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Pepperdine University

Graduate School of Education and Psychology

EXPERIENCES OF CLINICIANS USING MINDFULNESS-BASED THERAPY WITH ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE: A QUALITATIVE ANALYSIS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Nathan Edwards

October, 2015

Thema Bryant-Davis, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Nathan Edwards

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Thema Bryant-Davis, Ph.D., Chairperson

Shelly Harrell, Ph.D.

Anna Leshner, Psy.D.

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ACKNOWLEDGEMENTS

My deepest gratitude to my chair, Dr. Thema Bryant-Davis, whose guidance and words of encouragement have made this process possible and manageable. Also, I would extend much appreciation to Dr. Shelly Harrell and Dr. Anna Leshner, the gracious members of my committee who provided much needed feedback, enthusiasm, and positivity towards the completion of this endeavor. Further thanks to the participants of this study, who so selflessly volunteered their time and knowledge for the advancement of mindfulness research. Finally, countless thanks and boundless love to my wonderful wife whose patience and support truly made completion of this project possible.

VITA

Education

PEPPERDINE UNIVERSITY – GSEP - Los Angeles, CA — October 2015

Candidate for Doctorate of Psychology - Clinical Psychology — ***(Expected Graduation)***

APA Accredited Program

ARGOSY UNIVERSITY - Seattle, WA — August 2011

Master of Arts - Clinical Psychology

UNIVERSITY OF NORTH CAROLINA at CHAPEL HILL - Chapel Hill, NC — May 2004

Bachelor of Arts - Psychology

Graduate Clinical Experience

California State University, Northridge (CSUN) - Northridge, CA — August 2014 - Present

Predoctoral Intern

A University counseling center providing mental health services to a widely diverse student body. With an enrollment of almost 40,000, CSUN has a large Hispanic population with a high number of first-generation college students. Services include short-term (8 session) individual counseling, group counseling, triage services, as well as outreach workshops provided to students and faculty.

Summary of duties:

- Provide individual therapy to a culturally and otherwise diverse population of college students with an array of clinical presentations utilizing a short-term therapy modality.
- Co-facilitate a psychoeducational group focused on Anxiety Management using a CBT framework, a process group dealing with Relationship Issues, and Mindfulness and Relaxation workshop.
- Complete a minimum of three intake evaluations each week.
- Co-teach the *RAISE Your GPA* class, focused on the development of academic confidence and strategies to improve scholastic performance.
- Co-teach an advanced Peer Education class for the *Blues Project* focused on increasing knowledge of depression and suicide in order to prepare students to design and provide relevant outreach programs.
- Received intensive crisis management and triage assessment training and utilized this knowledge to monitor and maintain the safety of clients presenting in crisis.
- Collaborate with the wider campus community through provision of consultation and outreach presentations on a wide range of topics including General Information on Mental Health, Stress Management, and Mindfulness.
- Engage in weekly professional seminars and trainings focused on a range of topics including Crisis Intervention, Multicultural Competency, Group Therapy, Termination Issues, First Generation College Students, and Group Therapy.
- Receive three hours of weekly supervision on individual cases (two hours with primary supervisor and one with secondary) and additional supervision related to group therapy work.
- Participate in two hours of weekly video group and video group supervision with training director and fellow interns.

U.S. Department of Veterans Affairs - Los Angeles, CA August 2013 - July 2014

Mental Health Extern

An outpatient medical facility providing comprehensive services to an extremely diverse population of veterans and their families. Patients differ with regards to culture, ethnicity, age, socioeconomic background, and tour of combat duty. The mental health department utilizes a multidisciplinary team approach to facilitate treatment that is tailored to the unique needs of the individual or target population.

Summary of duties:

- Provide individual counseling for a diverse group of veterans with a range of clinical presentations utilizing a time-limited, cognitive-behavioral framework focusing on symptom reduction and skill building.
- Co-facilitate a psychoeductaional group for Filipino veterans of World War II focused on issues related to PTSD, anger management, stress reduction, and health and wellbeing.
- Co-facilitate additional skills-based groups focused on addiction management, relapse prevention, and coping skills including mindfulness and relaxation.
- Engage in a weekly behavioral medicine seminar focused on the intersection between the field of psychology and medicine through discussion of issues related to assessment, treatment, and clinical implications of health issues such as diabetes, heart disease, chronic pain, etc.
- Attend a weekly law and ethics seminar that serves to increase proficiency in these areas through analysis of legal and ethical dilemmas within questions drawn from the EPPP and vignettes.
- Participated in *Target Diabetes*, a behavioral medicine program designed to raise awareness of the risks associated with diabetes and provide veterans managing diabetes with education related to insulin and blood sugar management, nutrition, and exercise.
- Attended 5-week training in Acceptance and Commitment Therapy (ACT), which focused on theory, treatment goals, and clinical application through intervention analysis and interactive demonstration.

UCLA Aftercare Research Program - Los Angeles, CA July 2012 - July 2013

Predoctoral Intern

A research-based outpatient clinic specializing in the study of cognitive impairment and potential improvement within a population of first-break schizophrenic patients. Participants presented with a diverse range of backgrounds, cultural affiliations, and clinical constellations; however, the age range consisted, almost exclusively, of young and emerging adults. A multidisciplinary team worked to provide treatment through individual, group, and family therapy, medical and psychiatric consultation, and provision and monitoring of medication and compliance.

Summary of duties:

- Participated in program development designed to assess the efficacy of combined cognitive training and physical exercise on a population of first-break schizophrenic patients.
- Co-facilitated cognitive training and physical exercise groups by providing support, guidance, and modeling for patients participating in the research program.
- Co-facilitated groups focused on goal achievement and skill building in order to provide a bridge between cognitive improvements and real life success.
- Co-facilitated psychoeducation groups focused on dissemination of information related to schizophrenia; symptoms, medication, and management strategies.
- Provided individual counseling for patients within the research protocol towards the treatment of a wide range of symptoms including anxiety, low self-esteem, and adjustment to the challenges associated with the diagnosis of schizophrenia.

- Aided in the academic and professional success of patients by providing supported education and employment services.
- Facilitated family meetings in order to provide psychoeducation, progress updates, and coordinate effective and integrated management of symptoms.
- Administered brief-neuropsychological tests required to assess cognitive functioning at various intervals within the protocol, including the Matrics Consensus Cognitive Battery (MCCB) and the UC San Diego Performance-Based Skills Assessment (UPSA).
- Coordinated care with an integrated staff including psychiatrists and case managers.
- Engaged in weekly group supervision with various members of the research team in order to assess and improve efficacy of the interventions associated with the research protocol.
- Engaged in weekly individual supervision to discuss the progress of individual therapy.

Pepperdine University West LA Clinic - Los Angeles, CA September 2011 - July 2014

Mental Health Extern

An outpatient, school-based clinic providing community mental health services to a wide range of patients and presenting problems. Treatment is tailored to the unique needs of the client and can include long-term therapy. Enrollment in the clinic is referral-based and services are provided on a sliding scale to increase access for underserved, underprivileged or marginalized members of the community.

Summary of duties:

- Provide individual counseling for adults and couples towards the treatment of a wide range of clinical issues including, but not limited to, depression, anxiety, low self-esteem, relationship conflict, emotional dysregulation.
- Facilitate crisis intervention, treatment planning, and case management for a diverse population of clients.
- Administered clinical measures including the Beck Depression Inventory, Beck Anxiety Inventory, Outcome Questionnaire 45.2, and the Working Alliance Inventory in order to facilitate psychodiagnostic evaluation and treatment planning.
- Maintain detailed case notes including session summary, case formulation, and treatment goals.
- Conduct and prepare intake evaluations and reports in order to facilitate treatment planning and intervention.
- Provide case presentations, including a case summary and conceptualization among colleagues towards the goals of improving the overall treatment and building confidence as a professional clinician.
- Engage in weekly supervision, including individual, group, peer supervision and case conference in order to receive feedback on cases and maintain a positive treatment trajectory.

JOBCORPS, Sedro-Woolley, WA

September 2010 - June 2011

Mental Health Extern

A residential vocational facility devoted to academic and career training of late adolescents and young adults from diverse cultural and socioeconomic backgrounds. A comprehensive health and wellness team worked together to provide services that facilitated participants continued success and overall wellbeing. Mental health treatment comprised of individual and group therapy, crisis intervention, and case management.

Summary of duties:

- Provided individual counseling for adolescents and young adults struggling with a variety of clinical issues including, but not limited to, depression, anxiety, trauma and trauma related stress, low self-esteem, academic difficulties, substance abuse issues.
- Co-facilitated and women's depression group that focused on psychoeducation and skill-building in order to improve coping with depressive symptoms and reduce associated behaviors and cognitions.
- Facilitated crisis intervention, treatment planning, and case management for a number of individual patients.
- Maintained detailed case notes including session summary, case formulation, and treatment goals.
- Contributed to integrated staff meetings concerning behavior/mental health issues of students in order to coordinate care and improve treatment for the students and patients.
- Engaged in weekly consultation with the center mental health consultant/supervisor.

Selected Outreach Provided to Students

- **Intro to UCS Services.** An introduction to UCS services presented to first year students of the U100 course.
- **Stress Management.** A seminar focused providing pyschoeducation around the stress response and provision of strategies to cope with and manage stress as a college student.
- **Mindfulness and Relaxation.** A seminar developed to introduce students to the concept of mindfulness and provide basic practice strategies that can be utilized daily. Students were given a brief understanding of the origin and concepts of mindfulness and then were lead through an experiential component focused on breathing and progressive muscle relaxation.
- **Self-Care and Wellbeing.** A seminar designed to encourage discussion of concepts related to self-care. Members were asked to speak of their experiences of self-care as well as obstacles to such practice. Self-care strategies were also discussed and provided.

Research

Pepperdine University - Culture and Trauma Lab — September 2011 - July 2012

Research Assistant

- Participated in weekly meetings designed to increase knowledge of issues related to trans-cultural experiences of trauma led by Dr. Bryant-Davis, a nationally published leader in the field of trauma treatment and cultural competence.
- Read background material regarding trauma and its effects on various populations.
- Performed coding activities for transcribed interviews of adolescent survivors of sexual human trafficking and abuse.
- Conducted literature reviews related to cross-cultural conceptions and effects of childhood physical abuse.
- Aided in the development of a poster presented at the 2011 Association of Women in Psychology Conference related to HIV reporting among ministers within the African-American Community.

UNC-Chapel Hill Psychology Department - Chapel Hill, NC — June 2003 - August 2003

Research Assistant

- Read background material regarding the theoretical and empirical origins of a research program concerned with interdependence processes in close relationships.

- Performed coding activities, including the coding of videotaped interactions, relevant to research concerning the so-called "Michelangelo phenomenon."
- Engaged in data entry and accuracy checking using a variety of programming techniques.
- Prepared an APA-style empirical manuscript summarizing project activities and findings.

Additional Experience

RCS Corporations - Kawaguchi, Japan April 2008 - August 2008

English Language Instructor

- Taught English classes for Elementary and Junior High School students of all grades through the use of engaging activities, reading and games.
- Planned lessons and activities for more than 60 classes a week that included both collaborative teaching with a Japanese teacher and individual teaching.

INTERAC - Kita Ageo, Japan October 2007 - March 2008

English Language Instructor

- Collaboratively planned and taught up to 60 English classes a week with a number of Japanese English teachers across a variety of public Junior High Schools.
- Planned lessons and taught special needs classes of up to 10 students for children with developmental delays or learning disabilities.

NOVA Group - Omiya, Japan January 2006 - October 2007

English Language Instructor

- Taught English classes of up to four students of various ages using a manualized format based on student skill level.
- Lead children's classes of up to 8 students from ages 2-12 combining reading and written exercises, practice through conversation, and games.
- Provided specialized language training through courses including business, travel, and TOEIC that provided students with skills in their area of interest.

Publications

- Bellete, N., Edwards, N., Ford, L., & Bryant-Davis, T. (2012, March). Gender and the integration of HIV/AIDS information in the African-American church: Implications for intervention. Poster presentation for the annual Association of Women in Psychology Conference, Palm Springs, CA.
- Bryant-Davis, T., Ellis, M. U., & Edwards, N. (2013) Therapeutic Treatment Approaches for Ethnically Diverse Survivors of Interpersonal Trauma. Handbook of Multicultural Mental Health, 2nd Edition. In F. A. Paniagua & A. Yamada (Eds.) Elsevier: Philadelphia, PA

Trainings and Associated Programs

- **The Mentorship Program** - A two-year program developed and lead by David N. Elkins, Ph.D. Members are given the opportunity to consume literature focused on current research and theory

related to humanistic/existential practice. Additionally, members meet with leading practitioners throughout the course of the program for a day long discussion of their work and theories.

- **Mentalization-Based Treatment: Basic Training** - A three day workshop led by Peter Fonagy, Ph.D. designed to introduce the basic theory and concepts of mentalization-based treatment. The workshop included lectures, video review, and demonstrations to enhance learning. Additionally, members engaged in role-plays to practice the techniques with facilitator support.

Professional Affiliations

American Psychological Association (APA)

ABSTRACT

The long-term devastation caused by childhood sexual abuse among adult survivors has been well documented within the literature. Similarly, numerous studies have addressed efficacy of various treatment modalities targeting psychological sequelae associated with such abuse. However, despite the recent rise in popularity of mindfulness within the field of psychology, as well as indication of tremendous psychological benefits associated with such practice, few studies have sought to understand the connection between mindfulness and healing among abuse survivors. The current study attempts to bridge the gap in the literature by examining the experiences of clinicians using mindfulness as a framework for their treatment of adult childhood sexual abuse victims. Participants (*N*=6) were recruited from the Los Angeles area and the qualitative design utilized semi-structured interviews as a means of data collection. Grounded theory analysis of the data revealed a complex and dynamic interplay of elements that captured the nature of mindfully framed treatment with abuse survivors. Results suggested that core elements of mindfulness practice, along with therapeutic conditions and factors related to the therapist's way of being, allow growth and change within the client. However, it was further revealed that the interplay of such elements was surrounded by the tremendous impact of a clinician's personal mindfulness practice, which fostered essential healing elements. While the observed results provide no conclusive data, the importance of environmental conditions, as well as therapeutic presence, rather than a focus on specific techniques or interventions suggests implications for work with abuse survivors. Additionally, it is hoped that further research continues to observe mindfulness and provide support for its implementation as a viable and effective treatment for trauma survivors.

Introduction

Childhood sexual abuse remains a widespread problem that causes devastation among its victims. While experiences of such trauma may differ, the effects can persist throughout adulthood and cause serious harm to one's mental health and ability to function. Although both males and females can be victims of sexual abuse during childhood, women have been found to be at higher risk of such victimization than their male counterparts (Conklin, 2012). Some estimates suggest that between 12-40% of females have experienced at least one form of sexual abuse during childhood or adolescence, with estimates for males falling between 4 and 16.5% (Conklin, 2012; Finkelhor, Hotaling, Lewis, & Smith, 1990). Further reports suggest that between one-fifth and one-third of women report a history of childhood sexual abuse (as cited in Zwickl & Merriman, 2011). According to the U.S. Department of Justice (1997), 15% of rape or sexual assault and rape victims are under the age of 12. In 2009, local child protective services across the country identified 65,964 cases of substantiated or indicated sexual abuse of children, which accounted for 9.6% of all maltreatment reports during that year (U.S. Department of Health & Human Services, 2009). Furthermore, among female students in grades 5-8, 7% endorsed some form of sexual assault; a number that increased to 12% for females in grades 9-12 (Schoen, Davis, Collins, Greenberg, Des Roches, & Abrams, 1997).

The clear variance in prevalence rates has a number of possible explanations. Underreporting or lack of disclosure of abuse may make accurate analysis of prevalence difficult (as cited in Zwickl & Merriman, 2011). This is particularly true for males, who are less likely to report a history of childhood sexual abuse (CSA) and penetrative abuse than females (Zwickl & Merriman, 2011). It should be noted that according to Lanktree, Briere, and Zaidi (1991), underreporting may be related to an absence of direct querying on the part of the clinician within

child psychiatric settings. Their research indicated a four-fold increase, from 7-31%, of sexual abuse reporting when such experiences were directly queried within a sample of 64 children involved in treatment at an outpatient psychiatric clinic.

A further explanation for the variance in prevalence rates may reflect a lack of consensus around the definition of sexual abuse. Currently, various definitions of CSA within the literature confound any generalized discussion of the prevalence and effects of CSA (Conklin, 2012). With regards to the latter issues, depending on the focus of research, the conceptualization of CSA can range from narrow to quite broad. For example, in his study observing the impact of CSA on risk development for HIV or AIDS later in life, Gwandure (2007) defined sexual abuse only as "unwanted sex with a perpetrator older than them before the age of 14 years" (p. 1314). While this definition may seem limited, given Gwandure's research focus and the importance of understanding the development of risky sexual behaviors later in life that could lead to an increased risk of HIV/AIDS, it seems clear that a narrow definition was necessitated as a broader conceptualization may not have yielded such robust results.

On the other end of the spectrum, Finkelhor, Hotaling, Lewis, and Smith (1990), use a much broader definition of CSA that includes memories of an individual attempting to, or succeeding, at having "any kind of sexual intercourse" with the victim, including oral sex or sodomy (p. 20); an initial description that leaves open the definition of sexual intercourse to any interpretation of the victim. Finkelhor et al. further include any experience of sexual abuse that may have involved inappropriate touching, grabbing, kissing, or rubbing in a public or private setting. Again, the authors leave the definition open to interpretation by the victim. Additionally, experiences involving nude photographs being taken of the victim, inappropriate exposure on the part of the perpetrator, or exposure of the victim to sexual activity are included.

Clearly this definition spans a much wider range and further allows for interpretation of events on the part of the victim.

As a narrower definition of CSA seems to limit the focus of observation, a broader conceptualization seems warranted. Furthermore, as sexual abuse experiences differ and interpretations of events can vary from individual to individual such a definition would better capture the reality, while simultaneously honoring the totality, of one's traumatic experience. As such, the broader definition described by Finkelhor and colleagues (1990) will be used as the basis for understanding CSA within this report.

Effects of Childhood Sexual Abuse

The early literature concerning the deleterious impact of CSA on overall well-being is extensive. According to such research, clear links can be drawn between the presence of a history of CSA and both immediate and long-term sequelae including psychological and medical difficulties, behavioral problems, interpersonal challenges, and sexual dysfunction (Briere & Elliot, 1994; Browne & Finkelhor, 1986; Finkelhor & Browne, 1985; Herman, 1992). More recent literature continues to support these early findings and has attempted to extend the body of research through the use of science and an advanced consideration of psychological processes in an effort to deepen the understanding of the tremendous impact of CSA on the physical, emotional, and psychological well-being of survivors. Although experiences of abuse differ and there is no consistent emergent pattern of effects across victims (Wilson, 2009), the extensive array of harmful outcomes can be organized into domains that provides some structure to the understanding of the nature of such sequelae. For the purposes of this report, these domains will include *psychological symptoms*, *physiological symptoms*, and *additional factors.* The following will briefly summarize the relevant research across these domains.

Psychological Symptoms. The link between CSA and the emergence of long-term psychological difficulties is strongly represented in the literature (Briere & Elliot, 1994; Browne & Finkelhor, 1986). According to Sigurdardottir, Halldorsdottir, and Bender (2012), men with a history of CSA are 10 times more likely to be diagnosed with a mental disorder including PTSD. Among children, these researchers found that PTSD and ADHD were the two most common diagnoses among victims of CSA. Similarly, Seifert, Polusny, and Murdoch (2011) found a relationship between a history of CSA and increased PTSD symptoms among male combat veterans suggesting that early exposure to trauma may increase the risk of future development of PTSD. Addressing the serious long-term effects of CSA, Cutojar et al (as cited in Dolan & Whitworth, 2013) found that a history of CSA was associated with an elevated risk of mental illness and criminality among women at a 46-year follow-up. Dolan and Whitworth (2013) supported these findings through their own research that suggested that women with a CSA history more frequently received prior and recent psychiatric services than those without a history of abuse. In their qualitative study, Fields, Malebranche, and Feist-Price (2008) examined the experiences of CSA among thirty African-American, homosexual males. The data collected revealed a range of psychological symptoms including depression, anxiety, suicidality, social isolation, "acting out," including engagement in high-risk sexual behaviors, and additional deleterious mental health conditions.

A further study by Chen et al. (2014), conducted among 6,017 cases, with 5,983 controls of Han Chinese women, found that CSA was strongly associated with an increase in risk of developing recurrent major depression. Moreover, it was found that CSA affected the clinical expression of the major depression as those women with both a history of CSA and major depression tended to have an earlier age of onset, longer depressive episodes, and an increased

risk of suffering from dysthymia and phobia. Additionally, similar to past research findings (Browne & Finkelhor, 1986), the use of threats, the degree of upset experienced by the victim at the time of the abuse, and the younger the age at the time of abuse were also associated with the diagnosis and intensity of major depression. Chen et al. also found associations between any form of CSA and suicidal ideation or attempt and feelings of worthlessness and guilt.

van Gerko, Hughes, Hamill, and Waller (2005) examined the relationship between a history of childhood sexual abuse and adult eating behaviors, finding that a repeated history of CSA was associated with specific elements of adult eating pathology. In particular, of the 299 women sampled those who reported a history of childhood sexual trauma appeared to exhibit more frequent pathological eating behaviors including binging and various forms of purging. However, body image disturbance was the only form of disordered eating attitude that was observed. In the discussion of their results, van Gerko et al. explain that as CSA was not linked to restrictive or non-purging behaviors, it can be understood that CSA may have acted as a moderator of the link between other causal factors and the development of eating pathology. In other words, the presence of a CSA history may steer eating pathology towards disorders of bulimia or body-image.

Further research has found links between the presence of a CSA history and severe mental illness. Sheffield, Williams, Blackford, and Heckers (2013) examined the relationship between CSA and the presence of auditory hallucinations among a sample of 114 psychotic disorder patients with various diagnoses. According to their results, psychotic disorder patients experienced higher rates of childhood trauma relative to healthy controls. Furthermore, those psychotic patients who experienced auditory hallucinations reported significantly more severe childhood sexual, physical, and emotional abuse than those who had never experienced such

hallucinations. While it was clear that the inter-relationship between the various forms of abuse contributed to the presence of auditory hallucinations, it was noted that in the absence of CSA, physical and emotional abuse showed no significant relationship with auditory hallucinations. This suggests a unique component of CSA that increases the risk for emergent auditory hallucinations.

The literature also suggests that CSA can have a significant impact on the sexual functioning of both men and women (For a review see Aaron, 2012; Leonard & Follette, 2002; Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, Asuan-O'Brien, 2002). Such dysfunction can often manifest in the form of sexual maladjustment during childhood and adolescence, including a preoccupation with sex or sexual risk-taking, which can ultimately increase the risk of further victimization later in life (Bramsen, Lasgaard, Koss, Shevlin, Elklit, & Banner, 2013; Easton, Coohey, O'leary, Zhang, & Hua, 2010). However, sexual difficulties can persist into adulthood in the form of psychiatric disorders involving sexual functioning (Easton et al., 2011).

In their study measuring the impact of CSA on sexual functioning, Najman, Dunne, Purdie, Boyle, and Coxeter (2005) found significant relationships between the presence of a CSA history among female survivors and sexual disorders including those associated with arousal or orgasm, lack of desire, or pain. Similarly, in their investigation of sexual practices in the United States, Laumann, Michael, and Gagnon (1994) found that among women who disclosed a history of sexual abuse, 40% reported a loss of interest in sex, 32% reported a decrease in pleasure related to sexual activity, and 59% reported that emotional problems interfered with sexual functioning. Meston, Rellini, and Heiman (2006) found that women with a history of CSA had higher levels of negative affect associated with sexuality than those without a sexual abuse history. In a similar study by Rellini, Ing, and Meston (2011) attempting to observe the implicit

and explicit processing among CSA survivors, the researchers found some impairment in the implicit processing of sexual stimuli among such survivors. When compared to women with no history of abuse, it was found that survivors showed little difference in association between pleasure and sexual and neutral constructs. The researchers hypothesized that this impairment may lead to a weakened activation of attention to sexual stimuli resulting in a decrease in interest and motivation.

Although the research did not suggest a correlation between CSA and sexual dysfunction in men, a relationship was found between those with a history of CSA and compulsive sexual behavior in adulthood (Aaron, 2012). In his review of the literature, Aaron (2012) discusses the increase in high-risk sexual behavior, aggressive or hostile behavior, lifetime sexual partners, and rates of STD's among males with CSA histories. Such findings highlight the tremendous cross-gender impact of CSA on the sexual functioning of survivors.

Physiological Symptoms. According to Wilson (2009), adult survivors of CSA report more health symptoms and doctor visits when compared to those with no CSA history.
Such symptoms included disorders of the gynecological, gastrointestinal, respiratory tract, musculoskeletal, and neurological systems. In their study of the health reports and doctor's visits of 608 adult women, Newman et al. (2000) similarly found that women who endorsed a history of CSA reported more somatic symptoms than controls including greater frequency and intensity of headaches, sinus pain, muscle pain, migraines, and gastrointestinal symptoms of bloating, constipation, diarrhea, indigestion, vomiting, and abdominal pain. Additionally, women with a CSA history also reported more fever and productive cough than control subjects. In a similar study, Romans, Belaise, Martin, Morris, and Raffi (2002) found CSA to be a prominent risk factor for a variety of medical conditions including chronic fatigue, bladder problems, pelvic

pain, headaches, asthma and cardiovascular problems, and diabetes. Alexander et al. (1998) also reported that approximately 57% of patients suffering from fibromyalgia reported a history of CSA.

Further physiological symptoms observed among adult CSA survivors have been used to understand the emergence of psychological symptoms addressed above. For example, Heim et al. (2002) underscored the impact of traumatic experiences such as CSA on the physiology of the developing brain leaving survivors of such trauma at greater risk of developing psychiatric disorders later in life. Work by Sheffield, Williams, Woodward, and Heckers (2013) provided some startling findings in support of these claims. Their data, concerned with the grey matter volume in psychotic disorder patients with a history of CSA, showed a negative correlation between the total grey matter volume in one's brain and the severity of CSA experienced. According to their observations, psychotic patients with a CSA history had significantly smaller volumes of grey matter than both healthy controls and psychotic patients without a CSA history. Additionally, grey matter volume reduction among such patients was more widespread than among psychotic disordered patients with no history of CSA and controls. It was observed that those psychotic patients without a history of CSA exhibited reductions in grey matter mainly in the cerebellum whereas those reporting a CSA history exhibited global reductions across a number of brain regions. While it seems clear from the data that reductions in grey matter occur in individuals with psychotic disorder regardless of the presence of a CSA history, Sheffield et al.'s study casts an alarming light on the truly pervasive and devastating impact of CSA on the developing brain.

With regard to sexual dysfunction, Rellini, Hamilton, Delville, and Meston (2009) examined the cortisol response of adult women during psychological sexual arousal. Their

findings showed that for women with a history of CSA, greater cortisol responses, a hormone that activates the adrenergic constriction of smooth muscles potentially associated with sexual activity and arousal, were associated with greater perceived states of psychological sexual arousal. The inverse was true for those women without a history of CSA. However, the nature of this response was unclear from the data presented.

Additional Factors. As discussed earlier, it is clear that CSA increases a survivor's risk of both psychological and physiological harm. However, additional risks associated with CSA are present that can be understood as both effects of and pathways to further risk and damaged well-being. Some of these risks include revictimization, engagement in criminal activity, substance abuse, and high-risk behaviors, including sexual risk-taking (Bramsen et al., 2013; Classen, Palesh, & Aggarwal, 2005; Dolan & Whitworth, 2013). Although researchers have developed numerous theories that help to explain the relationship between CSA and increased risk behaviors (Briere & Elliot, 1994; Finkelhor & Browne, 1985), there remains a gap in the literature focusing on empirical studies in this area (Jones et al., 2013).

Women with a history of physical and sexual abuse in childhood are increasingly vulnerable to further victimization in adulthood (For review see Classen et al., 2005). A study by Wager (2012), examining the relationship between psychogenic amnesia of CSA and later revictimization, found that among the 210 participants sampled, those with a history of CSA exhibited 2.4 times the risk of adult sexual assault. The chance of risk jumped to 4.4 for adolescents with a similar CSA history. In an attempt to further understand the relationship between revictimization and CSA, Bramsen et al. (2013) examined the effect of mediating variables among a sample of 327 adolescent females. The results showed that those variables accounting for the relationship between the two constructs were higher number of sexual

partners and increased likelihood of engagement in high-risk sexual behaviors. Colangelo and Keefe-Cooperman (2012) outlined both the nature and consequences of such high-risk sexual behaviors including earlier consensual sexual activity, increased rate of teenage pregnancy and abortion, increased risk of unprotected sex, and greater number of sexual partners. Numerous studies have discussed the manifestation of these behaviors as *externalized* responses to the horrible trauma of CSA (Aaron, 2012; Colangelo & Keefe-Cooperman, 2012). In their seminal report reviewing the impact of CSA, Finkelhor & Browne (1985) discuss the shaping of a child's sexuality in a fashion that is both "developmentally inappropriate and interpersonally dysfunctional" (p.2). However, other studies have emphasized the involvement of alcohol and other substances, understanding the connection between CSA and revictimization as a byproduct of engagement in substance use, leaving one vulnerable to sexual and physical victimization (Barnes, Noll, Putnam, & Trickett., 2009; Han et al., 2013).

In a study observing the relationship between CSA, symptoms of PTSD, alcohol use and adult sexual assault among gay and lesbian survivors, Han et al. (2013) found that while CSA did not confer risk for adult sexual assault among lesbians, alcohol was an important risk factor. Interestingly, these findings did not hold for gay men within the sample as alcohol use as well as PTSD severity was unrelated to risk of adult sexual assault, suggesting that men may utilize differential strategies of emotional regulation that may increase risk for adult sexual assault. This latter finding is striking when considered against additional research by Davis et al. (2012) suggesting that among men, CSA experiences were directly related to sexually aggressive intentions through misperceptions of partner arousal, even when confronted with clear sexual refusal, and cognitions of sexual entitlement. These misperceptions and cognitions were increased when alcohol was consumed and further strengthened in proportion to the level of

intoxication. Such findings may reflect a gender differentiation in the manifestation of Finkelhor and Browne's (1985) discussion of the impact of *traumatic sexualization*. It appears that for women, CSA experiences may lead to increased risk of future revictimization through externalized sexual behaviors as well as maladaptive coping strategies that increase vulnerability. However, for men, the impact of CSA on sexuality may alter perceptions of partner sexual interest, while also increasing cognitions of entitlement. Such factors may lead to increased risk of perpetration of abuse among male survivors of CSA, continuing a vicious cycle of abuse.

The risk of substance abuse and dependence among victims of CSA is well documented within the literature (Klanecky, McChargue, & Bruggeman, 2012; Sartor et al., 2013). In a study examining the link between early substance use among adolescent female survivors of CSA, Sartor et al. (2013) found that, even when controlling for genetic and environmental influences, links existed between CSA and early initiation of substance use involving alcohol, cannabis, and cigarettes. According to the data, the associations found were significantly more pronounced for alcohol than for cannabis or cigarettes with respect to decreases with age in CSA associated risk. Further studies have similarly associated CSA with increased rates of alcohol abuse and dependence, nicotine dependence, cannabis use and related disorders, (as cited in Sartor et al., 2013).

Klanecky, McChargue, and Bruggeman (2012), attempted to understand the increased tendency to gravitate towards substance use by investigating the concept of a desire-to-associate among college students with a CSA history and lowered levels of dissociative abilities. According to their results, it was found that the desire-to-dissociate explained problematic drinking among this sample. In other words, the unwillingness to remain connected to their

internal experience (*experiential avoidance)* may have led members of this sample to turn towards alcohol in order to produce desired dissociative effects.

Addressing further risk factors associated with CSA, Dolan and Whitworth (2013) conducted a retrospective case note study of 225 women seen by a medium-secure forensic service. Of those in the sample, 55% of the women endorsed a history of CSA and among these women, a higher proportion were not in paid employment and significantly higher lived in a temporary accommodation. Similarly, a great number of abused women within the sample had children who were in the care of other family members or the state. A higher proportion of the abused women also had previous criminal convictions with a younger age of first conviction and a greater number of previous arrests.

When taken together, the tremendously deleterious impact of CSA becomes clear. Whether considering the immediate effects upon the developing child or the long-term sequelae that persist into adulthood and wreak havoc on one's functioning, the devastation is vast and pervasive. In light of such understanding, the need for effective treatments to address the needs of CSA survivors is evident. With a focus on both assuaging the damaging effects of such trauma and mitigating further risk across multiple areas of potential vulnerability, psychological treatment requires sensitivity, thoughtful implementation, and observed efficacy.

Treatment Options for Victims of CSA

Unfortunately, early awareness of the prevalence and detrimental effects of CSA was foiled by widespread denial and neglect. Consequently, the development of appropriate treatments to counter adverse symptomatology and provide a road to recovery was slow (Wells, Glickauf-Hughes, Beaudoin, 1995). Nonetheless, according to Wells, Glickauf-Hughes, and Beaudoin (1995), as awareness of this epidemic grew, so too did the availability of treatments

aimed at resolving the effects associated with sexual abuse victimization. These treatments, emergent during the 1980s, often viewed victims as a homogenous group who experienced similar symptoms and would therefore naturally respond similarly to a universal treatment modality. A main component of these resolution-focused treatments was the requirement of patients to recall details of the abuse in order to bring about a cathartic release (Cahill, Llewelyn, & Pearson, 1991). This concept drew criticism from practitioners who believed that many patients lack sufficient readiness or coping skills to handle active trauma work (Saywitz, Mannarino, Berliner, & Cohen, 2000; Wells, Glickauf-Hughes, & Beaudoin, 1995). Furthermore, other patients may not exhibit severe pathology linked to their CSA experiences or may have different goals for treatment (Saywitz et al., 2000). Fortunately, as clinicians continued to evolve their understanding of CSA and its effects on psychological well-being, it became clear that CSA experiences do not yield a distinct syndrome (Kendall-Tackett, Williams, & Finkelhor, 1993; Ross & O'Carroll, 2004; Wilson, 2009) and therefore, the treatment options should vary in response to the diverse needs of each client. However, such variability demands empirical study and support in order to best understand what works and accordingly adapt treatment to the patient (Finkelhor & Berliner, 1995; Harvey & Taylor, 2010).

Literature focused on reviews of quantitative studies measuring outcome data for treatment modalities used with victims of CSA only began to appear in the 1990s, focusing mostly on child and adolescent victims of CSA (Saywitz et al., 2000). In their seminal review of such empirical studies, Finkelhor and Berliner (1995) examined 29 treatment outcome studies for sexually abused children. It was observed that those victims treated showed improvement, confirming the belief that therapy was an effective tool for facilitation of recovery. However, their review was limited as it is unclear from the data whether the improvements observed were

due to the implementation of treatment, the passage of time, or other external factors (Ross & O'Carroll, 2004; Saywitz et al., 2000). Despite these limitations, Finkelhor and Berliner called for additional large-scale empirical studies to accurately address the question of how best to treat victims of CSA. Since then, a number of controlled and randomized controlled studies have been conducted to measure treatment outcomes and efficacy among the population of CSA victims (Saywitz et al., 2000).

From a review of the literature, it appears that the data supports Cognitive-Behavioral Therapy (CBT) as the favorable treatment for CSA related symptomatology among children and adolescents with regards to overall efficacy (Finkelhor & Berliner, 1995; Ross & O'Carroll, 2004; Saywitz et al., 2000). Parallel support for CBT was similarly found among adult survivors of CSA. In their randomized clinical trial (RCT) measuring the effect of CBT for PTSD among adult female survivors of CSA, McDonagh et al. (2005) compared CBT treatment with present-centered treatment (PCT) utilizing and insight oriented approach. Their findings suggested that while both treatments were more effective at reducing symptoms than the wait list, CBT was more effective at achieving remission from PTSD symptoms at follow-up. However, it should be noted that the CBT condition had the highest rate of dropout (41.1%), possibly reflecting earlier concerns that many CSA victims may not possess the resources or readiness to manage the intensity of exposure-based treatments. Similarly, Chard's (2005) evaluation of Cognitive Processing Therapy for the treatment of PTSD for Sexual Abuse (CPT-SA), a variation of CBT with a focus on sexual trauma, found that utilization of this treatment among a sample of 71 women produced statistically and clinically significant improvement of symptoms related to PTSD, depression, and dissociation from pre to posttreatment. Furthermore, observed gains were maintained at both 3-month and 1-year follow-up. Bohus et al., (2013) also found support

for the use of Dialectical Behavior Therapy (DBT) among survivors of CSA with a PTSD diagnosis. In their randomized controlled trial among a sample of 74 female subjects, it was found that those women randomly selected for the DBT group displayed significantly greater improvements than those in the treatment as usual (TAU) group. Of particular note was the fact that such improvements were observed regardless of borderline features, which was a featured component of this study.

However, the results of these studies should be interpreted with caution when considering the relative scarcity of empirical studies focusing on the efficacy of alternative treatments (Saywitz et al., 2000). Moreover, while many researchers suggest that trauma in childhood can develop into complex PTSD in adulthood (Cohen, 2008; Singh & Sikes, 2011), many of the studies supporting CBT as the treatment of choice base their research on the assumption that PTSD is the best conceptualization of the psychological disturbance emergent from CSA (Jones & Ramchandani, 1999, as cited in Ross & O'Carroll, 2004). This is particularly problematic given the diversity of symptom expression and psychological distress, and the overall differences among patient characteristics (Higgins-Kessler & Nelson Goff, 2006; Ross & O'Carroll, 2004; Saywitz et al., 2000). In fact, when observing reduction of general symptoms rather than abuse-specific or PTSD related issues, often no significant differences are found between behavioral treatments, supportive therapy, or treatment as usual conditions (Bohus et al., 2013). For this reason, Cohen (2008) argues that CBT may not be sufficient to treat the complex array of difficulties experienced by members of this population. Instead, remaining open to adaptation of treatment, and implementation of additional techniques in order to supplement the treatment of choice is necessary.

Although there are few empirical studies measuring the efficacy of alternative modalities as a treatment for CSA sequelae (Ross & O'Carroll, 2004; Saywitz et al., 2000), some support has been for additional techniques. In their randomized experimental evaluation, Edmond, Rubin, and Wambach (1999) found support for the use of Eye Movement Desensitization and Reprocessing (EMDR) as a treatment for adult survivors of CSA. EMDR, a relatively new treatment, attempts to blend intrapsychic, cognitive, behavioral, and body-oriented themes into a single treatment aimed at transforming dysfunctional traumatic experiences into positive cognitions (Shapiro, 1996). The focus on eye-movement is used to desensitize the patient to traumatic stimuli actively being held in mind. In their study, Edmond, Rubin, and Wambach assigned 59 subjects to one of three groups including EMDR treatment, routine individual treatment, or a delayed control group. The results of their study indicated that subjects in the EMDR group showed greater improvement than controls with regards to trauma-specific anxiety, trauma-specific PTSD, depression, and negative beliefs. Statistically significant decreases in trauma-specific emotional disturbances as well as increases in positive self-referencing beliefs were further observed from pre to posttest within the EMDR group. Additionally, gains were more effectively maintained for subjects within the EMDR group as compared to the routine individual treatment group at 3-month follow-up. Although no significant differences were observed on measures between the EMDR group and the routine individual treatment group, these data suggest that EMDR may be a valuable treatment alternative for survivors of CSA. In a more recent study, Edmond and Rubin (2001) continued to find support for the short-term effectiveness of EMDR as a treatment for trauma symptoms among adult female survivors of CSA. However, their follow-up study further found that the therapeutic benefits of CSA can be maintained over an 18 month period suggesting stable and long-lasting results. Additionally,

Paivio and Nieuwenhuis (2001) found support for the use of Emotion-Focused Therapy (EFT) for treatment of adult survivors of abuse. Their study, conducted among 46 subjects, found that EFT was as effective as other time-limited treatments at reducing general symptoms, abuse-related issues, and interpersonal issues, with gains maintained at 9-month follow-up.

Overall, the literature suggests that CBT and Behavioral treatments are particularly effective at reducing abuse-specific symptoms and those related to PTSD (Chard, 2005; Finkelhor & Berliner, 1995; McDonagh et al., 2005; Ross & O'Carroll, 2004; Saywitz et al., 2000). However, according to Morrison and Ferris (2009) many approaches appear to be useful towards treatment of survivors of CSA including psychoanalysis, psychodynamic, existential and humanistic, solution-focused, social learning theory, family systems, and feminist theory. Nonetheless, it is clear that additional studies are needed to observe the efficacy of these modalities towards treatment of this unique population as the dearth of literature in this area is alarmingly vast. In particular, despite its rising popularity as a treatment technique, research on the use of mindfulness as an alternative method of healing in this area has been almost non-existent. This is unfortunate given the observed benefits attributed to mindfulness practice, particularly with regards to many of the sequelae resultant from exposure to CSA.

Understanding Mindfulness

Despite the recent surge in popularity, mindfulness has roots that go back to the teaching of the Buddha who lived and taught in northeast India during the 5th Century BC (Bodhi, 2011). According to Bodhi (2011), at the heart of the Buddha's teaching was a system of training that lead to insight and the overcoming of *dukkha*, or suffering. Within this system, mindfulness made up a large portion of the training and was held in prominence as a critical component of the journey to end suffering.

Although there is disagreement as to the original definition of mindfulness, it is clear that most understandings of the concept contain elements of *awareness, focused energy, attention, calling-to-mind, remembrance,* etc (Bodhi, 2011; Gethin, 2011). The Buddha, as quoted by Kornfield and Siegel (2010), described the practice thusly:

> My friends there is a most wonderful way for human beings to realize purification, to overcome grief and sorrow, to end anxiety and fear, and travel on a path of wisdom of compassion, and this is the establishment of mindfulness…There are four dimensions of establishing mindfulness. One establishes mindfulness of the body in the body, of the feelings in the feelings, of the mind in the mind, and of the dharma in the dharma. One establishes these both inwardly and outwardly.

While this description provides some clarity as to the meaning of mindfulness, little is explained with regards to the cessation of suffering. According to Teasdale and Chaskalson (2011), such understanding begins through the realization that suffering arises from craving and aversion, both rooted in psychological motivations of fear and avoidance. Teasdale and Chaskalson explain that aversion involves the removal of unpleasant states of being while craving reflects the need to cling to the object of desire out of the fear of losing it. Additionally, both craving and aversion reflect a desire for experiences to be different than they are and an unwillingness to accept the truth of each experience. Such motivations lead to the development of patterns of mental processes that interact in such a way so as to reinforce perpetuation of the pattern. In this way, suffering can be seen as actively created and re-created within each moment. De Silva (2014) refers to this as the "wheel of suffering" (p. 126) with adherence to the teachings of the Buddha providing a form of liberation.

Teasdale and Chaskalson (2011) suggest that the release from suffering then hinges on reconfiguration of these patterns so that the perpetuation of suffering can no longer arise. Mindfulness allows for such reconfiguration through various processes including changing the content the mind is processing by cultivating intentional awareness rather than automatic and unconscious reaction; changing how material is processed by cultivating an *approach* motivation through direct awareness of thoughts, feelings, and bodily sensations experientially within the moment; and changing the view of the material processed by changing the lenses through which we view various experiences.

From this explanation, it is clear that mindfulness is not a passive form of relaxation training. Rather the practice reflects an *active* process that requires committed training and development as a skill. However, it should be remembered that mindfulness represents only one of a number of practices related to the cessation of suffering (Bodhi, 2011; De Silva, 2014). The Buddha taught that through faithful practice and cultivation of ethics, nurturance of the wholesome, blameless living and other landmarks on the path, can come liberation and lightness of mind (De Silva, 2014). These practices can only be understood as interrelated, making up a lifestyle or way of being that can ultimately lead to a place of healing and spiritual peace. Nonetheless, with a focus on the cultivation of awareness and observation of experiential phenomenon towards the goal of reduced suffering, the philosophy of mindfulness fits nicely within the realm of psychology possibly providing an explanation for its recent rise in popularity among clinicians.

Mindfulness within Psychology

Mindfulness is a relatively new addition to the field of psychology (Bodhi, 2011; Gethin, 2011). As a therapeutic concept, mindfulness was first prominently introduced by John Kabat-

Zinn around 1979 when he began his Mindfulness-Based Stress Reduction (MBSR) program in Massachusetts (Bodhi, 2011). Since then, its popularity has grown significantly within the psychological milieu (Hart, Ivtzan, & Hart, 2013) and mindfulness has been incorporated into a number of treatment protocols including Acceptance and Commitment Therapy (ACT), DBT, Mindfulness-Based Cognitive Behavioral Therapy (MBCT) and MBSR (Dunn, Callahan, & Swift (2013). Additionally, mindfulness can be considered a transtheoretical tool that can be utilized by all therapists as an intervention strategy (Dunn, Callahan, & Swift, 2013) and has even been proposed as a common factor across all psychological theories (Shapiro, Carlson, Astin, & Freedman, 2006). Although, its psychological implementation is often removed from the spiritual and doctrinal nature of the practice, which ultimately offers a path towards cessation of suffering and eventual sainthood (De Silva, 2014), the use of mindfulness as a therapeutic intervention has nonetheless been consistently linked with positive psychological change and clinical efficacy (Hart, Ivtzan, & Hart, 2013).

Among practitioners, it is often difficult to reach consensus on a true definition of mindfulness, particularly given the separation from its spiritually-based roots (Germer, Siegel, & Fulton, 2013). However, a number of definitions do exist within the literature that suggests a commonality of understanding with regards to central elements of mindfulness. According to Kabat-Zinn (2003), mindfulness can be understood as "The awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (p. 145). A second definition (as cited in Germer et al., 2013) describes a two-step process of self-regulated and sustained attention on the immediate experience as well as an orientation towards such experience that is comprised of curiosity, openness, and acceptance. Shapiro et al. (2006) go further to suggest that mindfulness is a state

of consciousness that involves intentional awareness of one's moment-to-moment experience. While a component of attentional regulation is present within each of the definitions, a further qualitative element is recognized that appears to suggest that a way of being rooted in beliefs beyond simple skill development (Germer et al., 2013; Pollak, Pedulla, & Siegel, 2014; Shapiro et al., 2006).

Nonetheless, while a commonality exists among extant definitions, there remains a wide variety of options in terms of implementation of mindful practice into treatment (Germer et al., 2013; Mace, 2007; Pollak et al., 2014). According to Germer et al. (2013), the role of mindfulness within psychotherapy can be understood to exist along a continuum. This continuum ranges from implicit to explicit practice with implicit involving a way of relating to clients that is drawn from personal mindfulness practice and is independent of any theoretical orientation. Clinicians working from such a frame can best be described as *practicing therapists* (Germer et al., 2013, p. 24) and may fully adopt the broader philosophy and belief system inherent to mindful practice (Pollak et al., 2014). Such a method of working involves a way of relating to clients informed by elements of empathic attunement, enhanced tolerance, and compassion that facilitates the formation and sustainment of a healing therapeutic relationship (Germer et al., 2013; Pollak et al., 2014).

In the center of the continuum sits *mindfulness-informed psychotherapy* (Germer et al., 2013, p. 23) that is described as a way of working with clients that incorporates insights from mindfulness practice. According to Germer el al. (2013), this way of working borrows ideas from Western and Buddhist psychology, as well as from the clinician's personal practice, in order to influence the broader theoretical frame. Pollak et al. (2014) explain that such a frame may entail actively working to facilitate openness and acceptance within clients through expansion of

awareness and tolerance. They further explain that this is facilitated through a focus on the therapeutic relationship as well as adherence to a broader theoretical frame that ultimately drives the treatment.

Finally, on the explicit end of the continuum, Germer et al. (2013) describe a *mindfulness-based psychotherapy* (p. 24) that involves broadly teaching mindfulness skills to patients. Such skills may include formal practice consisting of various meditative exercises or informal practice involving mindful activities or structured exercises (Mace, 2007) This skills-centered way of practicing appears to be most common within the current field, with a variety of mindfulness-based treatments having emerged recently to address a wide range of psychological issues (Dunn et al., 2013; Germer et al., 2013; Mace, 2007). Nonetheless, as mindfulness continues to gain traction within the psychological realm, its relevance as a way of working is increasingly becoming recognized with many practitioners claiming mindfulness as their broad theoretical orientation (Germer et al., 2013). Additionally, recent research suggests a number of benefits associated with such practice that provides further support for the growing popularity of mindfulness as a way of working with clients.

The Benefits of Mindfulness

According to the literature, mindfulness has been linked with a number of beneficial outcomes including increased happiness, positive emotions and emotional regulation, vitality, optimism, sense of autonomy and life-satisfaction (Davis & Hayes, 2011; Hart, Ivtzan, & Hart, 2013; Hill & Updegraff, 2012; Shapiro et al., 2006). Additionally, mindfulness has been found effective as an intervention towards improvement of a number of psychological disorders including depression, stress, anxiety, and PTSD (Hart et al., 2013; Keng, Smoski, & Robins, 2011; Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2013; Williams et al., 2014). In their

meta-analysis of the efficacy of mindfulness-based therapy towards treatment of anxiety and depression, Hofmann, Sawyer, Witt, and Oh (2010) identified 727 relevant articles and examined 39 of these studies to measure pre-posttest effect size estimates. They found that mindfulness-based therapy (MBT) was associated with large effect sizes related to improvements of both anxiety and depression. Additionally, their findings suggested that MBT was effective across a wide range of symptom severity, even when symptoms were associated with chronic or medical conditions such as treatment-resistant depression, cancer, or pain. Further support for the effects of mindfulness as a treatment for depression, anxiety and stress was found in a number of additional studies.

In their study examining MBCT as prevention against relapse of recurrent depression, Kuyken et al. (2008) found that the implementation of MBCT produced superior outcomes to those of people using maintenance antidepressant medication with regards to symptom mitigation, psychiatric comorbidity, and psychological and physical quality of life. In fact, of the 123 participants sampled, 75% of those randomized to the MBCT condition completely discontinued their antidepressant medication. Similarly, Geschwind, Peeters, Drunker, van Os, and Winchers (2011) measured the effects of MBCT on a sample of 120 adults with a history of major depression or residual depressive symptoms. Their study attempted to observe the relationship between MBCT and levels of positive affect as it is related to well-being and resilience against depression. Their findings suggested that compared to baseline measures and the control group, those participants exposed to the MBCT group experienced higher levels of overall positive affect, increased appraisal of activities as pleasant, and higher levels of reward experience. Additionally, increases in positive affect among the MBCT group were associated with decreased depressive symtpomatology, which may provide an understanding of some of the

mechanisms of change within mindfulness practice. In a further study, Williams et al. (2014) examined the effectiveness of MBCT on relapse prevention of depressive symptoms among 300 participants with a history of major depression. Although they did not find support for general risk reduction related to MBCT when compared against treatment as usual (TAU) or cognitive psychological education (CPE), significant differences were found when childhood trauma was accounted for. For those participants with a history of trauma, MBCT was found to be more effective towards prevention of symptom relapse. The contrasts between MBCT, TAU and CPE were significantly moderated by the severity of abuse, with higher levels of abuse associated with increased effectiveness of MBCT.

Additionally, among a sample of 124 firefighters, Smith et al. (2011) found that trait mindfulness was negatively associated with PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when further resilience factors were controlled for. Similarly, Bormann, Thorp, Wetherell, Golshan and Lang (2013), found that among veterans with military trauma experiences, the use of meditation or mindfulness interventions coupled with traditional therapy produced significant differences in PTSD symptoms when compared to a treatment as usual control group. The meditation or mindfulness interventions seemed to have the greatest impact on hyperarousal symptoms underscoring the benefits of mindfulness as a facilitator of self-regulation. Additionally, significant differences were observed with regards to a decrease in depressive symptoms and improvements in quality of life and spiritual well-being.

In further support of the efficacy of mindfulness, this practice has also been linked with increased emotion regulation, decreased reactivity, and improved cognitive flexibility (Davis & Hayes, 2011; Goldin & Gross, 2010). Burg, Wolf, and Michalak (2012) further found that mindfulness breathing exercises increased the heart rate variability of a sample of 23

undergraduate students. They explain that heart rate variability is an indicator of one's ability to self-regulate both emotions and behavior. Moreover, links between mindfulness and interpersonal benefits have been found including increased levels of empathy, perspective taking (Wachs & Cordova, 2007), marital and relationship satisfaction (Kozlowski, 2013), as well as improved sexual satisfaction (Brotto & Heiman, 2007). Furthermore, a number of physiological benefits have been observed as well. Nyklíc, Mommersteeg, Beugen and Ramakers (2013) found that among a sample of 88 participants with stress-related complaints, those randomized to the MBSR treatment displayed stronger overall decreases in blood pressure as well as smaller blood pressure responses when presented with a stressor.

From these data, it is clear that mindfulness can provide a wealth of physiological and psychological benefits. As such, the clinical implications of such findings are quite vast. Such implications become particularly meaningful when comparing the benefits of mindfulness with the negative sequelae associated with CSA histories. From such a comparison, it can be hypothesized that mindfulness may provide a pathway to healing for many survivors. Strangely, little has been written in the literature regarding the use of mindfulness as a viable therapeutic intervention for CSA. Even fewer studies have been conducted that directly assess the efficacy of mindfulness with this population. The following presents a brief review of the relevant literature available.

Mindfulness and Childhood Sexual Abuse

Although there is a gap in the literature related to an understanding of mindfulness as a therapeutic intervention for survivors of sexual abuse, some studies have begun to focus their attention in this area. Kimbrough, Magyari, Langenberg, Chesney and Berman (2010) examined the efficacy of an 8-week MBSR program with daily home practice of mindfulness skills among

a sample of 23 adult survivors of CSA. Participants were led in formal meditation practice that included sitting meditation, progressive body awareness, contemplative walking, and gentle yoga stretching. These exercises were used to draw participants' awareness to their present-moment experience in a nonjudgmental fashion while also fostering a sense of compassion for self and others. Participants were also asked to engage in mindfulness practice at home and were additionally provided with a text to increase their understanding of the tenets of mindfulness. Their study assessed symptoms of anxiety, depression, PTSD, and mindfulness at baseline, 4, 8, and 24 weeks. They found that at 8 weeks, statistically significant changes were observed in all outcomes. These changes remained stable until the conclusion of the study at 24 weeks. The largest effect size was found related to decreased depressive symptoms at 8 weeks. Similarly, PTSD symptoms were decreased in the criterion areas of reexperiencing, avoidance, and hyperarousal. This is particularly significant given the centrality of avoidance as a key component in the development and maintenance of PTSD.

In a further study, Brotto, Seal, and Rellini (2012) compared the efficacy of a brief CBT intervention against a brief mindfulness intervention towards the treatment of sexual distress related to a history of CSA among a sample of women. Of the 20 participants, those randomly assigned to the mindfulness based treatment (MBT) showed significant changes in both genital and subjective arousal from pre to posttreatment. In comparison, those in the CBT group showed no significant difference in levels of arousal.

These studies seem to suggest that mindfulness may be a useful therapeutic intervention among survivors of CSA. Furthermore, the wealth of efficacy studies supporting mindfulness as a beneficial component of both physiological and psychological health further supports its usefulness. However, despite its growing popularity both within the field and among lay

practitioners, limited research on its applications and the mechanisms of change exist within the literature. The present study attempts to address this gap by examining the use of mindfulness among the CSA survivor population. Specifically, this study will gain a deeper understanding of how practicing clinicians understand the benefits of mindfulness with this population and further, how they observe and understand change within their clients as a result of such practice.

Methodology

This project attempts to fill in some apparent gaps in the literature by adding depth to the understanding of effects and mechanisms of change inherent to mindfulness practice with adult victims of CSA. In order to facilitate this deeper understanding, a qualitative approach will be used to focus on clinician experiences using a mindfulness based approach to treatment of adult clients expressing distress related to CSA trauma. The nature of qualitative research is that it is both *idiographic* and *emic*. That is, the focus of inquiry is concerned with understanding the individual as a unique and complex entity (idiographic) through language-specific means (emic) (Morrow, 2005; Ponterotto, 2005). For the purposes of this study, this will involve a selection of clinicians chosen to participate in semi-structured interviews designed to capture their experience utilizing a mindfulness based approach with this population.

A qualitative approach allows for observation of elements of experience that facilitates a broader understanding of a particular phenomenon (Leech & Onwuegbuzie, 2007; Polkinghorne, 2005) through analysis of categories of meaning found among or within a small group of individuals (Morrow, 2005). In this way, the inductive approach utilized within this study will allow for the experiences of participants to be fully captured and synthesized in order to allow themes to organically emerge from the data (Leech & Onwuegbuzie, 2007). Such themes will then inform the generation of an abstract theory that will reflect the voices and experiences of the participants and ultimately deepen understanding of the observed phenomenon (Charmaz, 2006; Creswell, Hanson, Clark Plano, & Morales, 2007).

Participants

Participants for this study were recruited from the Southern California psychological community. In order to determine the appropriate number of participants included, the literature

related to qualitative design was reviewed. Although some literature posits that among interview-based studies, participant numbers mean little (Morrow, 2005) and that reliance on depth rather than breadth is essential (Creswell et al., 2007), a broad range of participant inclusion has been suggested, indicating that approximately 3 to 25 interviews will allow for sufficient diversity to identify themes and develop the possibilities of experience (Creswell et al., 2007; Morrow, 2005). In order to allow for adequate capture of the experience of the clinicians selected, 6 participants were included in the study.

Additionally, participants for qualitative research are not chosen based on their ability to fulfill representative requirements of statistical analysis but rather on their ability to fully capture the observed experience (Polkinghorne, 2005). As such, the inclusion criteria for participants within this study were an essential and purposively constructed component of participant selection. In order to be included in the study, participants must have been a licensed mental health professional currently engaging clients in individual counseling, with a minimum of three years' experience post-graduation. Furthermore, they must have possessed a working knowledge of the concepts of mindfulness and must further incorporate this practice into both their professional and personal lives. A working knowledge of the concepts of mindfulness was determined through a brief initial screening (See Appendix B) whereby potential participants were asked how they defined mindfulness, if they cultivated their own personal mindfulness practice, and how mindfulness informed their professional work. Moreover, participants must have had experience conducting mindfulness-informed therapy with adult trauma survivors for whom issues related to CSA had been a focus of treatment. Included participants must have worked in such a fashion with, at minimum, more than one adult CSA survivor and have been

incorporating mindfulness practice for longer than one year. Participants were also required to provide written consent to be digitally recorded.

Participants were recruited from the local Los Angeles area and were identified through internet-based searches of private practitioners using Google or PsychologyToday.com as search mediums. Two participants were referred to the study by a colleague of the principal investigator. Twenty-seven candidates were approached in total, including those referred, who appeared to meet the necessary inclusion criteria. All were contacted via telephone or email in order to discuss their interest in participation in the study and to provide them with some brief information about the study as well as the recruitment flyer (See Appendix D), which provided additional details.

Initially, using PsychologyToday.com, search criteria focused on MBSR and trauma were used to find participants using mindfulness as a treatment orientation with trauma survivors. Approximately six participants were approached using such criteria; however, of the five who responded, four indicated that they utilized mindfulness as a skill rather than an overarching framework for treatment. The other potential candidate declined participation based on scheduling conflicts. As such, none of these candidates were included in the study. In response, the search criteria were shifted to include spirituality in order to widen the search net while also finding participants for whom mindfulness was more than a simple intervention tool.

Among the remaining twenty-one potential candidates, only fourteen responded to the principal investigator's initial communication. Of those, six declined participation based on time and scheduling difficulties. A further three indicated that they did not fit the criteria due to their lack of experience with trauma-focused work or integration of mindfulness with such a population. The remaining five candidates expressed an interest in the study and agreed to

participate. However, one later dropped out due to scheduling difficulties and a further participant was recruited through referral from a colleague.

Of those candidates that expressed an interest in participation, a time was scheduled to conduct a brief initial screening via telephone in order to determine eligibility for inclusion. This screening included a short series of questions aimed at learning about each candidate's professional background while also determining how they understood the concepts of mindfulness and how mindfulness informed their work. The screenings took approximately 10 to 15 minutes, after which potential candidates were informed of their eligibility in the study. If participants met the inclusion criteria, a further time was determined to meet for the full in-person interview. Each participant received compensation in the form of a $10 gift card from a local coffee shop.

Consent Procedures

Prior to any data collection, participants were informed of the purpose and nature of the study. They were also provided with a copy of an informed consent (See Appendix E) document, which explained that all of the information gathered would be used only for research purposes, that their participation in the study was entirely voluntary, and that they had the right to discontinue at any time. Additionally, the informed consent outlined the audio recording requirement. It was explained that by signing the document, participants gave permission to be digitally recorded with the understanding that all recordings would be deleted upon completion of the study. Finally, the potential need to re-contact participants to clarify responses was included and discussed. However, no further contact was required for any of the participants. In order to maintain confidentiality, participant names were excluded from the study. Instead, participants were assigned a random number, which corresponded to their interview and name.

This was recorded on a master sheet held by the study designer. The coding sheet will be destroyed upon completion of study. Participants were provided with a personal copy of the informed consent for their records and the interviewer similarly obtained a signed copy for the purposes of the study. The informed consent document was written in clear and understandable language and was reviewed with each participant prior to any data collection procedures. To ensure confidentiality, signed consent forms were scanned and stored electronically in a separate location from additionally collected data. The digital forms were stored on an encrypted flash drive held by the principal investigator. All hard copies of consent forms were immediately destroyed through shredding after being scanned and stored electronically.

Data Collection

In order to gather the necessary data, the principal investigator conducted six, in-person, single-round interviews, which lasted an average of 45 minutes. All interviews were conducted in a place of the participants' choosing. Five of the interviews were completed at participants' private offices with the final interview conducted at a participant's home. The interviews were semi-structured, with questions initially focusing on participants beliefs about the efficacy of mindfulness before moving deeper to understand clinician experiences using mindfulness with an adult CSA survivor population. Included questions related to how participants understood the benefits of such interventions, observed changes, and client reactions (See Appendix C). It should be noted that while the interviews contained some structure, the order of questioning varied depending upon participant responses in order to create a maximally organic interview process. The interviews were digitally recorded with a recording device supplied by the principal investigator. All recordings were stored on a separate encrypted flash drive owned and maintained by the principal investigator. Upon completion of the interviews, captured

information was transcribed verbatim by the researcher. These transcriptions were similarly be stored on the same encrypted flash drive and were linked to the interview recordings only by the randomly assigned participant number. The flash drive was kept in a locked file cabinet at the principal investigator's home. All data will be kept for a minimum of three years following the study's completion and will then be destroyed in its entirety.

Results

Data Analysis Approach

Semi-structured interviews were used as the main method of data collection within this study. These interviews were then analyzed based on the qualitative principles of grounded theory in order to move beyond mere description of the data towards a deeper understanding that could form the basis of an abstract theory (Creswell et al., 2007). According to Charmaz (2006), this method of analysis allows for a derivation of meaning that emerges from the data rather than from preconceived theories present within quantitative methodology. Such analysis necessitated an active and multi-layered process beginning with immersion in each of the individual transcript narratives (Charmaz, 2006). This involved rereading of each transcript to identify relevant quotes and key concepts from the text. Each line of text was reviewed and given a code that would form the framework of a theory as the data was refined throughout the process. Such codes were annotated within the margins of each transcript. Within this phase of *initial coding,* the data was observed in an open manner, allowing the material to define the course of analysis and thus gaining an understanding of what is suggested from the data. This process was repeated with each following transcript, enabling for an understanding of the interrelationship between emergent codes (Charmaz, 2006; Cho & Lee, 2014).

Once all of the coding possibilities were exhausted, *focused coding* was used to further refine the initial codes and later organize the data into meaningful categories (Charmaz, 2006; Cho & Lee, 2014). Within this process, the data were scrutinized in order to draw out the most significant or frequent codes. Charmaz (2006) explains that this allows one to "capture, synthesize, and understand the main themes in a statement" (p.59). As this process continued, patterns begin to emerge within the data that allowed for the organic development of relevant

and meaningful categories. Initially broad, the list of categories was continuously refined in order to capture the core elements of the phenomena, while also reflecting the dynamic nature of grounded theory analysis (Middle & Kennerley, 2001).

In the final stage of the analytic process, *theoretical coding* was used to further refine the data into a meaningful theory that cast some understanding on the observed phenomenon (Cho & Lee, 2014). Such a process allows the story, initially fractured within the data, to be woven together into a coherent theory (Charmaz, 2006). As such, the refined categories were organized in a manner that allowed for observation of their interrelationship, which facilitated the development of the emergent theory that explained the phenomenon captured within the data.

Reliability and Validity

In any analytic process, it remains essential for the research to strived for reliable and valid results (Creswell et al., 2007). With regards to reliability, further means of strengthening the results and ensuring a purer and increasingly refined observation of the target experience include additional safeguards that will increase both dependability and credibility of the results (Morrow, 2005). Towards such ends, a second coder was utilized in order to increase reliability of analytic results. The second coder was chosen by chairperson of the current study and was trained in the same analytic style as the principal investigator. The principal investigator and the second coder conducted data analysis separately followed by a comparison that yielded good reliability on the general themes. Additionally, the principal investigator and second coder had a discussion following the initial analysis to confirm analytic findings. Although different language was sometimes used, the subsequent discussion revealed that similar themes were perceived across the interviews. For example, while the principal investigator may have observed emergent codes related to therapeutic *presence*, the second coder found those indicative

of a *way of being with clients*. Upon discussion, it was agreed that the inherent essence of the data was similarly understood between coders and, thus, reliability could be confirmed. However, the principal investigator then conducted a closer analysis to further distill the themes in an effort to gain the deepest understanding possible. The second coder did not complete such an in-depth analysis and so reliability is based on the initial coding comparisons; however, core elements of analysis remained the same with only some reorganization and addition of categories as well as differential language observed.

An auditor was used to confirm the face validity of emergent themes from the closer analysis. This auditor reviewed the themes and subsequently approved the validity of the constructs and developed theory. Following this, the emergent themes were then compared with the current literature for additional triangulation.

Grounded Theory Account

During the analytic process, five main categories, one with two subcategories, were identified that appeared to best capture the essence of the collected data. These interrelated categories formed the framework of a theory that appeared to tell the story of the data. The identified categories, shown in Table 1, reflect characteristics of the observed phenomena including those related to the therapeutic strategy employed, therapeutic conditions, the impact of the therapist's own mindful practice, core features of mindfulness practice, and the markers of change observed within CSA survivors.

It should be noted that all coded data did not fit into the observed categories. Some codes emerged only from one participant or did not seem to reflect a broader category of meaning within the analysis. As such, a decision was made by the principal investigator to focus only on the data that seemed to emerge with prevalence across participant narratives. Those codes

considered salient appeared frequently across the data and were emergent within the narratives of at least three participants.

Table 1.

Categories Emergent from Qualitative Interviews

Core Elements of Mindful Practice	Therapeutic Strategy	Therapeutic Conditions	Impact of Therapist Mindful Practice	Markers of Change
Nonjudgmental awareness Presence Tolerance/ Acceptance Compassion	Structural components: Orienting clients Assessment Structuring treatment	Safety Trust Agency Validation	Awareness Attunement Compassion Acceptance	Awareness Acceptance/Tolerance Empowerment Self-efficacy Improved relationships Compassion Forgiveness
	Therapeutic presence: Attunement Openness Connection			

Core elements of mindful practice. The participants in the study all spoke to features of mindfulness that appear to produce therapeutic benefit for clients. Such features were understood to facilitate healing, both within the general context of treatment as well as with survivors of CSA. Within all of the narratives, some mention was given to the importance of *nonjudgmental present-moment awareness* as a key component of therapeutic growth. For example, one participant stated "Well, I think that mindfulness is foundational to developing awareness and there is some change that can happen without awareness but I think that profound change comes as a function of awareness." Another participant responded similarly by explaining, "Well, it's something that's integral, I believe, to psychotherapy." Other participants spoke of awareness as an "attentional process" that allows us to "change our relationship" to our minds in a way that is facilitative of change. This was particularly relevant as many participants

spoke of the importance of awareness in shifting one's perception of the mind and thoughts. One participant stated that:

> It can be a profound revelation that thoughts are just thoughts, they're not necessarily real. They're not necessarily predictive. That we have hundreds, thousands a day and most of them aren't present focused. So having someone pull themself into the present moment can be a huge relief, a major relief.

Another participant spoke to the importance of this shift by explaining that mindfulness allows us to "not let our minds torment us but to somehow change our relationship in training the mind that allows us to have a more full or fulfilling or meaningful life." However, participants further elaborated on their understanding of awareness, including a holistic experience that incorporates "thoughts, emotions, bodily sensations, and impulses." Similarly, another participant spoke to how this can aid in the processing of trauma by stating that "we want to process it in terms of cognitive process, in terms of emotional processes, and in terms of somatic processes." When understood together, the importance of awareness as "a state of just being" that "slows us down," was quite significant as such a state facilitated one's ability to "subconsciously experience something without it over-activating their mind/body in a negative way."

Nonetheless, while nonjudgmental awareness appeared to reflect a central tenet of mindfulness that facilitated therapeutic growth, with one participant stating that "awareness is the first step," it did not stand in isolation. A further participant noted the importance of *compassion* by explaining that, "it's not only being aware of it but also being aware of it in a way that's sort of compassionate and kind." This was similarly reflected by another participant who indicated that "anything that's done under awareness shifts. Especially under compassionate awareness."

Additionally, participants noted the importance of a *presence,* indicating that "if you can pull the person into the present moment, out of whatever their trauma was, then you can begin to integrate that trauma." The concept of presence was further explained as a participant noted:

> The more we get trapped in this part/future and miss out of the present, the more that we have this sort of very reactive mind and then become very intolerant of pain and, you know, we find that our lives become very limited.

This statement was echoed by another participant who explained that mindfulness "stops people from being reactive." Another participant spoke of the active nature of such present focus by indicating that "when things intrude on those thoughts, intrude on us, that are past focused or future focused, that we actively pull ourselves back to the moment."

Participants further spoke to mindfulness practice as facilitative of *tolerance* or *acceptance*. One participant indicated that "thoughts come in your mind and instead of yelling at them and making them go away you have to learn how to tolerate thoughts but not engage with them." Another participant echoed the importance of this by explaining that mindfulness introduces "the idea that we're not gonna try to change things because that's gonna increase our cognitive load. We're just gonna watch them go by, like the leaf on the river." A further participant noted the benefits of such elements by stating that:

> Having a way of being in self-control, having some self-control with their emotions and not giving into their emotions but just observing it. Just experiencing it. Just having the thoughts come in and just knowing that the thoughts will transmit themselves. It also reframes it for them.

A further participant similarly explained that such acceptance, facilitated through mindful practice, allows us "to step into things that were harder or to be presented with things that we

would be disconnected from and in doing so, people who had really, very severely narrowing of lives can experience more expansion, more fulfillment."

Therapeutic strategy. Another emergent theme reflected the therapeutic strategy employed to facilitate recovery among CSA survivors. Within this category, two subcategories were identified relating to *structural components* of the treatment as well as the overall *therapeutic presence* employed by the practitioner. Participants spoke to how each of these areas impact the treatment and subsequent healing within their clients.

Structural components. All participants within the study spoke to the importance of early considerations to treatment and indicated that it was beneficial to provide psychoeducation at the outset as a means of *orienting* clients to this way of working. One participant explained that "there's always a psychoeducation portion when it feels right." Another similarly stated "I use psychoeducation as the introduction piece." Other participants spoke of how they go about providing such education with one indicating that "I begin to educate them about what mindfulness is and how that will benefit them while they are going through this process of healing." This participant continued by describing how they present the benefits of mindfulness by stating:

> So I explain and I educate them about the mind/body experience that becomes incorporated when they practice mindfulness, because they're in a state of being calm which sends certain hormones to their brain, to let them know they're in a safe, controlled environment versus if they were without it, they may activate their fight or flight instincts, which could cause them to be more reactive and more impulsive.

This participant further added:

> So I give them that kind of perspective of the pros and cons as well as the mind/body approach where, you know, kind of in some simplistic ways of how that would help them to be less reactive if they were to incorporate a mindfulness practice.

Others explained that they use metaphors to bring the concepts to life. One participant stated that they often incorporate metaphors from existing theoretical approaches. This participant noted a reformulation of the ACT metaphor of *Passengers on the Bus* by responding:

> Like some of us are hardy SUV's and we can take the bumps really hard. Those aren't the folks that end up here. And then some of us are like vintage Aston Martin's right? We're unique, we're special, we're creative, we're great to look at but we don't take the bumps that well. So I use that to really normalize that it's not better or worse, it's just knowing thy vehicle and maintaining it and being mindfully caring of it.

Still others spoke of the importance of relying on research to educate clients about the benefits of mindfulness. One participant stated that:

> I tend to tell people that I'm an evidenced-based clinician and that I do CBT and where CBT is headed is really...we've found that...research has shown that incorporating techniques that come from Zen or mindfulness or the East or principles tend to be very compatible.

A further participant echoed this by indicating that "I present it as a scientific intervention because that's when we use it...we use it because there's research that shows it works."

Participants additionally spoke of the usefulness of providing an understanding that was experiential in nature or personalized for the client. One participant explained that:

> I always try to blend something towards a person's experience. So if someone's already doing yoga, I might say well similar to the yoga you do...because I always want to give people, kind of a methaphoric understanding of the tracks of your experience.

Another similarly responded by commenting that

> One example that I use a lot for present moment is saying to someone, "have you ever been in the zone? Have you ever, do you play sports? Have you ever done any sort of art, whether it's performance or visual, whatever medium? Have you ever been in a conversation where you were fully engaged in and getting energy from the other person? That's mindfulness. That's when you are fully in the moment..." So trying to link a concept to their experience and have it come from them instead of imposing your own concept onto them.

The participants agreed that psychoeducation was essential to treatment with one participant stating that "It's cultivating hope and expectancy." However, one participant noted the importance of considering the population you are working with when attempting to determine how to introduce and structure treatment. This participant explained that "It depends on the population actually" and continued by stating:

> I work with mostly middle-class people who are aware of what mindfulness is and so they have seen it thrown around and are aware that it's sort of like, you know, it's sort of a thing that's happening now, very common. They're less threatened by it and they're more open to it. But when I worked with mostly Pentecostal women in the Hispanic community, explaining mindfulness, in Spanish no less, was a little bit more complicated and really, even saying a word like yoga would be quite threatening because that would go against their spiritual, religious beliefs. So, okay, this is just about paying attention.

> This is about paying attention to a specific part of your body. This is about being with your breath, honoring your breath. So I really use a very sort of circuitous ways of explaining in and introducing it and just making a scene like hey, we're just gonna pay attention to what's already there. So really, sort of simplifying it.

Connected to this idea, the data suggested a consensus among the participants that treatment should be structured based on the needs of each individual client. This idea of a tailored approach was reflected across almost all of the participant narratives. With regards to such individualized structure, one participant indicated that "I tend not to do too rigid manualized treatment. I try to target it towards someone." Another participant similarly spoke to the importance of meeting clients where they are by stating:

> I don't think there's a generic way to do it. I think it depends on the client and again, leading the client where they are. Where they are in their process of healing. Where they are in terms of their awareness of their own processes and their ability to tolerate what you're giving to them and tolerate their own internal processes. So I think, again, the intervention is really meeting them where they're at.

However, a number of the participants expanded this idea by indicating that tailoring the treatment in a way that was experiential for the clients was most effective. One participant explained that it was important to find "What works for them in their life? How do we build on that? How do we create a mindfulness practice around that?" A further participant noted the importance of this by stating "They couldn't just talk about it and how to be this idea. They have to really experience it to believe in it."

Within the concept of a tailored approach to treatment, participants acknowledged the importance of *assessing* a client's level of experience, with one participant stating that "I would

not just throw someone who doesn't have any skill set into a sort of, formal mindfulness-based stress reduction format or open-focused, kind of meditative, long, sitting piece." Similarly, another participant explained that it may be useful to reserve "the more difficult practices, the more contemplative practices for later on down the line when they can tolerate it." Correspondingly, some participants spoke of introducing grounding skills early in treatment to provide clients with a basic skill-set. It should be noted that only two participants spoke of grounding as an important element. However, the principal investigator chose to include this within the overall analysis as it felt particularly relevant to an understanding of the intersection between mindfulness and work with trauma survivors. One participant noted "In terms of basic clinical work of working with people who have had experiences in trauma, one of the first things that I want to teach is grounding." Other participants spoke to the connection between grounding skills and trauma treatment. One indicated that:

> I feel like grounding is an important skill to teach when you're dealing with trauma because it gives a sense of efficacy and control over something that feels uncontrollable, which is usually an affect regulation and an affect tolerance.

While a further participant similarly explained:

> Being able to ground the person externally, through their senses is usually more comfortable and an easier process than trying to do traditional mindfulness practices, because someone who's been sexually abused, their body is no longer a safe place. So to say, go internal can be a terrifying process because that's no longer a safe space, which is part of the process of disassociation.

Within the participant narratives, it was agreed that such structural approaches worked to keep clients engaged and connected to the treatment. However, a further theme emergent in the

data suggested that beyond such considerations, a way of being with clients was necessary to allow for stimulation of core elements of mindfulness that ultimately facilitated healing and growth. For the purposes of this study, this way of being is referred to as *therapeutic presence.*

Therapeutic presence. Within participant responses, analysis revealed that a significant subtheme within the category of therapeutic strategy, referred to a way of being that seemed conducive to healing within the relationship. This way of being appeared within the narratives as a complex tapestry of interwoven elements that formed to encapsulate a healing presence. Such elements are reflected within the following responses.

A major element of such presence appeared to be a sense of *openness* to experience within the therapist. Within the participant responses, such openness seemed to reflect a willingness to meet the client where they were in each moment while also moving towards and sitting with their pain. To this point, one participant noted:

> So, if I notice someone and while they're talking about maybe CSA, and maybe they have an emotional moment. I will want to, sort of, take a move towards present moment in a very reverential way and I…"I notice as you were speaking about that, you're eyes well up a little bit." And always in that inviting and reverential way. "Would you feel comfortable giving that part voice?" or "could you step closer to that and give it voice." Sometimes when I ask people to step closer to it, they can start to cry or get very emotional.

Another participant similarly spoke to such openness by stating that "And so, you know, I like to take people to go into painful places and invite them to be present with it." Correspondingly, another participant explained that mindful therapy is helping clients:

> Step closer to experience with compassion that's opposed to judgment and self-attack; having people identify how the intense feelings or negative core beliefs that they've developed can show up and have them have an awareness, not to challenge them, but to change the link between that and compensatory or maladaptive behaviors.

A further participant indicated their way of being with clients by stating that "I accept you and I wanna move toward where you wanna go" with another speaking to openness as a form of "active listening to the client with all of our senses."

Within such openness, some participants also reflected a sense of modeling of acceptance and tolerance for their clients. This acceptance extended to both the client's experience as well as the therapist's own internal process. One participant explained that:

> Also, I want to model that the intense affect that comes along with it doesn't have to be avoided but that it can actually be tolerated and engaged in and there's something, I think relieving because they can feel safe.

This participant further indicated that "I really want to, sort of track and honor their experience in a way that they feel like I can handle it. I can be with it. I can be connected to it and not reactive." This participant went on to add that "Because if I'm going to ask them to be present, I need to be very present in the challenge of their experience."

Such openness further was expressed in a willingness to be with the client wherever they were in their journey of healing. This meant allowing the client to have a sense of control over the direction and speed of treatment in order to promote self-agency and safety within the relationship. With regards to this, one participant stated "I want them to always feel like they have a say in how they want the sessions to go or what they wanna get out of the sessions, out of their therapy." Another participant responded in kind by explaining:

> Yeah. I would sort of validate, depending on how long I've been working with them, I have the yoga group, for example, with survivors. I talked about it, I acknowledged, I talked about Posttraumatic Stress Disorder, I acknowledged how feeling the body can be really scary and if you wanna get up and leave, you can leave. By giving people outs, so it was all, it was also, like the atmosphere that I wanted to create was that like, whatever is happening is okay. But just so that the clients also feel like I'm not doing something wrong or if I'm having a bad reaction. I want people to judge their reaction and also really empower them to follow their bodies, even if following their body meant getting up and walking away. Or crying. Or doing whatever.

An additional participant similarly spoke to such acceptance by indicating:

> So I want to have a lot of reverence for, you know, here's a person who had a lot of their early experience taken from them and forced or pushed and so to give them a sense of agency and choice in how they want to define it.

A final participant summed up the element of openness as a component of therapeutic presence by explaining:

> You know one thing I like about mindfulness in psychology is it adds a reverence to the material that we have in the room, because we sit in reverence of the pain. Pain is not a symptom to go away but pain is a teacher. You know, the past are sort of these terrible things but we sit and we honor it. So just like you would create a sacred space maybe before you do meditation or some spiritual ritual, we create a sacred space in the room and then in a place of reverence and honor, we allow people to share their stories and step to their pain. And then to be an empathic other in the room with them and to connect

> with them and feel pain along with them can help them tolerate what feels unbearable and help it to feel bearable for them, while we go on that journey.

Within the previous statement, the quoted participant goes beyond a sense of openness to speak to an additional element reflective of a sense of *connectivity* within the construct of a therapeutic presence. Participants spoke to the importance of this sense of togetherness within the therapeutic dyad as well as a focus on having the client feel as though they were not alone as they struggled with their experience. Several participants referenced such connection with one participant stating that "I really want them to not feel alone in their experience." Another participant noted the power of such connection by stating "And there's this like, powerful moment because at least they're not alone in their pain and I'm like: 'yeah, that's so hard that that's what you live with all the time." Two other participants provided some indication of how they attempt to create such a feeling within their work with one explaining that they have stated to clients:

> 'Wow, I'm hearing you. I'm feeling you. I'm validating you. I'm right here in the emotion soup. Wow! Notice these thoughts. Notice how these familiar thoughts are now coming up and remember when you didn't feel this way,' and highlighting that they're in the weather of the storm and being right there next to them and not trying to make the storm go away by any stretch of the imagination.

While the other participant reflected on her work with a trauma survivor who had regressed to a child-like state:

> I remember some of my first interactions with her were sitting on the floor and playing with her. And where mindfulness comes in is, we played. You know. And we were in the moment of play. And I had to join her in being mindful because you know, here I

> was, a crisis worker and wanted to talk about things, be active in my interventions. What do you need? Well what she needed was to play and have somebody actively be in the moment of playing with her. And I think that allowed her to have some trust with me. We had a foundation of which we could establish a relationship that was non-intrusive to her. That again, that her, where her needs were, which at that moment was as a six-year-old, playing with dolls.

A further participant spoke to the benefit observed within a client as a result of such connection by noting:

> And I really saw her flourish, like I think part of her, what was healing for her, was developing a relationship with me and yes, there were a lot of like transference, like mother-daughter transference, counter transference things going on. But I think even in all of that, that was very healing for her.

Interwoven with such elements of openness and connection, the data seemed to suggest an additional ingredient necessary to the recipe of presence. Among the responses, the salience of *attunement* as a significant component appeared to emerge. Almost all participants spoke to such a stance with one participant noting:

> I watch everything about the patient, not just what they say but their body language, their physiology, their respiration, how they're tracking, are their eyes open or closed, do they seem they're in their body or not. And then really in a loving, compassionate way, with awareness, track their experience, notice "oh did you just tune out there" and they say "oh yes, I did" and I say "well maybe something triggered you or maybe it's your bodies way of protecting you."

Another spoke to the importance of such attunement with trauma survivors by indicating that:

> I think that there’s an art in that and one has to always be careful of re-traumatization but not so fearful of it that they lack the courage to work with someone. And I think that attunement is really important.

Similarly, a further participant echoed such sentiment by speaking to the responsibility inherent in such work to accurately track a client's experience to determine how to proceed in treatment. This participant noted that:

> So I think it really is the therapist’s job to get into that experience so that you know how to, how to follow the energy, and one has to be aware of one’s own energy as well, in doing this work, like sort of, like a back-and-forth. You’re sharing energy with the client. Where you’re picking up on their energy. Is this person open right now? Is this person in a collapsed state? How far can we go?

Another participant similarly spoke to the importance of such responsibility in order to maintain safety within the treatment and relationship by noting "It’s up to us to figure out where safe intervention is going to be, as the clinician. And that’s a really sacred responsibility, especially in working with trauma victims because you don’t wanna re-traumatize them."

Therapeutic conditions. An additional theme emergent in the data reflected various conditions within the therapeutic frame that appeared conducive to healing among CSA survivors. Participants seemed to speak to various conditional elements, with some providing responses that appeared to overlap in many ways. One participant spoke to the importance of *safety* and *trust* within treatment by noting "You’re building a safe container. You know, it’s your job constantly as a therapist to build a safe container." This sentiment was shared by another participant who explained:

> So being able to establish a sense of safety, whatever that means for them. Sometimes it can be a visualization. Visualize your safe space. But I think if we think about mindfulness from that umbrella perspective, that it's up to us to figure out where safe intervention is going to be, as the clinician. And that's a really sacred responsibility, especially in working with trauma victims because you don't wanna re-traumatize them.

A further participant indicated the importance of trust by stating "It's just really first focus on the relationship and the trust building."

Participants went on to speak of an interrelated condition of *agency* or *control* that seemed facilitative of safety as well as a sense of trust within the therapeutic relationship. One participant explained that:

> I acknowledged how feeling the body can be really scary and if you wanna get up and l eave, you can leave. By giving people outs, so it was all, it was also, like the atmosphere that I wanted to create was that like, whatever is happening is okay."

A further participant explained that "I want them to always feel like they have a say in how they want the sessions to go or what they wanna get out of the sessions, out of their therapy," while another echoed such responses by stating:

> And so, you know, I like to take people to go into painful places and invite them to be present with it. But then also, if they're not, then I don't have to push them or say well you need to go there if you want to get better…you know, it's like, you may not be ready for this.

Additionally, participant responses suggested the importance of a sense of *validation* within the therapeutic relationship. One participant spoke to the importance of such a condition by noting:

> I think it can be an uncomfortable concept for people. It's a difficult thing to think about the fact that we create our own reality in a lot of ways. And being able to take somebody who has been in a trauma and expose them to the idea of you create your own reality with your mind can be a really hard thing to put together, because when we think about, well let's take the concept of no judgment. How do you not judge; it always goes to the extreme. How do you not judge someone? How do you take that stance?

Another participant similarly expressed a sense of validation in their response explaining:

> And there's an element of it that's unfair and unjust but what you do with that experience is within your ability, if you're given the proper tools. But that's a really hard thing for someone to conceptualize, who's been in a lot of pain. And we get used to being in pain. It becomes comfortable.

This participant further expressed a sense of validation by speaking to a conceptualization of one's adaptation to trauma. The participant responded:

> And in terms of childhood sexual abuse, there's a lot of dissociation that comes with that and dissociation is an adaptive skill, an amazingly adaptive skill for a lot of people. The issue with adaptive skills is that when the circumstances change, the adaptation may no longer serve the person. So if you're dissociating in your everyday life, whereas it might have been a protective factor in a trauma, it's now a hindrance and it can be dangerous as well. So working with that disassociation and working through that dissociation, I think, is important. And that can be when the client dissociates in your office, which can happen. Or teaching them the skills for and to identify it. That that's what's happening and that that's a normal process. That there's not something wrong with them. That it's

> introducing the idea that that was an adaptive skill. And letting them know how resilient they are, that they were able to do that. They were able to survive.

A final participant spoke clearly to the significance of validation by stating:

> People need to feel validated. They need their story heard, especially trauma survivors. They don't want somebody telling them they're wrong, the way they see the world is wrong right away. Because that's basically what we're telling them. Like, you've learned to see the world this way and it's wrong. It's causing you suffering. So I think there's this consistent, this sort of orientation has been consistent for me with all my clients.

Impact of therapists' personal mindfulness practice. An additionally salient theme emergent in the data reflected the profound impact of the participants' own personal practice of mindfulness on their work with CSA survivors. All participants noted of the clear importance of such practice with some indicating that this was essential to effective work when utilizing such a frame. One participant spoke explicitly to such necessity by stating:

> I think that if you just apply mindfulness techniques without really understanding what you're targeting to conceptualize well, then you can misapply or you can, once again become an invalidating other. And I think that having a real grounding in, I don't know, good theory and practice is important. And I don't think all clinicians are.

Another participant similarly explained that:

> So if you have not really reflected on, become of aware of your own biases, your own autopilot, the way your mind/body vehicle gets out of alignment sometimes and then actively work to, you know, work with it in this compassionate, kind, nonjudgmental, letting go kind of way, there's just no way.

A further participant additionally noted "So without doing this work for myself, I don't really think that I could a good job with other people. It would be limited, it would be limited." This participant went on to expound on this idea by explaining:

> I need to constantly tune my instrument, which is my brain and my body, my whole self, in order to serve others. Right? So I constantly have to be in a state of awareness in the world, in order to continue opening myself, opening myself to love! To others. Awareness. So I see sort of an agent of change. Because if I'm not aware that I'm human, I'll, there's things that I won't see or things that I might not feel, and the client is definitely experiencing something that they're not sharing with me, I'm not picking up on it. So it's really about like tuning for me.

The impact of a personal practice on a clinician's *awareness* was further identified by other participants with one indicating "And it kinda helps open up your subjective awareness." This participant went on to speak to an increased sense of *willingness* or *acceptance* embedded within such awareness by stating:

> It minimizes your knee-jerk reaction or at least creates awareness for what you want to be a knee-jerk reaction. It slows everything down. Gives you a little bit, you know, gives you a minute. And so I think that that's helpful in the therapy room.

A further participant noted similar benefits of increased awareness in their response noting "Like as I've become more aware, then I've helped other people come to their own awareness."

Participants further spoke to a facilitation of *compassion* and *empathic attunement* as a result of personal practice. One participant commented that:

> I think that all of us have our own experiences of pain or experiences that are overwhelming or losses or things and so there's something about being human that can be

> challenging. And so, whatever practice that a person has it's because we're on our own journey of growth and healing or trying to, you know, leave this world in a little bit better place than we found it or there's some sort of higher value or ethical principle and you don't have to be spiritual or believe in anything that's magic and just be a person committed to, sort of, ethical practice or wanting to do good for certain reasons. And I think that gives the work a sort of humanness and then also a humbleness because we're sitting across from someone that's really not that dissimilar from ourselves.

This same participant went on to add that "In some ways I have reverence for them, for them coming, for the process in a bigger way, and somehow all of that creates a frame around all of this."

Overall, the consensus among participants was that a lived experience was necessary for effective therapeutic work through a mindfulness frame. One noted clearly that "You can't take people where you haven't been and especially from a skills perspective, you can't teach people how to ride a bike unless you've fallen off and are comfortable yourself." In similar fashion, another participant explained that "I feel like my journey very much informs, like I teach what I know to be true for myself..." This participant went on speak more about the impact of a lived experience by stating "And then, I see whatever they're doing as courage because I know what it's like to face my own pain and I know what it's like to have my own practice, to have my own growth process." Another participant added comically that "It creates buy-in. It's like, what's the vitamin your doctor's on? I want that vitamin."

Markers of change. The final theme emergent within the data reflected participant observations of change and growth within CSA survivors. Participants spoke to a variety of

changes observed; however, all indicated an increased sense of *awareness* and *acceptance* within clients. One participant noted such observation by stating:

> And I'll see clients start to do things like…I have a young woman I'm working with now where she's starts to be…to say, just rote…it's starting rote. "I'm noticing that I'm having the thought. I'm noticing that I'm having the thought" as opposed to "It's not fair. Oh my God, I can't believe this is happening." "I'm noticing that I'm having the thought that this isn't fair. I'm noticing the thought that I hate this." Which really gives a healthy breathing space to starting to back out of the experience.

A further participant observed similar growth in a client by indicating "She was more aware of her symptoms. She was more aware of her reactivity. That really helped, I believe. I'd like to believe that. It was at least a significant part of the progress." Another participant further noted progress in a CSA survivor who had been unable to detach herself from an abusive relationship. The participant explained:

> So getting her to go a job interview, and I think part of that is the insight and awareness gained from the mindfulness and being able to pause for a moment and stop the reflexive behavior that would keep her maintained in this relationship.

Woven into such responses, participants seemed to suggest a decreased sense of reactivity as a result of such awareness. From further responses, such decreased reactivity appears to provide evidence of increased acceptance or tolerance within clients. One participant spoke to the connection between awareness and acceptance by stating:

> So it's both these two things: decentering, stepping back, something like "I'm noticing the thought," being able to see thinking as it's happening rather than as a fact. And being

> able to, sort of, let themselves have a day when they're not in perfect form and that's OK and validated and then move forward on Monday.

Additionally, a further participant similarly indicated the marker of acceptance they search for in clients by noting "So if someone is able to access their own experience, in the here and now, and be able to regulate and tolerate their emotional experience, their cognitive experience and their somatic experience..."

Participant responses further appeared to reflect a sense of *empowerment* and *self-efficacy* through the therapeutic work. One participant observed within a client that "I saw her really change a lot of things, really learn to stand on her own two feet. Really sort of manage her symptoms in a way that helped her function more effectively." Another participant noted that "What I sensed from them and what they expressed was a sense of freedom and it goes back to what I was saying before, about being fully alive." A further participants similarly added that such work "Empowers them to be able to define what is present moment versus subconscious memory" while another observed "I really feel like, it's like she had more control over her body. Like more and more."

Moreover, participants indicated an *improvement in interpersonal relationships* among their clients. One participant explained that such improvements are not only external but pertain to the therapeutic relationship as well. This participant stated "Well certainly when there's dramatic changes, but I think what I look to most is the process between me and the client. So how did they engage with me? Are they present? What's their level of comfort?" A further participant similarly reflected the importance of relationships by noting:

> What kind of attachment relationship do they have? And I think that's a way that you can measure change as well, because a lot of people who have been through trauma, and

> certainly any kind of interpersonal trauma, are a little reticent to trust and especially if they have had childhood abuse or trauma of some kind, the attachment process, in and of itself, has usually been disruptive. You can look at anything from anxious avoidant to disorganized, right? Attachment styles. So how does the person have the reparative experience with the clinician? It's definitely something that you can observe in the room that is evidence for the clinician; that is in front of you.

Another participant, who facilitated mindfulness groups for adult female CSA survivors, noted such observed improvements within the group by commenting that "Well, like group cohesion and kind of, they were creating relationships with each other, supporting one another, and I think that was a big deal." Similarly, an additional participant noted that a client was "...Less reactive in his relationship now."

In addition to such measures of growth, participants seemed to indicate markers of *compassion* and *forgiveness* within clients. Participant responses seemed to suggest that both features were multidirectional, with clients experiencing and increased ability to find compassion and forgiveness for self and others. One participant spoke to the continued progress of a client in this area by stating "So it's, it's still a work in progress so it's learning how to be self-forgiving and self-compassionate and self-loving so he can begin to love himself, has been the product of using mindfulness." A further participant similarly acknowledged such observed markers by commenting that:

> He, it's a reminder of why it's part of his healing to be forgiving of his father and his mother, because she didn't; he talked about how she didn't; they actually never talked about it, even though she knew. So coming from that place of being able to forgive her as well and to forgive himself.

Another participant responded in kind by noting the profound impact of such elements by indicating:

> Some of them have been able to say, you know, I can see if, let's say like it was a father who molested them. They could find a place of forgiveness for the father because they've been able to be in a place of more of that non-judgmental, compassionate hearted experience where they also begin to realize that well, maybe the father was also abused himself.

Through analysis of participant responses, each thread was understood to be a part of a larger complex design. When taken together, the tapestry created seemed to suggest a dynamic process of interactions that ultimately informed some growth within adult CSA survivors. Such an understanding informed the development of a theory to elucidate the nature of this process. From the data it appears that a therapist's own personal mindfulness practice lends itself to a way of being that creates conditions conducive to healing and growth within the context of a mindful orientation to treatment. This theory will be outlined in further detail and supported through existing literature within the subsequent section.

Discussion

In keeping with the recent rise in popularity of mindfulness within the field of psychology (De Silva, 2014; Hart, Ivtzan, & Hart, 2013), this study sought to further understand some of the elements that comprise a mindfulness based therapeutic practice with adult CSA survivors. A qualitative, grounded theory approach was utilized to give voices to clinicians working with adult survivors in this way and to allow the data to guide analysis towards an understanding that would inform the development of a potential theory. Six practitioners, working within Southern California, volunteered to share their experiences through audio-recorded, semi-structured interviews in service to such an endeavor.

Analysis of the data relied on the principles of grounded theory, which posits that meaning should be derived from the data, rather than from any previous theories or beliefs (Charmaz, 2006). As such, the data was observed openly, allowing an understanding to take shape organically based on the emergent themes embedded within the participant narratives. Within the data, five key categories or themes emerged related to core features of mindful practice, therapeutic conditions, therapeutic strategy, impact of the therapist's personal mindfulness practice, and markers of change. A discussion of each of these categories is presented within this current section. However, in addition to the emergence of themes, as analysis continued, these themes were organized into a theory that aided in an understanding of the phenomena observed across the data. This theory, along with methodological considerations, potential contributions and limitations of the study, as well as implications for future research are further addressed in this section.

Overall, the results suggest that participants viewed mindfulness as a beneficial means of working with adult survivors of CSA. However, much like any therapeutic practice

(McWilliams, 2004; Safran, 2012), the pathway to healing is multidimensional and dynamic in nature. Participant narratives reflected the importance of core elements of mindful practice that, when stimulated within specific therapeutic conditions, facilitate growth and healing. Furthermore, the emergence of such conditions was understood to be dependent on an approach to treatment, and general way of being, facilitated and guided by a therapist's own personal mindfulness practice. The following figure visually summarizes the proposed theory and the subsequent sections further detail the essential elements comprised within this theory.

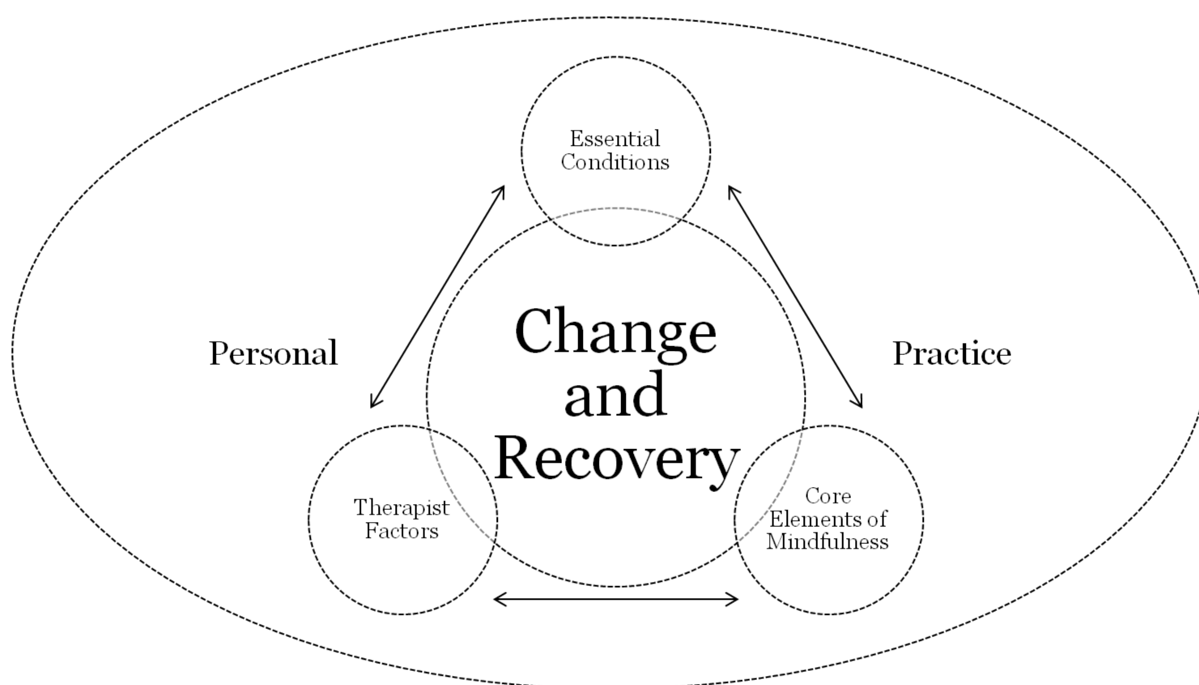

Figure 1. Dynamic nature of healing within a mindfulness framework

Core Elements of Mindfulness Practice

The literature quite thoroughly addresses the main features of mindfulness that seem to produce some benefit for practitioners (De Silva, 2014; Epstein, 2003; Pollack, Pedulla, & Siegel, 2014; Teasdale & Chaskalson, 2011). According to Kabat-Zinn (2003), mindfulness can be defined as: "The awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (p. 145).

Epstein (2003) spoke similarly as he explained that mindfulness is a state that allows for insight, presence, and reflection. In their brevity, these definitions reflect the heart of such practice and capture many of its essential elements.

Such elements were similarly reflected by the participants in the study who spoke of mindfulness as an active and attentional process of nonjudgmental, present-moment awareness. All of the participants emphasized the importance of awareness to the process of change, facilitated by the developed ability to reflectively observe one's process and respond with decreased automaticity and increased flexibility. A number of participants noted the importance of a holistic awareness that incorporates the totality of one's experience including thoughts, feelings, bodily sensations, and impulses. Participants further agreed that “present-moment” awareness was a central element of mindfulness as people are often “tormented” by the “past/future.” Some participants indicated that such present-moment awareness was particularly salient for trauma survivors who can become consumed by past experiences. Follette, Palm, and Pearson (2006) provide support for this idea by similarly stating that a reflective focus on the present-moment may prevent trauma survivors from ruminating on the past and future or attempting to avoid painful experiences altogether.

However, participants indicated that the core features of mindfulness extended beyond basic awareness to include the practice of nonjudgment. One participant spoke of learning to tolerate one's experience, while many of the participants indicated a shift away from a change strategy to one of acceptance and willingness. Within the narratives, this shift was viewed as a movement from symptom reduction to one of distress tolerance correspondingly referenced in the literature (Hayes & Strosahl, 2005; Pollak, Pedulla, & Siegel, 2014; Walser & Westrup, 2007). Several participants noted this stance of acceptance or willing tolerance allowed clients

to separate from their minds in a way that freed them to respond with greater self-control. Current discussions of mindfulness in the literature have similarly identified acceptance as an interrelated construct with mindfulness (Hayes, 2005; Orsillo, Roemer, Lerner, & Tull, 2004) and have further addressed the growing body of research related to such interventions with trauma survivors (Thompson, Arnkoff, & Glass, 2011). Interestingly, participants also spoke of the similarity of such a treatment orientation to exposure, which allows clients to increasingly confront and build tolerance for their distress.

Finally, consistent with the literature, participants spoke of the presence of compassion within their understanding of mindfulness. Some participants noted that compassion and kindness are essential elements of mindful awareness that bring about change and healing within a client. According to Roeser and Eccles (2015), while a consensual definition of compassion remains elusive, a growing body of research has been working to document the processes associated with compassion training that appear related to benefits such as improved health and well-being, as well as overall stress reduction. Some of the participants noted the connection between compassion and trauma with one participant explaining that many trauma survivors struggle with shame and pain and that bringing compassionate awareness grants increased freedom and expansiveness within one's life. Another noted the negative self-schemas that form as a result of early traumatic experiences and indicated that awareness done in a way that is compassionate and kind could provide some relief from such harsh self-judgment.

Such findings illustrate the commonality of features of mindfulness that are similarly reflected within the substantial body of literature (Epstein, 2003; Kabat-Zinn, 2003; Thompson et al., 2011). The participants in this study spoke to many of the salient elements that comprise mindful practice with narratives that overlapped and, in many cases, matched almost precisely.

All of the participants agreed that these elements were essential features of the healing process within a mindfully-based therapeutic approach. Moreover, participants acknowledged the efficacy of such practice with trauma survivors and further spoke to the therapeutic growth they witnessed in adult CSA survivors within their own clinical experiences. However, the data gathered in this study revealed that while such growth is stimulated by core elements of mindful practice, the emergence of change is dependent on the presence of various conditions embedded within the therapeutic context. The voices of the participants spoke the nature of such conditions that appeared conducive to healing.

Therapeutic Conditions

Much has been written on the necessary conditions conducive to healing within psychotherapy (Norcross & Wampold, 2011; Rogers, 1961; Schneider, 2008; Stolorow, 2007). Within the current study, participant responses appeared to similarly suggest the presence of conditional elements critical to facilitation of healing within survivors of CSA. One practitioner noted that it was the responsibility of the therapist to continuously build a safe container, while another indicated that they strive to create an atmosphere of acceptance, where the client understands that "whatever is happening is OK." Participants agreed that such an atmosphere would allow clients to develop a sense of trust that would contribute to their growth within treatment. Additionally, participants acknowledged the importance of validation within the therapeutic frame, particularly when working with trauma survivors. A number of participants noted how meaningful it can be to create a space where clients are able to tell their stories in a way that allows them to feel heard and understood. It was further noted that a validating environment facilitates a balance between acknowledging the pain a client is in while also creating a space to introduce a new way of being with such experiences. Furthermore, some

participants spoke to elements of empowerment or control within the therapeutic environment that similarly facilitated a sense of safety and agency within the clients. One participant expressed their desire to have clients feel as though they have a say in how the sessions proceed and what they get out of it. Another similarly spoke to a tendency to strive to create an atmosphere of acceptance, where the client understands that "whatever is happening is OK."

Overall, the participant narratives suggested a powerful combination of elements that combined to create a therapeutic environment imbued with safety, trust, agency, and validation. While research clearly supports the presence and potency of such conditions with trauma survivors (Colosimo & Pos, 2015; Follette et al., 2006; Geller & Porges, 2014; Herman, 1992; Thompson et al., 2011), it is often unclear how these elements can be fostered within the therapeutic dyad (Pollak et al., 2014). Data from the current study suggests that particular factors related to the therapists' given approach to treatment, and more importantly, a general way of being with clients, may allow for the emergence of such optimal conditions necessary for client growth.

Therapist Factors

By attempting to understand the experiences of clinicians working mindfully with adult survivors of CSA, it became apparent that the therapeutic work went beyond a set of simple interventions employed by the participants. There was intentionality inherent within all of the narratives and a way of approaching treatment that was guided by mindful principles used to create a framework for each therapeutic encounter. Analysis of the collected data allowed for observation of two distinct themes that related to dimensions of treatment. These reflected the particular therapeutic strategy employed by each participant as well as the impact of the

practitioners own mindful practice on their way of being with their clients. The subsequent sections explore these themes in greater detail.

Therapeutic strategy. As derived from the participant narratives, therapeutic strategy broadly refers to how participants approached treatment with their clients as well as their way of being in the room with survivors. This particular theme was broken into sub-categories focused on structural components of treatment as well as therapeutic presence. The structural components seem to reflect broad ways of framing and orienting clients to treatment that may be universal or transtheoretical in nature. However, the theme of therapeutic presence suggests a way of being with clients that closely mirrors many of the core principles of mindful practice similarly referenced by participants as well as the extant literature (Bruce, Manber, Shapiro, & Constantino, 2010; Davis & Hayes, 2011; Epstein, 2003; Kabat-Zinn, 2003; Thompson et al., 2011). When understood in connection with the impact of practitioners' personal mindfulness practice, the implications for treatment suggest that personal mindfulness practice may allow therapists to internalize mindful principles that ultimately inform their way of being with clients in a manner that facilitates healing and growth.

Structural components. While there is certainly no indication of a correct way to approach treatment (Pollak et al., 2014), most of the major orientations agree that appropriately orienting clients to the therapeutic process is essential to the deliverance of effective work with clients (Beck, 1995; McWilliams, 2004; Safran, 2012; Walser & Westrup, 2007). Participant responses similarly reflected the extant literature by mirroring the importance of such orientation. Almost all of the participants spoke of providing psychoeducation at the outset of treatment and working to inform clients of the benefits of mindful practice. One participant indicated they provide clients with a clear understanding of what mindfulness entails and how

this may impact clients. Additionally, some participants spoke of using metaphors to explain mindful concepts such as awareness or acceptance. However, most of the participants agreed that providing psychoeducation in a manner that drew on personal client experiences or was blended towards a client's experience, proved much more effective. Furthermore, relying on existing research and evidence to create buy-in among clients was further discussed. Nonetheless, however the initial orientation was approached; all participants agreed that this was an essential first step to treatment with one participant explaining that this process instilled hope and expectancy within clients, while also decreasing resistance to the process.

Participants went on to further discuss two interrelated elements of assessment and treatment structure. When taken together, the emergent theme seems to suggest a tailoring of treatment to client needs, or meeting each client where they are in the moment. To this end, some of the participants spoke of determining where each client was in terms of their awareness and ability to tolerate their own internal processes as well as the treatment offered. Additionally, a further participant noted the importance of knowing the population in order to best orient clients to treatment as well as understand which interventions would be appropriate within the given context. Another participant emphasized observation of the processes that are activated within each client as a means of tailoring treatment and identifying helpful interventions. Pollak et al. (2014) similarly discussed the complexity of choosing practices useful to within a given moment to a particular individual. They speak to a number of considerations to keep in mind when determining how to approach a mindful treatment including which skills to emphasize, religious or secular practices, and a movement towards safety or sharp points. However, regardless of the various considerations, Pollak et al. agreed that an individualized approach was most appropriate.

Within the study, some of the participants noted the importance of introducing grounding skills to trauma survivors at the outset of treatment in order to provide survivors with a sense of agency and control over their ability to manage emotional states. However, the data largely suggested that all of the participants agreed with the current literature (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Norcross, 2001; Pollak et al., 2014) in that there was no generic way to approach treatment and that a tailored or personalized approach was essential, particularly when working with trauma survivors given the risk of emotional dysregulation, dissociation, and relative lack of safety often present with such clients (Follette et al., 2006; Thompson et al., 2011).

Many of the participants emphasized that regardless of the interventions chosen, an experiential approach was critical with one participant explaining the importance of building a practice around a client's life and what already works for them. A further participant noted that clients have to really experience the effects of mindfulness and truly live it to believe in it. Moreover, participants further agreed that following an initial assessment of each client, a titrated approach to treatment that balances exposure with safety, while allowing clients to move at their own individual pace, is most effective. A number of the participants agreed that this involved providing the client with options for treatment as well as allowing them to guide the speed and direction throughout the process. Some of the participants explained that such an approach provides a framework of safety, trust, and control that ultimately proves healing to the clients. A few of the participants further spoke to this balance and noted the sacred responsibility of the therapist to continuously monitor the client in order to determine the line between safe intervention and retraumatization. Acknowledgement of this responsibility appears to move beyond the mere structural components of treatment and touches on a broader way of

working with clients. This phenomenon seems to reflect a way of being, or therapeutic presence, that creates conditions facilitative of growth and healing.

Therapeutic presence. The idea of presence is certainly not unique or novel within the field of psychology and the scientific literature has not been remiss in addressing the nature of and role that presence plays within the therapeutic milieu (Colosimo & Pos, 2015; Geller & Porges, 2014; Pollak et al., 2014). According to current research, it has been suggested that therapeutic presence may reflect a stance at the core of the development of a positive and healing relationship within the therapeutic dyad (Geller, Greenberg, & Watson, 2010; Geller & Porges, 2014). The idea of presence has been described broadly in attempts to understand factors that improve treatment alliances. Such research has suggested that warmth, empathy, understanding, acceptance, and a willingness to approach clients in an open and collaborative manner appear facilitative of the development of a strong alliance and positive therapeutic outcomes (Bruce et al., 2010; Norcross, 2001; Norcross & Wampold, 2011; Rogers, 1961). However, in a more focused definition, Geller (2013) explains that presence involves bringing one's whole self into the therapeutic encounter, while remaining grounded in oneself and attuned to a client's moment-to-moment experience. Additionally, Geller noted that such presence further involves an openness to the client's world as well as the therapist's own experience, which is used to draw on internally based knowledge, skill, and wisdom. Researchers agree that such a stance allows clients to feel safe and secure, which opens the process to deeper and increasingly healing work (Bruce et al., 2010; Davis & Hayes, 2011; Geller et al., 2010). Within the current study, participants similarly reflected the extant literature as they spoke of their way of approaching treatment with adult CSA survivors. Through their responses, it became clear that various

elements embedded within the broad concept of presence, facilitated the emergence of the previously discussed conditions necessary to the healing process.

Among almost all of the participants, it was agreed that remaining open and accepting of the client within their experience was facilitative of healing through the promotion and trust and compassion. While participants referenced the concept of openness in different ways, the central element of this state of being revolved around a willingness to sit with and move towards a client's pain while guiding them closer to their own experience. One participant spoke of this in terms of inviting clients to be present with their pain while also attempting to honor their experience in a way that conveyed an ability on the therapist's part to handle it. Another expressed the idea of moving towards where the client wants to go. Still, another participant spoke of creating space for clients to have their experience while also attempting to draw their awareness to the connections between such experiences and behavior. Embedded within participant responses related to the concept of openness was the idea of modeling of acceptance and tolerance that allows clients to learn that experiences are transitory and can be managed. One participant spoke to how acknowledgement of a client's experience can lead to the understanding that intense affect does not have to be avoided. Another participant emphasized the importance of remaining open and present as you are asking a client to do the same. Such a stance can be particularly salient with trauma survivors who may struggle with their ability to remain present with their experience (Follette et al., 2006). As such, therapist modeling of acceptance and tolerance could facilitate similar growth within the client.

Colosimo and Pos (2015) similarly argued for openness as a dimension of therapeutic presence and explained that such receptivity allows the client to feel understood and connected to the therapist. The facilitation of connection with the client further represented a major element

of therapeutic presence. Colosimo and Pos further explain that such connectivity communicates a here-and-now presence to the client in service of their healing. Further research suggests that such connection invites the client to move deeper within the therapeutic work, allowing for a sense of safety and trust that creates a space for the emergence of deeper issues (Geller et al., 2010; Geller & Porges, 2014). Herman (1992) noted the centrality of connection within work with trauma survivors and explained that "Recovery can take place only within the context of relationships; it cannot occur in isolation" (p. 133). Follete et al. (2006) similarly indicated that a focus on the therapeutic relationship is an essential component of treatment with trauma survivors given the often limited experience with safe and trusting intimate relationships. They add that such a focus is a prerequisite to any addressing of a client's trauma history.

Participants similarly spoke to the concept of therapeutic connection with one stating that the development of a trusting relationship was primary within an understanding of treatment. Additionally, a further participant noted their desire to have clients not feel alone within their experience and added their intention of expressing a presence with and understanding of whatever was arising within the client. This was echoed by an additional participant who noted the importance of extending a sense of togetherness with the client and allowing them to feel as though the therapist was right there with them in the storm. Another participant explained that actively being present with the client and responding to their needs in a non-intrusive manner, allowed for a sense of trust that created a foundation upon which a healing relationship was built. Follete et al. (2006) noted that the ability to create a safe and nurturing relationship within the therapeutic environment may ultimately set the stage for the client to begin to do so outside the therapeutic experience.

However, interrelated to these ideas of openness and connection was the concept of close attunement to the client. Participants agreed that this was essential to a way of being within the therapeutic encounter and spoke of closely tracking their clients in an attempt to remain open to a full understanding of their experience within each moment. One participant noted the importance of tracking the entirety of one's experience from the content of their words to their body language and respiration. It was explained that this allows for a level of connection that conveys understanding while also stimulating awareness within the client. However, when considered alongside acceptance, attunement allows for a guidance of treatment based on the needs of each client that promotes a sense of safety and trust. Geller, Greenberg, and Watson (2010) explain that attunement, facilitated through therapeutic presence, can provide a more effective way of responding to the moment-to-moment needs of each client, while Geller and Porges (2014) review extant literature that speaks to the importance of attunement and therapeutic presence as mediators of safety within the therapeutic relationship. In support of such literature, one participant spoke to the importance of following the energy within the therapeutic encounter, which includes both the energy of the client as well as the therapist, in order to determine how to proceed and how far to go. Another participant referred to such attunement as an art that allows the therapist to straddle the balance between safety and exposure. Correspondingly, a further participant explained that while it is important to invite clients to be present with their pain, it is equally imperative to not push them towards an experience that they may not be ready for. As mentioned above, participants agreed that such considerations were particularly relevant for work with trauma survivors given the risk of retraumatization and activation of issues related to control and self-agency.

While such elements of therapeutic presence appear essential to the development of trust, safety, and validation within the relationship, it was further observed that they appear to facilitate management of resistance to the treatment. Some of the participants noted that if resistance arose, they would work to meet the client where they were, while also giving clients the option of how to proceed. In this way, participants noted their willingness meet the client while also allowing them to have a sense of control over the course of treatment. Another participant spoke of wondering about the function of resistance, while also attempting to understand what the therapist is doing to elicit such a response in the client. This approach again reflects a willingness to step towards the client's experience in a way that fosters a sense of agency as well as connection with the therapist.

From the data, it can be understood that both the structural components of the treatment facilitated by the therapist, along with a stance of therapeutic presence, create a potent atmosphere for healing within the client. While the implications of such observations appear broad and could be applied across populations, the participant narratives speak to considerations specific to adult CSA survivors that suggest that such features may be particularly restorative among such a population. However, while understanding of such elements suggests implications for future treatment, the cultivation of such a therapeutic strategy within practitioners remains unclear (Pollak et al., 2014). From the data observed within this study, it appears that a therapist's personal mindfulness practice may provide a means of inculcation of such a way of being.

Impact of Practitioners' Personal Mindfulness Practice

Within the literature, there exists some consensus that the ability to appreciate the transformative nature of mindfulness practice, both individually and within therapeutic practice,

necessitates a personal practice (De Silva, 2014; Pollak et al., 2014). As outlined above, the benefits of such mindfulness practice are quite clear (De Silva, 2014; Epstein, 2003; Teasdale & Chaskalson, 2011) and certainly extend to practitioner as well as patient (Bruce et al., 2010; Davis & Hayes, 2011; Pollak et al., 2014). In a review of the literature, Pollak et al. (2014) found that therapists and other health care professionals who engaged in regular mindfulness practice enjoyed a range of benefits including improvements in perceptions of work satisfaction as well as increased self-acceptance, self-compassion, life satisfaction, and overall well-being. With regards to its impact on clinical functioning, Epstein (2003) speaks of abilities of clinical reflection, awareness, and presence cultivated through mindful practice. Bruce et al. (2010), similarly suggest that psychotherapist mindfulness can positively impact the ability of a clinician to relate to their clients. Such findings hold significant implications for clinicians within the field as these components appear consistent with a way of being facilitative of positive growth within clients (Colosimo & Pos, 2015; Geller & Porges, 2014; Pollak et al., 2014).

Consistent with such research, the participants within the current study inferred similar benefits of such practice. When considered in connection to the therapeutic factors previously discussed, the implications suggest that a therapist's own mindful practice may facilitate the emergence of a therapeutic approach or presence ultimately facilitative of healing within clients. Within the data, there was a consensus that a lived experience of such practice was essential to authentic and effective work with clients, and a number of participants noted that such experience was the cornerstone of empathic attunement and compassion within the therapeutic relationship. Many participants shared the sentiment that a clinician cannot take a client where one has not been themselves, while others reflected on their ability to see the humanity in their clients through their own willingness to struggle with personal challenges. One participant noted

their tendency to teach what they know to be true for themselves while also cautioning that attempting to apply such principles to treatment without a firm experiential grounding could lead to painful misattunement that could ultimately result in retraumatization with CSA survivors. While broad, the participants' discussion of a lived experience ultimately spoke to the interrelation of developed abilities of awareness, tolerance, compassion, and empathic attunement, understood as therapeutic presence, through a personal practice of mindfulness that they believed encompassed their work with survivors.

Furthermore, the participants' indication of the importance of personal awareness on empathic attunement within the therapeutic relationship closely mirrors Siegel's (2010) supposition that therapist mindfulness practice can lead to a presence that allows clinicians to separate their own preoccupations from the encounter in order to take in the totality of the client's experience. Bien (2006) similarly added that mindful practice allowed a therapist to listen deeply to clients in a manner that fostered healing and growth within clients, while Bruce et al. (2010) posited that the basis for an attuned relationship with the client is the therapist's own attuned relationship to self, facilitated through mindful practice. Participants provided additional support for such statements by conversely explaining that a lack of personal awareness within the therapist would damage the ability to empathically resonate with a client and could potentially leave the therapy limited in some fashion.

With regards to the interrelation between awareness and tolerance, a participant bridged this gap by indicating that subjective awareness allows for recognition of internal reactions within the therapist that creates time and space to respond in a more thoughtful manner. Another participant responded similarly by explaining that the willingness to honor one's own pain creates a reverence that frames the work with clients. Such a response fits with findings from

Cohen-Katz et al. (2005) who similarly noted that mindfulness practice among health care professionals led to reports of a greater capacity for empathy and presence without reactivity or defensiveness.

Such responses also reflected an increased sense of compassion within participants as one spoke to an openness to all experience, including pain as well as love, fostered through a sense of personal awareness. This participant went on to indicate that such openness brings a humanity to the work that draws attention to the connection between therapist and client. According to Siegel (2010), such connection, or *resonance*, creates a state of togetherness that facilitates a sense of safety and trust conducive to positive change within clients.

Markers of Change

While the literature addressing the various psychological and physiological benefits associated with mindfulness is quite vast (Davis & Hayes, 2011; Hart et al., 2013; Hill & Updegraff, 2012; Keng et al., 2011; Shapiro et al., 2006; Vujanovic et al., 2013; Williams et al., 2014) studies assessing efficacy of such a treatment approach with trauma survivors have been scant (Thompson et al., 2011). Nonetheless, participants within this study provided indications of various changes observed through their work with adult survivors of CSA that closely match the broad benefits of mindfulness discussed in the extant literature. As such, the findings observed within this study, while not suggestive of any correlation between such practice and treatment outcome with trauma survivors, certainly highlight some important implications for future clinical treatment.

Consistent with the literature, participants were in consensus with regards to their observation of increased awareness and acceptance among many of their clients. Participants observed such features as they viewed their clients increasingly able to take a reflective stance

with regards to their thoughts or feelings while also remaining open to the totality of their experience. One participant noted that this involved a two-step process of stepping back from thoughts or feelings, while also allowing one to be where they are emotionally. Participants further observed increased awareness through client recognition of patterns of reactivity as well as triggers for reactive or maladaptive responses. Some participants further spoke of acceptance in terms of increased ability to regulate experience, with one participant noting that this included regulation and tolerance of emotional, cognitive, and somatic experiences. Many of the participants explained that the development of such abilities allowed for the creation of space observed in their clients' decreased reactivity and improved overall functioning. One participant noted the fluidity, warmth, and flexibility observed in a particular client while another participant spoke of the reduction in feelings of shame and increased functionality and engagement in life as a result of such attributes. Such findings are reflected in literature that similarly links mindfulness practice with increased emotion regulation, decreased reactivity, and improved cognitive flexibility (Burg et al., 2012; Davis & Hayes, 2011; Goldin & Gross, 2010).

Participants were in further agreement that increases in ability to identify, tolerate, and regulate experiential phenomenon provided a sense of empowerment for clients and increased feelings of self-efficacy. Such benefits were evidenced in clients' abilities to better manage their symptoms, increasingly tolerate their experience, and gain further control over the entirety of their lives. In support of this, Luberto, Cotton, McLeish, Mingione, and O'Bryan's (2014) study examining self-efficacy as a mediator between mindfulness skills and emotional regulation, found an association between utilized mindfulness skills and levels of self-efficacy that partially mediated the relationship between the mindfulness skills and the ability to self-regulate. Participants noted that this was particularly important for trauma survivors who often struggle

with feelings of victimization and lack of agency or control (Bramsen et al., 2013; Browne & Finkelhor, 1986; Follette et al., 2006).

According to extant literature, mindfulness has also been found to improve the quality of interpersonal relationships (Atkinson, 2013; Davis & Hayes, 2011; Kozlowski, 2013). Given that this has been found to be an area of difficulty for adult survivors of CSA (Briere & Elliot, 1994; Browne & Finkelhor, 1986; Colangelo & Keefe-Cooperman, 2012; Finkelhor & Browne, 1985; Herman, 1992), the implications for such practice among this population is profound. In support of such implications, participants noted improvements in interpersonal connection and relationships both within the therapeutic dyad and among the clients broader social context. One participant spoke of the changes observed in a client with regards to the therapeutic relationship. This participant explained that the client flourished within the therapeutic dyad and noted that the developed relationship was healing for the client. Several participants spoke of the trust that emerged within the therapeutic relationships as well as the increased openness to the therapist and a willingness to discuss things that were initially difficult to address. Furthermore, participants spoke of improvements in interpersonal relationships outside of therapy, with one participant observing a client's decreased reactivity in personal relationships. Another participant spoke of a client’s willingness to engage his partner and noted an improvement in the client's sexual relationship as well. Such findings certainly speak to the powerful and healing nature of both the therapeutic relationship as well as a mindful approach to treatment.

Finally, several participants spoke to further observable changes within their clients related to the interrelated attributes of compassion for self and others as well as forgiveness. Although some participants indicated that this area is particularly slow for CSA survivors who struggle with negative core beliefs, others spoke to the continued progress they observe in clients

who are better able to forgive themselves while also access self-compassion and self-love through mindful practice. Another participant reported the immensity of a client's ability to find forgiveness for the perpetrator of her abuse through adoption of a stance of nonjudgmental, compassionate awareness. Barnard and Curry (2011) spoke to such compassion and noted that mindfulness may foster this through installation of self-kindness and an appreciation of the common humanity inherent to us all. Capturing the hope and tremendous power of such work, a final participant recounted an experience with a client who struggled with intense feelings of shame and subsequent withdrawal from life and relationships as a result of prolonged CSA. Towards the end of their work together, the participant spoke to the tremendous shift observed in the client who was able to reengage the world with a sense of agency while also feeling more secure in his body and increasingly able to engage his partner.

Potential Contributions and Limitations

The central aim of this study was to add to the current body of literature regarding the use of mindfulness as a means of working therapeutically with survivors of CSA. Given the scarcity of literature focused on such constructs, it is hoped that the results obtained through this study will broaden the understanding of the benefits of and mechanisms of change related to mindfulness practice with this population. Moreover, it is hoped that the current study will inspire further research, both qualitative and quantitative in nature, to further assess the efficacy of mindfulness as a treatment option, particularly among trauma survivors. Optimistically, further research in this area will continue to raise awareness of the importance of this practice and allow for movement within the field towards an increasingly holistic and mind-body focused approach to treatment.

With regards to limitations of the study, the sample demographics, as well as the restricted geographic location of recruitment, may warrant caution when attempting to draw significant conclusions from observed findings. While the study was exploratory in nature, the experiences of participants within the current study may not be reflective of the broader population of clinicians using mindfulness within their professional practice. Furthermore, the recruitment procedures, as well as the criteria requirements, may have created a sampling bias towards individuals who fundamentally believe that mindfulness is an effective way of working therapeutically. Additionally, participants' belief in the benefits of such practice within their own personal lives may further the objectivity of the collected data. As such, the data gathered may similarly be reflective of a narrow band of the professional population.

Likewise, it should be noted that interpretations drawn from this study were based on the clinical experiences of therapists using mindfulness as a way of working with trauma survivors. A main component of the data collection process involved having participants reflect on cases that best addressed the immediate questions. However, the clients within such cases, seeking therapeutic services that include such mindful practice may, themselves, be biased or increasingly open to the concept of mindfulness as a beneficial means of treatment. With this in mind, inferences drawn from such narratives should be understood as subjective accounts of experience that broadly speak to the larger practice of mindfulness intervention.

Additionally, while the purpose of the study was to deepen understanding of clinician experiences using mindfulness with CSA survivors, the inferences drawn from the data may be influenced by personal bias on the part of the principal investigator. While precautions were taken to reduce such biases through maintained awareness on the part of principal investigator as

well as the inclusion of a second coder and auditor to verify analytic veracity, it remains possible that some latent and unconscious biases impacted the research process.

Areas for Future Research

While research on the efficacy of mindfulness as an effective addition to current practice continues to grow, there remains a gap within the literature examining the relationship between mindfulness as a treatment for CSA survivors. The goal of the current study was to develop an understanding of such a connection; however, it is also hoped that through such understanding, further research continues to examine the efficacy of mindfulness with this population. With regards to future areas of research, it would be important to conduct further qualitative research with CSA survivors who participated in mindfully-based treatment. This would provide additional voice to the discussion of mindfulness, while also casting light on perceptions of such practice among clients rather than clinicians.

Additionally, the data collected within the current study was broad and spoke to a variety of elements of mindfully-based treatment with adult CSA survivors. Future research could attempt to focus the study in a more directed manner in order to understand specific elements of such treatment. For example, further studies could hope to understand, in more detail, how personal practice impacts clinicians or provide an overview of such work through detailed case analyses. Also, studies focused on examination of a spiritual component of mindfulness in order to address whether this somehow alters the implementation of such practice into treatment would provide beneficial data to the extant literature. Moreover, added quantitative assessment through randomized controlled trials to compare mindfully-based treatment with alternative orientations in order to assess efficacy among CSA survivors would play a large role in providing support for mindfulness as an effectual way of working with trauma.

Conclusion and Implications

The purpose of the current study was to broaden the understanding of clinician experiences using mindfulness a frame for their work with adult survivors of CSA. It was hoped that such an understanding would add to the extant literature as to the potential benefits of mindfulness among this population, while further providing areas for future research that would continue to support mindfulness as a potent agent of healing within the therapeutic encounter. The results of this study suggest a complex interrelation between elements of mindful practice that may hold significant implications for clinical practice.

It was evident from the data that a clinician's own personal mindfulness practice can result in increased awareness and tolerance that creates a frame around the treatment and ultimately guides both the structural components as well as the therapist's way of being present with clients. Furthermore, a lived experience of such practice allows for a compassionate attunement to clients as well as an ability to understand the humanity of others. Such features suggest the importance of such practice and indicate that mindfulness goes beyond a set of rote interventions and rather informs a way of being facilitated through such practice.

Through careful orientation to the treatment modality, accurate assessment and thoughtful tailoring of the therapy, clinicians further instill a sense of hope and collaboration within their clients. Additionally, the emanation of openness to experience, empathic attunement, and connection from the therapist further creates healing conditions of safety, trust, agency, and validation that stimulate core elements of mindfulness within clients. Again, such findings emphasize the importance of connectivity between client and therapist rather than the employment of specific interventions. A focus on the relationship, as well as the fostering of a

healing environment, then appears central to effective work, particularly among trauma survivors.

Finally, the findings of the study shed light on significant growth observed within clinical examples from participants. Evidence of increased awareness, tolerance, and improved interpersonal relationships among trauma survivors, as well as a heightened sense of empowerment and self-efficacy suggest that such a way of working may hold tremendous benefit for CSA survivors. However, most notably, the ability to find compassion and forgiveness for self and others truly speaks to the potency of this approach. While the findings within this study are representative of a small and methodologically limited sample, the results instill a sense of optimism given the profound accounts of healing within participant narratives. As research continues to explore these areas, it is hoped that mindfulness continues to find support as an effective facilitator of healing within the psychological community.

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APPENDIX A

Review of the Literature

Author/Year	Title	Sample	Research Design	Main Findings
Aaron, 2012	The Pathways of Problematic Sexual Behavior : A Literature Review of Factors Affecting Adult Sexual Behavior in Survivors of Childhood.	NA	Literature Review	• Variances exist in adult sexual behaviors in response to CSA. o Some respond with fear, withdrawal, and avoidance of sexual behavior. o Others display sexual impulsiveness and acting out behavior. • There are two distinct factors that account for differences in sexual behavior among adult survivors of CSA. o Gender of victim. o Age at onset of victimization. • Clinical implications suggest that CBT techniques may be useful to address phobias or anxiety related to perceptions and attitudes towards sex. However, psychodynamic or trauma-focused techniques may be better suited to address internalized shame and behaviors reflective of compulsive traumatic reenactments.
Alexander et al., 1998	Sexual and physical abuse in women with fibromyalgia : Association	• Sample (N=75) included women diagnosed with fibromyalgia and assessed	Quantitative	• Purpose of study to assess the relationship between sexual/physical abuse and healthcare usage among women with FM. • 57% of FM patients reported a history of CSA

	with outpatient health care utilization and pain medication usage	for sexual/physical abuse along with healthcare and medication utilization.		compared. • Additionally, abused patients reported increased utilization of healthcare services for problems other than FM. • Also, abused patients utilized more medication for pain. • Abused patients characterized by significantly greater pain, fatigue, functional disability, and stress.
Barnes, Noll, Putnam, & Trickett, 2009	Sexual and physical revictimization among victims of severe childhood sexual abuse.	• Sample group including CSA survivors (*N*=93 females). • Sample group including non-CSA survivors, (*N*=96 females). • 54% of total sample was Caucasian. • Sample ranged from low to middle SES. • Mean age at most recent interview was 24.64 years. • No statistical differences in demographic information between two sample groups.	Quantitative longitudinal Study (15-year prospective using logistic and ANOVA models). Adolescents and young adults reporting revictimization (traumatic sexual/physical experiences) subsequent to CSA compared against women with no CSA history who reported traumatic victimization.	• Compared with non-CSA survivors, abused women were almost twice as likely to experience revictimization. • Additionally, for abused women, perpetrators were more likely to have been non-peers and the (re)victimizations were more likely to have resulted in injury.
Bodhi, 2011	What does mindfulness really mean? A canonical perspective.	NA	Literature Review	• Author attempts to understand the meaning and function of mindfulness through review of Buddhist texts.

				• Mindfulness may include both the concept of *bare attention* and *clear comprehension*, which provides a bridge between the observational stance of mindfulness and the development of insight. • Author also discusses the use of mindfulness for secular purposes. o He acknowledges that this may be acceptable and useful as a means of alleviating suffering; however, he warns against reductionism that would not honor the religious rooting of the practice.
Bohus, Dyer, Priebe, Krüger, Kleindienst, Schmahl, Niedtfeld, et al., 2013	Dialectical behaviour therapy for post-traumatic stress disorder after childhood sexual abuse in patients with and without borderline personality disorder: A randomised controlled trial.	• Sample (*N*=74) included female patients with CSA-related PTSD. • Almost half of the sample also met criteria for co-occurring BPD. • Sample members randomly assigned to 12-week residential DBT-PTSD program or TAU-wait list.	Quantitative (Between-group method).	• Assessed efficacy of a newly developed residential treatment approach for women with CSA-related PTSD. • Significant improvement (reduction of PTSD symptoms) observed in DBT-PTSD group compared to TAU-WL, with large between-group effect sizes. • Improvements also observed in global social functioning and depression. • Neither number of BPD criteria nor severity of symptoms was related to treatment outcome. • Results suggest that DBT-PTSD is an effective treatment for CSA-related PTSD regardless of severe co-occurring

				psychopathology or BPD.
Bormann, Thorp, Wetherell, Golshan, & Lang, 2013	Meditation-based mantram intervention for veterans with posttraumatic stress disorder: A randomized trial	• Sample (*N*=156) included outpatient veterans with diagnosed military-related PTSD. • Veterans randomly assigned to either a medication and case-management group (TAU) or TAU augmented with a 6-week group mantram (spoken word) repetition program (TAU + MRP).	Quantitative (Prospective, single-blind randomized clinical trial).	• Significantly greater reductions in reported and clinically observed PTSD symptoms among TAU + MRP group compared with TAU alone. • At post-treatment, 24% of TAU + MRP subjects had clinically significant improvements in PTSD symptoms compared with 12% of TAU subjects. • TAU + MRP subjects also reported improvements in depression, mental health status, and spiritual well-being. • MRP may be an effective adjunct to psychopharmacology and case-management.
Bramsen, Lasgaard, Koss, Shevlin, Elklit, & Banner, 2013	Testing a multiple mediator model of the effect of childhood sexual abuse on adolescent sexual victimization.	• Sample (*N*=327) included Danish female adolescents. • Mean age was 14.9 years.	Quantitative (Cross-sectional study utilizing a multiple mediator model).	• Investigated potential mediating pathways between CSA and adolescent peer-to-peer sexual victimization (APSV). • Results suggest that CSA was significantly associated with adolescent sexual victimization. • However, when mediators (number of sexual partners, sexual risk behavior, and signaling sexual boundaries) were included, direct path between CSA and APSV was no longer statistically significant. • Number of sexual partners and sexual risk behavior

				fully accounted for link between CSA and APSV. o Number of sexual partners was strongest mediating factor. • Revictimization may be understood as being related to greater exposure to threat (larger number of partners) with increased risk behavior and poor sexual communication.
Briere & Elliot, 1994	Immediate and Long-Term Impacts of Child Sexual Abuse	NA	Literature Review	• Authors survey the literature to provide an understanding of the effects of CSA. • Authors discuss both immediate and long-term effects of CSA. • 3 stages of impact: o Initial reactions to victimization o Accommodation to ongoing abuse involving coping behavior o Long-term consequences. • Long term consequences include: o PTSD o Cognitive distortions o Emotional distress o Impaired sense of self o Avoidance o Interpersonal difficulties • Authors also discuss mitigating factors that may alter expression of distress: o Age at time of abuse o Extended and

				frequent abuse o Incest o Presence of force o Greater number of perpetrators.
Brotto, Seal, & Rellini, 2012	Pilot study of a brief cognitive behavioral versus mindfulness-based intervention for women with sexual distress and a history of childhood sexual abuse	• Sample (*N*=20) included partnered seeking treatment for sexual concerns. • Mean age was 35.8 years. • 70% in a relationship; 25% single, and 5% did not indicate status. • Majority of sample identified as Euro-Canadian (85%). • Sample members randomized to a CBT-control group (*N*=8) and an MBT group (*N*=12).	Quantitative (Multilevel Methodology).	• Overall, women in the MBT group showed a significant change in concordance between genital and subjective sexual arousal at posttreatment and when compared against the control group. • CBT group did not demonstrate significant change in concordance rates. • Treatment also indicated a slightly larger increase in subjective sexual arousal among MBT group when compared to CBT group at posttreatment. • Mindfulness-based treatments are associated with enhanced sexual functioning.
Browne & Finkelhor, 1986	Impact of Child Sexual Abuse: A Review of the Research.	NA	Literature Review	• Authors review the chronic effects of CSA throughout development and lifespan. • Initial reactions often involve emotional reactions (fear, anxiety, depression, anger, hostility) as well as negative self-perceptions (shame and guilt). Additionally, physical effects (sleep and eating disturbances, pregnancy), difficulties in social functioning (truancy,

				running away, early marriage) as well as inappropriate sexual behavior also observed. • Long-term effects include depression, anxiety, tension, feelings of isolation or stigmatization, and negative self-concept. • Additionally, damaged interpersonal relating, sexual dysfunction, and impaired social functioning were also observed as long-term effects. • Important distinctions related to abuse: o Duration and frequency o Relation to offender o Type of sexual act o Force or aggression used o Age at onset o Sex of offender o Parental reaction o Institutional response
Burg, Wolf, & Michalak, 2012	Mindfulness as Self-Regulated Attention.	• Sample (*N*=23) included 20 female and three male undergraduate psychology students. • Mean age was 23.8 years old. • Majority of participants indicated that they had no prior mindfulness experience.	Quantitative (Correlational study using Spearman's rank correlation).	• Designed to test the hypothesis that Heart Rate Variability (HRV) is the physiological correlated of mindfully self-regulated attention. • Participants better able to self-regulate their attention during the mindfulness-breathing exercise displayed significantly higher values on indices measuring HRV. • Higher HRV during mindfulness practice may indicate enhanced self-regulated attention to the present-moment

				experience. • Such findings suggest that continued mindfulness practice may increase regulatory abilities associated with better health and functional adaptation.
Chard, 2005	An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse.	• Sample (*N*=71) included women with a mean age of 32.77. • The majority of participants identified as White (81.4%). • Average age of onset of abuse was 6.4 years.) • *n*=36 women were assigned to the active treatment group; *n*=35 were assigned to the wait list control group.	Quantitative	• Purpose of study to compare the efficacy of CPT-SA with a wait-list control group. • Participants within the active treatment group (CPT-SA) reported significant statistical and clinical gains on symptom measures of depression, PTSD, and dissociation from pre to post test. • Treatment gains were found to be maintained at 3-month and 1-year follow ups. o Some continued improvements observed on PTSD scores after 3-month follow up.

Chen, Cai, Cong, Liu, Gao, Li, Tao, et al., 2014	Childhood sexual abuse and the development of recurrent major depression in Chinese women.	• Data drawn from existing data set.
		• Based on a total of 6017 cases recruited from 58 mental health centers and psychiatric departments across China.
		• 5983 control cases were also utilized, drawn from
			Quantitative (Logistic regression).	• Study produced four main findings:
				    o Among Han Chinese women, CSA history robustly associated with increased risk of recurrent MD (rMD).
				    o CSA affects the clinical features of rMD.
				        ▪ Those with CSA history had earlier age of onset,

		patients undergoing minor surgical procedures. • All cases and controls were female with four Han Chinese grandparents. • Cases were between 30-60 years old and had two or more episodes of MD. • Controls were matched with cases based on region and were similarly aged (40-60) with no history of MD.		longer episodes, and increased risk to suffer from dysthymia and phobia. o Any form of CSA associated with suicidal ideation or attempts and feelings of worthlessness or guilt. o The use of force or threats, magnitude of upset experienced by victim, or younger age at time of victimization were significant associated with rMD.
Classen, Palesh, & Aggarwal, 2005	Sexual revictimizaition: A review of the empirical literature	NA	Literature Review	• Author attempts to understand the nature of sexual revictimization among CSA survivors. • The occurrence of CSA and its severity are the best predictors of revictimization. • Multiple traumas, especially childhood physical abuse and recency of sexual victimization are associated with higher revictimization risk. • Revictimization associated with higher distress and various psychiatric disorders. • Additionally, revictimization can lead to interpersonal difficulties,

				poor coping, negative self-concepts, decreased affective regulation ability, increased self-blame and shame.
Classen, Palesh, Cavanaugh, Koopman, Kaupp, Kraemer, Aggarwal, et al., 2011	A comparison of trauma-focused and present-focused group therapy for survivors of childhood sexual abuse: A randomized controlled trial	• Sample (*N*=166) included women with a history of CSA. • Participants randomized into three groups: o Trauma-focused group psychotherapy (*n*=55). o Present-focused group psychotherapy (*n*=56). o Waitlist (*n*=55)	Quantitative (ANOVA)	• Designed to compare the efficacy of trauma-focused group psychotherapy (TFGT) with present-focused group psychotherapy (PFGT) towards reduction of risky HIV behaviors and PTSD symptoms among women with CSA histories. • PFGT found to be more effective at reducing overall HIV risk when compared to TFGT. o However no difference observed when compared with waitlist. • No advantage was found of TFGT at reducing PTSD symptoms when compared to PFGT. • Greater reduction in anger symptoms found within the TFGT group. • Neither group significantly reduced sexual revictimization rates, risky sex, or substance use.
Cohen, 2008	Using feminist, emotion-focused, and developmental approaches to enhance cognitive-behavioral therapies for posttraumati	NA	Literature Review	• While research shows that CBT and trauma-based therapies are useful form women with SA histories; unique characteristics related to CSA may make generalizability of such findings difficult. • CSA unique as a traumatic stressor. • Given the unique nature of CSA, considerations should

	c stress disorder related to childhood sexual abuse			be taken with respect to treatment. • Feminist, emotion-focused, and developmental approaches can enhance CBT/trauma-based treatments.
Colangelo & Keefe-Cooperman, 2012	Understanding the impact of childhood sexual abuse on women's sexuality.	NA	Literature Review	• Authors examine the prevalence of CSA along with its deleterious long-term impact on psychological, emotional, and sexual functioning. • Authors discuss the significance of internalizing and externalizing behaviors on expression of sexuality. o Internalization produces negative feelings about sexuality, which may impact sexual satisfaction and functioning. o Externalization may result in high risk sexual behaviors (i.e. increased number of partners, earlier sexual activity, etc.) • Additionally, the authors address treatment implications. o Importance of therapeutic alliance. o Safety is most important o Phase-based approach: ▪ Therapeutic alliance ▪ Addressing CSA and trauma symptoms

				▪ Individual growth and sexual development.
Conklin, 2012	Child sexual abuse I: An overview	NA	Literature Overview	• Author disseminates information related to prevalence rates, demographic considerations, risk factors, and signs and symptoms of sexual abuse.
Creswell, Hanson, Clark Plano, & Morales, 2007	Qualitative Research Designs: Selection and Implementation.	NA	Literature Review	• Authors discuss a number of qualitative study design approaches and provide information related to origins, definitions, variants, and research procedures. o Narrative, case study, grounded theory, phenomenological, and participatory action research designs are discussed.
Davis, Schraufnagel, Jacques-Tiura, Norris, George, & Kiekel, 2012	Childhood Sexual Abuse and Acute Alcohol Effects on Men's Sexual Aggression Intentions.	• *N*=220 Male social drinkers. • Average age was 25.5 • Majority of participants were Caucasian (69%). • 35.6% identified as full-time students. • On average, participants reported consuming 8.7 standard drinks per	Quantitative (Path Analysis)	• CSA history may facilitate sexual assault perpetration through effects on cognitions. Additionally, alcohol may exacerbate these effects. • CSA not directly related to sexual aggression intentions. • However, men with CSA history and more intoxicated men viewed the female character as increasingly sexually aroused and reported higher sexual entitlement cognitions. o Both associated with greater

		week.		resistance to condom use and sexual aggression intentions.

Davis & Hayes, 2011	What are the benefits of mindfulness? A practice review of psychotherapy-related research.	NA	Literature Review	• Author outlines research-based evidence in support of the benefits of mindfulness-practice.
				• Mindfulness associated with affective benefits:
				  o Increase emotional regulation
				  o Decreased rumination
				  o Reduced symptoms of anxiety and depression
				  o Increased positive affect
				  o Decreased reactivity and increased response flexibility.
				• Additionally, mindfulness associated with interpersonal benefits:
				  o Ability to respond constructively to relationship stress
				  o Increased empathy and skill in identifying partner's emotional state
				  o Decreased relational stress
				  o Enter conflict with less anger and anxiety.
				• Intrapersonal benefits also observed:
				  o Enhanced functions associated with middle and prefrontal lobe area of brain.
				    ▪ Self insight
				    ▪ Morality

				▪ Intuition ▪ Fear modulation. o Increased information processing speed and decreased task effort.
Dolan & Whitworth, 2013	Childhood sexual abuse, adult psychiatric morbidity, and criminal outcomes in women assessed by medium secure forensic service.	• Sample (*N*=225) included case files of women seen by forensic services in the UK. • Of the 225 cases reviewed, 126 had a recorded history of CSA and the remaining 129, with no CSA history were used as a comparison group.	Quantitative (Descriptive statistics using chi-square analysis and independent t-tests).	• Compared psychosocial and criminal characteristics of women with and without CSA history. • Examination of abused women's social functioning indicated that a higher proportion were: o Not in paid employment. o Lived in temporary housing. • Additionally, women with CSA history evidenced a higher rate of adult victimization. • Fewer of the abused group demonstrated stable relationships and a greater number had children in the care of other family members or the state. • Higher proportion of the abuse sample had recent contact with psychiatric services, received inpatient treatment, or had been detained in secure hospitals. • Although no significant difference in proportion of psychotic disorders or aggressive/violent behavior, higher prevalence rates of self-harm, trauma related disorders, and personality disorders among women with CSA

				history. • Higher prevalence rates of neurotic disorders among women with CSA history. • Higher proportion of abused women had prior criminal history and younger age at first conviction.
Dunn, Callahan, & Swift, 2013	Mindfulness as a transtheoretical clinical process.	NA	Literature Review with Clinical Material	• Author uses clinical material to emphasize the use of mindfulness within sessions. • Author discusses various utilizations of mindfulness: o Informal o Therapist mindfulness within session o Pre-session mindfulness for therapists.
Easton, Coohey, O'leary, Zhang, & Hua, 2010	The Effect of Childhood Sexual Abuse on Psychosexual Functioning During Adulthood.	• Sample (*N*=165) included adults who reported a history of CSA • Majority of participants were female (80.6%) • Average age range was within the 30's.	Quantitative (Secondary Data Analysis)	• Primary purpose to understand the variability in psychosexual functioning among individuals with a CSA history. • Two factors negatively affected all dimensions of sexual functioning: o Age at time of abuse o Telling someone at time of abuse. • Older age at time of abuse & older age of disclosure led to increased fear of sex, feelings of guilt related to sex, and decreased sexual satisfaction. • Being injured by abuser or being abused by more than one person negatively influenced emotional/behavioral

				dimensions of sexual functioning.
Edmond & Rubin, 2001	Assessing the long-term effects of EMDR: Results from an 18-month follow-up study with adult female survivors of CSA	• Sample (*N*=42) included a majority (71%) of the women included in the original study. • 83% identified as White with a mean age of 36 years. • CSA survivors reported severe histories of abuse with mean age of onset at 6 years.	Quantitative	• Purpose of study to assess efficacy of EMDR as a treatment to reduce trauma symptoms among female CSA survivors. • Findings suggest that therapeutic gains demonstrated in the original study were maintained at 18-month follow-up. • EMDR group not only maintained gains but demonstrated slight improvements across all measures. o Control group's scores decreased slightly. • Possibly greater sense of trauma resolution among EMDR group: o Lower use of individual therapy among this group o Those who sought therapy received fewer sessions than within control group. •
Edmond, Rubin, & Wambach, 1999	The effectiveness of EMDR with adult female survivors of childhood sexual abuse	• Sample (*N*=59) included were randomized to one of three conditions: o EMDR group o Routine individual treatme	Quantitative	• Purpose of study to assess efficacy of EMDR as a treatment to reduce trauma symptoms among female CSA survivors. • Findings suggest that on every measure, the EMDR group scored significantly better than controls at posttest. o EMDR reduced trauma-specific anxiety, PTSD,

		nt o Delayed treatment control • The mean age was 35, with a majority identifying as White (85%).		depression, and negative beliefs. • EMDR found more effective at maintaining gains at 3-month follow up. o Particularly related to trauma-specific anxiety and depression. o Also trauma-specific emotional disturbances and increasing positive beliefs about a trauma memory. • Gains were observed within EMDR group despite limited expertise of clinicians administering treatment.
Fields, Malebranche, & Feist-Price, 2008	Childhood sexual abuse in black men who have sex with men: Results from three qualitative studies	• Sample across three studies (*N*=87) included Black men who reported having sex with men. • Combined CSA prevalence rate of 32% was found within the total sample. • Variation in mean age, geographic location, and sexual identification existed across studies.	Discussion of results from three qualitative studies (Semi-structured one-on-one interviews conducted).	• Common themes emergent across studies included: o Prolonged and repeated abuse by close male relative. o Blaming of same-sex desire on CSA experiences. o Reported adverse mental health reactions to CSA. ▪ Depressive symptoms ▪ Social isolation ▪ Suicidality ▪ Acting out • Despite variations in sample demographics, common CSA experiences have led to similar adverse mental health effects.
Finkelhor & Browne,	The Traumatic Impact of	NA	Theoretical Conceptualization	• Authors discuss the deleterious impact of CSA and propose a framework

1985	Child Sexual Abuse : A Conceptualization			from which to understand such effects.
				• Four traumagenic dynamics are proposed:
				  ○ Traumatic sexualization
				  ○ Betrayal
				  ○ Powerlessness
				  ○ Stigmatization
				• The impact of such dynamics on development and manifestation of psychopathology is discussed.

Finkelhor, Hotaling, Lewis, & Smith, 1990	Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors.	• Sample (*N*=2626) included men (*n*=1,145) and women (*n*=1,481) over 18 years old randomly chosen by a computer.
		• Sample conformed to census demographics within the US during 1985.
			Report of findings from a national survey of adults concerning a history of CSA (Brief phone interviews conducted on issues related to CSA.)	• Prevalence rates indicate that 27% of females and 16% of males endorsed some CSA experience.
				• Median age of abuse was 9.6 for women and 9.9 for men.
				• Boys more likely to be abused by strangers whereas girls were more likely to be abused by family members.
				• Boys were more likely to not report abuse.
				• Of surprise:
				  ○ Large amount of actual or attempted intercourse
				  ○ Small amount of coercion.
				• Risk factors for abuse observed:
				  ○ Growing up in an unhappy family most powerful risk factor.
				  ○ Living without a natural parent.
				  ○ Region – with pacific states showing a markedly higher rate of abuse.

				o Ethnicity o Age o Inadequate sex education.
Geschwind, Peeters, Drunker, van Os, & Winchers, 2011	Mindfulness training increases momentary positive emotions and reward experience in adults vulnerable to depression: A randomized controlled trial.	• Sample (*N*=130) included adults with a lifetime history of depression and current residual depressive symptoms. • Majority of participants were female (75%) and all were Caucasian. • Mean age of participants was 43.9 years. • Sample members randomized to MBCT group (*n*=64) or a waitlist control group (*n*=66).	Quantitative (Multilevel linear regression analysis).	• Purpose of study to determine if mindfulness-based cognitive therapy can increase momentary positive emotions as well as the ability to make use of natural rewards in daily life. • MBCT associated with both enhanced experience of pleasant daily-life situations and increased positive affect responsiveness to pleasant situations. • Compared to baseline and control group, MBCT associated with: o Increased overall positive affect o Higher appraisal of activities as pleasant o Higher levels of reward experience. • Increases in positive affect associated with reduction in depressive symptoms. • However, no active intervention control group – Interpretations of data should be made with caution.
Gethin, 2011	On some definitions of mindfulness.	NA	Literature Review	• Author discusses the various understanding of "mindfulness" and attempts to increase understanding of the concept through review of traditional and modern literature.
Goldin & Gross, 2010	Effects of mindfulness -based stress	• Sample (*N*=14) included	Quantitative (Paired t-tests)	• Purpose of study to examine the relationship between MBSR and brain-

	reduction (MBSR) on emotion regulation in social anxiety disorder.	individuals who met DSM-IV criteria for SAD. • The mean age was 35.2 years and the sample was ethnically diverse.		based indices of emotional reactivity and regulation of negative self-beliefs in patients with SAD. • MBSR related changes included reductions in symptoms of social anxiety, depression, rumination, and state anxiety. Additionally, increased self-esteem was observed. • From pre to post, patients with SAD reported reduced negative emotion experience when using breath-focused attention.

Gwandure, 2007	Sexual assault in childhood: risk HIV and AIDS behaviours in adulthood	• Sample (*N*=80) included equal numbers of male and female participants.
		• 40 members reported CSA history while 40 had no such experience.
		• Age range of participants was 25 to 35 years.
			Quantitative (2-Way ANOVA design).	• Examined hypothesis that CSA is a risk factor in HIV/AIDS prevention in adulthood.
				• Participants with CSA history displayed risk for HIV/AIDS infection.
				  o Use of alcohol/drugs before sex.
				  o Partners had other sexual partners.
				• Participants with CSA history also at risk for PTSD, depression, suicidal ideation, self-esteem and locus of control issues.

Han, Gallagher, Franz, Chen, Cabral, & Marx, 2013	Childhood sexual abuse, alcohol use, and PTSD symptoms as predictors of adult sexual assault among lesbians and gay men.	• Sample (*N*=342) included participants enrolled in a larger study of sexual victimization among minorities. • Participants identified as either *female*	Quantitative (Structural Equation Modeling design).	• Purpose of study to assess risk factors associated with adult sexual abuse (ASA) among gay and lesbian populations. • Among lesbians, although CSA and PTSD were significantly related, they did not predict ASA. • Alcohol was found to be an important risk factor for ASA among lesbians. o Inhibited cognitive

		and lesbian or *male and gay*. • Final sample consisted of 122 female lesbians and 117 gay men. • Mean age of sample was 33.56 years. • Majority of participants were Caucasian (64.8%).		abilities. o Increased motor impairment. o Exposure to perpetrators who use alcohol to facilitate assault. • Among gay men, CSA significantly predicted ASA and was associated with PTSD severity. • However, PTSD severity and alcohol use were unrelated to ASA.
Hart, Ivtzan, & Hart, 2013	Mind the gap in mindfulness research: A comparative account of the leading schools of thought	NA	Comparative Literature Review	• Purpose of review to compare two major schools of thought (Langer and Kabat-Zinn) on the concepts of mindfulness and treatment. • Three areas of convergence: o Definitions o Centrality of self-regulatory mechanisms in their interventions. o Effect of health and well-being. • Differences include: o Philosophies o Components of mindfulness. o Goals o Target of mindful awareness o Theoretical scope o Conceptual focus o Measurement tools o Target audience o Interventions used to induce mindfulness o Mechanisms underlying

				interventions o Outcome of interventions.
Harvey & Taylor, 2010	A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents.	NA (39 studies analyzed)	Meta-analysis	• To review the efficacy of treatment with sexually abused children and adolescents. • Overall, psychotherapy as treatment for effects of CSA appears beneficial. o Symptom reduction and improved self-esteem and overall functioning. • Large effect sizes were found for global outcomes and PTSD/trauma symptoms. • Moderate effect sizes found for internalizing symptoms, self-esteem, externalizing symptoms, and sexualized behavior. • Small effect sizes found for coping/functioning, caregiver outcomes, and social support. • Therapy produces different effects according to the outcome being measured.
Heim, Newport, Wagner, Wilcox, Miller, & Nemeroff, 2002	The role of early adverse experience and adulthood stress in the prediction of neuroendocrine stress reactivity in women: A multiple regression analysis	• Sample (*N*=49) included women with a range of presenting concerns. • 12 with no history of early-life stress or psychiatric disorder; 14 abused as children without	Quantitative (Multiple Regression Analysis)	• Purpose of study to examine the relationship between early childhood abuse and increased neuroendocrine reactivity. • It was observed that the presence of early adverse experiences was related to sensitization of the HPA axis to stress in women. • The number of traumatic events was significantly predictive of maximum ACTH concentrations in response to stress. o Increased

		current major depression; 13 abused as children with current major depression; 10 with current major depression but no history of childhood abuse. • Ages ranged between 18 and 45.		neuroendocrine reactivity in women with a history of childhood trauma is affected by adulthood trauma. • Psychopathology, particularly severity of depressive symptoms, was found to be related to maximum ACTH concentrations.
Higgins-Kessler & Nelson Goff, 2006	Initial treatment decisions with adult survivors of childhood sexual abuse: Recommendations for clinical experts	• Sample (*N*=11) included national experts on treatment of CSA. • *Expert status* was determined through establishment of specific criteria. • Of the 11 participants, four were male and seven female. • Training status included psychologists (6), social workers (2), licensed professional counselor (1), marriage and family therapist (1), and a	Qualitative (Phenomenological)	• Purpose of study, to examine treatment recommendations for therapists making initial decisions with survivors of CSA. • Creation of a safe environment that is conducive to disclosure. • Assessing for history of CSA is a process, not an event. • With regards to determining focus of treatment, decisions to address trauma are based on clients' willingness and interest. • In assessing how multiple modalities should be utilized in the therapy process, therapists should provide more than one modality of treatment to an individual client (e.g. individual and couples).

		registered mental health counselor (1). • On average, experts held 21.5 years of clinical experience, with 18.4 as the mean number of years specializing in treatment of CSA survivors.		
Hill & Updegraff, 2012	Mindfulness and its relationship to emotional regulation	• Sample (*N*=96) included 70 female and 26 male participants. • The majority of participants were Caucasian (*n*=80) • The mean age of participants was 19.19.	Quantitative (Correlational design).	• Purpose of study to assess the relationship between mindfulness and emotional regulation. • Findings showed support for a relationship between mindfulness and effective emotional regulation. o Self-reported levels of mindfulness were associated with lower levels of emotional reactivity. o Mindfulness ratings also negatively related to certain individual emotions including anger, sadness, fear, shame, depression, etc. o Mindfulness also related to lowered reports of emotional dysregulation. o Mindfulness also found to be related to increased emotional

				awareness and higher levels of emotional differentiation for both positive and negative emotions.
Hofmann, Sawyer, Witt, & Oh, 2010	The effect of mindfulness -based therapy on anxiety and depression: A meta-analytic review.	NA	Meta-analytic Review (Effect size analysis)	• Review the efficacy of mindfulness-based treatment for anxiety and mood symptoms. • MBT found to be effective towards treatment of anxiety/mood related symptoms. o Across a range of severity and even when such symptoms were associated with other disorders. • MBT may not be diagnosis-specific but rather may address processes occurring in multiple disorders by changing various dimensions of well-being.
Jones et al., 2013	Linking childhood sexual abuse and early adolescent risk behavior: The intervening role of internalizing and externalizing problems	• Sample (*N*=832) included youth with maltreatment data from at least 3 points between the ages of 2-12. • Participants divided into subsamples: sexual intercourse (*n*=657) and alcohol use (*n*=667). • Subsamples evenly split by gender.	Quantitative (Group-based trajectory analysis).	• Purpose of study to examine the indirect effects of CSA on risky behavior (alcohol use and sexual activity) at age 14 through the role of caregiver reported internalizing/externalizing problems at age 12. • CSA not directly linked with alcohol use or sexual intercourse. o However, they were indirectly linked through increases in externalizing problems. o Externalizing problems increased the risk of both

		• About half of the youth in each subsample identified as African American (55%). However, race controlled for in primary analyses.		alcohol use and sexual intercourse for girls. However, only sexual intercourse was associated with externalizing problems for boys.
Kendall-Tackett, Williams, & Finkelhor, 1993	Impact of sexual abuse on children: A review and synthesis of recent empirical studies.	NA	Literature Review	• Authors reviewed 45 studies to examine the impact of CSA. • Literature suggested that abused children demonstrated more symptoms than non-abused (with abuse accounting for 18-45% of variance). • Occurring most frequently were fears, PTSD, behavior problems, sexualized behavior, and poor self-esteem. o No one symptom characterized a majority of abuse sample. • Some factors affected the degree of symptomatology: o Penetration o Duration and frequency of abuse o Force o Relationship to perpetrator o Maternal support. • Two-thirds of victims showed recovery during first 12-18 months. • Absence of a specific syndrome related to CSA and no single traumatizing process.

Keng, Smoski, & Robins, 2011	Effects of mindfulness on psychological health: A review of empirical studies.	NA	Literature Review	• Authors review the literature to assess the effects of mindfulness on psychological health. • Three areas of empirical research are observed: o Correlational research o Intervention research o Laboratory-based experimental research. • Findings suggest that mindfulness can lead to the emergence of positive psychological effects: o Increased subjective well-being o Reduced physiological symptoms and emotional reactivity o Improved behavioral regulation.
Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010	Mindfulness Intervention for Child Abuse Survivors.	• Sample (*N*=27) included adult survivors of CSA aged 21 years or older. • Participants engaged in an 8-week MBSR program followed by an 8-week assessment. • Additionally, three refresher classes were provided through final follow-up at 24 weeks.	Quantitative	• Purpose of study to assess efficacy of a pilot mindfulness-based stress reduction treatment protocol for survivors of CSA and related symptoms of depression, anxiety, and PTSD. • Statistically significant changes observed in all outcomes and remained significant until conclusion at 24-weeks. o Particularly significant association between MBSR engagement and reduction in depressive symptoms.

				○ Similar association between MBSR and reduction of PTSD symptoms: particularly avoidance.
Klanecky, McChargue, & Bruggeman, 2012	Desire to dissociate: Implications for problematic drinking in college students with childhood or adolescent sexual abuse exposure.	• Sample (*N*=298) included undergraduate students from a Midwestern university. • The mean age of participants was 19.87. • The majority of participants were female (54%) and Caucasian (88.6%).	Quantitative (Hierarchical Linear Regression)	• Purpose of study to investigate the desire to dissociate among survivors of CSA with a restrictive range of dissociative abilities. ○ Additionally, problematic drinking as a substitute for dissociation among this population was examined. • Consistent with research, problematic drinking was associated with CSA. ○ However, it was the *desire to dissociate* and not dissociative experiences that explained this relationship. • It is possible that a desire to dissociate and avoid difficult experiences among CSA survivors leads to problematic drinking.
Kuyken et al., 2008	Mindfulness-based cognitive therapy to prevent relapse in recurrent depression.	• Sample (*N*=123) included individuals with at least three or more episodes of depression.	Quantitative (Parallel 2-Group randomized control trial)	• Purpose of study to compare efficacy of MBCT with med support with anti-depressant medication (ADM) for treatment of recurrent depression. • Those in the MBCT group discontinued ADM use (75%). • Relapse/recurrence rates for MBCT group were lower than for ADM alone group (47% versus 60%).

				• MBCT found more effective at reducing residual symptoms of depression and psychiatric comorbidity. • MBCT observed to be more effective at improving quality of life with regards to physical and psychological domains. • No significant differences in terms of annual cost.

Lanktree, Briere, & Zaidi, 1991	Incidence and Impact of Sexual Abuse in a Child Outpatient Sample: The Role of Direct Inquiry.	• Sample (*N*=64) included review of randomly sampled charts.
		• 29 charts randomly selected from outpatient files; 35 charts reflected cases where clinicians directly asked about CSA.
			Quantitative	• Purpose of study to examine the impact of direct inquiry of sexual abuse in a sample of child psychiatric outpatients.
				• Sexual abuse reports increased from 7% to 31% when patients were directly queried.
				• Sexual abuse history found to be associated with psychological problems.
				    o Increased risk of suicide attempt.
				    o Greater number of psychological symptoms.
				    o Increased risk of diagnosis of MDD.

Laumann, Michael, & Gagnon, 1994	A political history of the national sex survey of adults.			
Leonard & Follette, 2002	Sexual Functioning in Women Reporting a History of Child Sexual Abuse:	NA	Literature Review	• Authors review prevalence rates along with rates of sexual dysfunction among female CSA survivors. • They identified problems with sexual desire and/or arousal as common to CSA survivors.

	Review of the Empirical Literature and Clinical Implications .			• Authors address the cognitive and affective components associated with such dysfunction: o Self-blame, guilt, and anger. • Theoretical explanations of sexual dysfunction are also reviewed: o Experiential avoidance o Emotion theory • Authors discuss treatment considerations o Treatments tailored to unique issues of survivor. o ACT for experiential avoidance o EFT for emotional difficulties
Leonard, Iverson, & Follette, 2008	Sexual functioning and sexual satisfaction among women who report a history of childhood and/or adolescent sexual abuse	• Sample (*N*=22) included women with a history of CSA. • Majority of participants were Caucasian (77.3%) and were enrolled in at least one course in university (68.2%).	Quantitative	• Purpose of study to examine the relationship between predictor variables (experiential avoidance, relationship psychological distress, etc) and sexual functioning and satisfaction in a sample of women with CSA history. • Sexual functioning was not found to be significantly correlated with sexual satisfaction. o Sexual functioning only found to be correlated with relationship violence. ▪ Higher levels of violence associated with lower sexual

				functioning. • Sexual satisfaction significantly correlated with relationship violence and satisfaction, anger, distress, and experiential avoidance. • Important to consider both historical (abuse history) and current factors (relationship functioning) in treatment of CSA survivors. • Individual treatment utilizing mindfulness practice may be useful towards ameliorating experiential avoidance.
Loeb et al., 2002	Child sexual abuse: Associations with the sexual functioning of adolescents and adults	NA	Literature Review	• Authors review the research related to the effect of CSA on sexual functioning as well as gender and ethnic differences in sexual functioning among male and female survivors. • Few differences in prevalence rates across ethnicities; however, differences in how abuse experiences were processed by individuals and families were observed. • Authors discuss physiological effects of CSA as well as high-risk sexual behaviors, both which contribute to adolescent and adult sexual dysfunction. o Addressed across gender and ethnicity. • Additionally, abuse survivors who later become perpetrators are addressed.

McDonagh et al., 2005	Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse.	• Sample (*N*=74) included women with CSA histories who also met criteria for PTSD.
		• No differences between participants on demographic characteristics.
		• Participants randomized to either a CBT intervention group (*n*=29), a PCT group (*n*=22), and a wait-list control group (*n*=23)
			Quantitative	• Purpose of study to compare efficacy of CBT for treatment of CSA-related PTSD symptoms with PCT and a wait-list control group.
				• Findings suggest that both CBT and PCT were more effective at reducing PTSD symptoms than wait-list control group.
				  o Marked improvements in PTSD symptom severity, state anxiety, and trauma-related cognitive schemas.
				  o Neither was superior to WL towards reducing symptoms of depression, anger, hostility, or improving quality of life.
				• It was found that CBT was found to be superior to PCT towards achievement of remission from PTSD diagnosis at follow-up.
				• High drop-out rate observed among CBT condition (41.4%).
				  o Comparisons should be interpreted with caution.

Meston, Rellini, & Heiman, 2006	Women's history of sexual abuse, their sexuality, and sexual self-schemas.	• Sample (*N*=119) included 48 female survivors of CSA and 71 control participants. • Among control	Quantitative (Hierarchical Linear Regression).	• Purpose of study to examine differences in self-perceptions as a sexual person between women with and without CSA history. Additionally, if such perceptions mediate link between early unwanted sexual

		participants, mean age was 27 with a majority identifying as Caucasian (35). • Among CSA survivors, mean age was 28 years with a majority identifying as Caucasian (42).		experience and later adult sexuality. • Findings suggest that women with a history of CSA had lower scores on positive, romantic/passionate sexual self-schema. • Women with CSA history also observed to have higher levels of negative sexual affect when compared to control group o Romanic passionate self-schema explained negative sexual affect independently from depression and anxiety related to CSA o Through CSA experiences, sexuality may have become linked to negative affect, affecting sexual self-schemas. • No significant difference in arousal levels for CSA and non-CSA participants.
Morrison & Ferris, 2009	The Satir Model with Female Adult Survivors of Childhood Sexual Abuse	NA	Literature Review	• Purpose of review to explore the range of treatment approaches for survivors of sexual abuse with a focus on the benefits of the Satir model. • Satir model emphasizes the impact rather than the story of the abuse. • Emphasizes positive growth potential of clients. • Focus is placed on client's inner strengths and capacity to know how treatment can best facilitate their growth

				and healing.

Najman, Dunne, Purdie, Boyle, & Coxeter, 2005	Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study	• Sample (*N*=1793) included randomly selected adults drawn from the Australian Commonwealth Electoral Roll.
		• 49% of the participants were male (*n*=876) and 51% were female (*n*=908).
		• Comparison between sample and population indicated similar age and gender distribution but higher SES within sample.
			Quantitative	• Purpose of study to examine the impact of CSA on sexual functioning on a randomly selected sample of Australian adults.
				• Findings suggest that women were more likely to experience a wide-range of non-consensual sexual acts than men.
				    o Men more likely to report anal intercourse.
				• CSA significantly associated with sexual dysfunction symptoms.
				• CSA had greater impact on self-reported sexual functioning of women than men.
				• Gender differences in reaction to CSA experiences.
				    o Women reported fear, confusion, or embarrassment.
				    o Men reported indifference, slight anxiety, or positive pleasure.
				• No association found between CSA and physical or emotional pleasure related to adult sexual activity.
				• Women, but not men, with CSA histories, reported more sexual partners over their lifetime.

Newman et al., 2000	The relationship of childhood sexual abuse and depression	• Sample (*N*=602) included adult female members of a large	Quantitative (Parametric analysis).	• Purpose of study to examine the medical utilization of adult female victims of CSA. • Sexually abused participants reported more

	with somatic symptoms and medical utilization	California-based HMO. • The mean age of sample was 45 and the majority reported being employed (67.8%).		somatic symptoms than controls. o Headaches, sinus pain, muscle pain, migraines and GI symptoms. o More fever and productive cough than controls. • Abused participants reported more disability from illness than non-abused participants. • With regards to medical-utilization, it was found that participants significantly under-estimated the number of doctor visits they had made. o However, it was found that abused patients visited the doctor significantly more than non-abused in the past year. o Significantly more outpatient internal medicine and outpatient surgical visits for abused participants. o More self-reported lifetime surgeries among abused participants. • Additionally, abused participants who had higher BDI scores reported significantly more emergency room, in-patient internal, and inpatient ophthalmology visits. • However, depression did not moderate somatic

				symptom reporting or disability.
Nyklíc, Mommersteeg, Beugen, & Ramakers, 2013	Mindfulness-Based Stress Reduction and Physiological Activity During Acute Stress : A Randomized Controlled Trial	• Sample (*N*=88) included healthy individuals from the community reporting elevated stress levels. • 44 participants randomized to MBSR group. • 44 participants randomized to wait-list control group.	Quantitative (MANCOVA)	• Purpose of study was to examine the effects of a MBSR intervention on cardiovascular and cortisol activity during acute stress. • No significant differences in heart rate or salivary cortisol levels observed from pre to post test between groups. • Overall blood pressure levels showed larger decrease within MBSR group. o Blood pressure responses to stressor were observed to be smaller at post-test for MBSR group.
Rellini, Ing, & Meston, 2011	Implicit and explicit cognitive sexual processes in survivors of childhood sexual abuse.	• Sample (*N*=56) included women with a mean age of 28.5 years. • 34 women endorsed a history of CSA, while 22 had no CSA history. • The majority of women identified as Caucasian (65% and 55% of the CSA and non-CSA group respectively).	Quantitative (Quasi-experimental).	• Purpose of study to examine the implicit and explicit cognitive processing of sexual stimuli among female CSA survivors. • Implicit processes of sexual stimuli were found to be impaired among CSA group when compared with NSA group. o Possibly indicative of weaker activation of attention for sexual stimuli, leading to inhibited motivation and interest in sexual stimuli. • CSA group did not show a stronger disagreement between implicit and explicit attitudes towards sexuality.

Rellini, Hamilton, Delville, & Meston, 2009	The Cortisol Response During Physiological Sexual Arousal in Adult Women With a History of Childhood Sexual Abuse.	• Sample (*N*=44) included both women with and without CSA experiences.
		• Among the CSA group (*N*=24), the mean age was 31 with a majority identifying as Caucasian (79%).
		• Among the NSA group (*n*=20), the mean age was 28 with the similar demographic makeup (Caucasian = 65%).
			Quantitative (ANCOVA)	• Purpose of study to measure cortisol and physiological sexual arousal during exposure to sexual stimuli in women with and without a CSA history.
				• Findings suggest a complex relationship between cortisol and sexual stimuli that is mediated by PTSD symptoms in CSA survivors.
				• PTSD symptoms accounted for 9.6% of all variance in cortisol levels.
				• For CSA survivors, increased cortisol level was associated with greater perceived states of physiological sexual arousal.
				  o The inverse was found to be true for NSA group.
				• Further research needed to fully understand these findings.
				• When compared with NSA group, CSA participants displayed lower vaginal pulse amplitude response.
				  o When controlling for PTSD symptoms, the group differences disappeared.

Romans, Belaise, Martin, Morris, & Raffi, 2002	Childhood abuse and later medical disorders in women. An epidemiological study.	• Sampling was drawn from previous study and follow-up study investigating the relationship between CSA	Quantitative (Correlational Design).	• Purpose of study to examine the medical impact of CSA on adult female survivors. • Findings suggest that chronic fatigue was most clearly associated with abuse. • Additionally, bladder

		and development of adverse outcomes in adulthood. • The initial study had a sample of 477 participants (252 reporting CSA and 225 indicating no abuse). • The follow-up study included 354 of the original participants (173 reporting CSA and 181 controls). • In the most recent study, the mean age was 46.6 years with the majority married or cohabitating (70.1%).		problems, pelvic pain, headaches, asthma and cardiovascular problems, diabetes, and IBS were all found to be linked with both CSA and physical abuse.
Ross & O'Carroll, 2004	Cognitive behavioural psychotherapy intervention in childhood sexual abuse: Identifying new directions from the literature.	NA	Literature Review	• Purpose of review to assess various treatment modalities related to CSA-related PTSD conceptualizations. • Strong emphasis on therapeutic relationship identified across studies. o Therapist should be immune to shock and embarrassment o Adopt a non-judgmental attitude o Convey empathic understanding and provide support.

				• Some studies suggested that recalling the events of the abuse were critical, while others called for treatment based on the unique response pattern of survivor. • From review of outcome studies, it was observed that CBT had the greatest evidence base for effectiveness in CSA. o Gradual exposure described as cornerstone of treatment. • Screening for PTSD is crucial and facilitates both conceptualization and appropriation of treatment.
Sartor, Waldron, Duncan, Grant, McCutcheon, Nelson, Madden, et al., 2013	Childhood sexual abuse and early substance use in adolescent girls: The role of familial influences.	• Sample (*N*=3761) included female twins who were sampled from data collected from the Missouri Adolescent Female Twin Study. • The mean age of participants was 21.7 years. • The majority of participants identified as European American (85.4%) with the remainder identifying as African American	Quantitative (chi-Square Tests of Association).	• Purpose of study, to examine the extent to which the relationship between CSA and early use of alcohol, cigarettes, and cannabis are mediated by risk factors associated with familial dynamics. • CSA remained a significant predictor of early initiation of use after accounting for familial influences. • Across substances, it was found that decreased CSA associated risk with age was much more gradual for cigarettes and cannabis. • Estimated risk associated with CSA in youngest age range was more than twice as high for alcohol than for cigarettes or cannabis. • Significant overlap between contributions of CSA and familial influences on early use of cigarettes and

		(14.6%).		cannabis. • No change in CSA-associated risk for alcohol use when controlling for genetic or shared-environmental factors.
Saywitz, Mannarino, Berliner, & Cohen, 2000	Treatment for sexually abused children and adolescents	NA	Literature Review	• Authors review the extensive literature addressing the deleterious effects of CSA as well as the need and efficacy of various treatment modalities. • Authors conclude that no single form of treatment is sufficient to address the variable needs of survivors. o Treatments must be individualized on the basis of clinical presentation and the context of treatment environment. o Working with caretakers is essential. • For abuse-specific treatments, authors support the use of CBT-based of outcome studies. o Some form of exposure is also supported. • For asymptomatic children, provision of psychoeducation, screening, and prevention awareness may be sufficient. • For complex or multi-problem cases, long-term, multifaceted interventions are required.
Schoen, Davis, Collins,	The commonwealth fund	• Survey sample (*N*=6748) included both	Survey	• Findings suggested high rates of reported abuse, depressive symptoms, and

Greenberg, Des Roches, & Abrams, 1997	survey of the health of adolescent girls	girls and boys in grades 5-12. • Participants asked to complete a questionnaire on topics including abuse, violence, mental health, risky behaviors, access to healthcare, and communication with providers.		high risk behaviors. • Sexual or physical abuse reported by more than 1:5 high school females. • See study for full break down of findings.
Seifert, Polusny, & Murdoch, 2011	The Association Between Childhood Physical and Sexual Abuse and Functioning and Psychiatric Symptoms in a Sample of U.S. Army Soldiers.	• Sample (*N*=204) included soldiers stationed in a southern U.S. Army facility. • Participants included 108 active duty enlisted men and 96 enlisted women. • Mean age of participants = 24 years.	Quantitative (Cross-Sectional Survey using one-way ANOVA).	• Almost half of the sample reported a history of childhood physical abuse and about ¼ more indicated both physical and sexual abuse histories. • Prevalence of problem drinking appeared to be elevated among participants endorsing both physical and sexual abuse. • Soldiers with both physical and sexual abuse histories reported greater PTSD symptoms than those with no abuse history or physical abuse only.
Shapiro, 1996	Eye movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research.	NA	Literature Review	• Purpose of study to examine the outcome literature related to EMDR as a treatment for PTSD. • Initial research results of EMDR suggested highly positive outcomes for treatment of PTSD. o However, instruction of

				EMDR methodology was complicated. • A significant number of studies have been conducted on the efficacy of EMDR since its introduction. • Original controlled study found substantial treatment effects when compared to a placebo condition. o Efficacy measured by self-report on a SUDS scale as related to PTSD symptoms (nightmares, flashback, intrusions) o Four further controlled studies have replicated these results. • Additional studies have continued to find support for the efficacy of EMDR.
Sheffield, Williams, Blackford, & Heckers, 2013	Childhood sexual abuse increases risk of auditory hallucinations in psychotic disorders.	• Sample (*N*=195) included 114 psychotic disorder patients and 81 healthy controls. • The patient and control groups were similar with regards to gender, race, or parental education.	Quantitative (MANOVA, one-way ANOVA, ANCOVA)	• Purpose of study to assess the relationship between CSA experiences and auditory hallucinations in a comparison study of psychotic disorder and healthy control patients. • Psychotic disorder patients experienced higher rates of childhood trauma than healthy control group. o Trauma seen as a risk factor for severe psychiatric disorders. • Psychotic disorder patients who experience auditory hallucinations report significantly more severe

				childhood sexual, physical, and emotional abuse than patients with no auditory hallucinations. • In the absence of CSA, physical and emotional abuse showed no significant association with AH. o Suggests that CSA may be a greater risk factor for AH. • CSA only related to AH, not other psychotic symptoms.

Sheffield, Williams, Woodward, & Heckers, 2013	Reduced gray matter volume in psychotic disorder patients with a history of childhood sexual abuse.	• Sample (*N*=86) included 60 individuals with psychotic disorder and 26 healthy controls.	Quantitative (ANOVA, voxel-based analyses)	• Purpose of study, to examine the relationship between childhood abuse, psychosis, and brain development among psychotic disorder patients and a healthy control group.
				• Findings suggest a significant negative correlation between total grey matter and severity of CSA.
				  o Psychotic patients with a CSA history had significantly smaller grey matter than healthy controls and psychotic patients with no CSA history.
				• Psychotic disorder patients with CSA history exhibited more widespread patterns of grey matter reduction (frontal lobe, occipital lobe, and cerebellum).
				  o Compared to healthy controls, psychotic disorder

				patients with no CSA history showed reductions in grey matter only in the cerebellum. • Psychotic disorder patients with CSA history also had increased grey matter reduction in bilateral prefrontal cortex. o This area often reduced in individuals with trauma experience. • While reductions in grey matter are observed in many psychotic disorder patients, abuse experiences may present additional risk for reductions.
Sigurdardottir, Halldorsdottir, & Bender, 2012	Deep and almost unbearable suffering: Consequences of childhood sexual abuse for men's health and well-being.	• Sample (*N*=7) included Icelandic men who experienced CSA. • The men ranged in age from 30-55. • All participants sought professional help for their CSA experiences.	Qualitative (Phenomenological Approach)	• Purpose of study, to understand relationship between CSA and health and well-being among male survivors. • CSA had serious and prolonged consequences for the men's health and well-being mentally, physically, sexually, and emotionally. • The men suffered in silence and have come close to taking their lives. o What prevented suicide was revealing their experiences to others. o Social prejudice kept them silent. • Participants projected emotions outward: o Hyperactivity o Antisocial behavior • Men reported feelings of worthlessness and shattered

				self-image from youth.
				• Sense of disconnection
				  o From self, others, body, emotions.
				• Prolonged state of stress
				  o Depression
				  o Decreased immune system functioning
				• Misdiagnosis of ADHD.

Smith, Ortiz, Steffen, Tooley, Wiggins, Yeater, Montoya, et al., 2011	Mindfulness is associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems in urban firefighters.	• Sample (*N*=124) included firefighters in a metropolitan area of Albuquerque, NM. • Sample was 93% male with 50% identifying as Hispanic.	Quantitative (Hierarchical multiple regression).	• Purpose of study to examine the association between trait mindfulness, other resilience resources with measures of health in a population of urban firefighters. • Trait mindfulness was observed to be negatively correlated with PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for additional resilience factors.

Teasdale, & Chaskalso n, 2011	How does mindfulness transform suffering? II: The transformati on of dukkha	NA	Literature Review	• Authors discuss the mechanisms of change inherent within mindfulness practice.
				• Transformation of suffering through:
				  o Changes in *what* the mind is processing
				  o Changing *how* the mind is processing it
				  o Changing the *view* of what is being processed.

van Gerko, Hughes, Hamill, & Waller, 2005	Reported childhood sexual abuse and eating-disordered cognitions and	• Sample (*N*=299) included female patients recruited from a specialist eating disorder	Quantitative (Cross sectional design using regression analysis, MANCOVA)	• Purpose of study to examine the relationship between CSA experiences and eating pathology. • Findings suggest that reported CSA associated with specific elements of

	behaviors.	clinic. • All met DSM-IV criteria for eating disorders. • Participants were of similar age and BMI with the exception of those meeting for ED NOS – binge eating, who were older and heavier.		eating pathology. o Participants with such trauma used a range of eating behaviors more frequently (binge-eating and three methods of purging). • However, trauma survivors reported only aspect of eating attitude (body image disturbance). • While no causal link can be interpreted, the argument that CSA may steer eating pathology in the direction of bulimic behaviors and body image disturbance can be made.
Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2013	Mindfulness in the treatment of posttraumatic stress disorder among military veterans.	NA	Literature Review	• Authors address how mindfulness practice may be used towards treatment of military veterans. • Review current treatments for PTSD. • Introduce and discuss how mindfulness may be helpful for those suffering from PTSD. o Present centered awareness and non-judgmental acceptance of distressing internal states and trauma-related triggers. o Increased tolerance of distressing experiences. o Increased awareness may facilitate further treatment. o Decreased physiological arousal and stress

				reactivity. o Mindful distraction exercises.
Wachs & Cordova, 2007	Mindful relating: Exploring mindfulness and emotion repertoires in intimate relationships	• Sample (*N*=66) included 33 married couples. • The mean age was 40 for husbands and 38 for wives. • The duration of marriage averaged 12 years. • Thirty two couples had children with the modal number of children being one. • The majority of participants identified as White with only three identifying as non-White.	Quantitative	• Purpose of study to assess the relationship between conscious attending to the present moment, enactment of emotions, and relationship quality. • Findings suggested a significant correlation between mindfulness and global marital adjustment. • With regard to emotional repertoire, mindful participants were found to be superior at identifying their own emotions, as well as communicating their emotions to others. • Mindfulness also found to be associated with increased empathy as well as anger out and control of anger out subscales of measures. • Couples who are mindful may enjoy increased relationship stability and health. o This may lead to increased satisfaction and inter-partner harmony.
Wager, 2012	Psychogenic amnesia for childhood sexual abuse and risk for sexual revictimisation in both adolescence and adulthood	• Sample (*N*=210) included community respondents to a web-based trauma survey. • The majority of participants were female (74.3%) and	Quantitative (Regression Analysis).	• Purpose of study to examine the risk conferred through psychogenic amnesia for memories of CSA on later likelihood of revictimizaiton. • Support was found for the hypothesis that victims of CSA who experience psychogenic amnesia are at increased risk of sexual

		European/White (86%) • The mean age was 33.4 years.		victimization than counterparts who retain memories of CSA. • In current findings, those with a CSA history displayed 2.4 times risk of revictimization in adulthood and 4.4 times greater risk of revictimization in adolescence. • No significant findings when gender comparisons were analyzed. o However, women with CSA history reported 3 times the rate of amnesia for abuse related memories than male counterparts. o Women with CSA history displayed just over twice the likelihood of revictimization in adolescence and adulthood when compared to similar men.
Wells, Glickauf-Hughes, & Beaudoin, 1995	An ego/object relations approach to treating childhood sexual abuse survivors	NA	Literature Review	• Authors discuss intrapsychic considerations in treatment of CSA survivors. • Authors discuss controversy around resolution therapy that attempt to achieve catharsis through recollection of abuse experiences. o Authors call for careful assessment of ego structure/functioning of client o With neurotic

				patients, sufficient ego strength may suggest a focus on recollection. o However, authors suggest therapeutic caution when approaching treatment in this way. o For clients with borderline ego/object relations development, the use of cathartic approaches can be overwhelming or retraumatizing. • Authors warn against the use of hypnosis as a means of recovering trauma memories. o They suggest that this may be used to bolster ego strength, pain control, or containment functions. • Authors suggest that the sequence of treatment include: o Initial stabilization o Remembering and reexperiencing trauma o Integration and resolution of memories o Development of new coping skills and reconnection.
Williams, Crane, Barnhofer, Brennan, Duggan,	Mindfulness-based cognitive therapy for preventing	• Sample (*N*=227) included individuals between 18-70	Quantitative (Cox proportional hazard regression	• Purpose of study to compare MBCT with both CPE and TAU towards prevention of relapse related to MDD.

Fennell, Hackmann, et al., 2014	relapse in recurrent depression: A randomized dismantling trial	years with a history of at least three depressive episodes. • Participants required to be in recovery or remission. • Participants were randomized to MBCT, CPE, and TAU groups in a 2:2:1 ratio.	models)	• This study revealed no significant general risk reduction in those randomized to MBCT as compared to CPE or TAU. • However, for those with more history of childhood trauma histories, MBCT did make a difference when compared against TAU group. • In a more powerful model, the severity of childhood abuse significantly moderated contrasts between MBCT and CPE, as well as MBCT and TAU. o Suggests that MBCT is more effective at preventing relapse to MDD when severity of childhood abuse accounted for.

Wilson, 2009	Health Consequences of Childhood Sexual Abuse.	NA	Literature Review	• Author provides an overview of research addressing health consequences resultant from Child Sexual Abuse.
				• She identifies psychiatric, physiological, social, and disease disorders affecting this population.
				• Additionally, she discusses the long-term health consequences observed in adult CSA survivors.
				  o Depression
				  o Obesity
				  o Auto-immune disorders
				  o Somatic concerns
				  o Eating Disorders
				  o Addictions

				• Author further discusses clinical implications, particularly for practicing nurses.

Wilson, Vidal, Wilson, & Salyer, 2012	Overcoming sequelae of childhood sexual abuse with stress management.	• Sample (*N*=32) included female adult survivors of CSA.
		• The mean age of sample was 39 years.
		• The majority of participants identified as Caucasian (*n*=27)
			Quantitative (Quasi-experimental Design with paired sample t-tests.)	• Purpose of study to examine efficacy of stress management education program towards improvement of coping among adult CSA survivors.
				• As measured by the ways of coping questionnaire, following a 4-week stress management training course, improvements in coping were observed.
				   o Increased seeking of social support behaviors
				   o Reduced escape avoidance behaviors
				   o Increased planful problem solving behaviors
				   o Increased positive reappraisal behaviors.

Zwickl & Merriman, 2011	The association between childhood sexual abuse and adult female sexual difficulties.	NA	Critical review of the literature	• Authors discuss the extensive literature addressing the deleterious effects of CSA with a particular focus on the association between CSA and adult female sexual dysfunction • Additionally, the multidimensional nature of the female sexual response is reviewed. • Authors discuss theoretical models associating CSA and sexual functioning and propose a new model of such association (See pg. 23 for model diagram).

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APPENDIX B

Initial Screening

Initial Screening Questions

1. I'd like to begin just by hearing about how you define mindfulness?
2. How long have you been utilizing mindfulness within your practice?
3. Do you practice mindfulness within your own life?
4. Have you been trained in any mindfulness-based treatments?
5. How long have you been practicing as a clinician?
6. What are your experiences treating survivors of trauma, specifically CSA?
7. How do you incorporate mindfulness into your practice with such survivors?

APPENDIX C

Interview Questions

Target Questions

1. How does mindfulness inform your work with adult survivors of CSA?
2. How do you understand mindfulness being helpful within the general context of psychological treatment?
    a. Please tell me how you understand mindfulness producing change within clients?
3. Do you feel that mindfulness is suited for work with survivors of CSA?
    a. How so?
4. Please tell me how you introduce the concept of mindfulness to your clients?
5. Do you experience any resistance when introducing/employing these interventions?
    a. How is this managed within the clinical setting?
6. Please tell me about the interventions you use with survivors of CSA and how those are chosen?
7. How do survivors react to mindfulness interventions?
    a. Does this change over time?
8. Will you speak about the progress you notice throughout treatment related to mindfulness use?
    a. How can this be observed?
    b. How can you know this is related to mindfulness practice?
9. Do you experience any challenges that you notice are specific to survivors of CSA?
    a. Is there any difficulty around body-related awareness with CSA survivors?
        i. If so, how do you work with this?
10. Are there any contraindications to using mindfulness with this population?
11. Please discuss how you believe your personal mindfulness practice impacts your work with clients.
12. Please discuss a case in which mindfulness proved helpful?

APPENDIX D

Email Recruitment Flyer

Experiences of Clinicians Using Mindfulness-Based Therapies with Adult Survivors of Sexual Abuse: A Qualitative Analysis

Volunteers are needed for a dissertation research project focused on the experiences of clinicians using mindfulness interventions with adult survivors of Childhood Sexual Abuse

Who is conducting the Project?

My name is Nathan Edwards and I am a doctoral student of clinical Psychology at Pepperdine University, Graduate School of Education and Psychology. I am currently working on my dissertation, which is supervised by Thema Bryant-Davis, Ph.D.

What is the Project?

The literature addressing the intersection of mindfulness and adult survivors of child sexual abuse has been largely scarce. Furthermore, a true understanding of the first-hand benefits and mechanisms of change inherent within mindfulness practice is similarly absent. The intent of this project is to fill these gaps by capturing such experiences from clinicians proficient in utilization of mindfulness interventions with this population.

Who Can Participate?

To participate in the study you must be/have:

- Licensed mental health professional currently engaging in individual therapy;
- Minimum of 3 years post-graduation;
- Working knowledge of the concepts of mindfulness;
- Must incorporate mindfulness practice in both professional and personal life;
- Experience longer than one year incorporating mindfulness into professional work;
- Experience conducting mindfulness-informed therapy with adult trauma survivors for whom issues related to CSA have been a focus of treatment;
- Minimum experience with at least one client that fits such criteria;
- Willingness to be audio recorded.

What is Involved?

If you decide to participate in this study, it will involve completing an audio recorded interview. The interview will ask a series of questions about your experiences using mindfulness interventions with clients from this population. The interview may take as long as 45-60 minutes and can be completed via Skype or in-person at a location convenient to you. You will receive a $10 Starbucks gift card for your participation.

What if I Have Questions?

If you are interested in finding out more about the project or simply have questions, please feel free to contact me. My contact information is provided below:

Nathan Edwards, M.A.
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive
Los Angeles, CA, 90045
Nathan.edwards@pepperdine.edu

You may also contact Dr. Bryant-Davis who supervises my research project. Her information is provided below:

Thema Bryant-Davis, Ph.D.
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive
Los Angeles, CA, 90045
tbryant@Pepperdine.edu

If you are interested in participating in the research project, you may contact me in the following ways:

- You can call me toll free at the following number (xxx)xxx-xxxx
- You can email me at Nathan.edwards@pepperdine.edu

APPENDIX E

Informed Consent Form

Experiences of Clinicians Using Mindfulness-Based Therapies with Survivors of Sexual Abuse: A Qualitative Analysis

Purpose of the Study and Invitation

You have been invited to participate in this research study because you have demonstrated an understanding of the concepts and practice of mindfulness and have integrated such techniques into your clinical work. In addition, your clinical practice has granted you the opportunity to work with survivors of childhood sexual abuse and who may have benefitted from the incorporation of such mindfulness interventions. The purpose of this research study is to better understand the experience of using mindfulness with survivors of childhood sexual abuse. This includes gaining a deeper understanding of the process of change through mindfulness, how growth is observed in the client, symptom interaction with mindfulness interventions, and overall efficacy. While mindfulness has certainly gained popularity within the field of psychology, very little research has examined its efficacy with this particular population. This study will attempt to add to the body of literature in this area by providing a voice to the clinicians who utilize this important practice. The information provided in this consent form will help you decide whether to participate. If you have any questions or concerns at any time, please do not hesitate to voice them.

What does this Study Involve?

This study simply involves one interview lasting approximately 45-60 minutes. The interviews will be conducted in person at the convenience of each participant. Each interview will be digitally recorded and transcribed verbatim for data analysis. The digital recordings will not be shared with others and will be kept well-secured on an encrypted flash drive to be maintained by the principal investigator. The recordings will be used only for the purposes of this research study and will be deleted upon its completion. Similarly, the transcriptions will contain no identifying information and will be additionally maintained electronically on the encrypted flash drive. Further follow-up interviews may be required in order to provide clarification or gather additional information. Such follow-up interviews should not exceed 30 minutes and would be conducted at the convenience of the participant. In order to maintain confidentiality, participant names will not be included in the study. As such, participants will be assigned a random number that will correspond to their name and interview. This information will be stored on a master list, to be used to identify participants if a follow-up is required. This list will be stored separately from any identifying data and will be password protected in order to ensure confidentiality. The list will be destroyed after all data-collection, including follow-up interviews, is completed.

What are my Rights?

Participation in this study is entirely voluntary. Each individual may refuse to participate or discontinue participation at any time during the study without negative consequence. In addition, each participant may refuse to provide an answer to any question during the interview.

How will Confidentiality be Protected?
Any information obtained during this study that could identify you will be kept strictly confidential. Additionally, it is asked that client names, affiliated institutions, clinics or further potentially identifying information be omitted or amended in order to protect the privacy of such individuals. The only person who will have access to your research records are the study personnel, the office of the Institutional Review Board (IRB), and any other person or agency when required by law. The information from this study may be published in scientific journals or presented at scientific meetings but no identifying information will be revealed at any time. In addition, the audio recordings will be stored on an encrypted flash drive and will be locked in a secure cabinet by the investigator. These recordings, along will all other data, will be deleted upon completion of the study. Similarly, verbatim transcriptions will be de-identified and stored on the same encrypted flash drive.

What are the Potential Risks?
Participation in the study poses no more than minimal risk. However, it is possible that for some, reflecting on clinical cases involving childhood sexual trauma may bring up feelings sadness and may be uncomfortable. It is also possible that you may experience some boredom and fatigue but are free to take breaks if and when needed. If you would like to discuss your reflections, you may speak with the study chairperson, Dr.Thema Bryant-Davis, or the investigator can provide referrals for counselors/therapists in the area.

What are the Potential Benefits?
While the study may not provide direct benefits to all participants, it is hopeful that the data collected will contribute to the field of psychology and the body of literature regarding the use of mindfulness as an intervention for survivors of childhood sexual abuse. As a result, clients may indirectly benefit from the increased knowledge base and the data surrounding the efficacy of mindfulness as a useful intervention tool.

What Compensation will be Received?
All participants will be compensated with a $10 gift card from Starbucks. Discontinuation of the study will not affect eligibility for this compensation provided the informed consent has been signed and the participant has begun the interview process.

Documentation of Informed Consent
You are voluntarily making a decision whether to participate in this research. Your signature indicates that you have read and understood the information presented above and agree to participate. Your signature further indicates that all of the information on this consent form has been explained to your satisfaction and that you understand that you will receive a copy of the signed form if desired. Informed consent documents will be scanned and stored electronically for maintenance purposes. All hard copies held by the principal investigator will be immediately destroyed following electronic conversion and the electronic copies will be password protected to ensure confidentiality. If you have any additional questions or concerns during the study, please feel free to contact your interviewer, Nathan Edwards at nathan.edwards@pepperdine.edu. Additionally, you may contact the chairperson for this study

at (818) 501-1632 or tbryant@Pepperdine.edu. If you have any questions or concerns about your rights as a research participant you may contact Thema Bryant-Davis, PhD, Chairperson of the Graduate and Professional School's Institutional Review Board, Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA, 90045, (818) 501-1632.

____
Name of Participant (please print)

_______________________________ _______________
Participant's Signature Date

I have explained and defined in detail the research procedures in which the participant has consented to participate. Having explained this and answered questions, I am co-signing this form and accepting this person's consent.

_______________________________ _______________
Investigator's Signature Date

APPENDIX F

IRB Approval Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

April 3, 2015

Nathan Edwards

Protocol #: P0215D08
Project Title: Experiences of Clinicians Using Mindfulness-Based Therapies with Adults Survivors or Childhood Sexual Abuse: A Qualitative Analysis

Dear Mr. Edwards:

Thank you for submitting your application, *Experiences of Clinicians Using Mindfulness-Based Therapies with Adults Survivors or Childhood Sexual Abuse: A Qualitative Analysis,* for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Bryant-Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

In addition, your application to waive documentation of informed consent has been **approved**.

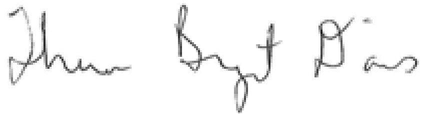
Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected

situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual*
(see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the Institutional Review Board (IRB) at gpsirb@peppderdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,



Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Thema Bryant-Davis, Faculty Advisor