consequences beyond PTSD. Yuan et al. (2006) noted that depression, somatoform disorders, substance use disorders, eating disorders, and sexual dysfunction are often seen in survivors of sexual violence. Other researchers have found that survivors of sexual

trauma often have high comorbidity rates involving PTSD, depression, and substance use (Kessler et al., 2005). Faravelli, Giugni, Salvatori, and Ricca (2004) found that survivors of rape tend to experience a higher prevalence of comorbid PTSD, eating, mood, and sexual disorders than women who have experienced nonsexual life threatening events. These disorders may be experienced singly, but comorbidity in survivors is common. The APA (2013) explained that those with PTSD are 80% more likely to meet the criteria for at least one other mental disorder.

Characteristics that Affect Mental Health Outcomes

Poor mental health outcomes due to sexual trauma can be severe and especially long lasting. In a national survey of women, Zinzow et al. (2012) found rape to be an established risk factor for several mental health disorders, such as PTSD, major depressive episodes, and substance use disorders. This risk increased under certain rape characteristics. For example, women with rape histories involving substance facilitation and forcible tactics had the highest levels of PTSD, major depression, and alcohol abuse.

Zinzow et al. (2012) also found that assault characteristics impact the longevity of psychiatric issues. Over half of the survivors who were forcibly raped while under the influence of alcohol or drugs developed lifetime PTSD. These victims were almost 5 times more likely to have lifetime major depressive episodes than women who had not experienced a rape (Zinzow et al., 2012). Zinzow et al.'s (2012) findings also supported previous studies which linked sexual trauma to a high prevalence of comorbidity of PTSD and another mental health disorder (Faravelli et al., 2004; Kessler et al., 2005).

Mental health outcomes can also be linked to a survivor's social and behavioral characteristics. In a study of 780 sexual assault survivors, Vandemark and Mueller

(2008) found that survivors of sexual violence were at greater risk of experiencing 5 or more poor mental health days in the last 30 days. This mental health outcome was predicted by low income and low educational attainment. Vandemark and Mueller also examined behavioral characteristics and their relationships with mental health outcomes. They found a significant association between poor mental health and smoking, while exercise and a healthy diet were protective factors. Social and emotional support were also found to be an important influencers of outcomes. Emotional support such as utilizing supportive services was a protective factor, as was having health insurance.

Physical Consequences of Sexual Violence

Survivors of sexual violence often experience poor physical health outcomes. The association between sexual assault and poor physical health has been documented in the research for several years. Cloutier, Martin, and Poole (2002) studied associations between sexual victimization and health risk factors in a non-clinical statewide sample of women. Sexual assault victims, especially victims of forced intercourse or the threat of forced intercourse, were found to be more likely to perceive their overall health as being fair or poor. These women were also more likely to report experiencing poor physical and mental health in the past month. After controlling for sociodemographic factors and health care coverage, victims of forced intercourse or the threat of forced intercourse were found to be more likely to smoke cigarettes, be hypertensive, have high cholesterol levels, and be obese (Cloutier et al., 2002).

More recently, Black et al. (2011) found that women with a history of sexual violence, including intimate partner violence or stalking, had a higher prevalence of

disorders such as irritable bowel syndrome, diabetes, and asthma compared to women who had no history of sexual violence. The largest disparities in health outcomes between women with and without a history of sexual victimization were in the prevalence of chronic pain, frequent headaches, activity limitations, and difficulty sleeping. Survivors were found to experience these health problems at significantly higher rates than those without a history of sexual trauma (Black et al., 2011).

Survivors of sexual violence are more likely to report poor physical health overall. Poor physical health outcomes have also been linked to the physical severity of the assault (Cloutier et al., 2002; Demaris & Kaukinen, 2005). In a national sample of 7,700 women, Demaris and Kaukinen (2005) concluded that the more physically severe the sexual assault, the more likely the survivor was to report fair or poor health. More recently, in a national sample of college women, Zinzow et al. (2011) discovered that female rape survivors tended to indicate poor health based on a self-report scale, with repeated victimizations increasing the likelihood of poor health status. The study also showed that survivors of a rape in which the perpetrator used force or threats of force were twice as likely than other rape survivors to report poor health.

Mindfulness

Bishop et al. (2004) defined mindfulness as the self-regulation of attention. Mindfulness allows for increased awareness of mental events in the present moment, while adopting an attitude toward one's experiences in the present moment characterized by curiosity, openness, and acceptance. Williams (2008) described clinical mindfulness practice as cultivating three skills: intentionally paying attention to each moment as events unfold both internally and externally, noticing habitual reactions to these events,

and developing the ability to respond to events with an attitude of curiosity and compassion. Mindfulness in psychotherapy encourages acceptance of one's experiences in order to gain emotional regulation (Follette et al., 2006). The practice of mindfulness has been incorporated into clinical interventions such as mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT).

Mindfulness-Based Stress Reduction

Mindfulness-based stress reduction was developed by Jon Kabat-Zinn at the University of Massachusetts Medical Center (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010). MBSR was originally designed to serve as a stress reduction program for patients experiencing chronic illnesses, but has since been used to address a variety of physical illnesses and types of psychological distress (Kabat-Zinn, 1991). According to Kabat-Zinn (1991), the attitudinal foundation of a mindfulness practice requires non-judgment, patience, a beginner's mind, trust, non-striving, acceptance, and letting go. Mindfulness also necessitates commitment, self-discipline, and intentionality. One cannot learn to be mindful without regular practice outside of the program's classes.

A MBSR course typically includes eight weekly group classes lasting up to 3 hours, as well as a 1-day silent retreat. Each session involves learning and practicing formal meditation practices; learning and reinforcing informal practices such as mindfully carrying out activities of daily life; observing the present moment non-judgmentally while paying attention to the physical, emotional, and cognitive experience; and discussing the previous week's lessons and home practice experiences (Kabat-Zinn, 1991).

Meditation practice is taught and practiced at home utilizing sitting meditation, body scans, walking meditation, and gentle yoga. Over the weeks, the time spent in sitting meditation increases as does the field of attention during the sitting meditation. It is expanded using a step-by-step technique to include breath, body sensations in particular regions, body awareness as a whole, sounds, and finally thought processes. Participants are also asked to practice mindfulness in their daily lives while doing regular activities such as eating or driving (Kabat-Zinn, 1991).

Mindfulness-Based Cognitive Therapy

Mindfulness-based Cognitive Therapy was originally designed by Segal, Williams, and Teasdale (2002) to treat major depressive disorder through a combination of MBSR and cognitive therapy (A.P. Brown, Marquis, & Guiffrida, 2013). MBCT does not strive to change thoughts or emotions, but the participant's relationships with these thoughts and emotions. According to Segal et al. (2002), the goal of MBCT is to help individuals make a change in their relationships to thoughts, feelings, and body sensations that contribute to depressive relapse. The core skill that MBCT strives to teach is the ability to recognize and disengage from modes of mind that are characterized by rumination and negative thoughts. This skill is taught through the use of attention and awareness. Teasdale et al. (2002) described the goal of MBCT as the development of metacognitive awareness. Metacognitive awareness is the understanding that negative thoughts and feelings are passing events of the mind, do not reflect the true self, and are not always accurate representations of reality (Teasdale et al., 2002).

MBCT is a manualized treatment program conducted over eight sessions in groups of up to 12 participants (A. P. Brown et al., 2013). Segal et al. (2002) designed

the early sessions to focus on teaching participants to switch from a mode of doing to a mode of being. Sessions one through four focus on teaching participants how to pay purposeful attention, in each moment, non-judgmentally. These early sessions center on noticing how easily the mind wanders and how to use of breathing and body awareness techniques that can bring the mind back to focus. Participants also learn to be aware of how a wandering mind can lead to negative thoughts and feelings.

MBCT's later sessions, five through eight, focus on teaching participants how to allow negative thoughts and feelings simply to be there when they arise before responding with specific skills and strategies. Participants are taught to become fully aware of and acknowledge a thought or feeling, then move their attention to their breath for a minute before expanding attention to the entire body. The participants can then decide if this was just a passing thought or feeling or if it was something that should be dealt with either now or later. Participants are taught to recognize warning signs for their depression, as well as to develop specific plans of action for when the warning signs occur (Segal et al., 2002). In a randomized controlled trial of MBCT for depression, it was found that MBCT worked by increasing mindfulness and self-compassion while teaching people to be more attuned to thoughts and feelings without explicitly trying to change them (Kuyken et al., 2010).

Mindfulness and Mental Health

Mindfulness-based interventions have been found to have utility in the treatment of mental disorders often associated with sexual trauma, such as depression and substance use (Khoury et al., 2013; Witkiewitz et al., 2014). In a meta-analysis of 20 studies covering a wide range of clinical populations Grossman, Niemann, Schmidt, and

Walach (2004) found that mindfulness-based interventions can result in improved quality of life, reduced depression and anxiety, improved coping, and improvements in other affective dimensions of disability. Benefits were also seen in physical well-being, such as reduced physical symptoms, increased physical function, and reduced sensory pain (Grossman et al., 2004).

Mindfulness-based interventions have been found to be a successful treatment option for those suffering from depression, which as noted above is one of the mental disorders experienced most frequently by survivors of sexual violence. A study by Kuyken et al. (2008) utilized a parallel two-group randomized control trial which compared those on maintenance antidepressants with a group receiving MBCT while tapering or discontinuing maintenance antidepressants. Kuyken et al. found that relapse and recurrence rates over a 15-month follow-up were 47% for the MBCT group compared to 60% for the maintenance antidepressants group. MBCT was more effective than maintenance antidepressants in reducing residual depressive symptoms, reducing psychiatric comorbidity, and improving quality of life in both physical and psychological domains.

Chiesa and Serretti (2011) supported these findings in a meta-analysis of 16 MBCT trials, in which each study utilized a control group. Chiesa and Serretti also found MBCT to reduce relapses in major depression. Their meta-analysis further showed that relapse rates at 1 year were similar between those who received MBCT in combination with decreased maintenance antidepressants and those who continued regular use of maintenance antidepressants.

Mindfulness-based therapies have also been shown to be useful in treating substance use, a disorder that is frequently associated with sexual trauma (Spatz Widom et al., 2006; Zinzow et al., 2012). Bowen et al. (2006) described mindfulness as a useful treatment for substance use disorders for several reasons. Mindfulness practices can provide an environment that is tolerant of different religious beliefs, they allow for flexible treatment goals, and they have less associated stigma than more traditional substance use treatment programs. Bowen et al. compared a 10-day mindful meditation program to chemical dependency treatment and substance use education in an incarcerated population and found that the mindful meditation group showed significant reductions in alcohol, marijuana, and crack cocaine use in post-release assessment. These participants showed decreases in alcohol-related problems and psychiatric symptoms. Conversely, participants showed increases in positive psychosocial outcomes such as increased alcohol-related control and increased optimism.

Mindfulness-based relapse prevention has been shown to be effective in improving substance use relapse rates in women, as well as in decreasing drug use days (Witkiewitz et al., 2014), Mindfulness-based relapse prevention was also associated with fewer legal and medical problems when compared to a typical relapse prevention group at a residential treatment center which focused on increasing social support, coping skills to address cravings and high risk situations as well as problem solving and goal setting (Witkiewitz et al., 2014). In a systematic review of 24 studies done by Chiesa and Serretti (2014), it was found that mindfulness-based interventions were effective in reducing the consumption of alcohol, cocaine, amphetamines, marijuana, cigarettes, and

opiates to a significantly greater extent than the consumption rates noted among waitlist controls, non-specific educational support groups, and some specific treatment groups.

Overall, mindfulness-based interventions have been shown to be efficacious in a variety of areas. Khoury et al. (2013), in a meta-analysis that included 209 studies and a total of 12,195 participants with diverse characteristics, found that mindfulness-based therapies were an effective treatment for a variety of psychological problems and were especially effective in reducing anxiety, depression, and stress. The gains made under mindfulness-based interventions were also found to be maintained at follow-up. Follow-up periods across studies ranged from 3 weeks to 3 years with a weighted mean of 28.92 weeks. Results at follow-up were found to be largely similar to results at the end of treatment.

Mindfulness and Trauma

The field of research in mindfulness has grown in the recent years to encompass a variety of disorders. The application of mindfulness specifically for trauma is in the early stages of empirical research, but has shown great promise. Cultivating mindfulness can be beneficial in addressing common trauma reactions and symptoms. Common trauma reactions in survivors of sexual violence often include emotional numbing and avoidance (APA, 2013). Follette et al. (2006) suggested that avoidance is the opposite of mindfulness.

Trauma symptoms create a disconnection from the self and others, as well as have the possibility to increase distressing thoughts (Follette et al., 2006). Goodman and Calderon (2012) posited that techniques used in mindfulness practice, such as the body scan, can aid in reestablishing the mind-body connection and bringing focused attention

to the body and the breath, which can in turn allow survivors to reduce arousal symptoms when there is no real threat. Survivors may then have an increased sense of safety and control. Follette et al. (2006) theorized that mindfulness may help survivors of trauma to increase focus on the present moment, increase psychological flexibility, and reduce avoidance by increasing attention and purposeful behavior.

Empirical research in the field of mindfulness has demonstrated clinical efficacy in treating survivors of trauma. Kimbrough et al. (2010) conducted an open-trial pilot study of an 8-week MBSR program with 27 survivors of CSA. The classes followed the manual designed by Kabat-Zinn (1991). Statistically significant improvements were observed in measures of PTSD, depression, and anxiety. Depression was most significantly reduced. Of the PTSD symptoms, avoidance was the most greatly reduced, supporting the theory put forth by Follette et al. (2006) that mindfulness would be beneficial in addressing avoidance. Kimbrough et al. also reported clinically significant increases in mindfulness measures.

Kearney, McDermott, Malte, Martinez, and Simpson (2012) also found success after the implementation of an MBSR program with veterans with PTSD. In their longitudinal follow-up study with 92 veterans, 22 of whom were female, the researchers found that 47.7% of the veterans had clinically significant improvements in PTSD symptoms, depression, experiential avoidance, and behavioral activation, as well as mental and physical quality of life, over a 6-month period. Mindfulness scores also increased significantly. Kearney et al. concluded that the MBSR program is a safe option for participants with PTSD and that it is cost-effective due to the group format.

MBCT has also been found to be effective in treating trauma survivors. King et al. (2013) conducted a pilot study of MBCT with combat veterans with chronic PTSD. The MBCT group consisted of 20 combat veterans. The control group consisted of 17 combat veterans who received either PTSD psychoeducation and skills or imagery rehearsal therapy. MBCT was adapted for PTSD treatment by advising participants to use breathing techniques when confronted with upsetting trauma reminders and with PTSD symptoms throughout the day. Researchers found the intervention to reduce PTSD symptoms and self-blame cognitions, especially avoidant symptoms. King et al. concluded that MBCT is an acceptable treatment approach for PTSD symptoms and trauma-related negative cognitions. The MBCT group showed a significantly greater reduction on the clinician-administered PTSD scale than the treatment as usual group (King et al., 2013).

Mindfulness as a Complementary Treatment

Goodman and Calderon (2012) outlined the possibilities for the use of mindfulness in trauma work and noted that it can be utilized as both a primary and complementary treatment. A. Lang (2013) argued that mindfulness builds attentional skills, which can reduce symptoms of psychological distress, and can also be useful as a complement to cognitive behavioral therapy (CBT). CBT is the most widely accepted treatment for trauma and typically includes prolonged exposure therapy, which Kearney et al. (2012) noted is hindered by a high dropout rate. Cohen (2008) emphasized that emotional processing therapies such as prolonged exposure can result in worsening of symptoms and long-term avoidance of traumatic material if done prematurely. Cohen emphasized the importance of teaching distress tolerance, affect regulation, and

grounding skills prior to initiating emotional processing therapies such as prolonged exposure. King et al. (2013) reasoned that mindfulness-based interventions may serve as an adjunctive preparation for exposure therapies, as well as a complement to cognitive therapy. King et al. stated that mindfulness may increase the ability to tolerate experiencing negative emotions, which would strengthen exposure therapy. It may also increase the development of cognitive skills, which would facilitate cognitive therapies.

Conclusion

Mindfulness-based therapies have been shown to have efficacy with survivors of trauma, reduce PTSD symptomology, most notably avoidance, and lead to improvements in overall psychological well-being and quality of life. Mindfulness practice is often taught in a group format, which makes it a cost effective intervention in the treatment of trauma. Positive results from mindfulness programs have also been found to be maintained at follow-up. Mindfulness programs offer several benefits for survivors of sexual trauma and future research is expected to continue to validate the effectiveness of mindfulness in the treatment of sexual trauma.

CHAPTER 3

METHODS

Identification of Potential Funding Source

In order to identify a potential funding source, the grant writer explored private as well as state and federally funded grant opportunities. Publically funded grants were reviewed on the Grants.gov website. The grant writer used the key words and phrases "women," "mental health," and "rape." The grant writer searched for grants that were available to nonprofits with 501 (c) (3) status under the categories of health, humanities, and human services. Grants from a variety of government agencies were reviewed. Although this search produced several grant opportunities, the goals of the available grants and the proposed project were not completely compatible. Many of the grants found were for specific cultural groups or for research examining legal processes for female survivors of both sexual and intimate partner violence.

The grant writer also explored private funding sources utilizing online databases such as Google, the Long Beach Nonprofit Partnership, and the Foundation Center. Key words and phrases used were "women," "mental health," "mindfulness, "Los Angeles County," and either "foundation" or "grant." The searches conducted on the Foundation Center website were found to be the most helpful since they also detailed total giving amounts, making selection of an appropriate funder easier.

Criteria for Selection of Funding Source

The criteria for the selection of the funding source were established based on three guidelines: compatibility with program goals, area served, and funding available. Potential funders were evaluated along these guidelines in order to ascertain the best fit. In order to be considered, the funder's interest areas were required to align with women's empowerment. More generally, an appropriate funder would need to express interest in underserved populations, social services, mental health, sexual violence, and/or program development. Funders were also evaluated based on the geographic area served. Foundations and grants with interests specific to the Los Angeles County area were given priority. Lastly, the amount of funding available was evaluated. The mindfulness-based program for survivors of sexual violence required complete, not partial, funding. Potential funders' total amount of yearly giving was required to be at least $111,380, in order to meet the funding needs of the proposed mindfulness-based program.

Description of Funding Source and Submission Process

The funder selected by the grant writer was the Ahmanson Foundation, based in Beverly Hills, California. According to the Ahmanson Foundation (2015), their goal is to serve Los Angeles County through the funding of projects in the areas of arts and humanities, education, health care, homelessness, underserved populations, and human services. The Ahmanson Foundation selects nonprofits that can demonstrate strong fiscal management, efficient operation, and quality programs in these areas. The goal of the foundation is to enhance the quality of life as well as the cultural legacy of the Los Angeles community.

The funder was selected based on its compatibility with the grant criteria. The Ahmanson Foundation's areas of interests closely align with the mindfulness-based program, which is designed to meet the needs of an underserved population, the female victims of sexual violence. According to the Ahmanson Foundation (2015), 28 grants were funded from 2009 to 2014 in Los Angeles County specific to the needs of women, including the Long Beach Women's Shelter, the Downtown Women's Center, and the Women and Children's Crisis Center. The total amount of giving in this area was $2,534,200. The Ahmanson Foundation has clearly demonstrated interest in funding projects related to empowering and healing women.

In order to receive funding from the Ahmanson Foundation, a letter of inquiry must be submitted by mail to the Grants Administrator for preliminary screening. The letter must include a mission statement, a description of programs offered, an explanation of the need for support, a project budget, the amount to be requested, and an explanation of current funding. Once the preliminary letter is approved, a full grant proposal may be submitted. The Ahmanson Foundation does not require use of a specific form for the full grant request.

Needs Assessment and Collection of Data Needed for Grant

In order to assess the needs of the target population, a thorough literature review was completed. The grant writer studied peer-reviewed articles written within the last 10 years that were published in scholarly journals. Articles addressing sexual violence, trauma, mental health, mindfulness practice, and mindfulness-based interventions were used to understand the needs of the population. The grant writer also reviewed current

statistics about the prevalence of sexual violence, including sexual assault, rape, and childhood sexual abuse.

Data needed for the grant were collected through consultation with staff at the Long Beach Trauma Recovery Center, including mental health clinicians and administrators. Clinicians offered insight into the needs of clients with a history of sexual trauma and the importance of evidence-based interventions. Administrators provided data on the agency history, numbers served, fiscal status, and management of programs.

CHAPTER 4

GRANT APPLICATION

Executive Summary

The proposed mindfulness program aims to increase positive coping skills and decrease trauma related symptoms in female survivors of sexual violence through the offering of mindfulness-based stress reduction (MBSR) courses. Mindfulness, the practice of nonjudgmental awareness of the present moment while accepting whatever arises in that moment, will teach participants to accept their experiences while learning skills to improve emotional regulation (A. P. Brown et al., 2013). The courses will be offered in both English and Spanish in a group format. The target population of the program will be females with a history of sexual trauma.

The mindfulness program will be held at the Long Beach Trauma Recovery Center, based in Long Beach, California. The Long Beach Trauma Recovery Center is committed to creating a better quality of life by bringing mental health care, advocacy, outreach, education, and evidence-based services to diverse victims of trauma and their families. The Long Beach Trauma Recovery Center offers all services at no charge and is one of only two trauma centers in California.

The mission of the mindfulness program, the Long Beach Trauma Recovery Center, and the Ahmanson Foundation are closely aligned. Each share a commitment to empower underserved communities through the provision of evidence-based services that enhance quality of life. A mindfulness program for survivors will be a unique offering

for the Los Angeles area that has been demonstrated to be effective in meeting several of the needs common to survivors of sexual violence.

Problem Statement

Sexual violence against women is an epidemic in the United States that affects women across all racial, socioeconomic, and age groups. According to the National Intimate Partner and Sexual Violence Survey, conducted by the Centers for Disease Control and Prevention, 1 in 5 women has been raped at some point in her life (Black et al., 2011). The National Violence Against Women Survey found that 21.6% of rape survivors experienced their first rape before the age of 12, while 32.4% experienced their first rape between the ages of 12 and 17 (Tjaden & Thoennes, 2006). In Long Beach alone, there were 657 reported rapes between 2009 and 2014 (City of Long Beach, 2015). Although these numbers are alarming, the Department of Justice found that only 35% of rape and sexual assaults are reported to the police, making the actual number likely to be much higher (Truman & Langton, 2014).

Literature Review

Consequences of Sexual Violence

A woman's response to sexual violence is complex and affected by several factors such as the nature of the trauma, environmental conditions, support systems, access to resources, and individual characteristics (Yuan et al., 2006). Sexual trauma can affect women in a multitude of ways. Women often experience negative mental and physical health consequences (Black et al., 2011). Nickerson et al. (2013) noted that the mental health disorder most frequently associated with sexual trauma is Posttraumatic Stress Disorder (PTSD). Women and survivors of sexual violence are among the groups with

the highest rates of PTSD (American Psychiatric Association, 2013). However, women who have experienced sexual violence are also at high risk for several other mental health disorders, including depression, anxiety, and substance use (Black et al., 2011). The experience of living with these disorders can affect a survivor's ability to lead a full and productive life. Vandemark and Mueller (2008), in a study of 780 sexual assault survivors, learned that these women were at greater risk than women who had not experienced sexual violence of experiencing 5 or more poor mental health days in the last 30 days.

Survivors of sexual violence frequently experience several mental health disorders at once. Those with PTSD are 80% more likely to have another diagnosis (American Psychiatric Association, 2013). Research has found that survivors often have high comorbidity rates involving PTSD, depression, and substance use (Kessler et al., 2005). Faravelli, Giugni, Salvatori, and Ricca (2004) also found that survivors of rape tend to experience a higher prevalence of comorbid PTSD and eating, mood, and sexual disorders than women who have experienced nonsexual life threatening events.

Women who have experienced sexual trauma also often experience poor health outcomes. In a national sample of college women, Zinzow et al. (2011) learned that female rape survivors typically indicated poor health on a self-report scale, with repeated victimizations increasing the likelihood of poor health status. Black et al. (2011) found that survivors of sexual violence had a higher prevalence of disorders such as irritable bowel syndrome, diabetes, and asthma than women without a history of sexual trauma. Large disparities in health outcomes between women with and without a history of sexual victimization were discovered in the prevalence of chronic pain, frequent headaches,

activity limitations, and difficulty sleeping. Survivors experienced these health problems at significantly higher rates than other women (Black et al., 2011).

Mindfulness

According to Williams (2008) clinical mindfulness practice fosters three skills: intentionally paying attention to each moment as events unfold both internally and externally, noticing habitual reactions to these events, and developing the ability to respond to events with an attitude of curiosity and compassion. Follette et al. (2006) indicated that mindfulness may help survivors of trauma to increase focus on the present moment, increase psychological flexibility, and reduce avoidance of trauma reminders.

Mindfulness and Mental Health

Mindfulness-based interventions are effective in promoting overall well-being and in the treatment of disorders that affect survivors at high rates. In a meta-analysis of 20 studies covering a comprehensive range of clinical populations Grossman et al. (2004) found that mindfulness-based interventions resulted in improved quality of life and coping skills, as well as reduced depression and anxiety. Advancements were also seen in physical symptoms, physical function, and sensory pain (Grossman et al., 2004). Khoury et al. (2013), in a meta-analysis including 209 studies and 12,195 diverse participants, found mindfulness-based therapies as effective as other interventions in treating several psychological problems, including anxiety, depression, and stress. The gains made were found to be maintained at follow-up of up to 3 years after participation.

Mindfulness and Trauma Symptoms

Mindfulness has been used to treat both depression and substance use, two disorders commonly experienced by trauma survivors. A study by Kuyken et al. (2008)

compared a group taking maintenance antidepressants with a group receiving mindfulness-based cognitive therapy (MBCT) while tapering or discontinuing use of maintenance antidepressants. MBCT was more effective than maintenance antidepressants in reducing depressive symptoms and psychiatric comorbidity, and in improving quality of life in both physical and psychological domains. In the arena of substance use, a systematic review of 24 studies done by Chiesa and Serretti (2014) found that mindfulness-based interventions were effective in reducing the consumption of alcohol, cocaine, amphetamines, marijuana, cigarettes, and opiates to a significantly greater extent than the reduction rates noted among waitlist controls, non-specific educational support groups, and some specific treatment groups. Mindfulness has also been associated with fewer legal issues, medical problems, and drug use days when used in relapse prevention (Witkiewitz et al., 2014).

In studies focused specifically on populations that have experienced trauma, mindfulness has improved outcomes and reduced symptoms. Kimbrough et al. (2010) conducted an open-trial pilot study of an 8-week MBSR program with 27 survivors of childhood sexual abuse. Statistically significant improvements were observed in measures of PTSD, depression, anxiety, and mindfulness. Kearney et al. (2012) also found success in the implementation of an MBSR program with veterans with PTSD. In this prospective longitudinal follow-up study with 92 veterans, the researchers found that 47.7% of the veterans had clinically significant improvements in PTSD symptoms, depression, experiential avoidance, and behavioral activation, as well as mental and physical health quality of life, over a 6-month period. Mindfulness scores also increased

significantly. Kearney et al. concluded that the MBSR program is a safe and cost effective option for participants with PTSD.

King et al. (2013) conducted a study of MBCT for chronic PTSD. The control group, 17 combat veterans, received either PTSD psychoeducation and skills training or imagery rehearsal therapy. Results showed that MBCT reduced PTSD symptoms and self-blame cognitions. King et al. concluded that MBCT is an acceptable treatment approach for PTSD symptoms and trauma-related negative cognitions. The MBCT group showed a significantly greater reduction in the clinician administered PTSD score than the treatment as usual group (King et al., 2013).

Target Population

The proposed mindfulness-program will be held at the Long Beach Trauma Recovery Center. This agency treats victims of crime and their families exclusively. The mindfulness-program will specifically target adult female survivors of sexual violence. Women not only experience sexual violence at much higher rates, but are also more likely to develop PTSD and co-occurring disorders, making this population extremely vulnerable thus clearly suitable candidates to receive this intervention (American Psychiatric Association, 2013). MBSR courses will be available to both English and Spanish speakers. Participants will be referred by clinicians at the Long Beach Trauma Recovery Center and from other agencies in the Long Beach area, such as the Women's Shelter of Long Beach, the Children's Clinic, and Counseling and Psychological Services at California State University, Long Beach.

Description of Program

The proposed mindfulness program will focus on the use of MBSR, which was developed by Jon Kabat-Zinn (1991) at the University of Massachusetts Medical Center. MBSR was originally designed to serve as a stress reduction program for patients experiencing chronic illnesses, but has since been used to address a variety of physical illnesses and types of psychological distress (Kabat-Zinn, 1991). The program will follow the MBSR course format used at the University of Massachusetts, as outlined in *Full Catastrophe Living* (Kabat-Zinn, 1991). MBSR courses are offered in a group format and for eight sessions.

Each MBSR session will include a discussion of a mindfulness topic, a discussion of the previous week's home practice assignments, and the introduction and practice of a formal mindfulness technique to be assigned as that week's daily home practice. Formal techniques should be practiced for 30 minutes per day, between sessions. Weekly informal practice will also be expected, which involves bringing mindful attention to routine activities such as driving, washing dishes, or interacting with a friend.

The proposed mindfulness program will offer MBSR courses in both English and Spanish. During each cycle there will be four MBSR courses offered. Two of these groups will be led by the program director and two will be led by a bilingual meditation instructor. Each MBSR course will be open to up to 10 participants who must commit to attending weekly, as well as to committing 30 minutes per day to practice at home.

MBSR Course Outline

Session one. The first session will focus on an introduction to mindfulness practice and psychoeducation about the benefits of mindfulness. The participants will

engage in an ice breaker activity. Awareness of breath and body scan techniques will be introduced. Body scan will be assigned as a formal practice.

Session two. The session discussion will center on understanding one's reaction to events. Sitting meditation with a focus on the breath technique will be introduced. Formal practices of body scan and sitting meditation will be assigned.

Session three. The session will focus on attention to the present moment. Mindful yoga techniques will be introduced. Formal practices assigned will be mindful yoga and sitting meditation to be practiced alternatively, along with the body scan to be practiced once.

Session four. The session will focus on stress and stress management. The technique to be introduced is sitting meditation with focus on body sensations and sound. Formal home practice will be the continuation of yoga and sitting meditation with awareness of body and sound to be practiced alternatively.

Session five. This session will include discussion on using mindfulness to observe and appraise events, as well as understanding thoughts as events that can be evaluated. Techniques introduced will be sitting meditation with awareness expanded to whatever arises in the present moment. The formal practice assigned will be sitting meditation with expanded awareness.

Session six. This session will focus on communication and interactions with others. The technique introduced will be mountain meditation. Formal practice will be a free choice of any combination of body scan, sitting meditations, or yoga with at least one day focused on mountain meditation.

Session seven. Session seven will explore the relationship between mindfulness

and compassion. The technique to be introduced is loving compassion meditation. Formal practice will be a free choice of any combination of body scan, sitting meditation, yoga, or mountain meditation with at least one day focused on loving kindness meditation.

Session eight. The final session will focus on mindfulness for daily life and the continuation of the practice. Leaders will share resources for further study of mindfulness practice. Participants will be asked to share their experiences during the course. The participants will receive certificates of completion.

Goals, Objectives, and Outcomes

Goal 1: Increase positive coping skills of sexual violence survivors.

Objective 1: Enroll 200 sexual violence survivors into the MBSR program.

Outcome 1: 80% of participants will increase engagement styles of coping by at least 1 point on the Coping Strategies Inventory (Garcia, Franco, & Martinez, 2007; Tobin, Holroyd, & Reynolds, 1984).

Outcome 2: 80% of participants will decrease disengagement styles of coping by at least 1 point on the Coping Strategies Inventory.

Goal 2: Decrease trauma symptoms.

Objective 1: Enroll 200 sexual violence survivors into the MBSR program.

Outcome 1: 80% of participants will decrease their PTSD Checklist for DSM V score by at least 10 points (Weathers et al., 2013).

Outcome 2: 80% of participants will reduce their Beck Depression Inventory score by at least 10 points (Beck, Steer, & Brown, 1996).

Goal 3: Increase mindfulness of participants.

Objective 1: Participants will complete homework 75% of the time.

Outcome 1: 95% of participants will increase mindfulness scores on the Mindful Attention Awareness Scale by at least 1 point (K. W. Brown & Ryan, 2003).

Evaluation Plan

The proposed mindfulness program will be evaluated by a master's level social worker (MSW) who will act as the program director. The program director will provide the funder with interim and final evaluation reports. During each cycle of the mindfulness groups, the number enrolled and attending each session will be recorded. A pre-test and post-test will be used to measure changes in coping, trauma symptoms, and mindfulness. Participants will complete the Coping Strategies Inventory, PTSD Checklist for DSM V, Beck Depression Inventory, and Mindful Attention Awareness Scale prior to beginning the program, as well as after the 8th session. The participants will also complete a brief satisfaction survey asking them to rate their satisfaction with the program and their instructor and to provide suggestions for improvement. With validated scales and participant feedback, the program director will be able to monitor the success of the program between cycles and make adjustments to the curriculum as needed.

Host Agency

The proposed mindfulness program will be hosted by the Long Beach Trauma Recovery Center. The Long Beach Trauma Recovery Center opened in 2014 after being selected by the California Victim's Compensation Program (CalVCP) to become only the second trauma center in California. The Long Beach Trauma Recovery Center was created in partnership with California State University, Long Beach, and St. Mary's

Hospital. The Long Beach Trauma Recovery Center's commitment to providing evidence-based trauma treatment makes it a unique agency in the state and an invaluable resource to those whose lives are affected by crime. The Long Beach Trauma Recovery Center also offers culturally sensitive case management, community outreach, and education. All services are provided at no charge (B. Ghafoori, personal communication, February 17, 2015).

Since its opening in April 2014, the Long Beach Trauma Recovery Center has provided over 190 victims of crime with mental health services. All services are funded by CalVCP and provided by licensed mental health clinicians or masters level graduate students. Long Beach Trauma Recovery Center clientele are predominantly female (79%) and Hispanic (52%) with a mean age of 32 years old. Of all clients at the Long Beach Trauma Recovery Center, 35% name sexual assault as their primary trauma (S. Wong, personal communication, December 10, 2014).

The Long Beach Trauma Recovery Center is led by executive director Dr. Bita Ghafoori, a leading researcher in the field of trauma. Dr. Ghafoori has published several articles on the study of trauma, mental health access for diverse and underserved communities, and military trauma (Ghafoori, 2012; Ghafoori & Hierholzer, 2010; Ghafoori, Barragan, Tohidian & Palinkas, 2012). Dr. Ghafoori is also a coordinator and professor in the Marriage and Family Therapy (MFT) program at California State University, Long Beach. Reporting to Dr. Ghafoori is the assistant director, Deborah Luken, who is also a professor in the MFT program and a specialist in the field of childhood trauma. Dr. Ghafoori and Deborah Luken lead a clinical staff consisting of

both licensed MSWs and MFTs. The clinical staff supervise graduate level interns from local MSW and MFT programs (B. Ghafoori, personal communication, February 17, 2015).

The mindfulness program director will be an MSW who will report to Dr. Ghafoori. The program director will supervise a certified Spanish speaking meditation instructor who will lead two MBSR groups per cycle in Spanish. The program director will also supervise a graduate level intern who will assist with program management.

Budget Narrative

Program Supervisor: This position requires a person with the MSW degree with experience in MBSR who will be responsible for implementing the MBSR program. This individual will supervise outreach and recruitment of participants, lead two MBSR groups per cycle, supervise other program staff, oversee collection of evaluations, analyze data, and submit reports to the funder. This position is a full-time position compensated at $60,000 per year with 31% fringe.

Certified Meditation Instructor: This position requires a Spanish speaking individual with certification allowing him/her to lead a meditation course. This individual will do outreach and recruitment for Spanish speakers, lead two MBSR groups per cycle, translate any necessary course materials into Spanish, and collect evaluation data from Spanish speaking groups. This is a part-time position compensated at $20,000 per year with 20% fringe.

Program Supplies: Program supplies needed for the mindfulness program include 10 yoga mats ($15 each), yoga blocks ($10 each), and meditation pillows ($40 each) which will be used in each group meeting. Ten copies of *Full Catastrophe Living* in both

TABLE 1. Budget

Type of Cost	Cost
Personnel	
Program Director/MSW/FTE/100%	$60,000
Benefits and taxes @ 31%	$18,600
Certified Meditation Instructor/Bilingual/PTE/50%	$20,000
Benefits and taxes @ 20%	$4,000
TOTAL SALARIES AND BENEFITS	$102,600
Direct Program Costs	
Program Supplies	$1,180
Refreshments for Program Participants	$2,400
Office Supplies	$1,200
Printing & Duplicating	$2,000
Bus Passes	$2,000
TOTAL DIRECT PROGRAM COSTS	$8,780
In-Kind Donations	
Administrative Costs @ 10%	$11,138
Rent (Includes Utilities and Telephone)	$70,000
Industrial Internet	$2,400
Leased Equipment	$3,600
TOTAL IN-KIND DONATIONS	$87,138
TOTAL PROGRAM COSTS	$198,518
TOTAL REQUESTED FROM FUNDER	$111,380

English ($16 each) and Spanish ($32 each) to be read from during group meetings will be needed to guide discussions. A Tibetan singing bowl ($40) will be used to begin and end each meditation. A package of 100 blank discs ($10) will be purchased in order to provide participants without internet access the audio needed for at-home practice.

Refreshments: Refreshments will be provided to participants at each group meeting. There will be five MBSR cycles. Each cycle will consist of four groups that meet weekly for 8 weeks. This amounts to 160 total meetings with $15 per meeting to be spent on water, tea, and light refreshments.

Office supplies: Approximately $100 per month will be spent on necessary office supplies for a total $1,200 per year. This amount will cover pens, paper, folders, a whiteboard, and dry erase markers.

Printing and Duplicating: Approximately $166 per month will be spent on printing and duplicating. This amount will cover the printing of fliers, weekly attendance sheets, worksheets for participants, and evaluation packets.

Bus passes: Bus passes will be necessary to assist program participants whose finances may prevent them from attending consistently. The majority of Long Beach Trauma Recovery Center clients are low income and without reliable transportation. This amount will cover 500 day passes ($4 each).

In-kind Donations: In-kind donations are to be provided by the Long Beach Trauma Recovery Center and funded by CalVCP. Administrative costs are calculated at 10% of total direct program costs. Rent, utilities, telephone, and cleaning services at

approximately $5,833 per month will be provided by the Long Beach Trauma Recovery Center. Industrial internet access will be provided at the rate of $200 per month. Leased equipment which includes the use of two desktop computers, one laptop, a projector, speakers, and Titanium electronic medical record software will be provided at approximately $300 per month.

Timeline

Months 01-02

Hire staff

Begin outreach and recruitment

Prepare necessary course materials

Months 03-04

Implement first cycle of groups

Months 05-06

Implement second cycle of groups

Evaluate first cycle of groups

Revise curriculum as needed

Submit interim progress report to funder

Months 07-08

Implement third cycle of groups

Evaluate second cycle of groups

Revise curriculum as needed

Months 09-10

Implement fourth cycle of groups

Evaluate third cycle of groups

Revise curriculum as needed

Prepare grants for future funding

Month 11

Implement fifth cycle of groups

Evaluate fourth cycle of groups

Submit grants for future funding

Month 12

Evaluate fifth cycle of groups

Summarize evaluation data

Submit final report to funder

CHAPTER 5

LESSONS LEARNED

Identification of Need for Proposed Program

The grant writer's decision to focus on mindfulness for survivors of sexual trauma was influenced by both scholarly and fieldwork experiences. Through both research and direct practice, the grant writer was made aware of the prevalence of sexual violence against women and the resulting symptomology that often emerges when one has experienced sexual violence. The prevalence of sexual violence and its broad range of negative outcomes made an evidence-based practice that could reduce psychological distress in a large population of women seem necessary to the writer. The mindfulness movement in psychotherapy has grown since it was introduced by Kabat-Zinn (1991). The focus on learning the practice of mindfulness rather than addressing specific symptoms made mindfulness an attractive option considering the broad symptomology present in survivors of sexual violence.

The need for services for survivors became even more apparent when the grant writer began fieldwork at the Long Beach Trauma Recovery Center. A majority of the clients are women, many of whom had histories of sexual victimization. As the number of clients requesting services grew, a cost effective group format became a possible way to treat more clients successfully. Several clinicians at the Long Beach Trauma Recovery

Center have expressed interest in mindfulness practice and now incorporate mindfulness techniques into individual psychotherapy.

The decision to focus on survivors and mindfulness was strengthened through the creation of a comprehensive literature review which showed that mindfulness-based interventions were effective. Although research articles on the use of mindfulness with sexual violence survivors exclusively were not as extensive, there was ample evidence that mindfulness could be used to treat disorders that are associated with sexual violence. The field of research regarding mindfulness and trauma is promising and is continuing to grow.

Location of Potential Funding Source

Identifying a proper funding source was a new experience for the grant writer and one that led to many possibilities. The grant writer explored grants from both state and federal sources, but found the purpose of the proposed projects to be incompatible with the goals of this mindfulness program. The grant writer also utilized internet searches which led to an array of options, many being charitable giving sources from large private companies. The grant writer learned that many companies engage in charitable giving, but often have very specific criteria for types of programs they are willing to fund.

The most beneficial source of information about potential funding sources came from fellow social work graduate students. This became an important lesson for the grant writer about the importance of relationships with other professionals, and networking. Members of the grant writer's cohort shared listings of foundations which detailed the focus of their giving, and estimates on the amount of funding that was available. It was

through this resource that the grant writer learned of The Foundation website which became an invaluable resource, and the place where a funder was identified.

Strategies to Enhance the Likelihood of Funding

In order to increase the likelihood that that the grant proposal would be accepted, and funding would be acquired the grant writer decided to use partialization. By breaking the proposal into manageable pieces, the grant writer ensured that each piece was thoroughly complete. By taking time to clearly think through each section of the grant proposal, the grant writer demonstrated mastery of the subject matter and presented a clear and well thought out plan for the implementation of the mindfulness program.

In order to demonstrate mastery of the subject matter, the grant writer presented a thorough literature review. This review established the prevalence of sexual violence, the importance of evidence-based practice for survivors, and the benefits of mindfulness in a variety of areas. The review also served to demonstrate that the grant writer could successfully implement a mindfulness program based on a solid understanding of the population and their needs.

The next phase of successfully completing the proposal was to identify clear goals, objectives, and outcomes. This clearly communicated the purposes of the program and provided markers its evaluation. First, the grant writer created goals that could be reliably measured such as increased coping skills and decreased psychological symptoms. The grant writer focused on the use of validated scales to measure attainment of these goals. By creating clear benchmarks for success, such as a reduction in PTSD scores by 10 points progress, can be clearly measured. The use of clear goals and reliable tools to measure outcomes assures the grantor that the program will be professionally managed

and scientifically evaluated. Clearly defined goals, objectives, and outcomes were necessary to develop an evaluation plan that could effectively monitor the program, as well as present this information to the funder periodically in a consistent and comprehensive manner.

The final piece of the grant proposal was creating a well thought out budget. In order to create a complete and detailed budget, the grant writer first researched the curricula of other MBSR courses. The grant writer found that due to the emphasis on seated meditations and at- home practice, the creation of a welcoming and comfortable setting would be key. The grant writer decided to utilize yoga mats and blocks, as well as meditation cushions, to ensure that participants would be comfortable during the sessions. The grant writer also decided to include a class set of books in both English and Spanish that could be used as a tool for learning and discussion during the course. The grant writer used online retailers to select these materials, ensuring that they would be purchased at the lowest possible prices. These prices and quantities are referenced in the budget narrative, demonstrating to the funder that each request for funds had been carefully thought out.

Selecting staff to implement the program effectively was of a high priority. The grant writer decided that the best use of funds would be to hire a full-time master's level social worker who could both oversee the program and lead MBSR courses. The grant writer also decided that a part-time bilingual meditation instructor to be supervised by the program director would be a cost effective way to include Spanish speaking clients. The justification for all funds was detailed in the budget narrative, including not only program

and personnel costs, but also for other needs, such as administration, office supplies, and printing costs.

Relevance to Social Work Practice and Policy

The use of mindfulness for sexual trauma survivors carries several important implications for social workers. The National Association of Social Workers (2008) outlined the core values upon which the social work profession is based. These core values include service and competence. The social work mission is to be of service to vulnerable populations. It has been clearly shown in this thesis that sexual violence survivors become vulnerable to negative consequences not only in their mental health, but also in the realms of physical health and relationships with others. They also encounter difficulties due to environmental factors such as lack of supportive services, and a culture that condones violence against women. As social workers it is imperative to fill the gaps in service for this population, increase understanding of their needs, and utilize treatment that empowers survivors to overcome their traumas and begin healing.

Competence in practice is necessary. As social workers it is of the upmost importance to maintain a practice based on evidence and treatments that have been substantiated by research. In order to effectively meet the needs of a diverse population of sexual violence survivors social workers must have an understanding of the variety of interventions available. Survivors of sexual trauma are both diverse and unique. Each survivor will require treatment tailored to his/her specific symptoms. Increasing understanding of available treatment options is necessary for competent practice and effective treatment. Additionally, increased understanding of interventions that are

effective and done in a group format would allow social workers to serve multiple clients at once in a cost effective manner.

Importance of Grant Writing in Social Work Practice

The ability to write captivating grant proposals with high likelihood of funding is a skill that is imperative to the field of social work. Social service agencies often struggle with funding acquisition and must be able to garner funds from a variety of sources. Grants are necessary to fund programs that address violence, inequality, racism, sexism, and other forces that disproportionately affect women and people of color. As a social worker, the ability to write a grant not only allows one to bring necessary funding into one's organization, but also ensures that the mission of social work, i.e., to enhance quality of life and promote the well-being of all, continues to move forward.

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