Women's Experiences of Self-Compassion in Coping with Sexual Problems Following a Sexual Assault

by

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Abstract

The majority of sexual assault incidents in Canada are committed against women and girls. Among the many injurious sequelae survivors can experience post-sexual assault are sexual problems. Sexual concerns related to desire, arousal, pain, orgasm and/or sexual well-being can last for years after the assault. Given the strong association between sexual well-being and both mental and physical health, it is crucial to understand how women effectively cope with sexual concerns stemming from sexual assault. Although self-compassion has been studied as a positive way of coping with other forms of trauma, no study to date has examined self-compassion's role in addressing the needs of female sexual assault survivors, specific to sexual issues. Thus, this study explored women's experiences of self-compassion in coping with sexual problems following a sexual assault. Interpretative phenomenological analysis (IPA) was used to explore in detail how female survivors made sense of their world and the meanings these experiences held for them. Data were collected from 10 women across Canada in the form of semi-structured interviews held either in person or over the phone. Data analysis revealed eight themes: (a) honouring time, (b) quieting the inner critic, (c) connecting with social supports, (d) countering societal messages, (e) asserting personal boundaries and taking control, (f) engaging in regular self-care, (g) rebuilding a relationship with one's body, and (h) persevering through emotional challenges. Clinical implications, limitations, and direction for future research are also discussed.

Keywords: self-compassion, sexual problems, sexual well-being, sexual assault, female survivors

Preface

This dissertation is an original work by Debra Joan Campbell. The research project, of which this dissertation is apart, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "Women's Experiences of Self-Compassion in Coping With Sexual Problems Following a Sexual Assault", No. 00094717, 2019.

Dedication

To the resilient women outlined in this study who shared with me their self-compassionate experiences as it pertained to their sexual problems post-sexual assault – thank you. Your heroic stories had an unexpected transformative effect on me. It is because of my own personal growth that was achieved vicariously through your lived experiences that I can say with certainty that sharing your wisdom with survivors of sexual violence will have a positive impact on their healing. I am forever grateful to have been a part of your healing experiences.

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Chapter 1: Introduction

Each year, sexual violence against women and girls constitutes one of the most significant rights violations in Canada (Benoit et al., 2015). The World Health Organization (WHO, 2013) estimates that, at some point in their lives, 1 in 3 women and girls around the world will experience sexual violence [defined by Fedina al., (2018) as any non-consensual sexual act, and referred to in this study as *sexual assault*; please see Appendix A, Glossary of Terms and Definitions, for additional definitions]. Although females are not the exclusive victims of such crimes, in Canada, 87% of all sexual assault incidents in 2014 were committed against women and girls (Conroy & Cotter, 2017). Women who are young, single, Aboriginal, and LGBTQ2S+ are at an increased risk of sexual assault (Conroy & Cotter, 2017; Cybulska, 2007; Dylan et al., 2008; Logie et al., 2014). Also, women are more prone to experience sexual assault if they have mental health issues, if they have encountered adverse life events, such as homelessness or childhood sexual assault, or if they engage in night-time activities (e.g., going to night class, work, bars, or clubs; Conroy & Cotter, 2017; Cybulska, 2007; Daigneault et al., 2009).

The impact of sexual assault can be profound, creating many deleterious psychological consequences. Depression, suicidality, mental pollution (feeling dirty), shame, anxiety, and post-traumatic stress disorder are just a few of the negative outcomes that female survivors of sexual assault may experience (Guerette & Caron, 2007; McFarlane et al., 2005; Olatunji et al., 2008). In addition to these negative outcomes, the literature states that childhood sexual abuse (CSA) and adulthood sexual assault (ASA) can interfere with sexual well-being in adulthood (Crump & Byers, 2017; Kelley & Gidycz, 2017; Leonard et al., 2008; van Berlo & Ensink, 2000). This is significant, given the strong association between sexual health – which is inextricably linked

with sexual well-being – and mental and physical well-being (please see Appendix A, Glossary of Terms and Definitions, for the distinction between sexual health and sexual well-being; Edwards & Coleman, 2004; Khajehei et al., 2015; McCabe, 2009; Sims & Meana, 2010; Sutherland, 2012; WHO, 2006).

Female sexual problems can be defined as "discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience" (Tiefer, 2002, p. 200). Sexual problems can be caused by a range of factors, including psychological, relational, sociocultural, and/or medical issues (Tiefer, 2002). Such problems for women tend to be quite common (Aslan & Fynes, 2008). Among the most frequent concerns reported are problems with sexual desire, arousal, pain, orgasm, and sexual well-being (Crump & Byers, 2017; McCabe, 2009; Sims & Meana, 2010; Sutherland, 2012; Tiefer, 2002). Current psychological interventions to help with sexual problems include cognitive behavior therapy (CBT) to help with negative self-appraisals and cognitive distortions (Peixoto & Nobre, 2015, 2016). Mindfulness-based practices assist women in staying present during sexual activity, as well as increase awareness of bodily sensations – a problem often associated with sexual desire issues (Brotto 2017; Brotto et al., 2012). Additionally, relearning touch techniques – or for many women, learning touch techniques for the first time – can help women become comfortable with and enjoying touch, while communicating to their partners their thoughts and feelings throughout the process (Brotto, 2017; Maltz, 2012; Masters & Johnson, 1966).

In addition to the above-mentioned psychological treatments are practices that individuals may implement in their everyday lives, in nonclinical contexts. Self-compassion is one such practice that may hold promise for female sexual assault survivors who are struggling with sexual concerns. Self-compassion is defined as "being kind and understanding toward oneself in

instances of pain or failure rather than being harshly self-critical; perceiving one's experiences as part of the larger human experience rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them" (Neff, 2003a, p. 223). Research is revealing the many psychological benefits of self-compassion. For example, studies have explored how self-compassion is negatively correlated with self-criticism, shame, self-blame, and issues with body image (Braun et al., 2016; Kelly & Tasca, 2016; Wang et al., 2020). Self-compassion has also been shown to consistently advance psychological well-being (Neff, 2003a) and facilitate resilience (Leary et al., 2007). An increase in well-being has also been observed in interpersonal relationships. For instance, self-compassionate individuals show more kindness and caring towards their partners, and are more satisfied in their relationships (Neff & Beretvas, 2013). With regard to trauma, self-compassionate people participate less in avoidance coping mechanism, feel less threatened by triggering situations, and are more confident in exploring, rather than avoiding, painful memories (Thompson &Waltz, 2008). Additionally, Scoglio et al. (2018) found that self-compassionate women who had experienced interpersonal trauma, such as physical or sexual violence, had less posttraumatic stress disorder symptoms and emotion dysregulation, and were more resilient.

Only two studies to date have investigated self-compassion and sexual problems. (Ferreira et al., 2020; Santerre-Baillargeon et al. 2018). In Santerre-Baillargeon et al.'s (2018) study, data were collected from 48 women with vulvodynia (pain around the opening of the vulva; Santerre-Baillargeon et al., 2018), along with their partners. Measures included a structured interview, as well as self-report questionnaires pertaining to depression and anxiety, relationship satisfaction, sexual distress, and pain during sexual intercourse. Results of the study revealed that higher levels of self-compassion in both women and their partners were associated

with decreased anxiety, depression, and sexual distress, and increased relationship satisfaction. However, there was no change in the intensity of sexual pain during sexual intercourse.

Ferreira et al.'s, (2020) study examined whether an individual's self-compassion decreased stress in relation to their sexual issues on both their own and their partner's sexual satisfaction. Their sample consisted of 125 mixed-sex married couples who completed measures pertaining to self-compassion at baseline, as well as sexual distress and quality of sex (Ferreira et al., 2020; Raes et al., 2011; Shaw & Rogge, 2016) over a 21-day period. Results revealed that self-compassion improved sexual satisfaction in heterosexual couples, especially for men experiencing distress related to sexual problems. However, husbands who were high in self-compassion and experiencing sexual problems were found to be less motived to improve their sexual issues, resulting in their wives feeling sexually dissatisfied.

Although it is encouraging that interest is being shown with regard to self-compassion and sexual problems, research continues to be sparse. With the exception of these two studies, to my knowledge, no other study has explored self-compassion and sexual concerns, and none have studied self-compassion in the context of female survivors of sexual assault. Given the potential benefits of self-compassion, combined with the suffering associated with sexual concerns resulting from sexual assault, there is a vital need for more research in this area.

Statement of Purpose

The purpose of my study was to explore women's lived experiences of self-compassion in coping with sexual problems following sexual assault. I was interested in learning from female survivors how they understood and experienced self-compassion. Additionally, my aim was to gain insight into how these experiences of self-compassion helped survivors cope effectively with sexual concerns. Building knowledge and understanding around women's experiences of

self-compassion in relation to sexual problems following sexual assault is crucial for a number of reasons. Perhaps the primary reason is that this topic has not been studied before within the realm of counselling psychology, despite the significant relationship between sexual health and both mental and physical well-being (Edwards & Coleman, 2004; Khajehei et al., 2015; McCabe, 2009; Sims & Meana, 2010; Sutherland, 2012; WHO, 2006). Survivors of sexual assault often experience a host of negative psychological, physical, and relational consequences (Carey et al., 2018; Stein et al., 2004; van Berlo and Ensink 2000). Since research on self-compassion has shown promising effects on increasing well-being and resilience (Leary et al., 2007; Neff, 2003a), exploring this construct in the context of sexual well-being after a sexual assault is pivotal.

My exploration of women's experiences of self-compassion in relation to sexual problems after a sexual assault also helps address the dearth of research and training in sex-related topics within counselling psychology graduate schools (Miller & Byers, 2010). As a result of this critical oversight, many counselling psychologists may feel underprepared working with a client's sexual concerns. Therefore, the study's findings may serve as a basis for resources in this underdeveloped area of research. It also provides knowledge and understanding that may help inform counselling approaches for helping survivors overcome sexual concerns. Furthermore, the study's results contribute to emerging literature regarding the usefulness of self-compassion in addressing trauma among women. In conducting this research, I also aimed to help empower and give voice to women who have experienced the disempowering effects of sexual assault.

Research Questions

The current study addressed the central research question: What are women's experiences of self-compassion in coping with sexual problems after a sexual assault? I also explored the following sub-questions:

- How do female survivors experience and practice self-compassion in response to sexual problems related to sexual assault?
- What facilitates the experience and practice of self-compassion in coping with sexual concerns for female survivors of sexual assault?
- What barriers interfere with the practicing of self-compassion for women who are experiencing sexual problems after a sexual assault?
- How has practicing self-compassion in coping with sexual concerns after a sexual assault influenced other aspects of women's lives?

My study relied upon interpretative phenomenological analysis (IPA) to explore women's experiences of self-compassion in coping with sexual concerns after a sexual assault. IPA was an appropriate methodology for this study for a number of reasons. To begin with, IPA is appropriate for exploring in depth how people interpret and describe phenomenon, and the meanings that these experiences hold for them (Smith et al., 2009). This is important when exploring women's experiences of self-compassion. IPA is also suitable when the topic explored is under-researched or new, as in the present study (Smith & Osborn, 2004). Furthermore, IPA has often been used for topics that are "complex or ambiguous" (Smith & Osborn, 2004, p. 231), such as the main constructs in this study (self-compassion, sexual problems, and sexual assault). Additionally, learning about and sharing an individual's life experience, and the meaning

assigned to these experiences, can be empowering for individuals, especially if their voices were silenced by a sexual assault.

The Researcher

In conducting this study, I bring a number of perspectives, assumptions, and experiences based on my work, research, and volunteer experience. Ever since I can remember, I have wanted to become an agent of change for sexual assault. It was early in my career as a massage therapist that I recognized the mind/body connection, and that alongside my client's physical pain was oftentimes mental and emotional turmoil. Applying my strong belief in treating the mind and body as one entity, and my passion for helping sexual assault survivors, I wondered if massage could help victims of sexual abuse in their recovery. Given that the body is the site of the traumatic experience, and that post-traumatic sequelae are often somaticized, it seemed obvious to include the body in the healing process. I was fortunate to explore this hypothesis in my Master's thesis, "The Effect of Trauma-Informed Massage Therapy on the Long-Term Negative Consequences of Childhood Sexual Assault in Males" and found that, trauma-informed massage had a positive impact on male participants with histories of childhood sexual abuse.

After successfully defending my Master's thesis, I wanted to continue working with sexual assault survivors. I began working at a sexual assault centre in Nova Scotia, where I counselled women who had experienced sexualized violence. Sexual problems were amongst the many concerns women presented with at the clinic. Some of my counselling strategies included acceptance-based approaches, such as compassion-focused therapy (Gilbert, 2009), to help change the ways in which individuals relate to themselves through processes that generate warmth, understanding, non-judgment, and kindness toward themselves. Witnessing first-hand the suffering women experience from sexual assault, including sexual problems, deepened my

need to explore approaches such as self-compassion that may assist survivors in the recovery process. This led me to my current interest in exploring women's experiences of self-compassion in coping with sexual problems after a sexual assault. With the results of my study, I hope to develop knowledge and understanding of how self-compassion may help women survivors cope with sexual concerns.

Entwined amongst my work and academic experiences with sexual assault is my feminist worldview. To me, feminism means liberating those that have been disempowered living in what I believe to be a patriarchal culture – a culture where women are not entitled to the same power and privileges granted to men. It also means bringing attention to gender inequality and oppression, and giving a voice to those who have been silenced by violence, such as sexual assault. This strong desire to help individuals become more empowered is visible not only in my work and academic endeavours, but also in my volunteer experience. Prior to starting my PhD in September 2016, I volunteered as a Board Member at two sexual assault centres in Nova Scotia, where we worked collaboratively toward eliminating sexual assault, as well as advocating for social justice on issues of sexism, gender inequality, and other forms of oppression. Volunteering as a board member opened my eyes as to how global sexual assault is and how challenging, yet crucial, it can be to implement fundamental strategies for change. In line with my feminist lens, I hope my research exploring women's experiences of self-compassion can make a difference in the lives of women experiencing sexual problems following a sexual assault.

Based on my experiences noted above, I made the following additional assumptions. Firstly, I expected that women with sexual assault histories would find that self-compassion helped them to cope with sexual problems. This assumption is guided by research indicating that self-compassion assists in psychological well-being (Gilbert & Procter, 2006; Neff et al., 2007);

interpersonal relationships (Neff & Beretvas, 2013); trauma (Scoglio et al., 2018); and sexual pain (Ferreira et al., 2020; Santerre-Baillargeon et al., 2018). Secondly, women in the current study would feel empowered by having been given the opportunity to voice how their experiences of self-compassion helped them cope with sexual concerns after a sexual assault. Also, women would feel empowered knowing that their experiences of self-compassion may help other women in similar circumstances. This assumption is based on literature supporting cultural movements fighting violence against women, such as "Breaking the Silence". For instance, in Fox's et al.'s (2007) qualitative study exploring intimate partner violence and HIV in South Africa, female participants found that "breaking the silence" against intimate partner violence was not only important to help them cope, but it was also empowering to talk to others about their abuse. Furthermore, participants viewed "breaking the silence" as a prevention strategy against intimate partner violence. Meaning, the women in the study believed that by bringing attention to intimate partner violence by talking about the matter would help change cultural norms that condone abuse.

Relevance of This Study to Counselling Psychology

I believe that women's experiences of self-compassion in coping with sexual problems after a sexual assault fits well within the domain of counselling psychology. Counselling psychology is known for its strength-based approaches to working with clients (Bedi et al., 2011). Among the key strengths that counselling psychologists help promote in clients are resiliency, which stems in part from attributes women themselves bring to counselling, and empowerment, which counsellors seek to foster in their clients. Both of these factors have been explored extensively within the existing literature (Anderson, 2010; McWhirter, 1994; McWhirter, 1998; Orbke & Smith, 2013), offering key reference points for my study. I argue,

however, that within the literature focusing on trauma, sexual health – including sexual well-being – has been neglected as a distinct domain of study. This is also true regarding sex education within counselling psychology programs (Miller & Byers, 2010). Hence, clinicians may feel incompetent working with clients who present with sexual concerns. Through the dissemination of findings from this study, I hope to educate counsellors and contribute to resources regarding this underdeveloped area within the discipline of counselling psychology.

Empowerment and resiliency. Within the context of counselling, *empowerment* is defined as:

> the process by which people, organizations, or groups who are powerless or marginalized: (a) become aware of the power dynamics at work in their life context, (b) develop the skills and capacity for gaining some reasonable control over their lives, (c) which they exercise, (d) without infringing upon the rights of others, and (e) which coincides with supporting the empowerment of others in their community (McWhirter, 1994, p. 12).

Based on this definition, counselling psychologists can facilitate the process of empowerment in their clients in a number of ways. I have chosen sections (a), (b), and (e) of the definition to elaborate upon, as I feel they highlight key focal points within the study.

Section (a) states that counsellors help bring to clients' attention how they may have been affected by power differentials and systemic effects, including sexism and heterosexism, in various domains of their life (McWhirter, 1994; 1998). As outlined in this study, by applying a feminist lens, counsellors can educate women how their voices are often suppressed concerning sexual assault in a male privileged, patriarchal culture. In regards to section (b), counselling psychologists can also help clients develop coping skills and foster resilience (McWhirter, 1994). This entails helping clients acquire new skills, offering encouragement, and building clients'

confidence to carry-out their new skillset (McWhirter, 1998). Teaching clients coping skills is a large part of what counselling psychologists do (McWhirter, 1998). However, before offering new ways of managing life's difficulties, counsellors often begin by asking the client what coping skills they bring into the counselling relationship, or what has helped them survive in the past. In other words, the counsellor focuses on the client's strengths. Indeed, Lambert (1992) claims that the characteristics clients bring with them into the counselling sessions, such as their strengths, abilities, and willingness to change (also known as extra-therapeutic change factors) account for 40% of client change in the psychotherapy.

In addition to bringing social injustices to the client's attention and developing coping skills, section (e) refers to counselling psychologists empowering clients by providing help and support in the client's endeavors to connect interpersonally and with their community. Counsellors can also encourage the client's empowerment of others (McWhirter, 1994, 1998). This may involve the client planning community events to raise awareness about issues, such as sexual assault.

These three examples of how counselling psychologists can facilitate empowerment of their clients coincides with one of the primary goals of this study, which is to help empower participants and other survivors. Giving participants the opportunity, and thus a voice, to tell their experiences of self-compassion in coping with sexual problems post-sexual assault may help empower the participants, as well as other women with similar experiences.

Whereas empowerment is a powerful outcome achieved within counselling psychology's therapeutic alliance, *resilience* represents one of many strengths that clients bring forward into counselling and that is further strengthened in the course of therapy. Resilience is also in alignment with the positive aspects of the main construct (self-compassion) that was explored in

the current research study and has consistently been shown to help overcome adversities (Scoglio et al., 2018; Thompson & Waltz, 2008). In the context of trauma, the phenomenon of resilience includes two key elements: (a) an individual was exposed to a traumatic or adverse event; and (b) the individual successfully adapts afterwards (MacDermid et al., 2008). One of the main findings of what makes an individual resilient is having a positive support system, both within and outside of their family (Masten, 2001; Orbke & Smith, 2013). The therapeutic alliance formed between the counsellor and the client may represent such an external support system (Orbke & Smith, 2013). In fostering the resilience of clients who have experienced trauma, such as sexual assault, it is crucial for clinicians to emphasize the client's strengths, recognize opportunities for growth, and validate the client's experiences and coping skills. Shifting away from pathology and focusing on the client's skill set and resources can be quite empowering, and hence can help build resilience (Tedeschi & Kilmer, 2005, p. 230; Orbke & Smith, 2013). This is especially important when individuals lose sight of their resourcefulness and coping abilities (Anderson, 2010).

There is also an opportunity for growth once clients realize their own strengths (Bonanno, 2004). Clients may start to see themselves differently and reframe their experiences as helping them become who they are today. This newfound awareness of strengths and sense of identity, or post-traumatic growth, can help client's cope with present and future life difficulties by applying newly identified coping skills (Anderson, 2010). Bonanno (2004) states that people become more resilient when they believe they can grow from past experiences.

Sexual Well-Being. Although empowerment and resilience have been studied extensively within the counselling psychology literature, there has been a lack of attention to the topic of sexual well-being after a sexual assault. In fact, sex education has been relatively

neglected within the sphere of counselling psychology (Miller & Byers, 2010), despite there being a significant association between a person's sexual well-being and their mental and physical health (Edwards & Coleman, 2004; Khajehei et al., 2015; McCabe, 2009; Sims & Meana, 2010; Sutherland, 2012; WHO, 2006). This is unusual since trauma has been studied and practiced in varying ways within the discipline of counselling psychology (Merriman & Joseph, 2018; Sheikh, 2008; Vilenica et al., 2013).

Research provides explanations as to the lack of formal sex education in psychology graduate schools. First, graduate school administrators may feel that sex education is "common sense" and do not feel the need to offer formal training (Miller & Byers, 2010). Some may believe that the sex education youth received during secondary school is adequate training, and that students do not require additional training in graduate school (Miller & Byers, 2010). Even if this were true, previous sex education varies based on a number of factors, including: the province students received their sexual training; their teacher's knowledge of sexual health; whether parental permission was provided for children to receive sex education; and the schoolboard students attended (Cohen et al., 2004; Landry et al., 2000). Second, graduate programs may not know that some psychologists struggle with talking about sexual concerns with a client and may believe that general psychology training is enough to address such issues (Miller & Byers, 2010). However, Miller and Byers (2008) state that psychologists with specific training in sex-related topics are more confident and willing to work with clients with sexual problems than are psychologists with only general psychology training. Lastly, psychology institutions may not have trained faculty to address the topic of sexuality (Miller & Byers, 2010). As Wiederman and Sansone (1999) found, graduate programs that had faculty trained in the area of sexuality offered more programs related to sex. Therefore, to increase knowledge around sex

education amongst counselling psychology graduate students, graduate psychology programs may want to invest in hiring faculty with expertise within this domain and include sex education into their curriculum.

Miller and Byers (2010) offer suggestions as to how graduate programs can become better equipped to offering sex education, one of which involves providing resources to boost the psychologist's skillset. This suggestion is significant considering that one of the goals of this study is to inform counselling psychologists about ways in which self-compassion can help female sexual assault survivors cope with sexual problems. The authors further state that counsellors who are more grounded in sexual health knowledge may become better equipped and more confident to counsel clients with sexual concerns. This could take the form of addressing their client's questions and issues, and minimizing the chances of providing misinformation regarding the client's sexual health and development (Miller & Byers, 2010).

Summary

This chapter highlighted how sexual assault against women and girls continues to be a significant problem in Canada. It also summarized how female survivors often experience deleterious psychological, physical, and relational consequences as a result, including sexual concerns. I introduced the concept of self-compassion as a promising practice that may help women cope with sexual problems after a sexual assault, given self-compassion's many psychological advantages. However, there is a lack of research on this topic within the realm of counselling psychology. There is also a lack of sex education training in counselling psychology graduate schools, which may leave counselling psychologists feeling inept when working with sexual assault survivors experiencing sexual problems. To help address these gaps, I explored women's experiences of self-compassion in coping with sexual problems following sexual

assault. Potential contributions include adding to this underdeveloped area of research, as well as improving training within counselling psychology. I also hope to facilitate women's empowerment, by giving a voice to women who may have been silenced by the sexual assault, and helping others in similar situations.

In the remainder of this dissertation, chapter two discusses the research literature, bringing together important domains of research that inform this work. In chapter three, I provide an overview of my qualitative study, including my theoretical perspective, methodology, and methods. Chapter four includes vignettes of the 10 participants and details of the eight common themes. Chapter five discusses the study's key findings, clinical implications, limitations, and areas for future research.

Chapter 2: Literature Review

This chapter reviews the literature related to my study. I first discuss the definition and impact of sexual assault, as well as coping strategies commonly employed by sexual assault survivors. Next, the literature review covers counselling theories, models, and interventions for working with sexually assaulted women and girls. I then review the topic of sexual well-being through two models: the biomedical model and the psychobiosocial model. Prevalence, causes and treatment of sexual problems are then discussed. Lastly, the construct of self-compassion and how it relates to my study is explored. Specifically, I highlight two key figures within the field of self-compassion, and their approaches to developing a compassionate view towards oneself. The benefits of self-compassion, as well as psychotherapeutic approaches for fostering it, are also outlined. I point to areas of intersection between the self-compassion literature and the needs of women who experience sexual problems post-assault.

Sexual Assault

The task of defining sexual assault is complex, with there being no commonly agreed-upon definition for the term. Some definitions are broad and encompass more than one sexual act (e.g., Fedina et al., 2018; Sheley, 2018), whereas others are more specific, narrowing in on specific types of sexual victimization, such as forcible rape or unwanted sexual contact (Cleere & Lynn, 2013; Fedina et al., 2018). To further complicate matters, various terms are used interchangeably to describe similar sexual experiences. Sexual violence, sexual abuse, and sexual assault are just a few terms used synonymously to describe a myriad of adverse sexual encounters (WHO, 2003). As a result of definitional inconsistency and substitutional terms, findings among studies may vary, making the comparison of studies challenging.

In my study, I use Fedina et al.'s (2018) definition of sexual assault, as it appears to capture the majority of sexual victimizations experienced by women as described in the studies that I have reviewed. Specifically, Fedina et al. defined sexual assault as "a range of sexual victimization experiences including attempted and completed forcible vaginal, anal, or oral rape (physical force or threat of force), physically forced or coerced unwanted sexual contact (fondling, kissing, or other sexual touching), incapacitated rape (completed or attempted vaginal, anal, or oral intercourse while unable to consent due to intoxication or influence of drugs), and sexual coercion (completed or attempted vaginal, anal, or oral intercourse through the means of pressure, lies, intimidations, arguments, etc.)" (p. 86). A key aspect of this definition is "coerced" sexual contact, otherwise known as "non-consensual" sexual acts. This refers to a sexual act or acts done to another person without their consent. Furthermore, sexual assault is a form of sexual abuse or sexual violence, though in the literature the terms are often used synonymously. Therefore, in my literature review, I will also be including literature on sexual abuse and sexual violence where relevant. Lastly, this study's meaning of sexual assault can refer to women who were sexually assaulted as a child, as an adult, or both.

Adverse Sequelae of Sexual Assault

The effects of sexual assault can be experienced on many different levels. A survivor can experience symptoms physically, mentally, and interpersonally, with many symptoms overlapping and experienced at the same time (Carey et al., 2018; Kline et al., 2021; Stein et al., 2004; van Berlo & Ensink, 2000). The following section outlines these adverse consequences, beginning with physical symptoms.

Physical Effects. The range of physical complaints that can follow a sexual assault are vast. In her review of studies examining the physical health consequences of sexual assault,

Golding (1999) found that survivors perceived themselves to have poorer health and more physical problems following a sexual assault. Symptoms varied, ranging from chronic and widespread bodily pain, headaches, and digestion issues to menstrual and gynecological problems (Golding,1999). Stein et al. (2004) reported similar findings in their study on the relationship between sexual assault history, somatic symptoms, and anxiety. With the exception of back pain, women who experienced sexual trauma experienced significant somatic complaints. Complaints of facial and head pain were mentioned, as well as widespread bodily pain, numbness and tingling in the extremities, fatigue, trouble breathing, and sleep problems.

Mental Health Effects.

***Anxiety, Depression, and Suicidality*.** Just as sexual assault can have deleterious effects on physical health, it can also have serious mental health consequences. Stein et al. (2004) found that women who experienced sexual assault experienced increased health-related anxiety (e.g., anxiety or worry related to their health or about illness). Tarzia et al. (2017) investigated mental health issues related to sexual violence of 230 women attending Australian health clinics. After adjusting for childhood sexual abuse, women who reported at least one incident of sexual assault during adulthood experienced more anxiety, depressive symptoms, and feelings of hopelessness than women who had no histories of sexual assault. Carey et al.'s (2018) study on the mental health issues post-assault consisted of a sample of 483 first-year college females of varying ethnic backgrounds in the United States. The study found high levels of anxiety and depression amongst women who experienced sexual assault during their first year of college. A review examining the mental health consequences of sexual assault found that 23% to 44% of female survivors experienced suicidal ideation, and that between 2% and 19% had attempted suicide

(Campbell et al., 2009). And lastly, Martin et al., (2007) found that marital rape acted as a risk factor for suicide attempts amongst women.

Shame-Related Feelings and Behaviours. Feelings of shame and self-blame are common amongst sexual assault survivors. Indeed, sexual assault survivors tend to be especially prone to shame (Weiss, 2010). They often blame themselves for the assault and feel dirty, worthless, and unlovable (Kline et al., 2021; Olatunji et al., 2008; Vidal & Petrak, 2007). This internalized blame reinforces persistent shame. Shame is an emotion that can have negative consequences, affecting survivors' self-worth and perceptions of themselves (Weiss, 2010). Gilbert (1998, 2002) stated that shame can be internal (e.g., shame directed inward, often in the form of self-criticism) or external (e.g., beliefs that others view the self in a negative way). Van Vliet (2009) described shame as involving a host of complex thoughts, feelings, and behaviours, including self-judgement and an undesired identity. Weiss (2010) added that shame is associated with feelings of self-blame, stigma, and disgrace. Feelings of shame often lead to an individual engaging in avoidant behaviours, hiding themselves from others to evade disapproval (Feiring & Taske, 2005; Lewis, 1992).

Various studies have researched the relationship between shame and sexual assault. For instance, Vidal and Petrak (2007) investigated the degree of shame reported by women sexually assaulted as adults, including particulars of the assault that may contribute more to feelings of shame. The sample consisted of 25 female survivors of adult sexual assault (16 years or older) from both clinical and non-clinical populations in East London. The study revealed that participants experienced high rates of shame about themselves, their bodies, and how they believed others perceived them after the sexual assault. The majority of the women blamed themselves for what happened, and also experienced more shame than women who did not

blame themselves for the assault. Findings also suggested that shame increased when the offender was known to the survivor. Additionally, compared to women who experienced sexual assault only in adulthood, women who were sexually assaulted in both childhood and adulthood experienced more shame about themselves, as well as concerns about what others thought of them. Other factors associated with shame were if physical consequences occurred (e.g., sexually transmitted diseases [STDs]), or if the women had a medical exam following the assault.

Common throughout this section on shame-related feelings and associated behaviours is a feeling of "dirtiness" or "mental pollution" that survivors often experience after a sexual assault. Mental pollution can be defined as "a unique type of dirtiness, in which individuals develop internal feelings of contamination" (Olatunji et al., 2008, p. 4). Rachman (2004) claimed that sexual assault survivors feel a sense of dirtiness in the absence of any observable dirt, and that this perceived dirt tends not to be eliminated with repeated washes. Also, Olatunji et al. (2003) stated that a person's morals tend to guide their sexual beliefs and behaviours, and that sexual assault tends to violate a person's morals. As a result, sexual assault survivors are often left with an immoral feeling, making them vulnerable to mental pollution (Olatunji et al., 2008).

Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD). Acute stress disorder and PTSD are prevalent amongst female sexual assault survivors (Kessler et al., 1995; Kline et al., 2021; McFarlane et al., 2005; Rothbaum et al., 1992). Defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) as "exposure to actual or threatened death, serious injury, or sexual violence" (p. 271), the major difference between the two disorders is duration of the disturbance. The presentation of the disturbance for ASD is three days to one month, whereas for PTSD, the duration of disturbance is more than one month (APA, 2013). The presentation of symptoms varies from person to person, ranging from one or

more of the following: intrusion symptoms (e.g., flashbacks), avoidance of stimuli that reminds the individual of the traumatic event, and negative changes in thought, mood, arousal and reactivity (APA, 2013).

Several studies have found a relationship between ASD, PTSD, and sexual assault. For instance, Kessler et al. (1995) found that in comparison to non-sexual traumatic events, survivors of sexual assault were at the highest risk of developing PTSD. Elklit and Christiansen (2010) found a high prevalence of both ASD and PTSD among a sample of 148 female rape victims, of which half were adolescents. More than half of the participants either met the diagnostic criteria for ASD or exhibited the majority of ASD clusters, and just under half of the women met the criteria for PTSD three months' post-assault. Kline et al.'s, (2021) longitudinal study examined the temporal relationship between behavioral self-blame and PTSD symptomology of 126 female sexual assault survivors and found that behavioral self-blame served as both a predictor and an outcome of PTSD symptoms. Lastly, Walsh et al. (2014) explored the prevalence of sexual violence and PTSD amongst 1,306 African-Americans (761 women and 545 men) in the U.S. and found that sexual violence is not only prevalent among urban African-Americans, but was also associated with lifetime PTSD.

Relational Effects.

Interpersonal Problems. Interpersonal problems are another potential repercussion of sexual assault. For example, Kim et al. (2009) found that women sexually abused in childhood, and who experienced high levels of shame, experienced more interpersonal and family conflict (e.g., physical and verbal aggression) than women without a history of childhood sexual abuse. Also, women who experienced CSA were less happy in their relationships than non-abused women, had difficulty forming intimate feelings towards others, and struggled with self-

disclosure of personal information (DiLillo, 2001; DiLillo & Long, 1999). Cloitre et al. (1997) conducted a study investigating intrapersonal, interpersonal, and PTSD among women who were sexually assaulted in both childhood and adulthood (referred to as retraumatized women), women sexually assaulted only in adulthood, and women who were never sexually assaulted. The study found that retraumatized women suffered the most from interpersonal problems. In particular, retraumatized women experienced more trust issues and difficulty making judgement calls surrounding intimacy. Results also revealed that retraumatized women struggled with assertiveness and being "too controlling and responsible" (Cloitre et al., 1997, p.449). The authors elaborated on this finding, suggesting that retraumatized women grapple with interpersonal power dynamics, such as when to be assertive, and mistakenly believing they are responsible and in control of events, when in fact, they may not be.

In some cultures, sexual violence may have wide-sweeping and severe social consequences (Amone-P'Olak et al., 2016; Kim et al., 2009). For instance, Kelly and colleagues (2012) conducted a qualitative study in the Democratic Republic of the Congo to better understand men's and women's perspective of sexual and gender-based violence, specifically the effects of rape. Their study revealed that women were often blamed for being raped, with "gossip and ridicule" contributing the most to communal stigma and humiliation (Kelly et al., 2012, p. 290). Also, shame, feelings of humiliation, and ostracism were some of the greatest barriers that survivors had to overcome (Kelly et al., 2012). In extreme cases, rape survivors were forced to leave their families and communities. Even if a husband and wife stayed together after the rape, the marriage often suffered, sometimes resulting in husbands becoming abusive towards their wives.

Sexual Problems. There is a growing body of literature to support the view that CSA and ASA can adversely influence sexual well-being in adulthood. Van Berlo and Ensink (2000) reviewed the literature regarding sexual problems after sexual assault that occurs in adulthood. Their review revealed that sexual engagement and enjoyment decreases after a sexual assault, and that sexual problems (e.g., fear and lack of sexual desire and arousal) can endure for years after the sexual violation. The researchers also uncovered factors that were related to sexual issues, including whether the women were assaulted at a young age, whether the perpetrator was known, and if the assault involved penetration. Self-directed anger, guilt, and shame were also identified as predictors of sexual problems (van Berlo & Ensink, 2000).

Kelley and Gidycz (2017) conducted a study to see whether sexual abuse symptoms of depression, anxiety, dissociation, sleep problems, and distress mediated the connection between ASA and sexual functioning problems. Sexual functioning problems were listed as difficulties with desire, arousal, orgasm, lubrication, and pain. Importantly, CSA was used as a covariate during analysis given the relationship between CSA and sexual functioning concerns as adults (Kelley & Gidycz, 2017; van Berlo & Ensink, 2000). Results revealed that neither ASA nor CSA histories were directly related with sexual functioning concerns. The authors offered an explanation for this finding, suggesting that participants in the study (who were younger and not part of the clinical population) had higher levels of sexual functioning than older women or those in clinical samples. However, the study did find that anxiety mediated the relationship between ASA, sexual pain, and lack of desire. Additionally, a higher sexual abuse trauma index mediated the relationship between ASA and orgasm and desire problems (Kelley & Gidycz, 2017). Lastly, depression was found to mediate the relationship between sexual pain and ASA.

Lipinski and Beck (2022) investigated how two psychological factors, posttraumatic stress symptoms and sexual self-schemas (i.e., perceptions of oneself sexually) impacted sexual functioning and satisfaction among 148 college female sexual assault survivors. Participants completed a number of on-line measures related to their trauma history (Koss et al., 2007) and symptoms (Weathers et al., 2013), as well as sexual self-schemas (Andersen & Cyranowski, 1994) and sexual function (Meston & Trapnell, 2005; Rosen et al., 2000). Results revealed that an increase in posttraumatic stress symptoms was associated with a more negative sexual schema, with sexual schemas partially accounting for a decrease in sexual satisfaction, arousal, and orgasm. Lipiniski and Beck explained this partial finding, stating that other factors, such as depressive symptoms, severity of sexual trauma, and lack of social support could have accounted for the association between posttraumatic stress symptoms and sexual functioning concerns. Additionally, the authors discovered that compared to non-heterosexual women, heterosexual participants experienced a more negative sexual self-schema and a decrease in their sexual arousal. However, the small proportion of sexual minority participants relative to participants who self-identified as heterosexual prevented the researchers from conducting further analysis or offering an explanation for this finding.

Lastly, Crump and Byers (2017) examined the impact of child sexual abuse and sexual assault in adolescence and adulthood on the sexual well-being of 299 sexual minority women in non-cohabiting dating relationships. The authors defined sexual well-being as "behavioural (genital and non-genital sexual frequency, duration of sexual encounters), motivational (sexual desire), and cognitive-affective (sexual satisfaction, anxiety, esteem, negative automatic thoughts) responses" (p. 164). In general, the women reported positive sexual well-being across cognitive-affective, behavioural, and motivational domains. However, childhood sexual abuse

involving attempted/completed penetration negatively affected participants' sexual motivation (desire) and some aspects of their cognitive-affective responses (sexual satisfaction and autonomic thoughts).

Coping Strategies Utilized by Sexual Assault Survivors

The range of adverse sequelae survivors of sexual assault experience is vast and complex. Learning how survivors cope during such a trying time can educate and empower others who are suffering during similar times. In exploring the relationship between self-compassion and sexual problems, it is useful first to consider the wide range of coping strategies that may be employed by survivors. To explore common coping strategies utilized by survivors of sexual assault, Tsong and Ullman (2018) investigated the coping strategies of 64 Asian American women (ages 18-53) who had experienced sexual assault as early as age 14. Results revealed that the majority of survivors used the coping mechanisms of acceptance and self-distraction to cope with the consequences of sexual assault. The coping strategies used the least were humour and denial. Participants who saw themselves as having little control over their healing process utilized more maladaptive coping techniques related to substance use, behavioral disengagement, and self-blame behaviours (Tsong & Ullman, 2018).

Other studies investigating coping mechanisms used amongst survivors found that survivors were better adjusted when they received emotional support at the time of disclosing the assault (Orchowski et al., 2013). Hoge et al. (2007) explained this phenomenon, stating that seeking support represents resilience by utilizing one's resources to help decrease the impact of the trauma. Furthermore, Orchowski et al. (2013) found that social reactions that involved attempts to control decisions for the survivor or those that blamed the survivor were associated with increased symptoms of PTSD, anxiety, and depression; over-reliance on validation from

others; low self-esteem; and less chances of the survivor utilizing problem-focused coping strategies (i.e., thinking critically about how to best cope with the traumatic event).

Theories Informing Treatment

Although there are several treatment theories and models that inform counselling interventions for recovering from sexual assault, this chapter focuses on two that are particularly influential in the context of working with sexual assault survivors: feminist theory and objectification theory (Courtois, 1991; Szymanski et al., 2011).

Feminist Theory. *Feminist theory* is concerned with exposing gender-based violence, such as sexual assault (Courtois, 1991). It looks at how differences in power and gender can contribute to sexual assault, as well as women's individual and collective experience (Courtois, 1991). This theory recognizes that perpetrators are primarily males and most victims are females (Conroy & Cotter, 2017; Courtois, 1991).

Feminist theory also recognizes that symptoms that develop as a result of trauma, such as sexual assault, are typical reactions to adverse situations and are not psychopathological in nature (Courtois, 1991). The symptoms that survivors may have developed help them cope and survive (Courtois, 1991). However, these same coping mechanisms can become maladaptive and create problems in other aspects of the person's life. For instance, avoidant coping mechanisms can be helpful in the initial stages of trauma (Van Vliet, 2010). However, in the long term, avoidant coping mechanisms can lead to increased distress (Frazier et al., 2005, Van Vliet, 2010). Therapists working from a feminist lens help the client see that they are not responsible for what happened to them, and place the incident(s) within a social, cultural, and political context (Courtois, 1991). Feminists support individuals in overcoming barriers related to their well-being and help create agency by identifying new and existing healthy coping skills, encouraging

assertive behaviour, and helping to establish boundaries– all of which can lead to individual and interpersonal change (Brown, 2004; Courtois, 1991).

Objectification Theory. Similar to feminist theory, *objectification theory* provides a foundation upon which to understand women's experience of sexual assault in a sociocultural context that sexually objectifies their bodies (Fredrickson & Roberts, 1997; Szymanski et al., 2011). Basically, the theory posits that "women are sexually objectified and treated as an object to be valued for its use by others" (Szymanski et al., 2011, p. 7). A woman's body is segregated from her as a whole, and her body parts are seen as sexual objects for fantasizing (Szymanski et al., 2011).

There are two ways in which objectification theory postulates that sexually objectifying women can negatively affect their mental health. The first is specifically through sexual objectification experiences (Fredrickson & Roberts, 1997; Szymanski et al., 2011). The second way is subtler and indirect and involves self-objectification, or women internalizing the sexual objectification experience and treating themselves as objects to be gazed at and evaluated based on how they look (Fredrickson & Roberts, 1997; Szymanski et al., 2011). Fredrickson and Roberts also state that objectification is one form of gender oppression. However, these researchers suggest that objectification possibly enables other oppressions women experience, including employment discrimination and sexual violence.

Models Informing Treatment

Feminist and objectification theory offer explanations for how women fall victim to sexual assault. Examining treatment models that help survivors heal from heinous crimes would be advantageous given that the journey to recovery can be long and painful. Scholars researching trauma have established various trauma models, goals, and treatment approaches that share many

commonalities and that can assist mental health practitioners when working with survivors of trauma (Briere, 1996; Chu, 1998; Courtois, 1991). Courtois (1991) summarized in her chapter the various stages common within therapy (p. 52), some of which include: recognizing the negative impact of the abuse and making the decision to seek therapy; memory retrieval; countering feelings of blame and shame; working through difficult emotions, such as anger and pain, and thought distortions; resolution of relational concerns (e.g., whether to confront the perpetrator); and the development of a new self-identity post-trauma.

Just as Courtois (1991) described the common themes surrounding treatment stages for trauma survivors, she also outlined three treatment phases suggested by theorists and mental health practitioners (e.g., Gil, 1988; Herman, 1997). Such phases are labelled the preliminary phase, resolution phase, and post-resolution or reconnection phase. In the preliminary phase, safety is a focus, both within the client (e.g., prevention of self-harm) and their environment (e.g., home life; Courtois, 1991). In the resolution phase, the client begins to recall and recount traumatic incidents of the abuse (Courtois, 1991). This process may come in various forms, such as memories, dreams, and triggers and be associated with various symptoms, such as numbness, dissociation, and denial (Courtois, 1991). The post-resolution or reconnection phase involves the mending of unresolved relational and intrapersonal problems which may not have been able to be fully addressed until abuse issues were resolved (Courtois, 1991). Specific trauma models that include variations of these phases include Judith Herman's tri-phasic trauma model (Herman, 1997), Briere's self-trauma model (1996), and Chu's stage-oriented trauma treatment model (1998).

Interventions

Having an established set of guidelines outlining the various stages of therapy and treatment of trauma provides counselling psychologists a framework from which to counsel sexual assault survivors. However, gaining insight into specific sexual assault interventions, especially those pertaining to sexual problems post sexual assault, may be more challenging given the scarcity of this topic in counselling psychology research and practice (Miller & Byers, 2010). In most cases, many therapists use a blend of techniques based on their training and theoretical orientation to achieve the therapeutic goals set in therapy (Dass-Brailsford, 2007). However, the needs of the client are a priority, as is consideration of the client's background and culture (Dass-Brailsford, 2007).

Cognitive-behavioral therapy is an effective technique that combines both cognitive and behaviour therapy to help clients see how their thoughts and/or behaviours may be contributing to how they feel, with the goal of returning the person to normal functioning (Dass-Brailsford, 2007). Changing faulty thinking and problematic behavioural patterns are at the core of CBT treatments (Kar, 2011). Exposing clients to their fears (exposure therapy), via imagination or in-vivo, as well as identifying and restructuring maladaptive thoughts, are common techniques used in CBT (Jaycox et al., 2002). Indeed, CBT is the most studied treatment for rape survivors experiencing PTSD (Foa & Meadows, 1997). To demonstrate the effectiveness of exposure therapy, Jaycox et al. (2002) conducted a CBT exposure technique called *prolonged exposure* on a 25-year-old female rape survivor. Prolonged exposure is typically carried out over nine to 12 sessions, and involves breathing exercises to assist with anxiety; psychoeducation surrounding the commonality of the symptoms; in vivo and imaginal exposure therapy; and cognitive restructuring or the identification and modification of negative thoughts. In this particular case

study, the female rape survivor received nine sessions of prolonged exposure, and experienced less PTSD symptoms and depression that were maintained at the one-year follow-up evaluation. Other studies have found similar findings when exploring CBT and PTSD for sexual assault survivors (Kar, 2011; McDonagh et al., 2005; Watkins et al., 2018).

Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) has been used in the specific treatment of sexual assault survivors experiencing sexual problems (Fiorillo et al., 2017; Leonard & Follette, 2002). The goal of ACT is treating avoidance and encouraging people to make changes congruent with their values (Leonard & Follette, 2002). Clients learn to accept themselves, their trauma history, and others. Ideally, the client becomes aware of and accepts their reactions to the traumatic event, while making changes in the direction of what is important to them (Leonard & Follette, 2002; Molavi et al., 2020). Behaviour strategies (e.g., exposure and self-monitoring), experiential exercises, and metaphors are a few of the interventions used by the therapist to assist client change (Leonard & Follette, 2002; Luoma et al., 2007). Specific to sexual assault and sexual problems, Leonard and Follette (2002) highlight the need for therapists to understand the context in which the sexual problem exists. With the therapist's help, the client identifies their triggers pertaining to sexual encounters that lead to avoidance. Once the triggering variable is known, the therapist helps the couple change or replace problem behaviours with more effective ones.

Within the trauma literature, emotionally focused therapy (EFT) for couples is a counselling approach that includes the trauma survivor's partner in the healing process (MacIntosh & Johnson, 2008). EFT for couples stresses the importance of healthy fulfilling relationships in the mental and physical well-being of an individual (Johnson & Greenberg, 2009). To attain such relationships, EFT therapists help couples identify problem emotions and

interaction patterns (e.g., criticize/attack and defend/distance cycle) that may create relationship distress (Wiebe & Johnson, 2016). With this new awareness, couples explore and voice to each other their relational needs with the intent of building new secure emotional attachments and improving relationship functioning that can then be used to problem solve within the couple's relationship and everyday endeavours.

Macphee and colleagues (1995) examined the effects of EFT for couples on women experiencing low sexual desire and their partners. A total of 49 Canadian couples participated, with 25 in the treatment group and 24 in the waitlist control group. Couples in the treatment group received 10 weekly sessions of EFT for couples and also attended a follow-up appointment three months' post-treatment. Women in the treatment group experienced significantly higher levels of sexual desire compared to the control group, as well as less depressive symptoms.

Knowing that interventions exist to help sexual assault survivors cope and recover from the sequelae of sexual assault is encouraging for counselling psychologists. Self-compassion, or showing oneself kindness in a non-judgemental way during turbulent times, and recognizing that one is not alone in one's suffering, may also be a way survivors can cope with sexual problems after a sexual assault. This approach may be especially effective in addressing one such problem, sexual concerns, which presents particular challenges to survivors. To gain a better understanding of the complex field of sexual well-being, this study explores contrasting treatment models, varying prevalence rates, causes, and treatment approaches.

Sexual Problems

The mental, physical, and relational impact of sexual assault can be vast (Carey et al., 2018; Stein et al., 2004; van Berlo & Ensink 2000). Treatment models and interventions have

been established to treat many of these symptoms. Less explicit within the scope of counselling psychology is how to treat women's sexual issues after a sexual assault. Within the literature, there appears to be two divergent models of approaching sexual problems in general: the biomedical model, and the psychobiosocial[1] model. Although the psychobiosocial model is more consistent with counselling psychology's emphasis on strengths (Bedi et al., 2011), and with the feminist approach taken in my study, the dominant approach taken in the medical field is that of the biomedical model (Deacon, 2013). What this means is that many of the women seeking help with their sexual problems will consult with their doctor or health care provider who will likely refer to the DSM-5 (APA, 2013) or the International Classification of Diseases (ICD; WHO, 2019) for guidance and possibly a diagnosis. It is, therefore, important to become familiar with both the biomedical and psychobiosocial approach, as each varies in its own way.

Models

The Biomedical Model. The biomedical model views health problems, including sexual issues, from a purely biological standpoint, with minimal emphasis on psychosocial theories and interventions (Deacon, 2013; Engel, 1977). According to the DSM-5 (APA, 2013), sexual problems are considered dysfunctions, and defined as a "heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (p. 423). Female sexual dysfunctions outlined in the DSM-5 include: Female Orgasmic Disorder, Female Sexual Interest/Arousal Disorder, and Genito-Pelvic Pain/Penetration Disorder (APA, 2013). The problem with dividing women's sexual problems into sexual dysfunction categories is that it makes the assumption that a woman's sexual response follows a sequential linear process of desire, arousal, and orgasm such

[1] Although the term "biopsychosocial" also appears in the psychological literature, I have adopted the term "psychobiosocial" in keeping with Tiefer's (2002) model and language.

as that outlined in earlier sexual response cycles of Masters and Johnson (1966; Tiefer, 2002). Reducing women's sexual problems to a purely physiological function negates or downplays the sociocultural, political, relational, and psychological factors that women say are at the root of their sexual problems (Tiefer, 2002).

The Psychobiosocial Model. The psychobiosocial model of women's sexual problems offers a different view than that of the medical model. Tiefer (2002), a feminist sexologist and sex therapist, along with a diverse team of academics and activists (Cacchioni & Tiefer, 2012), developed *The New View of Female Sexual Problems* campaign. This integrative group of individuals views women's sexual problems within a broader relational and cultural context (Tiefer, 2002). This alternative perspective encourages sexual problems and concerns to be seen from the individual's point of view rather than from the perspective of a medical expert. The New View campaign claims that medicalizing women's sexual problems, "a process whereby non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad, 1992, p. 210), may minimize critical social and political factors. Potential disadvantages of the medicalization of women's sexual concerns include: a focus on the normalcy of genital function and ignorance of social and political issues that women say contributes to their sexual problems (Tiefer, 2002).

Prevalence of Female Sexual Problems

Regardless of whether the biomedical or psychobiosocial model is used to view women's sexual problems, female sexual concerns are recognized as a worldwide problem, with prevalence rates around 30% to 50% (Aslan & Fynes, 2008). Although prevalence rates are high amongst the sexual assault population, the teachings of sex-related topics are negligible within counselling psychology graduate schools (Miller & Byers, 2010). This is surprising given the

significant connection between sexual health and well-being (Edwards & Coleman, 2004; Khajehei et al., 2015; McCabe, 2009; Sims & Meana, 2010; Sutherland, 2012; WHO, 2006) and counselling psychology's goal of advancing an individual's mental health (Bedi et al., 2011). Learning more about women's sexual problems, including its pervasiveness, is critical to effectively help women in their healing.

Detailing the extensiveness of women's sexual problems, the DSM-5 (APA, 2013) states that prevalence rates for female orgasmic disorder range between 10% and 42%, based on a variety of factors, such as "age, culture, duration, and severity of symptoms" (p. 431). The exact prevalence of female sexual interest/arousal disorder is unknown (APA, 2013), but prevalence rates appear to vary based on factors similar to that of female orgasmic disorder (APA, 2013). Similarly, the exact prevalence for genito-pelvic pain/pentration disorder is unknown (APA, 2013). However, the DSM-5 states that 15% of North American women experience pain during sex, and that this sexual issue is a common presenting problem in sex health clinics and specialists' offices (APA, 2013).

Causes of Female Sexual Problems

The New View campaign offers a classification system of causes based on a four-part psychobiosocial model that is congruent with counselling psychology's comprehensive and client-focused approach to working with clients (Bedi et al., 2011), the approach taken within this study.

The first category of the four-part psychobiosocial model lists social, cultural, political, and economic factors as contributors to women's sexual problems (Tiefer, 2002). Although some women may need "expert" medical interventions for their sexual problems, many sexual problems are caused by social and cultural factors that can be reduced and prevented in the

future. Such factors, according to Tiefer, include distress derived from the inability to meet perceived ideal sexual cultural norms, and lack of interest or fatigue due to family and work demands. The second category refers to intimate relational issues (Tiefer, 2002). Lack of sexual desire, arousal, inhibition, or avoidance may be caused from an abusive partner, unequal power in the couple's relationship, or problems with communication (Tiefer, 2002). The third category represents how sexual issues surrounding mistrust and dislike can be a result of past abuse, attachment and rejection issues, as well as anxiety and depression (Tiefer, 2002). It further states that sexual inhibition can occur as a result of fearing certain sexual acts or their potential consequences, such as pain (Tiefer, 2002). Medical factors are the last category of possible causes of female sexual problems in Tiefer's (2002) model. This category states that sexual problems can still occur despite having sufficient sex education and a supportive environment. Such concerns can include medical conditions related to any of the systems of the body (e.g., circulatory); pregnancy; STDs; and medication or medical treatment side-effects (Tiefer, 2002).

Women's Perspectives on the Causes of Their Sexual Problems

In addition to Tiefer (2002), other researchers and theorists have highlighted the need to investigate relational contributions to women's sexual issues (Sims & Meana, 2010). What continues to be missing in this much-needed area of research is a qualitative approach that asks women what they feel causes their sexual concerns (Sims & Meana, 2010; Tiefer, 2002). In line with the New View campaign's classification system for sexual problems, this section of my paper will explore – from women's perspectives – what caused their specific sexual problems. Hearing from women as to what they say contributed to their sexual issues will undoubtedly provide valuable information for this qualitative study. In the literature, some of the most

common sexual problems encountered include vulvar pain, orgasm problems, lack of sexual desire, and issues pertaining to sexual well-being.

Vulvar Pain. Women often disclose pain and discomfort during sexual activity (Rosen et al., 2020; Sutherland, 2010). To explore this phenomenon, Sutherland (2012) explored the lived experience of nine heterosexual Caucasian women who were in long-term relationships. Within her study, a common event that was linked to sexual pain was varying types of abuse in childhood, adulthood, or both. As a result, women reported feeling issues of safety in their current relationships. Participants also experienced shame and guilt if they had been sexually active with other partners before their current relationship or believed it was their fault for the sexual problems. Such feelings, often deeply entrenched into the minds of the women at an early age from attitudes internalized through their family upbringings, left the women feeling that sexual engagements were "negative, inappropriate, disgusting, or sinful" (p. 232). Women in the study also disclosed feeling uncomfortable and vulnerable to the real or perceived threat of sexual pain and discomfort. Additionally, the women felt powerless, used, and resentful towards their partner for wanting to have sexual interactions with them even though they knew it was painful. Participants in the study also engaged in negative self-talk during sexual contact, such as "Grin and bear it. Get it over with," (p. 234) and referred to their bodies as "garbage, trash, useless, mutant, and gimp" (p. 234). Physically, the women described their pain as "sharp as a knife", as well as symptoms of anxiety and numbness (p. 234).

Orgasm Problems. Various factors that can contribute to women's difficulty achieving orgasm include attitudes, relationship issues, and problems with anxiety (Frith, 2013; Tavares et al., 2018; Weeks et al., 2016). To investigate this phenomenon more in-depth, McCabe (2009) provided an overview on the causes and treatment of anorgasmia based on a sexual dysfunction

model she had earlier developed (McCabe, 1991). Information within her model was gathered from studies investigating individuals within a relationship and who were experiencing sexual problems (McCabe, 1991). According to McCabe's findings (1991; 2009), the contributing factors to anorgasmia are intergenerational, individual, and relationship influences.

In terms of intergenerational influences, McCabe stated that childhood events, such as abuse, can impact sexual functioning as an adult. Problems with the process of early socialization surrounding sex-related topics in childhood is also linked with sexual problems in adulthood. Stress, fatigue, and mood disorders are just a few individual factors that could also influence orgasm in women (Cyranowski et al., 2004; McCabe, 2009). Furthermore, McCabe found that performance anxiety was connected with the inability to orgasm, indicating that women become anxious as they concentrated on their arousal, making them less likely to experience an orgasm. Relationally, difficulty communicating (e.g., talking about what each partner needed during sexual encounters) appeared to be a main contributor not only to sexual problems but to quality of the relationship in general (McCabe, 2009).

Sexual Desire. Alongside sexual pain and orgasm issues, women can also experience a decline in sexual desire (Brotto et al., 2017; Cherkasskaya & Rosario, 2019; van Anders et al., 2022). Sims and Meana (2010) interviewed 19 married women who had lost sexual desire with their husbands. Their qualitative study revealed that the factors that attracted the women to marriage (e.g., feelings of safety and security of being in a monogamous relation) also interfered with their sexual desire later on in their marriage. Also, Sims and Meana found that as the women became more comfortable with their partners, both excitement and desire was lost. Sex also became "routine and mechanical" (p. 369). And while initially the women enjoyed the fact that their husband's knew what they needed to be sexually satisfied, with time, this comfort was

replaced with "boredom and predictability" (p. 369). Participants also disclosed that as their bodies changed after marriage (especially after childbirth), the women felt "fat" and "not sexy" (p. 372), which impeded sexual desire. Other factors affecting sexual desire included everyday obligations; and the women's roles as wives, mothers, and professionals interfered with feeling sexual. The women in the study often found it difficult to transition from one role to the role of a lover, with sex no longer being a priority for them.

Sexual Well-Being. In addition to sexual response concerns, women also disclose problems with sexual well-being. Lemieux and Byers (2008) investigated the relationship between CSA and multiple aspects of women's sexual well-being, such as experiences of being sexually revictimized as an adult, various sexual behaviours (e.g., casual sex, unprotected sex), sexual worries (e.g., sexual problems and sexual anxiety), quality of sexual engagements (e.g., sexual rewards and sexual costs), and cognitive-affective sexual appraisals (e.g., sexual self-esteem, sexual satisfaction). The 272 women who participated in the study were students between the ages of 17 and 48, who self-identified as heterosexual and were either married, cohabitating, or in an exclusive relationship with one person. Results from the study pointed to several adverse sexual sequelae for women who had experienced CSA that involved actual or attempted sexual penetration. For instance, many of these women reported being sexually revictimized as adults, and frequently participated in casual and unprotected sex, as well as sexual abstinence. These survivors also experienced less sexual rewards (e.g., pleasurable and gratifying sexual experiences), more sexual costs (e.g., sexual activity that entailed effort and/or generated pain, embarrassment, anxiety), and lower sexual self-esteem. Lemieux and Byer's study further revealed that women who had experienced adult sexual victimization incurred more sexual problems (e.g., diminished sexual desire, arousal, orgasm, and satisfaction), lower global

sexual satisfaction, and higher sexual costs. Additionally, adult sexual victimization worsened the sexual repercussions for the women who had experienced CSA that involved exclusively fondling.

Treatment of Female Sexual Problems

The causes and extent of women's sexual problems is not only varied, but complex. Choosing a treatment approach that captures this diversity is necessary. Approaches in alignment with this goal include various psychological and couple's interventions, as well as relearning touch exercises for sexual well-being.

Psychological Interventions.

Problems with Sexual Desire, Arousal, and Sexual Well-Being. Cognitive behaviour therapy is a common approach for working with women struggling with sexual desire, arousal and sexual well-being problems, since this population often struggles with cognitive distortions, negative beliefs, and negative affect (Brotto, 2017; Crump & Byers, 2017; Peixoto & Nobre, 2015; Peixoto & Nobre, 2016). Consequently, these negative distractions can cause a woman to judge herself negatively, and may interfere with her ability to tune into feelings of desire, arousal, and other aspects of her bodily sexual experience (Basson, 2001; Brotto, 2017). To explore the effectiveness of cognitive behavioural techniques on women experiencing low sexual desire, Frühauf et al. (2013) performed a meta-analysis on the efficacy of psychological interventions for sexual dysfunctions between 1980 and 2009. Frühauf et al.'s meta-analysis consisted of RCTs with a wait-list control group, and 14 RCTs that compared at least two psychological interventions together. Their meta-analysis revealed that the most effective CBT techniques to help with hypoactive sexual desire disorder included behavioural skills to improve

communication between partners, increase the couple's sexual skills, and reduce anxiety surrounding sexual performance (Brotto, 2017; Frühauf et al., 2013).

Mindfulness-based approaches have also been studied in relation to sexual desire disorders. Brotto (2017) defined mindfulness as "the practice of observing one's present-moment thoughts, emotions, and bodily sensations in a non-judgmental manner" (p. 14). She further stated that by practicing mindfulness, women with problems related to sexual desire may become more internally aware of feelings related to sexual arousal and desire, such as genital vasocongestion and tingling sensation. To explore this phenomenon, Brotto et al., (2012) conducted a study on 20 sexually active women who were experiencing sexual functioning problems and significant sexual distress associated with a history of CSA. Participants, who varied in ethnicity and age, were randomly assigned to either a CBT or a mindfulness-based therapy group. Results of the study revealed that compared to women in the CBT group, women in the mindfulness-based therapy group were more aware of their genital arousal posttreatment. Sexual distress also significantly decreased in both the CBT and mindfulness-based therapy group posttreatment, with no between-group differences. These results indicated that mindfulness-based treatments are successful for increasing sexual well-being and other health problems. This is an encouraging finding since mindfulness is a component of Neff's (2003a) definition of self-compassion, a promising approach explored in this study.

In addition to CBT and mindfulness interventions for helping women with problems with sexual desire and arousal, Esther Perel (2006) talked about rekindling desire in long-term relationships in her book *Mating in Captivity: Unlocking Erotic Intelligence.* She discussed how with long-term relationships comes security and predictability. However, Perel claimed that desire depends on just the opposite: unpredictability, novelty, and change. In her book, Perel

offered suggestions for how to incorporate desire back into the relationship, while still maintaining the stability of a long-term relationship. For instance, for couples with children, she suggested that partners create time for each other where they can rekindle desire and intimacy. This may take the form of a date night or a vacation without the children. In her counselling practice, Perel also explored a couple's cultural upbringing and how varying beliefs amongst couples may interfere with desire. For example, a woman learns from a young age that sex is shameful and finds it difficult to express herself sexually in her relationship. Perel discussed ways of working through these and other issues that help couples revive desire in their relationship.

Orgasmic Problems. To explore orgasmic problems in women, Kelly et al. (2006) conducted a behavioral assessment of heterosexual couples in which the woman experienced difficulty reaching orgasm. Participants included 47 heterosexual couples who were recruited via community and campus advertisements (e.g., flyers, doctor referrals). Couples were divided into three groups based on their health and sexual functioning: the anorgasmic group (both partners were free of any physical illness but the woman was anorgasmic in approximately 70% of all sexual activities); problem-free control group (couples experienced no health or sexual problems); and chronic illness control group (one of the partners experienced a physical illness [e.g., diabetes] but neither of the partners experienced sexual problems). Data were collected via interviews, self-report measures, and three videotaped discussion exercises amongst the couples that were later used for analysis. Results revealed that the anorgasmic group had more communication problems compared to both control groups, mostly when discussing sexual topics. For instance, male partners tended to blame their anorgasmic female partner more when discussing the topic of direct genital stimulation compared to other sexual and non-sexual topics.

Also, the anorgasmic group was less receptive (e.g., attentive listening) when it came to communication regarding all topics discussed, with anorgasmic women being less receptive compared to their partners. Lastly, no groups had difficulties expressing themselves clearly regarding sexual or non-sexual topics. This means that problems with blame and receptivity in the anorgasmic group was not attributed to issues surrounding clarity.

Some research has investigated psychological interventions for female orgasm problems, looking at the problem from different categorical perspectives (lifelong, acquired, generalized, or situational). Skills taught in directed masturbation appear to be the most effective for lifelong and generalized subtypes of female orgasm problems (Heima & Meston, 1997; Leiblum & Wiegel, 2002; Weeks et al., 2016). This technique involves the woman sexually stimulating herself so that she becomes aware of what feels good, with the intention of sharing this newfound awareness with her partner in sexual situations (Heima & Meston, 1997; Leiblum & Wiegel, 2002; Weeks et al., 2016). However, relational distress tends to be one of the main contributors to orgasmic problems in women diagnosed with acquired and situational sexual problems (McGovern et al., 1975; Leiblum & Wiegel, 2002). Acquired orgasmic problems have also been associated with the side effects of medication, such as antidepressants (Heiman, 2002; Leiblum & Wiegel, 2002). Treatment for the acquired subtype of orgasm problems varies and can range from improving sex education and skills to addressing body image (Heima & Meston, 1997; Kilmann et al., 1986; Leiblum & Wiegel, 2002; Rowland et al., 2018; Weeks et al., 2016).

In discussing treatment for female orgasmic problems, Weeks et al. (2016) stated that anorgasmia is most often a result of relationship issues, a lack of orgasm experience through masturbation, and psychological factors (e.g., performance anxiety, stress, inability to remain present during sexual encounters). Among the main strategies and techniques used to treat

orgasmic problems are cognitive behaviour interventions, such as directed masturbation (Barback, 2000; Heiman & Meston, 1997; Weeks et al., 2016). Directed masturbation, which includes self-stimulation and/or the use of vibrators, includes psychoeducation, self-exploration, and self-pleasuring exercises that therapists instruct clients to practice by themselves first. Once the woman learns what she finds pleasurable, this information is then communicated and practiced with her partner. Other therapeutic methods, such as sensate focus, can be included with directed masturbation. In fact, Hucker and McCabe (2013) suggested that the best treatment for anorgasmia includes directed masturbation, increasing a sense of comfort with the body, communication skills, couple therapy to address relational issues, and mindfulness-based treatments. Weeks et al. also suggested the use of sexual fantasy to help heighten sexual desire and arousal, which could then lead to orgasm.

Sexual Pain Problems. Cognitive behavioural therapy has also been used as a psychological intervention for female sexual pain problems. Corsini-Munt et al. (2014) conducted a cognitive-behavioral couple therapy pilot study for women with Provoked Vestibulodynia (pain at the entrance of the vagina). Examples of cognitive-behavioral couples therapy interventions included a psychoeducation component regarding sexual pain, as well as mindfulness exercises and communication skills. Results included a reduction in dyspareunia (painful intercourse), an increase in sexual functioning for the woman, and an increase in sexual satisfaction for both partners.

Additionally, Brotto et al. (2020) discovered that mindfulness-based cognitive therapy and CBT helped improve provoked vestibulodynia symptoms in women. In their RCT longitudinal study, the researchers investigated the long-term outcomes of these interventions, as well as mediators of change, which included: self-compassion, mindfulness, self-criticism,

decentering, pain acceptance, and pain catastrophizing. Participants were 130 women diagnosed with provoked vestibulodynia. Online questionnaires pertaining to pain and sexual distress were completed both before and after attending either 8 weeks of CBT or mindfulness-based cognitive therapy group treatment, as well as at 6 and 12 months post-intervention. Results revealed improvements in all three outcomes: pain elicited with vulvagesiometer (instrument that measures pain/sensitivity through the exertion of pressure; Brotto et al., 2020), pain associated with vaginal penetration (intercourse or other), and sex-related distress. Their study also unveiled improvements in the above-mentioned outcomes at the 12-month follow-up, with no group differences. Furthermore, whereas changes in self-compassion, mindfulness, and self-criticism were only found in the mindfulness-based cognitive therapy group, improvements in chronic pain acceptance, pain catastrophizing, and decentering, were found in both groups.

Masheb and colleagues (2009) also explored the phenomenon of sexual pain problems in women. In their study, Masheb et al. (2009) conducted a RCT on women with vulvodynia (chronic pain around the opening of the vagina), comparing CBT with supportive psychotherapy. Supportive psychotherapy consisted of client-centered talk therapy that focused on how the person was feeling, but did not include behavioural techniques. Women were either assigned to a 10-week 60-minute session of CBT or supportive psychotherapy. The study found that both groups experienced statistically significant improvements in pain severity, sexual functioning, anxiety, and depression. However, the CBT group experienced higher success in overall sexual functioning (except dyspareunia [painful sexual intercourse]) and decreased pain during medical examinations. An explanation for this finding could be that certain CBT techniques (e.g. sensate focus and assertiveness training) may be effective for sexual satisfaction and functioning issues, but not for the specific concern of dyspareunia (Masheb et al., 2009). The authors also added that

the lack of results seen in dyspareunia amongst participants may be a result of the study not including the use of vaginal dilators as part of their treatment, which is a commonly used intervention for vaginismus.

Relearning Touch Interventions

Although psychological interventions are a common treatment for women experiencing sexual problems, relearning touch techniques are also recommended. Two common approaches are sensate focus therapy and relearning touch techniques. *Sensate focus therapy* includes both the woman and her partner and consists of "specific, systematic touching by one person of the other, with early stages prohibiting any breast or genital touch, and subsequent stages including them" (Brotto, 2017, p. 12). The woman is instructed to concentrate on what the touch being provided by her partner feels like, as well as relaxing. The goal of sensate exercises is not to induce arousal or sexual pleasure, but rather for the woman to attend to touch and provide both verbal and non-verbal feedback to her partner about the touch (Brotto, 2017; Masters & Johnson, 1966).

Maltz (2012) devised a specific approach and techniques to help individuals who are experiencing sexual intimacy concerns as a result of sexual assault. She combines traditional sex therapy exercises with trauma recovery and interpersonal counselling approaches to help sexually assaulted individuals relearn touch techniques. Maltz states that the purpose of the exercises is not only to help sexual assault survivors enjoy physical contact, but to do so in a relaxed and present way, as well as aid in communicating thoughts and feelings throughout the process.

In her book entitled *The Sexual Healing Journey,* Maltz (2012) describes examples of specific relearning touch techniques. Red Light-Green Light is one example of relearning touch

techniques. In this technique, the couple massages non-sexual parts of each other's bodies, initiating touch by saying green light, counting to 10, then stopping contact by saying red light. Maltz (2012) states that traditional sex therapy can be applied when survivors indicate they want to focus on specific sexual functioning problems, such as difficulties with sexual desire, orgasm, or painful intercourse. She emphasizes that even traditional sex therapy can be modified for the survivor, allowing them to feel a sense of control over what and when they practice. Gaining a sense of control can also assist in dealing with difficult reactions that may arise from past abuse, as well as maintaining intimacy once sexual feelings intensify (Maltz, 2002).

Together, these interventions have been known to help women with their sexual problems. However, investigating a person's internal resources that have helped them cope during their everyday lived experiences outside of therapy would also be fruitful. Such an approach would be one that recognizes that suffering is universal and that one is not alone. It would enable one to work through difficult emotions and painful thoughts with understanding and kindness. Additionally, a valuable approach would be one that reveals an individual's strengths during troubling times and is linked to resilience. Self-compassion encompasses all of these positive attributes, which makes it a worthwhile phenomenon to explore in regard to sexual problems after a sexual assault.

Self-Compassion

Thus far, this study has described two of the three important constructs being explored in the current study: sexual assault and sexual problems. The third construct left to discuss is self-compassion. By describing the many benefits of practicing self-compassion, and discussing the psychotherapeutic approaches that foster compassion towards oneself, I will demonstrate why

self-compassion may be an appropriate coping mechanism in assisting sexual assault survivors with their sexual problems.

Approaches to Practicing Self-Compassion

Research on self-compassion has burgeoned since Neff (2003a; 2003b) first published her seminal articles on the definition and measurement of self-compassion. Two prominent leaders within the field of self-compassion are Kristin Neff and Paul Gilbert. Their approaches to self-compassion are outlined below.

Neff's Psychological Approach to Self-Compassion. Neff's (2003a) theory of self-compassion combines both Buddhism and Western psychology to describe a way of behaving towards oneself during troubling times that is caring, nonjudgmental, and compassionate. Neff (2003b) operationalized self-compassion as containing three central components: self-kindness, common humanity, and mindfulness. Although theoretically distinct, these components work together to create a more self-compassionate person during times of adversity (Neff, 2003b). Neff (2012) defines self-kindness as showing caring and understanding towards ourselves when we feel we have failed or are suffering, instead of harshly criticizing ourselves. Showing self-kindness means recognising our problems and inadequacies and doing what needs to be done to help ourselves in a non-judgemental manner (Neff, 2012). Common humanity involves an understanding that everyone – including ourselves – is imperfect. It is an understanding that universally, everyone suffers and that we cannot always be the person we want ourselves to be (Neff, 2012). Self-compassion allows us to see ourselves more broadly in relation to others and to recognize that we are not alone in our suffering. Mindfulness means taking an objective, non-judgemental perspective of our current experience, recognizing that we are suffering, and not identifying with negative beliefs (Bishop et al., 2004; Neff, 2012). A mindful approach does not

allow these negative thoughts and feelings to become part of our self-concept (Neff, 2012; Nolen-Hoeksema, 1991). Instead, such an approach broadens our perspective and provides clarity and self-assurance (Baer, 2003; Neff, 2012).

Gilbert's Evolutionary and Biopsychosocial Approach to Self-Compassion. In contrast to Neff's approach, Paul Gilbert's contribution to our understanding of self-compassion utilizes an evolutionary and biopsychosocial approach (Gilbert, 2009). Gilbert defines self-compassion as not only becoming aware of our own suffering, but also developing an empathic understanding of the causes of our suffering (Gilbert & Procter, 2006). He claims that self-compassion is an evolved skill that people can learn to comfort themselves and regulate their emotions by showing themselves caring and self-directed warmth (Gilbert & Procter, 2006). In his theory, Gilbert (2010) proposes that emotions are organized through three systems: threat and self-protection; incentive and resource-seeking; and soothing and contentment.

With regards to the first system, Gilbert (2009, 2010) claims that the threat and self-protection system has evolved in all living things. As humans, we are able to quickly detect threat and respond in ways that protect ourselves. Gilbert (2009) states that humans may react to threat on an emotional level (e.g., anger, anxiety), on a behaviour level (e.g., fight, flight, freeze, or submit), or on a cognitive level (e.g., thinking "better safe than sorry"). He further contends that early life events can cause the threat and protection system to develop automatic and conflicting responses. For example, a person who developed an advanced submissive response to threat early in life is well aware of the power of others, feels inferior to those with perceived power, and avoids relational conflict (Gilbert & Leahy, 2007).

Whereas the threat and self-protection system is developed to protect us in times of real or perceived danger, the incentive and resource-seeking system provides us with positive

feelings, guiding individuals towards rewards and resources such as food and sexual encounters (Gilbert, 2009; 2010). This system motivates us towards achieving certain goals in life. An over-stimulated incentive/resource-seeking system can cause an individual to desire more than what is often achievable (Gilbert, 2010). When this happens, the person's threat/self-protection system is activated, and the individual feels anger or frustration.

Gilbert (2009) asserts that animals, including humans, whose affect regulation systems are functioning in a balanced manner will enter the soothing/contentment stage when they are not reacting to threat and have sufficient resources. In this sense, contentment is described as a "peaceful well-being and quiescence – a state of 'not-seeking'" (Gilbert, 2009, p., 202). This system is most related to affection and kindness, and therefore this system is akin to compassion (Gilbert, 2010). It is not surprising that the soothing and contentment system has its roots in attachment theory (Dupue & Morrone-Strupinsky, 2005). For example, a parent caring for their infant shows love and nurturance and, as a result, the infant is soothed. This compassionate behaviour triggers the soothing and contentment system, reducing the threat response. Although the soothing and contentment system can be stimulated by others showing compassion towards us, it can also be brought forth by showing ourselves love, caring and understanding (Gilbert, 2009).

Sometimes, however, these three systems can become imbalanced (Gilbert, 2009). For example, Gilbert (2009) explains that people who have a heightened threat and self-protection/incentive and resource-seeking system tend to experience shame and self-criticism and have difficulty accessing the soothing and contentment system. Since sexual assault survivors often experience shame and may become harshly self-critical (Olatunji et al., 2008; Van Vliet, 2009), it is not unreasonable to assume that this population may have an

overdeveloped threat and self-protection system. As a result, the soothing and contentment system becomes difficult to access. Gilbert (2009) claims that one way of rebalancing these systems is with therapy, namely compassion-focused therapy (CFT).

Benefits of Practicing Self-compassion

Before delving into CFT and other psychotherapeutic approaches for fostering self-compassion, it would be advantageous to explore the many benefits of showing compassion towards oneself. Relief from mental health issues, recovery from trauma, and interpersonal benefits (including healing from sexual problems) are a few of the rewards individuals reap when practicing self-compassion (Neff, 2003a; Santerre-Baillargeon et al., 2018; Scoglio et al., 2018). These potential benefits are encouraging since sexual assault survivors can experience many, if not all, of these negative effects post assault.

Mental Health Benefits. Showing oneself compassion has consistently been found to decrease mental health issues, such as anxiety and depression, as well as increasing well-being. These benefits were demonstrated in Neff's (2003a) pilot study of her 26-item Self-Compassion Scale (SCS). The 391 participants rated how frequently they engaged in self-compassionate behaviour, and an overall self-compassion score was generated. Self-compassion was found to be negatively correlated with anxiety and depression and positively correlated with life satisfaction, suggesting that self-compassion may assist with psychological well-being and resiliency. In addition, self-compassion was negatively correlated with neurotic perfectionism. These findings suggest that self-compassionate people not only maintain a positive view of themselves, but are more accepting if they fail to meet their expectations.

Interestingly, Neff's (2003a) study revealed that women are less self-compassionate than men. The women who participated in the study felt more isolated and judgemental towards

themselves, over-identified with their negative thoughts and emotions, and were less mindful than the men in the study's sample (Neff, 2003a). These findings are consistent with other studies that have found women to be more focused on their negative feelings, more self-critical, and less self-compassionate than men (Bluth & Blanton, 2015; Leadbeater et al., 1999; Nolen-Hoeksema et al., 1999). However, other studies exploring self-compassion have found no gender differences (Iskender, 2009; Neff & Pommier, 2012). A possible explanation may be that self-compassion varies amongst gender based on the population sample (Neff & Pommier, 2012). Age may also play a factor. Whereas Neff and McGehee (2010) found no gender difference in self-compassion amongst high-school students, they did find that female college students were less compassionate towards themselves compared to male college students.

Various studies have also investigated self-compassion's role in emotional well-being. Galla (2016) conducted a longitudinal study examining whether self-compassion and mindfulness practices increased emotional well-being in stressed, but otherwise, healthy teenagers. The sample consisted of 132 adolescents (61% female) who completed questionnaires pertaining to self-compassion, mindfulness, and emotional well-being before, after, and three months after attending a five-day meditation retreat. Results revealed that participants showed an increase in self-compassion, mindfulness, and emotional well-being after the retreat, which was maintained three months after the intervention. Further analysis uncovered that self-compassion was more effective than mindfulness in decreasing stress, rumination, and negative affect. Additionally, self-compassion was positively related to an increase in life satisfaction and positive affect (Galla, 2016).

Trauma Recovery. Studies have also shown the benefits that self-compassion may have on the negative consequences of trauma. For instance, Thompson and Waltz (2008) explored the

relationship between self-compassion and posttraumatic stress symptoms of 210 university students (79 men and 131 women) who met the criteria for PTSD. Results revealed that avoidance symptoms, commonly associated with PTSD, were negatively correlated with the self-compassion total score. The authors elaborated on this finding, stating that trauma survivors often are triggered by environmental cues that remind them of the trauma, leading to avoidance behaviours. However, individuals high in self-compassion feel less threatened by these situations, and more willing to explore their painful memories rather than avoid them (Thompson & Waltz, 2008).

Similarly, Winders et al. (2020) conducted a systematic review on self-compassion, trauma, and PTSD. With no year range specified, they reviewed 35 studies from various databases, such as PsycINFO, PubMed, and Ovid Medline. The authors consistently found evidence to suggest that an increase in self-compassion was related to less PTSD symptoms regardless of study design, measurements used, sample, or type of trauma, including sexual assault. The review also indicated that diminished fear associated with self-compassion was connected to a decrease in PTSD symptomatology. Lastly, 8 of 11 studies using compassion-based models (trauma-focused CBT, CBT, and prolonged exposure) provided evidence for PTSD symptom reduction, with no specific intervention emerging as the most effective. Based on this finding, the authors tentatively put forth that interventions exploring self-compassion as either therapy itself, or as an adjunct to the applied therapy model, may lower PTSD symptoms.

Scoglio and colleagues (2018) investigated the interrelationship among emotion dysregulation, self-compassion, resilience, and PTSD symptoms in women who have experienced interpersonal trauma, consisting of either physical or sexual violence. Of the female participants, the majority had experienced extensive trauma during both childhood and

adulthood. Results supported the study's main hypothesis that the severity of PTSD symptoms and emotion dysregulation was negatively correlated to self-compassion, but positively associated with resilience (Scoglio et al., 2018).

Acknowledging the complexity of working with sexual assault survivors, McLean et al. (2021) aimed to develop a CFT-based intervention specifically for female survivors of childhood sexual abuse. These authors wanted to learn first-hand about any specific needs and considerations from the perspective of the survivors themselves, as well as exploring the perspectives of the counsellors who work with them. To do this, two focus groups were formed: one for female survivors of childhood sexual abuse and the second for counsellors. A consensual qualitative research design captured the perceptions and experiences of both survivors and counsellors, generating common themes related to the survivor, the counsellor, and the therapeutic process, all of which could augment or interfere with the cultivation of compassion. Examples from their findings of ways to increase self-compassion in survivors included receiving positive support from others, including counsellors. Therefore, counsellors can help generate self-compassion in survivors by providing them with positive support and assisting in the establishment of new relationship schemas. An example of a barrier in cultivating self-compassion was feelings of shame and self-blame. Interventions that educate survivors about how they are not to blame for the abuse can reduce feelings of shame and self-blame.

Further demonstrating self-compassion's potential effect on trauma is an IPA study conducted by Lawrence and Lee (2014), who explored trauma survivors' experiences of CFT. Participants (5 women and 2 men) met the DSM-IV TR (APA, 2000) criteria for PTSD, with trauma histories varying between repeated trauma during childhood to a single traumatic event during adulthood. Each participant received either individual or group CFT training, with semi-

structured interviews used to capture their experiences. Not only did participants find that self-compassion helped them gain a new hopeful outlook on life, but they engaged in activities for the sake of pleasure rather than for achievement purposes (Lawrence & Lee, 2014).

Interpersonal Benefits. The positive mental health benefits of self-compassion experienced intrapersonally can also be experienced interpersonally. Neff and Beretvas (2013) discovered that not only does a self-compassionate person experience greater well-being (happiness, authenticity, optimism), but such well-being also carries over into romantic relationships. These findings arose out of Neff and Beretvas's (2013) study on 104 heterosexual couples, whose average length of relationship ranged between 1 to 18 years. Couples varied in relationship status between married (39%), common-law (41%), and living apart (21%), with the majority having children (60%). The authors additionally found that individuals high in self-compassion showed kindness towards their partners in their relationships; were caring and accepting of who they were; and provided the freedom their partners needed to be happy. Furthermore, the study's results revealed that self-compassionate people experienced higher relationship satisfaction and secure attachment (Neff & Beretvas, 2013).

Yarnell and Neff (2013) also explored the relationship between self-compassion and the needs of oneself and of others during interpersonal conflict. Participants included 506 undergraduate college students who were instructed to think of a conflictual time with someone close to them. The researchers also had participants disclose ways in which the conflict was resolved (self-subordination, compromise, or self-prioritization), how they felt about the final resolution outcome, the emotional turmoil associated with the resolution, and their emotional well-being within a relational context. Results of the study showed that participants high in self-compassion resolved conflict in a compromising manner, believed that their conflict resolution

skills were authentic (e.g., their behaviour was in alignment with their internal beliefs; Neff & Harter, 2002), experienced minimal feelings of internal conflict, and maintained a high level of emotional well-being within their relationship (Yarnell & Neff, 2013).

Recovery From Sexual Problems. The positive interpersonal effects of self-compassion are also being experienced within sexual relations. Santerre-Baillargeon and associates (2018) investigated self-compassion among women with provoked vestibulodynia (along with their partners) as well as self-compassion's association with anxiety, depression, sexual distress, relationship satisfaction, and sexual intercourse pain. Data were collected from two research sites in North America from 46 heterosexual couples and 2 same-sex couples. Cultural backgrounds for participants consisted of English-Canadian, French-Canadian, and other, with an average age of 26 for the women with provoked vestibulodynia and 28 for their partners. Couples completed a structured interview together, and online self-report questionnaires were completed separately. Various measures assessed for self-compassion, anxiety, depression, sexual distress, pain, and relationship satisfaction. The study revealed that couples, where both partners had high levels of self-compassion, experienced less depression and anxiety (Santerre-Baillargeon et al., 2018). This is an important finding since anxiety and depression are not only common among women with provoked vestibulodynia, but can predispose the woman to sexual pain, as well as be a consequence of provoked vestibulodynia (Khandker et al., 2011). Santerre-Baillargeon et al. (2018) propose different possibilities for this finding, one being that self-compassionate people use healthy coping mechanisms, catastrophize less, and tackle difficult tasks as opposed to avoid them, which leads to less anxiety following a stressful situation (Allen & Leary, 2010; Santerre-Baillargeon et al., 2018). Also, the study suggested that when partners experienced high levels of self-compassion, they were also more satisfied with their relationship, and both women and their

partners had less sexual distress (Santerre-Baillargeon et al., 2018). However, as hypothesized, no relationship was found between self-compassion and the reduction of sexual pain intensity. This hypothesis was based on studies that found no relationship between various forms of chronic pain and self-compassion (Costa & Pinto-Gouveia, 2011 & 2013; Purdie & Morley, 2015; Sirois et al., 2015; Wren et al., 2012). The authors offered an explanation for this finding, suggesting that although self-compassion has been found to help participants adjust to their chronic pain (e.g., utilization of positive coping mechanisms, less catastrophizing, anxiety, and depression; Costa & Pinto-Gouveia, 2011 & 2013; Purdie & Morley, 2015; Sirois et al., 2015; Wren et al., 2012), self-compassion may be too "distal" to help with pain intensity. In other words, self-compassion has more of an effect on the variables related to pain than the pain intensity itself.

Other than Santerre-Baillargeon et al.'s (2018) study, the only other known study to research self-compassion and sexual problems was completed by Ferreira et al. (2020). They investigated whether an individual's self-compassion lessened distress related to their sexual concerns on not only their own but their partners' sexual satisfaction. To test this, 125 mixed-sex married couples completed a series of measures, including the Self-Compassion Scale Short-Form (Raes et al., 2011) at baseline. Then, for 21 consecutive days, the couples completed the 12-item Distress About Sexual Problems Scale (Ferreira et al., 2020) on days when genital sexual contact occurred, as well as completing the Quality of Sex Inventory (Shaw & Rogge, 2016) on a daily basis to measure sexual satisfaction. Findings revealed that when individuals were upset over their sexual problems, both partners were less sexually satisfied that day. The opposite occurred on days when individuals were more self-compassionate. Specifically, higher levels of individual self-compassion resulted in less sexual distress for both the individual and

the couple. The researchers also found that for husbands, but not wives, higher trait self-compassion resulted in more sexually satisfied partners on a daily basis. Also, a husband's level of stress about his sexual problems was negatively associated with his daily sexual satisfaction when he experienced low self-compassion, and no relationship was found when husbands experienced high self-compassion. This finding was also true for husbands when they experienced distress related to orgasm, desire, and subjective arousal. Additionally, while there was no relationship between a husband's stress level and his sexual problems and his wife's daily sexual satisfaction when the husband experienced low self-compassion, a negative relationship occurred when the husband had high self-compassion. The same findings were evident for husbands' duress pertaining to subjective and initial physiological arousal, the maintenance of physiological arousal, and pain. Thus, it appeared that husbands' self-compassion mediated the negative impact of distress concerning sexual problems and their own sexual satisfaction but increased their partner's level of duress. One plausible explanation for this finding offered by Ferreira et al. is that self-compassionate husbands saw their sexual experiences as rewarding regardless of any emotional and cognitive turmoil. However, this may also mean that husbands with high levels of self-compassion were less motivated to repair sexual issues between themselves and their wives, resulting in their partners feeling disappointed. These researchers also offered explanations for why wives' self-compassion did not mediate the relationship between daily distress about sexual issues and daily sexual satisfaction for spouses. They proposed that women sought social support from people other than their husbands, whereas husbands relied mostly on their wives for support. Using this theory, the authors stated that while self-compassion is important for men to cope with distress from sexual problems, women may rely on additional resources for coping. Furthermore, Ferreira et al. suggested that heterosexual

sexual scripts may play a role in this finding. For instance, one heterosexual sexual script involves men ensuring their partners are sexually satisfied and reach orgasm (Sakaluk et al., 2014). This places pressure on men to be good at sex. Therefore, any sexual problems that arise between a heterosexual couple implies that it is the male's fault. Self-compassion then becomes critical for men to cope with distress related to sexual issues.

Buffering Effect From Body Image Concerns. Another potential benefit of practicing self-compassion is its buffering effect on eating pathology and issues related to body image. Demonstrating this, Braun et al. (2016) conducted a systematic review of 28 studies utilizing various study designs. The review supported previous research suggesting that self-compassion is negatively associated with body dissatisfaction, comparing oneself to others, and basing one's self-worth on appearance. A negative relationship between self-compassion and body image avoidance (e.g., an individual avoids social situations where they anticipate being judged based on body image; Rosen et al., 1991) was also supported by the review. Furthermore, self-compassion was found to be positively related to body appreciation in females from the US, Canada, and Thailand (Homan & Tylka, 2015; Pisitsungkagarn et al., 2014; Wasylkiw et al., 2012).

More recently, Wang et al. (2020) examined the moderating effect of self-compassion on the relationship between body talk on social networking sites to body shame and body surveillance. In the study, body surveillance was described as constantly monitoring one's physical body and perceiving it from an outsider's perspective. Body talk involved conversations with others that focused on, reinforced, and constructed physical appearance ideals (Hart et al., 2017; Jones & Crawford, 2006). The sample consisted of 313 undergraduate students in China, 194 who were women. Participants completed measures related to body talk on social

networking sites (Jones et al., 2004), self-compassion (Raes et al., 2011), body surveillance, and body shame (McKinley & Hyde, 1996). Results revealed that self-compassion buffered the connection between body talk on social networking sites and body shame. However, self-compassion did not moderate the relationship between body talk on social networking sites and body surveillance. The authors of the study offered a plausible explanation for this negative association, stating that the type of social media platform, where people could *actively* compare and judge their own appearance, could decrease a person's self-compassion and result in an increase in body surveillance.

Psychotherapeutic Approaches for Fostering Self-Compassion

The fact that researchers are beginning to explore the relationship between sexual problems and self-compassion is encouraging, given that troubles with sexual desire, arousal, pain, orgasm and sexual well-being are just some of the sexual issues women can experience after a sexual assault (Kelley & Gidycz, 2017; Leonard et al., 2008; van Berlo & Ensink, 2000). However, to my knowledge, this study is the first to examine women's experiences of self-compassion in coping with sexual problems following a sexual assault. Learning how to convey compassion towards oneself would be beneficial, given the many negative consequences sexual assault survivors can experience. In the section below, I discuss three therapeutic approaches for strengthening people's self-compassionate practices: compassion focused therapy, compassionate mind training, and mindful self-compassion.

Compassion Focused Therapy. Out of Gilbert's compassion theory arose CFT, an integrative form of psychotherapy that draws from social, developmental, and evolutionary psychology; neuroscience; and Buddhist thinking (Gilbert, 2009). Compassion-focused therapy incorporates compassion as an important piece in the psychotherapy process (Gilbert, 2009). One

of the goals of CFT is to help clients understand the bioevolutionary reasons for symptom development (Gilbert, 2010). Gilbert (2009) claims that the primary reason people develop symptoms is a result of the brain developing an over-active threat system to keep the person safe from harm. He states from an evolutionary and biological perspective, this is not the person's fault, but rather a product of an automatic brain response and patterns of brain activation over time. Understanding this phenomenon may help clients develop more compassion toward themselves (Gilbert, 2009). Although individuals are not to blame for problematic patterns of brain activation, Gilbert argues people can take responsibility for their thoughts, feelings, and actions as they move forward in their healing.

Compassionate Mind Training. An integral part of CFT is compassionate mind training (CMT), or the skill-building component of CFT (Gilbert, 2009; Leaviss & Uttley, 2015). Compassionate mind training was originally developed for people with high shame and self-criticism (Gilbert & Irons, 2005; Mayhew & Gilbert, 2008). The theory behind CMT is that people high in shame or self-criticism find it challenging to soothe oneself when feeling distressed (self-soothe), partially because they never had the opportunity to learn these important skills (Mayhew & Gilbert, 2008). People with high shame/self-criticism often have a traumatic and shaming history (Mayhew & Gilbert, 2008). Helping people with chronic psychological challenges develop ways of becoming self-compassionate has shown to be beneficial (Gilbert & Procter, 2006).

The goal of CMT is to teach clients the attributes of compassion, which Gilbert (2009) lists as care for well-being, sensitivity, sympathy, distress tolerance, empathy, and non-judgement. Gilbert (2009) also describes specific skills clients can learn to develop these attributes and use on themselves when needed. These skills of compassion are not only

multimodal, but often found in other forms of psychotherapy, and involve imagery, attention, feeling, sensation, behaviour, and reasoning (Gilbert, 2009). To provide an example of the skill *compassionate attention* as an attempt to deactivate the threat protection system, the therapist may ask the client to focus their attention on something other than their problems, perhaps when the client showed compassion towards another person.

To demonstrate the effectiveness of CMT, Gilbert and Procter (2006) conducted an uncontrolled study on clients (4 women and 2 men with an average age of 45.2 years) who were attending a cognitive-behavioural-based day treatment for chronic, complex psychological difficulties. Participants completed 12 two-hour training sessions in CMT that involved exploring the topics of self-criticism, the nature of therapy, compassion and self-compassion as the basis of therapy, and the worries associated with becoming self-compassionate. The study unveiled that after receiving CMT training, clients were less self-critical, and experienced fewer feelings of anxiety, inferiority, and depression. Participants also engaged in more assertive behaviour, were able to self-soothe, and demonstrated more self-reassurance (Gilbert & Procter, 2006).

Other studies have also explored the effectiveness of CMT. For instance, Noorbala et al. (2013) researched whether CMT helped 19 Iranian female psychiatric patients, between the ages of 20 and 40, who were diagnosed with major depressive disorder. Participants were randomly assigned to either an experimental or control group. Those in the experimental group received 12 two-hour CMT group sessions over a 6-week period, whereas those in the control group did not receive any intervention. Results revealed that at the two-month follow-up assessment, participants in the experimental group experienced a significant decrease in depression and anxiety, as well as a reduction in self-criticism. Similarly, Irons and Heriot-Maitland (2021)

delivered an 8-week CMT course to adult in the general public (n = 55), where participants completed pre-and post-measures of self-compassion, compassion for and from others, attachment, self-criticism, positive emotion, intrapersonal welfare, and distress. Findings indicated that participants were more compassionate towards themselves and others, as well as being more open to receiving compassion from individuals. Significant improvements were also found in interpersonal relationships, well-being, self-criticism, and mental distress. Additionally, the above-mentioned changes were maintained 3 months after the conclusion of the course.

Mindful Self-Compassion. Mindful Self-Compassion (MSC; Neff & Germer, 2013) is another psychological intervention developed to augment self-compassion. Learning to be more mindful can assist in increasing self-compassion since mindfulness is not only a requirement for self-compassion, but an essential component (Neff, 2003a, 2003b; Neff & Germer, 2013). The MSC program is used on both clinical and non-clinical populations, which requires participants meeting for 2 or 2.5 hours once a week for 8 weeks, as well as attending a half-day meditation retreat. Basic mindfulness skills are taught, as well as other skills, such as self-kindness, which Neff and Germer (2013) regard as being an element of self-compassion.

Two studies were conducted to explore the effects of MSC on adults' self-compassionate capacities. The first study consisted of a non-clinical sample of 21 participants, primarily female and Caucasian, with a mean age of 51.26 and who had some prior meditation experience. Results revealed that participants experienced significant increases in self-compassion and mindfulness, which were maintained 6 months after the intervention (Neff & Germer, 2013). Other benefits included less stress, anxiety, and depression, as well as an increase in happiness and an overall sense of satisfaction of life in general.

Neff and Germer (2013) conducted a second randomized controlled study that compared the outcomes for non-clinical participants in an MSC course versus the waitlist control group. Results showed that compared to the control group, the MSC group had significantly higher levels of self-compassion, mindfulness, and compassion towards others. Participants in the MSC program also felt more content with life, experienced less mental health effects, and addressed difficult situations as opposed to engaging in avoidance behaviours (Neff & Germer, 2013). Results further uncovered that self-compassion remained stable at the 6-month and 1-year mark post-test. What the results of these two studies of the MSC program suggest is that MSC is efficacious at increasing self-compassion, mindfulness, compassion towards others, and other components of well-being (Neff & Germer, 2013).

Summary

As discussed in this chapter, sexual assault can have long-lasting, negative effects. Somatic, mental health, and interpersonal problems are just a few of the negative consequences women can experience after a sexual assault. More specifically, survivors often complain of headaches, body pain, anxiety, depression, and trust issues. Sexual problems are another concern that can result from sexual assault. Survivors may experience troubles with desire, arousal, orgasm, pain and sexual well-being, with some women reporting symptoms lasting months and even years. As self-compassion has been shown to ameliorate shame, depression, anxiety, and other symptoms that can plague survivors of sexual assault, it seems plausible that self-compassion may also help survivors cope with sexual concerns. However, to date, this has been an understudied area of research. Thus, in this study, I set out to explore women's experiences of self-compassion in coping with sexual problems following a sexual assault. In the next chapter, I will outline the details of how I conducted my study.

Chapter 3: Methodology

In this chapter, I outline the reasons that I chose qualitative research for this study. In this context, I discuss feminism – the theoretical lens through which I frame not only this study, but the world in which I live – as well as the epistemological and ontological assumptions of feminist paradigms. I then explain why I used IPA as my research approach to capture the richness of women's experiences of self-compassion in coping with sexual problems following a sexual assault. Next, I explore the philosophical assumptions of IPA, specifically phenomenology, hermeneutics, and ideography. I then outline specific methods that I used for recruiting participants, and describe the details of the study's data collection and analysis. I conclude the chapter by reviewing the criteria for establishing trustworthiness and credibility for my study, along with relevant ethical considerations.

A qualitative research approach was appropriate for my study, given that qualitative research seeks to understand how individual realities are experienced and constructed, based on the assumption that phenomena within the world are complex and can be viewed from multiple perspectives (McLeod, 2000). To achieve this understanding, qualitative researchers explore behaviours, perspectives, feelings, and experiences in depth, as well as investigate the quality and complexity of a situation through a holistic framework (Rolfe, 2006). Using an inductive approach, qualitative research applies methods in a conscientious and flexible manner (Creswell, 2007), allowing the researcher to immerse themselves in the topic and capture the complexity of the experience(s) being studied (McLeod, 2000).

Theoretical Perspective

The research approach taken in a particular study functions in tandem with the researcher's theoretical perspective – how they view and make sense of the world, and how they

understand and describe society and humankind (Crotty, 1998). A researcher's theoretical perspective influences how they conduct research, from the questions they ask to how they collect and analyze data (Creswell, 2013). This perspective also informs the question of which topics are considered worthy of investigation and the population to be studied (Creswell, 2013). Furthermore, the ways in which the researcher orients themselves within the research is determined by their theoretical perspective (Creswell, 2013). A theoretical perspective also influences final written reports (Creswell, 2013). For instance, it takes into account important considerations, such as power differentials between the researcher and participant, and how to avoid marginalizing participants (Creswell, 2013).

As a researcher, my theoretical perspective employs a feminist lens. A feminist approach explores women's experiences in a considerate manner and views their stories as genuine sources of wisdom (Campbell & Wasco, 2000). By headlining stereotypes and biases that have suppressed women's voices, lives, and experiences, feminist research critically challenges the established dogmas that oppress women (Hesse-Biber & Leavy, 2007). A feminist research perspective uses research to highlight the injurious impact sexual violence has on women. It seeks to empower and liberate women and marginalized people, as well as creating social change and promoting social justice (Hesse-Biber & Leavy, 2007).

Assumptions of Feminist Paradigms

Feminist research has been both methodologically and politically influential over the last few decades. For instance, it has contributed to important methodological ideas, such as "standpoint, positionality and reflexivity" (Burns & Walker, 2005, p. 66). It has also provided a voice for women in both society and research. For example, Burns and Walker (2005) discussed the ways in which male scientists and researchers in the past perceived women as "passive and

subordinate" and deemed unfit to participate in research (p. 66). Now, however, feminist research is viewed as being "for women as much as it is about women" (p. 66).

Feminist research has also raised important philosophical issues surrounding ontology and epistemology. Ontology is concerned with the nature of reality or the study of being (Creswell, 2013; Rawnsley, 1998). Epistemology, however, is what we consider as knowledge or how knowledge is known (Burns & Walker, 2005). Together, these philosophical concepts help us develop knowledge around reality. In this study, I discuss feminist metaphysics as an ontological position. First though, I discuss key developmental ideas in feminist epistemology.

Feminist Epistemology

As a pioneer in feminist epistemology, the Canadian feminist philosopher Lorraine Code started asking epistemological questions that were considered "outrageous" at the time (Code, 1981; Doucet & Mauthner, 2006). Such questions included whether the sex of knowledge bearers was epistemologically important and how issues such as power and masculinity influenced how we attained knowledge (Code, 1981; Miller, 1976). She saw feminist epistemology as being different from the mainstream orthodox epistemology, typically Anglo-American at the time (Code, 1991; Doucet & Mauthner, 2006).

Also, during this time – and in favour of feminist epistemology – feminist scientists were investigating gender bias in scientific research (Doucet & Mauthner, 2006). Their emphasis was on how male participants dominated both experimental and clinical medical research, whereas female participants remained relatively invisible (Doucet & Mauthner, 2006). Similarly, feminist philosophers were examining the link between feminism and epistemology, with a focus on gender (Doucet & Mauthner, 2006). It was less evident whether applying a feminist analysis to

these issues would suffice, or if a specific feminist epistemology needed to be created to address such matters (Doucet & Mauthner, 2006).

The question of whether to apply a feminist analysis or epistemology to gender-related concerns remained central until Sandra Harding (1987) highlighted three unique feminist epistemological stances: feminist empiricism, feminist standpoint epistemologies, and transitional (postmodern) epistemologies. *Feminist empiricism* emerged in the 1960s and 1970s as a critique to male dominated research, where the majority of knowledge considered universal was formed from a male point of view (Burns & Walker, 2005; Doucet & Mauthner, 2006; Harding, 1987). Resolution of this problem was to include women's and girl's experiences in research, in order to produce "value-free (objective) knowledge" (Burns & Walker, 2005, p. 67).

Adding women's and girl's voices to research is essential to feminist methodologies (Burns & Walker, 2005). However, the influence of the researcher's role, experiences, and biases when producing knowledge was not considered in this solution. This dilemma led to Harding's (1987) second epistemological stance, known as the *feminist standpoint*. Feminist standpoint criticized objectivity as being the goal in research and regarded it as being sexist. Harding believed that objectivity biased knowledge construction, and that a woman's experiences and consciousness are important in the generation of social knowledge. Additionally, Harding believed that women's oppressive experiences (their standpoint) have provided them with an extensive view of social reality, and that these subjective perspectives of the researcher are important in creating and interrupting research.

The fact that women and their experiences are different is at the heart of Harding's (1987) third stage of *feminist postmodernism*. Although it is acknowledged that oppression of women is a worldwide problem (Burns & Walker, 2005), differences are found amongst women

of varying race, ethnicity, sexuality, and disabilities (Charlton, 1998; Collins, 1990; Harper & Schneider, 2003). In other words, not only will women experience oppression differently, but women may also find themselves in an oppressed relationship with other women, for example, white middle-class women speaking on behalf of all women (Burns & Walker, 2005). Knowledge is, therefore, "partial and situated" (Burns & Walker, 2005, p. 68). To address this concern, Burns and Walker (2005) suggested that feminist research examine the complex interaction between gender and all aspects of individual differences. Postmodernism then posits that there are many forms of perceived realities, and there is no single established classification of the definition of "woman" (Burns & Walker, 2005). Therefore, one of the goals for current feminist researchers is to find ways of interfacing with the complexity and differences amongst individuals, while fighting for women's rights and resolving universal problems that women are faced with, such as oppression.

Presently, the distinctions between Harding's three feminist epistemologies have become obscured – a trend Harding herself not only expected but encouraged (Anderson, 2017; Harding, 1991, 1998). Whereas traditional theorizing in feminist epistemology involved investigating broad questions related to gender and knowledge (Anderson, 2017), modern feminists have an interest in exploring local or more specific ways gender influences knowledge production (e.g., within particular communities as the LGBTQ; Anderson, 2017). It was this transition from studying knowledge production broadly to more specific perspectives that feminists now agree on the convergence of the three types of feminist epistemology (Anderson, 2017).

This convergence demonstrates that there is no longer a single feminist standpoint that claims a broad epistemic dominance (Anderson, 2017). Feminists have now moved in a "pluralistic direction," recognizing that there are many equally differing, yet informative,

standpoints due to the merging of marginalized groups (Anderson, 2017). It is believed that knowledge will be richer when drawn from the insights and difficulties of marginalized groups, rather than from only privileged groups (Anderson, 2017; Harding, 1998). This new way of thinking views "subaltern" standpoints as more valuable, allowing society to envision more realistic social relations, compared to believing only in one dominant perspective (Anderson, 2017). As a result of this shift in thinking, feminists today tend to reject essentialism, or that the standpoints of every social group (e.g. advantaged and disadvantaged) are alike. Instead, feminists appreciate the uniqueness of each social group's standpoint, and view each as epistemically valuable (Anderson, 2017).

To ensure that I adhered to this pluralistic approach when exploring women's standpoints in the present study, I aimed to obtain an ethnically diverse sample as much as possible to learn from participants how they used self-compassion to cope with sexual problems post sexual assault. Also, as a researcher, I recognized the potential power differential between the participants and me. To help overcome this difference, I encouraged a collaborative dialogue between us and let the participants know I was there to learn from them. I also foregrounded in the research my biases and past experiences that may have influenced the way in which I approached and interpreted the research study.

Feminist Metaphysics

Whereas feminist epistemology examines how gender influences our conceptions of knowledge, *feminist metaphysics* investigates common beliefs and ideas that are taken for granted as being reality and investigates ways in which they may have been gendered (Haslanger & Sveinsdóttir, 2011). A common misconception, for example, is that sexual assault is about sex. However, sexual assault is about power and control over a perceived subordinate, with women

being the primary target (Donat & D'Emilio, 1992). The common belief that women are the inferior sex has dominated for centuries (Donat & D'Emilio, 1992). However, the feminist movement in the late 1960s has helped in uncovering the truth by reexamining misconstrued understandings around topics of women and sexual assault.

Indeed, one of the goals of feminist metaphysics is to demonstrate how "natural properties and relations" have been socially created (e.g., gender; Mikkola, 2016, p. 662). For instance, society typically uses the terms female and male to mean the same as women and men, respectively. However, in general, *sex* refers to biological and anatomical features distinguishing males and females, such as chromosomes, genitalia, and hormones (Muehlenhard & Peterson, 2011). *Gender* on the other hand, signifies the social construction of male and female and is associated with the terms men and women respectively (Muehlenhard & Peterson, 2011). Mikkola (2016) also adds that feminists acknowledge that people can be intersex, non-binary and transgender. The motivation behind distinguishing between sex and gender was to dispute biological determinism, or "the view that one's sex determines one's social roles and cultural traits" (Mikkola, 2016, p. 663). In the past, Mikkola asserted that various sociocultural and psychological variations were considered "real" or "natural" differences between women and men and were used as a reason to oppress women. For example, it would be pointless to grant political rights to women due to their "supposed natural" tendency to be uninterested in such political matters. Feminists argue that these "supposed natural differences" are socially constructed and are not innate (Mikkola, 2016).

The metaphysics of gender, or what gender is, is at the heart of what feminists consider social construction (Mikkola, 2016). However, feminists have highlighted how other constructs, such as sex, can be socially created (Mikkola, 2016). In the most explicit form of construction,

surgery can help people become a different sex. However, there are subtler ways construction can occur. For instance, some societies see women as inferior, resulting in them receiving less food and consequently, causing them to be smaller in size (Jaggar, 1983; Mikkola, 2016). This means that muscle mass, size, and strength are not only determined by biological factors, such as genes and hormones, but instead by opportunities to attain food and exercise. Examples like this infer that any secondary sexual characteristic, such as body shape and size, can be socially and culturally assembled (Haslanger, 1995; Mikkola, 2016).

Research Methodology

Choosing a research methodology and associated methods is one of the most important, yet challenging issues researchers face (Charlick et al., 2016). The chosen methodology must "fit" within the scope of the study, influencing the research question(s), and providing depth and breadth of the research findings. In the present study, I explored women's experiences of self-compassion in coping with sexual problems after a sexual assault. Viewing this study from a feminist stance, I was aware of women's issues, such as oppression, as well as the political and sociocultural factors that have contributed to the sexual concerns that women face as a result of the sexual assault. Therefore, I needed to choose a methodology that took these factors into consideration. Hence, I chose IPA.

There were a number of reasons why IPA was an appropriate methodological approach for this study. To begin with, IPA draws from phenomenology, which aims to attain and describe an individual's experience of a phenomenon – essential to capture women's experiences of self-compassion (McLeod, 2000; Pietkiewicz & Smith, 2014). In addition, the small sample size typically used in IPA, along with its idiographic approach, captures the richness and depth of participants' experiences that are so crucial in most qualitative research (Smith, 2004).

Interpretative phenomenological analysis is also a useful methodology for exploring complex topics (Smith & Osborn, 2004), such as the constructs studied together in this study: self-compassion, sexual assault, and sexual problems. Furthermore, IPA may help to give a distinct voice to vulnerable populations, such as sexual assault survivors (Charlick et al., 2016). For these reasons, this study used IPA to explore women's perceptions of self-compassion in the aftermath of a sexual assault and how women's perceptions relate to sexual concerns.

Philosophical Assumptions of IPA

Founded by Jonathan Smith (1996), IPA is a modern, widely accepted, qualitative methodological approach. It can be used in conjunction with other research methodologies or on its own (Charlick et al., 2016). Interpretative phenomenological analysis is derived from three theoretical approaches: phenomenology, hermeneutics, and idiography (Shinebourne, 2011).

Phenomenology

The philosophy behind phenomenology offers IPA a foundation for obtaining rich information about people's lived experiences (Smith et al., 2009). Phenomenology "aims at identifying the essential components of phenomena or experiences which make them unique or distinguishable from others" (Pietkiewicz & Smith, 2014, p. 8). It acts as a guide to help us understand the experiences of being human, especially what we find meaningful and what we consider important in the world we live in (Smith et al., 2009). There are two different approaches to phenomenological enquiry: descriptive and interpretive phenomenology. The roots of IPA can be found in both.

The goal of *descriptive phenomenology* is to describe a phenomenon, or lived experience, without assigning meaning to it (Smith et al., 2009). Edmund Husserl (1859-1938) is widely recognized as the founder of descriptive phenomenology (Charlick et al., 2016; Creswell, 2013).

To identify which factors make a phenomenon special, Husserl proposed using phenomenological reduction, which involves suspending our assumptions, or bracketing off sociocultural and historical context as much as possible to arrive at the pith of a given experience (Dowling, 2007). In IPA, this refers to the researcher suspending their presuppositions and judgements (bracketing), and focusing solely on the data presented in the transcripts (Charlick et al., 2016). In other words, the researcher attempts to put aside their own assumptions and experience when studying a particular lived experience.

Hermeneutics

Whereas Husserl developed descriptive phenomenology, Martin Heidegger (1962) developed *interpretive phenomenology* by including hermeneutics, the philosophy of interpretation (Creswell, 1994). Heidegger, a student of Husserl's, was more interested in ontology, the meaning of "being" and the way in which individuals make sense of their everyday lives (Heidegger, 1962). He introduced the German term *dasein*, translated roughly as persons or existence, and claims that *dasein* is never found outside of an environment (Wollan, 2003). Heidegger argued that it is absurd to analyze people apart from their relationship with their environment and other people. Consistent with Heidegger's views, IPA deems phenomenological inquiry an interpretative process (Pietkiewicz & Smith, 2014). Researchers using IPA attempt to understand what it is like to live the life of the participant by interpreting and making meaning of the participant's experiences (Pietkiewicz & Smith, 2014). Interpretative phenomenological analysis is considered dynamic in nature, and is often referred to as a *double hermeneutic* or *dual interpretation process* (Pietkiewicz & Smith, 2014). What this means is that where participants are trying to make sense of their world, the researcher tries to decipher that meaning and understand the participants' meaning making. Basically, IPA researchers attempt to interpret the

participant's own (interpreted) experience.

Idiography

The third theoretical approach that influences IPA is *ideography*. This is an "in-depth analysis of single cases and examining individual perspectives of study participants in their unique contexts" (Pietkiewicz & Smith, 2014, p. 8). In other words, individual differences are explored, providing a more complete understanding of that individual. This is in contrast to a nomothetic approach, where differences amongst people are studied, often with the intent of making general predictions about the population (Molenaar 2004). Both of the terms idiographic and nomothetic were both introduced into the English language by Gordon Allport in the late 1800s, but were used earlier in the writings by German philosopher Wilhelm Windelband (Shinebourne, 2011). However, it is because of idiography and the study of particulars that researchers feel comfortable making specific statements about individual cases (Pietkiewicz & Smith, 2014). Using an idiographic approach gives researchers the freedom to produce a single case study by examining one individual's case in detail (Shinebourne, 2011). Or, if researchers study more than one individual, they can move between the various themes found amongst the participant's transcripts, looking for similarities and differences (Pietkiewicz & Smith, 2014).

Methods

Participants and Recruitment

Coyne (1997) proposed that qualitative researchers use a small selective sample due to the in-depth nature of the study and analysis of data required. Pietkiewicz and Smith (2014) agreed with this statement, claiming that samples in IPA studies are generally small, to allow the researcher to conduct a detailed, in-depth examination of a certain phenomenon. However, there is no standard on the number of participants included in a study. In fact, Pietkiewicz and Smith

stated that it depends on various factors, such as richness of individual information; depth of analysis; and availability of participants. Smaller sample sizes allow the researcher to intently learn about each individual, and how they respond to specific events (Pietkiewicz & Smith, 2014). Samples in IPA also tend to be relatively homogeneous, with participants purposely chosen based on the phenomenon in question (Chapman & Smith, 2002). In accordance with these suggestions, this study recruited 10 adult female sexual assault survivors who had experienced sexual assault in either their childhood, adulthood or both. Participants ranged in age between 21 and 44, with three participants being in their 20s, four participants being in their 30s, and three participants being in their 40s. Eight of the 10 participants identified as Caucasian, with two of the women identifying as Chinese/Canadian and South Asian/Caucasian. Participants had experienced and practiced self-compassion in response to sexual concerns (e.g., desire, arousal, pain, orgasm troubles, and sexual well-being) post-assault and were willing to express these experiences.

Ensuring the emotional stability of participants is an important consideration when conducting research. Given the lasting impact sexual assault can have on survivors, precautions must be taken during the research process to not further re-traumatize participants, or cause undue duress. Studies investigating the impact research has on trauma survivors, including sexual assault survivors, have found that most trauma participants do not experience extreme psychological duress, and that many find the overall research experience to be positive (Becker-Blease & Freyd, 2006; Griffin et al., 2003; Jaffe et al., 2015). However, compared to non-trauma survivors, trauma survivors do report more distress regarding the research experience, especially trauma survivors with symptoms of PTSD (Jaffe et al., 2015). Jaffe and colleagues' (2015) meta-analysis on research participants' reactions to trauma research also found how disclosing the

assault for the first time can increase distress. Therefore, to minimize the risk of potential harm, participants were required to have disclosed the assault to at least one other person before participating in the current study. Also, the Impact of Event Scale – Revised (IES-R; Weiss & Marmar, 1997) was used to assess the extent of PTSD symptoms.

The IES-R is deemed a favourable self-report measure for assessing traumatic stress related to three major symptoms clusters of PTSD (intrusion, avoidance, and hyperarousal; Creamer et al., 2003). With sound psychometric properties, the IES-R reveals high internal consistency, with coefficient alphas ranging between .79 to .92, and test-retest correlation coefficients ranging between .51 to .94 (Weiss & Marmar, 1997). Using a Likert-scale, participants are asked to indicate how distressing each difficulty has been for them in relation to the traumatic event(s), with 0 representing "not at all" to 4 representing "extremely." Although there is no specific cut-off score, Creamer et al. (2003) recommended a cut-off score of 33 to accurately assess traumatic stress. Therefore, only participants who were not experiencing traumatic distress as indicated by an IES-R score of less than 33 were eligible to participate in the current study.

To summarize the inclusion criteria for the current study, participants were: (a) female; (b) 18 or 19 years or older; (c) self-identified as a survivor of sexual assault and experiencing sexual problems as a result of the sexual assault(s); (d) had disclosed the assault to at least one person; (e) had experienced self-compassion in response to sexual concerns post sexual assault; and (f) were willing to articulate their experiences of self-compassion in relation to their sexual concerns. Additionally, participants (g) were not in a state of traumatic distress as indicated by their score on the IES-R.

Participants were recruited at various sexual assault counselling centres, university

campuses, and online community listservs (e.g., Canadian Counselling and Psychotherapy Association's (CCPA) ListServ) across Canada. To acquire a purposeful sample, and when possible given the COVID-19 pandemic restrictions and the province in which the women resided, I met with counsellors at the various sexual assault counselling organizations to consult on the details of my study. When this option was not available, I provided the details of the study over the phone or via email. I also provided the counsellors with posters (Appendix B) about the study to display in their offices. Posters were advertised throughout university campuses across Canada. Interested participants contacted me via their preferred choice of communication (email or phone) where I discussed with them the particulars of the study and consent process, as well as emailed them the information letter and consent form (Appendix C) and the IES-R. After evaluation of the participant's returned IES-R, I contacted eligible participants to schedule an interview time and place. Three women were excluded from the study for being above the cut-off score on the IES-R (indicating high psychological distress), and 5 women were excluded due to a conflict of interest with the researcher. For those excluded, I took great care to discuss with them the reasons for exclusion and offered them a list of counselling resources (Appendix D) to assist in any distress participants may have experienced.

Data Collection

Semi-structured interviews tend to be the preferred method for obtaining data in IPA because of the rich, detailed information that can be obtained regarding the person's experience of a phenomenon (Pietkiewicz & Smtih, 2014). As Pietkiewicz and Smith (2014) stated, "semi-structured interviews allow the researcher and the participant to engage in a dialogue in real time" (p. 10). Smith (2004) also contended that an advantage of semi-structured interviews was

that it allowed the researcher to follow up on information obtained during the interview that the researcher deemed important.

The relationship between researcher and participant is also important when conducting interviews. In fact, Lincoln and Guba (1989) stated that this relationship is more important than uncovering the truth, and that showing dignity and respect to participants is paramount in building and maintaining rapport. This concept was also conveyed in Pietkiewicz and Smith's (2014) paper on IPA, when they stated that in addition to the researcher's interviewing skills, such as active listening and asking open-ended questions, that it was important to build rapport and gain the participant's trust, especially when discussing sensitive topics, such as sexual problems after a sexual assault.

In line with IPA's recommended method of data collection, and to encourage a respectful relationship with participants in the present study, when possible, face-to-face semi-structured interviews were scheduled once participants were approved for the study. Exceptions to face-to-face interviews were held when participants resided outside of the interviewer's province of NS, when provincial and/or university restrictions due the COVID-19 pandemic did not allow for in-person meetings, and/or when participants did not feel comfortable meeting face-to-face given the pandemic. In such cases, semi-structured interviews were held over the phone. In total, five interviews were conducted face-to-face with the remaining five interviews held via phone. Interviews took-place at a secure, confidential location such as the sexual assault centre where the women were recruited. In accordance with IPA guidelines for conducting semi-structured interviews, approximately one and a half hours was set-aside for each interview (Pietkiewicz & Smith, 2014). A second, and sometimes third, interview was also held with participants when follow-up questions emerged. In this study, 6 participants agreed to a second interview and 3

participants underwent a third. Although I contacted one participant multiple times for a follow-up interview, it appeared she was unavailable for a second interview. Prior to the interview commencing, I reviewed and obtained a signed copy of the information letter and consent form, and had participants complete the demographic form (Appendix E). Every effort was made to ensure participants felt safe and comfortable, such as, promoting a collaborative dialogue; ensuring a comfortable room temperature when in-person interviews took place; and frequent check-ins to monitor the impact of the interview on participants when body language and/or facial expressions were obscured due to personal protective equipment or sessions held over the phone.

Participants were asked to choose a pseudonym at the beginning of the interview to protect their anonymity. In alignment with IPA recommendations, I asked participants 8 interview questions with prompts (Appendix F; Smith et al., 2009). Sample interview questions included: What does self-compassion mean to you? In what ways have you practiced self-compassion since the sexual assault? What specific experiences of self-compassion has helped you cope with your sexual problems after the sexual assault(s). The interviews were audio-recorded and then transcribed verbatim. Throughout the interview, to help me later interpret participants' meaning, I also noted significant participant gestures and behaviours that I observed (e.g., kinesics, paralinguistics).

Data Analysis

Smith and colleagues (2009) outlined a step-by-step approach for the analysis of data using IPA. After transcription, the first step is for the researcher to immerse themselves in the data. To do this, I first read each transcript while listening to the audio-recording of the interview. This helped me to actively engage with the data. I then reread the transcript multiple

times, with the goal of becoming familiar with the data, and gaining a solid understanding of the transcript's content. Next, I took notes on anything significant or important the participant said or did that provided insight into that participant's experience of the phenomenon. To do this, I highlighted text that seemed relevant to the research questions and explained why I thought it was important. I also made note of any similarities, differences, or contradictions the participant made during the interview.

The third step of IPA involves capturing emerging themes from the initial notes (also referred to as codes). Themes are more evolved than the codes and are considered a "higher level of abstraction" (Pietkiewicz & Smith, 2014, p.12). In the current study, this step of analysis involved me uploading the participants' transcripts into the qualitative software package ATLAS.ti Version 8 (Scientific Software, 2012) to help organize the interview data. The lower-level themes corresponded to text in the participant's transcript and aimed to capture the essence of what the participant said. This process was repeated throughout the entire transcript. If similar themes were found throughout the transcript, I used the same theme title. However, different emerging themes represented richness.

Step four consists of discovering connections amongst themes and consolidating them (Smith et al., 2009). Whereas some themes were similar and clustered together, others became superordinate themes. Regardless of the type of theme, I referred back to the transcript to ensure the theme resonated with the original text. This process was iterative. What this meant is that while participants were making sense of their experiences, I was attempting to interpret participants' meaning making. This process is referred to as *double hermeneutics* (Pietkiewicz & Smith, 2014). Themes that no longer fit with other themes or that were not rich were discarded at

this stage. This helped to ensure the remaining themes were the most "accurate" in capturing the meaning participants assigned to the phenomenon being studied.

The fifth step of IPA involves repeating the same process with other transcripts. Smith and colleagues (2009) claimed that there are two ways in which to approach this step. One is to complete each transcript from the beginning as previously identified. The other way is to use the same themes from the first transcript to guide analysis (Smith et al., 2009). I chose to complete each transcript from the beginning, starting with the first participant interview and proceeding in order in which participants were interviewed.

The last step of IPA involved me recording similarities and differences amongst all transcripts, to help me gain a better understanding of the phenomenon. To do this, I engaged in what Smith et al. (2009) called *abstraction*, where I identified patterns amongst themes across all transcripts and created a super-ordinate theme. I also partook in *numeration,* meaning I clustered frequently emerging themes and constructed a super-ordinate theme (Smith et al.). Smith and colleagues stated that recurring themes indicate relative importance and can be viewed as an emergent theme. These authors also suggested that to be considered recurrent, an emergent or super-ordinate theme must appear in at least a third or a half of participant interviews. In line with these guidelines, for this study, themes were deemed recurrent when present in one-half (i.e., .5 or more) of participant transcripts.

Establishing Quality

Research quality, also known as rigor or trustworthiness (Creswell, 2013) is defined as the "systematic approach to research design and data analysis, interpretations, and presentation" (Hays et al., 2016, p. 173). Rolfe (2006) stated that establishing trustworthiness is imperative, and that the audience determines research quality based on the credibility of the researcher's

findings. It is therefore important for the researcher to explain the research process and findings in detail to help establish credibility amongst their readers (Hays et al., 2016). Additionally, Magolda and Weems (2002) highlighted that the unique, close relationship between researcher and participant(s) are key in minimizing harm in qualitative studies. While Magolda and Weems acknowledged that "harm is an inevitable outcome of fieldwork" (p.505), they also advised researchers to take the following specific relational steps to reduce potential ethical dilemmas and facilitate research rigor: First, treat participants as humans (e.g., respect and dignity). Second, ensure validity of findings by conducting member checks. And third, triangulate data (which also offers different perspectives on a phenomenon).

To maximize trustworthiness in this study, I honoured participants with respect and every attempt was made to make the women comfortable and feel safe. For example, I ensured a comfortable room temperature for face-to-face interviews and reassured participants of their confidentiality (e.g., pseudonyms), regardless of whether interviews were conducted face-to-face or over the phone. Member checks were also performed by nine of the 10 participants, meaning the women reviewed their transcript to confirm my understanding. Receiving participant feedback as to the accuracy of the transcripts strengthened the precision of my interpretations. Despite multiple attempts to contact one participant, and after the participant confirmed that she had received the transcript, she did not indicate that any revisions or additions were needed. Therefore, in keeping with the informed consent process, the interview data were retained. To add additional rigour, I worked closely with my supervisor who provided an extensive peer review throughout the research process. As part of the review, she reviewed my codes and themes, ensuring they were grounded in the data, were clear, and made sense. Having a different perspective also aided in identifying, modifying, or removing codes/themes.

My study also established trustworthiness through memoing, or the documentation of my research process (Birks et al., 2008). Memoing allowed me to immerse myself into the research to a greater depth, aid in the clarification of my thoughts and research ideas, and document the decision-making process (otherwise known as an audit trail). The audit trail chronicles the researcher's decisions and pursuits of the research process, which can then serve as evidence of establishing rigour of the research study (Creswell & Miller, 2000). Lastly, I clarified any researcher bias I had pertaining to the research study. I outlined any biases, prejudices, and past experiences so that readers have an understanding of my position that may not only impact the study's approach, but also interpretations (Creswell, 2013; Creswell & Miller, 2000).

Ethical Issues and Considerations

One of the first steps I took to ensure ethical responsibilities were adhered to in the current study was to attain approval from the Research Ethics Board (REB) at the University of Alberta. Once approved, data collection began. Furthermore, I followed the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017).

Since participants were discussing a delicate subject matter (sexual assault and sexual problems), steps were taken to ensure the well-being for each participant. For instance, the informed consent form that participants signed before the start of the study clearly stated the risks and benefits of participating in the study (please see Appendix C, Information Letter and Consent Form, for additional details). Participants were informed that they were free to refuse to answer any question(s) and could end their participation at any time without any negative consequences. As a precaution, participants were provided with a list of local resources (e.g., 24-hour crisis line) for support and counselling services in their area. I am also a trauma-informed doctoral counselling student, and was able to provide immediate assistance if necessary. For

example, if a participant showed distress (e.g., crying), I would inquire if she wanted to take a break or stop the interview. Rescheduling of the interview would be provided upon the participant's request. To my knowledge, however, no participants in the present study demonstrated distress during the interview.

In addition to receiving REB approval, following the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017), and obtaining a signed consent form, another way I ensured that ethical standards were adhered to was to maintain participant confidentiality. To maintain confidentiality in this study, participants chose a pseudonym to be used throughout the study. Also, any identifying and/or potentially identifying information was changed. To show my appreciation for participant's participation, participants received a $25 gift card of their choice (e.g., Starbucks). Also, a summary of the report will be offered to participants following the conclusion of the study.

Summary

This qualitative study used IPA to capture the experience of women's use of self-compassion in coping with sexual problems in the aftermath of a sexual assault. Theoretically, this study was grounded in a feminist epistemological stance, with an attempt to empower women to speak out about the deleterious effects of sexual violence (i.e., sexual concerns), and how self-compassion helped them cope. Data collection consisted of one-on-one semi-structured interviews, followed by data analysis that relied upon Smith and colleague's (2009) guidelines for IPA. Steps to ensure trustworthiness were carried out, such as the establishment of a trusting and supportive environment, member checks, peer reviews, memoing, and clarifying researcher bias. Lastly, I ensured that at all times, the study was conducted in accordance with the REB and the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017).

Chapter 4: Findings

The purpose of this study was to explore women's experiences of self-compassion in coping with sexual problems following a sexual assault. In line with IPA's idiographic approach, this chapter begins with vignettes that provide a short but detailed description of the lived experiences of each of the 10 participants. Following the vignettes is my presentation of the eight common themes that were apparent across participants.

Participant Vignettes

Sarah

Sarah was a Caucasian woman in her 30s. She was drugged and raped on two occasions by men she knew, resulting in her having no sexual desire and a loss of passion for life:

> I feel no desire at all. And for me, the harder thing is that the sense of desire expands beyond sexual desire. I used to feel a love for life, a love for other people, wanting to get to know people, like a deep sense of bodily enjoyment. I don't feel any of that anymore. It's more like a generalized numbness.

Sarah started practicing self-compassion to cope with "tough things" in her life, including the sexual assaults. She noticed that she was self-critical and deliberately made a strong effort to change her self-talk. An example of self-compassion for Sarah involved calling herself nice names and saying soothing comments to herself in a loving motherly manner. She started treating herself as she would treat a loved one by saying that everything would be okay. Sarah also connected with her body through dancing and listening to music as a form of self-compassion. Doing so brought about a sense of comfort and a "warm sensation" that spread throughout her body.

Showing herself compassion had an influence on Sarah's well-being. For example, she was able to "adjust to" and "embrace" her sexual concerns. Sarah also became more assertive after her sexual assaults, and she strengthened her ability to set and maintain boundaries. She felt that the traumas in her life moulded her into the person she was today. Sarah realized self-compassion was a reliable internal resource that came from within, that protected her from the difficulties of the outside world, and that helped her survive hardships.

Clara

Clara was a Caucasian woman in her early 20s who was sexually assaulted by a previous boyfriend on multiple occasions over a two-year period. It was not until the assault progressed to rape that she realized the other times were instances of sexual assault: "I didn't know I had been sexually assaulted until the last time it happened because I had never had sex before and never had any sexual contact until him." Clara chalked up her ex-partner's "persuading" and "manipulative" behaviour to "boys being boys." The sexual assaults led to her being unable to fully relax during partnered sex. This, in turn, resulted in anorgasmia and a loss of pleasure during masturbation.

Clara often encountered barriers when she shared her experiences with others. More specifically, she found that sociocultural influences, such as gender bias surrounding sex, interfered with her communicating her sexual problems with friends. A dominant discourse around masturbation for Clara was that it was less acceptable in society for girls to masturbate. She often found it difficult to disclose her masturbation experiences with her friends, stating: "people just don't feel comfortable enough to talk about masturbation." Not being able to discuss masturbation with others was difficult for Clara since sharing her experiences was an important

coping mechanism for her. However, she noticed that being more self-compassionate provided her with the confidence and patience to gradually relearn to masturbate.

One of Clara's self-compassionate experiences that related to coping with sexual problems after the sexual assaults was recognizing her progress over time. She realized that self-compassion was a process, and that it was more difficult to show herself compassion when the rape first occurred. For instance, initially, Clara noticed that she could not talk about the rape and previous sexual assaults out loud with others without becoming upset. With time, however, she noticed that sharing her sexual problems and sexual assault experiences with others became easier, marking progress in her healing.

Clara shared how she became a stronger person because of her self-compassion experiences. She found herself to be calmer and more "in-tune" with herself. Clara became independent and inspired to take control of her life, with a renewed confidence in her ability to overcome her sexual problems. She also felt ready to expand her social support, such as seeking sex therapy to further help her with her sexual problems.

Olivia

Olivia was a Caucasian woman in her late 20s who was sexually assaulted by her high school teacher/coach over multiple years. She sought therapy, specifically Eye Movement Desensitization and Reprocessing (EMDR), immediately after the abuse ended. Although EMDR helped her process the trauma, Olivia also found that EMDR resulted in reduced sexual desire. Self-compassion for her involved seeking both individual and couple's therapy for her sexual concerns. In part, therapy included mindfulness techniques to help her stay present during sexual activities, as well as encouragement of non-sexual forms of touch with her husband. Ultimately, therapy helped Olivia have more satisfying sexual experiences with her husband.

Self-compassion for Olivia also meant reframing negative sexual beliefs that she developed because of the abuse. Through therapy, she was able to identify old sexual thought patterns, such as "sex is a condition for receiving love" and "sex is an obligation." Reframing strategies included developing an awareness of her inner critic and saying positive things about herself. These strategies resulted in Olivia developing new sexual beliefs, such as "sex is safe" and "sex is mutual."

An important part of Olivia's self-compassion experiences in coping with her sexual problems involved rebuilding a relationship with her body. Self-compassion helped her make connections between body image, athletic performance, the abuse, and her sexual problems. For example, Olivia recognized the role that the abuse had on her body image and on her sexual well-being. She would catch herself thinking, "Maybe if I looked better, then we'll have better sex." Olivia was also able to piece together how her self-worth was equated to her appearance. For instance, she discovered "a lot of my self-worth is rooted in athletic performance." Self-compassion for Olivia, in relation to rebuilding a relationship with her body, included identifying her physical limits, playing her competitive sport for fun, and incorporating yoga into her workouts.

Margaret

Margaret was a Caucasian woman in her early 30s who was sexually assaulted three times by acquaintances. One assault happened during summer camp, and two assaults involved her being drugged at a bar and raped. The third sexual assault resulted in significant physical injuries. Margaret's sexual problems included primarily vaginismus and dyspareunia. At the time of the study, Margaret was pregnant. She wanted to associate vaginal trauma with something positive, the birth of her second child: "I wanted vaginal trauma associated with something that I

created and brought into this world and loved." Margaret also wanted to connect with her body in a "visceral" way during birth and not be afraid. She viewed having a vaginal birth as an opportunity for a positive transformative physical experience.

Self-compassion as a route that helped Margaret heal from the sexual assaults involved exploring her sexuality. For example, she started participating in sex-positive collectives such as theatrical performances, as well as joining a feminist collective. Margaret also bought her first vibrator and learned what she liked sexually through masturbation. She said she became "good at sex" when she was able to orgasm with a partner. Margaret attributed this success partially to "sleeping with sexually experienced women" and "communicating what I like sexually to men." She found discussing her sexual problems and experiences with others to be "nurturing and validating." Margaret also found that "transparency" and "communication" with sexual partners aided in more pleasurable masturbation experiences.

A positive outcome of showing herself compassion in relation to her sexual problems was a sense of freedom to be herself. This was a significant achievement for Margaret as she was socialized to make others feel comfortable by sacrificing her own emotions. Self-sacrifice for her included ignoring her instincts to process trauma in a way that felt right for her:

> When I go back to that thought of performing emotional labour for other people, me not feeling my feelings, that is purely for the comfort of other people. It serves me in no way… What might be considered an inconvenience for other people for a period of time, I think, is essential, particularly for people experiencing or processing trauma.

Self-compassion also entailed remaining her authentic self, making herself a priority, and saying no.

Colleen

Colleen was a Caucasian woman in her 30s who was sexually assaulted twice by two different men. Sexual problems for her involved the inability to engage in sexual activities that resembled the assaults, such as performing oral sex. A large part of Colleen's self-compassionate experience included regaining power within sexual situations. For example, she found herself repositioning herself in sexual activities to feel more in control: "If I didn't want to have a sex a certain way then I would just sort of move or do something to take control of the situation." She would remain grounded in decisions around sex by being more assertive, setting boundaries, and saying no to certain sexual acts. Colleen indicated that it helped to have a supportive husband who did not pressure her sexually.

Self-compassion for Colleen also meant "letting go" of the expectations of how she thought she should be, as well as caring less about what others thought. She recognized that perfectionism interfered with showing herself compassion. Colleen had an "idea of what I should be doing and then what I'm actually doing; and when they don't match, I've been better at letting that stuff go too." Part of the letting go process involved accepting that she was human and feeling "less apologetic for existing." Colleen no longer sacrificed herself and her needs to accommodate others: "I shouldn't have to make myself less than to accommodate other people." She began engaging in behaviours that aligned with her beliefs, which helped in her feeling "less responsible for men's reactions." For instance, Colleen would say: "If I don't feel like having sex, I'm not, and I don't really care what you're feeling right now."

For Colleen, the negative response from others upon disclosure of the first assault was worse than the assault itself, resulting in an increased use of alcohol. Although she received a positive response after disclosure of the second assault, she blamed herself for allowing another

assault to occur: "I guess I would always feel like things were my fault. If I didn't drink, then this wouldn't have happened. I felt like I was putting myself in those situations." Other strong emotions that inhibited self-compassion included feeling angry and repulsed when she had sex with her sober husband when she was drunk: "It felt very opportunistic of him to do that [have sex with me], and I would feel like he was assaulting me." Quitting drinking gave Colleen a different perspective on life. It also helped her in the "letting go" process and to become more self-compassionate. Additionally, quitting drinking improved communication with her husband. She was able to educate him about consent involving alcohol, and how it is an "imbalance of power" to have sex with her when she is drunk and unable to give consent. For Colleen, sobriety was a self-compassionate act.

Jay

Jay was a Chinese-Canadian woman in her mid 20s who was sexually assaulted by the person she was dating at the time. There were multiple assaults across the 6-month span of their relationship, with the final one being an attempted rape that involved being drugged. Since then, Jay was wary about starting a new relationship. She took the first year after the final assault to cope with the emotional trauma before dating again. Jay was careful about who she went on dates with, taking the time to get to know them before committing to a relationship. At the time of the study, she was in a supportive intimate relationship with her boyfriend who "comforted" and "reassured" her when she became triggered in sexual situations.

As part of her coping strategies, Jay sought therapy immediately after the final assault occurred. She formed a strong therapeutic relationship with her therapist, with whom she felt comfortable disclosing the details of the assault and her subsequent sexual problems. Jay attributed her "quick recovery" from the sexual assault to the strong alliance with her therapist.

Her therapist helped her to be more self-compassionate, which in return helped Jay to overcome strong emotions connected to the sexual assault, such as self-blame. As Jay stated, her therapist helped her "come to closure with what happened" and not to "put the blame on myself." Jay also benefited from connecting with other sexual assault survivors in a sexual assault support group. In the group, she learned to support not only herself but others as well.

Jay developed an enhanced resilience from showing herself compassion in relation to her sexual problems post-assault. She found she was able to "bounce back quickly" after challenges and "remain optimistic" during difficult times. Jay attributed building resilience to "keeping an open attitude" and "understanding that adversity is part of life." She would remind herself that she "survived a sexual assault," and she also engaged in self-reflection. In addition, self-compassion also involved self-care. For Jay, this included buying herself something enjoyable or doing something she loved, such as going on vacation and listening to music.

Robyn

Robyn was a Caucasian woman in her 40s who was sexually assaulted over a three-day-span by a man that she met on their first date. For her, sexual problems included a lack of sexual interest and trust towards men. She also experienced nervousness around dating again and "overanalyzed a guy's interest" in her: "I don't trust myself. I don't trust the guy. A lot of self-doubt. I have no interest in anything physical, nothing at all. I don't know if you would call me asexual, but I couldn't care less [about sex]." Robyn wanted to "take care" of herself first before she contemplated dating. Taking care of herself involved "colouring" and engaging in "arts and crafts." She found that being creative helped her connect with her inner child. Additionally, she regularly practiced mindfulness practices, such as using her five senses, to help her stay present

and to "not overthink things." All of these regular practices were forms of self-care that helped Robyn to be more self-compassionate.

Another important expression of self-compassion for Robyn involved creating a coherent narrative of her sexual assault experience, or a story that made sense. To help explain her experiences, she integrated new information into the original narrative using self-compassion strategies that helped her better understand how the past has shaped her present-day experiences. For instance, Robyn began listening to the story she was telling herself, which often involved "blaming myself for the assault." Becoming more self-compassionate helped her be less critical of herself and overcome these negative thoughts. She also began acknowledging and normalizing her feelings, recognizing that "validation comes from within." As she stated, "Being able to name the feeling and to be able to say it's understandable why I feel this way, to be able to put the two and two together, makes it much easier to deal with and face." Creating a coherent narrative helped her recognize her self-worth, assisting her in moving beyond the assault.

Also helping Robyn move past the assault was the development of positive personal qualities post-trauma. She saw these strengths as being outcomes and manifestations of her self-compassionate practices. For example, not only was Robyn more self-compassionate, but she also had more compassion for others. Furthermore, Robyn was able to remain optimistic during troubling times and developed an increased mental fortitude. As a result of being self-compassionate, she was more assertive in her needs and was able to set strong boundaries. She viewed herself as a "fighter" and learned to "never give up." Robyn also saw her future as "promising" and felt ready for the "next chapter in life."

Skylar

Skylar was in her 40s, Caucasian, and a single mother. She experienced childhood sexual abuse at the hands of her babysitter's brother, where the abuse involved unwanted touching and exploration. Skylar had difficulty answering the question of how the sexual abuse impacted her sexually due to her young age at the time of the abuse. Reflecting on this question, Skylar realized that she never felt she had a voice in her marriage and was timid to speak her mind. She saw herself as a "passive recipient" during sexual intimacy with her ex-husband, often dissociating until the sexual act was done. At the time of the study, Skylar had ended her marriage and was in a healthy, supportive relationship that allowed her to be an active participant. She felt safe not only to feel her feelings but to speak her mind and set boundaries. Skylar also had greater trust in herself and her choice in partners. She held herself accountable for her children, educating them about sex in an honest and truthful manner, and teaching them about boundaries and assertiveness.

Self-compassion for Skylar included persevering through difficult emotions. She started allowing herself to "feel my feelings" and developed an understanding that it was healthier for her to feel her emotions than push them away. Skylar understood the consequences of letting herself feel, knowing that it was going to get "harder before it gets better." She persevered through these troubling feelings, knowing that she would be "stronger in the end." Skylar began listening to her "mind and body telling me there's more to process." Making time to feel her emotions, while normalizing what she was experiencing, expediated her healing from her sexual problems.

Skylar also found that she had an improved sense of self because of her self-compassion experiences. Not only did she realize that she was worthy of being heard, but she was more

empathic towards others. Additionally, Skylar was able to "put life into perspective." She regained trust in herself and felt safe to take chances in life, such as finding a new partner. Skylar began living in the present moment, by "taking a step back" and giving herself time to reflect on and sort out her thoughts. She gained patience with herself and developed a strong mindset. Skylar recognized that "I am the reason for being more self-compassionate" through "my hard work" and "educating myself about self-compassion."

Delilah

Delilah was a Caucasian woman in her mid-40s who was sexually assaulted while at her babysitter's home. She did not remember being sexually abused until adulthood when she started experiencing implicit memories, or body memories, of the abuse. Delilah sought professional counselling for the sexual abuse and continued to process the trauma through therapy. Sexual problems for her ranged from promiscuity to having no sexual desire, feeling obligated to have sex, and pretending that sex was enjoyable even when it was not. At the time of the study, Delilah was in a loving relationship, where she and her partner engaged in an open relationship in which they were exploring their attraction to other people. She took great comfort knowing her partner's sexual needs were being met outside of their relationship and felt that having an open relationship had brought them closer together as a couple.

Becoming more self-compassionate allowed Delilah to enter a period of enlightened sexuality. She had different terms to describe this part of her life, such as "new sexual renascence period," phoenix rising energy," "sexual awakening," and "coming back to life process." During this newfound awareness, Delilah gave herself permission to consider her sexual needs for the first time in her life. For example, she allowed herself to have erotic fantasises and to "do what I want sexually." In doing so, Delilah "felt alive" sexually and had more desire than before.

A self-compassionate practice that Delilah engaged in included connecting to her "higher self." She used prayer to "channel divine energy" and to "remove obstacles to self-compassion." Delilah engaged in self-compassion visualizations and practiced Tonglen, a form of meditation practice. She would also call upon her higher self, whom she called "one in the white robes." Delilah discovered "one in the white robes" during a visualization. She would channel her higher self in times when she needed protection, and it became one of her main coping mechanisms.

Delilah made an intentional effort to practice self-compassion on a regular basis. She noticed that self-compassion became easier with practice, but also that it was a work in progress. The self-compassion process for Delilah involved, "noticing, checking in with what I need, and following through." She discovered that she felt more energized at the end of the day when she was self-compassionate.

Allie

Allie was a South Asian/Caucasian woman in her early 30s who experienced two sexual assaults. The first sexual assault involved inappropriate comments and touching by a boy Allie went to school with. The second sexual assault involved being raped at a party. She was diagnosed with depression and was actively suicidal after the first sexual assault, with depression worsening after the rape. For Allie, not having the assaults taken seriously was more detrimental to her mental health than the sexual assaults themselves. She experienced reduced sexual arousal and long refractory periods between orgasms. Allie found herself dating and having sex with men that none of her friends or family knew and for whom she lacked respect. This way, she explained, if she were to become triggered and upset during sexual activity, others would not find out and she would have little to lose. Allie questioned whether her sexual problems were the

result of the possible sexual side effects from the antidepressants as opposed to the sexual assaults, but she recognized that the two were connected.

Allie regarded herself as being in the beginning stages of showing herself compassion. She said she was "figuring out self-compassion on my own" but that it "didn't come naturally." Allie described this phenomenon as "treating yourself how you would treat others" and "being kind to yourself." Like many survivors, she blamed herself for the assaults. Allie felt as though she was "not worthy" of being kind to herself. Self-compassion for her included learning to "forgive" herself and to not be so "self-critical." Allie was curious if she could be more self-compassionate if partnered. She thought having someone convince her that she was "worthy of self-compassion" would help in her own exploration.

Common Themes

Eight common themes were apparent across the participants' experiences: (a) honouring time; (b) quieting the inner critic; (c) connecting with social supports; (d) countering societal messages; (e) asserting personal boundaries and taking control; (f) engaging in regular self-care; (g) rebuilding a relationship with one's body; and (h) persevering through emotional challenges. Table 1 indicates when a theme was relevant for particular participants. A detailed description of each common theme follows below. For each theme, I aimed to capture the women's experiences of self-compassion as they coped with their sexual problems post-sexual assault.

Table 1

Occurrence of Themes in Participant's Interview

	Honouring Time	Quieting the Inner Critic	Connecting With Social Supports	Countering Societal Messages	Asserting Personal Boundaries and Taking Control	Engaging in Regular Self-Care	Rebuilding a Relationship With One's Body	Persevering Through Emotional Challenges
Sarah	.	.		.	.	.	.	
Clara	.	.	.	.	.		.	.
Olivia	.	.	.	.		.	.	
Margaret		.	.	.	.		.	.
Colleen		.	.		.			.
Jay	.		.			.		
Robyn	.	.	.		.	.		.
Skylar		.	.	.	.	.		.
Delilah	.	.	.		.	.	.	
Allie	.	.	.	.			.	

Note: Dot indicates when a theme is relevant for the participant

Honouring Time

For many participants, self-compassion included becoming aware of the importance of time when coping with sexual problems after a sexual assault. Participants regarded self-compassion as being a process, and also described factors that influenced fluctuations in self-compassion. Some participants, for instance, found that self-compassion wavered over time based on various factors such as the appraisal of a situation. For example, Clara found that when she: "didn't fully recognize 100 percent what happened, or how I can move forward, was when it [self-compassion] kind of fluctuated if I felt good or bad about the situation." For others, self-compassion varied based on the stage they were at within their self-compassion journey. Showcasing this, Allie was in a nascent period of self-compassion, with the concept of self-compassion being new to her:

> The entire concept is kind of new. Like it's not something that I really looked into before. I actually only heard the term last year when my colleague was talking about it for something we were working on. So it's not something that I know much about.

She did not find that self-compassion came naturally to her and had only recently begun extending compassion to her sexual problems: "I don't think I have used self-compassion that much to deal with it [sexual problems]."

Although more advanced than Allie in her development of self-compassion, Clara found that being mindful of her thoughts during prayer before bedtime negatively impacted her sleep and dreams. It was not until she accepted the sexual assault and her sexual problems that prayer ceased to adversely affect her sleep:

> Sometimes when I'd try to be mindful and take, like, 10 minutes in the evening to just switch off my thoughts, sometimes it did make it worse because that would be then all I

> could think about for the rest of the night, especially in the evening, just before bed. It used to sometimes affect my sleep or affect my dreams. So I kind of stopped that for a while. But I think I probably did that too soon which is why it didn't work in a sense. Whereas now, I've accepted it, so I am able to do that without my thoughts going out of control.

Lastly, the women's perceived level of busyness was a factor that created fluctuations in self-compassion. For instance, Sarah found that showing herself compassion was "so much easier when I'm really busy" and more challenging when she was not busy. During those "moments of silence" or periods of not being busy, Sara experienced states of "depression" and emotional "pain", and found it difficult to "counteract them." However, she found that with time, self-compassion "ended up working after a while."

Whereas Sarah observed that not being busy was emotionally difficult, Olivia initially found herself too busy to find the time to practice self-compassion. She later decided to make self-compassion a priority: "You know, everybody is busy and everybody can say they don't have time, so it's just really, like, making it a priority." Olivia discovered that it was easier to show herself compassion on her day off and found it helpful to "ditch a timeline mindset because I know it's always going to be a process and not a finish line."

Like Oliva, other participants saw self-compassion as a process. Sarah, for example, found that self-compassion seemed to "[take] a lot of effort" but "over time it became a habit." Similarly, Delilah saw self-compassion as being an intentional practice that became easier with time: "Now it [self-compassion] feels more integrated. I am that way [self-compassionate] with myself. I still have to be intentional about it but it's not such a stretch anymore."

For Jay, self-compassion meant giving herself the time she needed to return to her original state of functioning:

> Even though it may not be a usual occurrence, … you take what's the realistic situation and you make the best situation out of it by giving yourself time and the resources that you may need to kind of get back to your original state of functioning.

Self-compassion also included learning how to be patient with herself and recognizing that time helped her cope with her sexual problems: "I think over time it [low sexual desire] just kind of resolved itself."

Akin to Jay, Robyn also gained patience in coping with her sexual problems. She acknowledged that progress would be made in a slow, compassionate manner, that involved coping with each day as it comes: "Although this was a horrendous situation in my life, I'm moving beyond that and it's taking one day at a time instead of … some days it's hour by hour and other days it's day by day."

Quieting the Inner Critic

After the sexual assault, the inner critic was a dominant mindset that impeded self-compassion for many participants. One way that participants were able to quiet their inner critic was to come to terms with and accept their sexual problems. Another way involved participants becoming aware of their inner critic and reframing their negative thoughts into more realistic and positive experiences. Both ways created more space for self-compassion and represented variations of the theme.

Sarah was one participant who used acceptance to quiet her inner critic: "In the past, a lot of my self-talk was very negative and critical and calling myself names like stupid and things like that." Furthermore, she said, "A lot of us tend to be our own worst critics, and we tend to

treat ourselves in ways that we would never treat other people." Sarah accepted that she lacked sexual desire and quieted her inner critic by "talking to myself very kindly and very gently and saying those things to myself and telling myself that I am a good person and things like that and that everything would be okay."

Like Sarah, Robyn described herself as being "very critical" and having a "very negative mindset." She applied self-compassion as a way "to not be so critical" on herself: "I'm just like trying to be compassionate and let myself, ah what's the word I'm looking for, lighten the load and not be so hard on myself." Robyn also used self-compassion to overcome her negative thoughts and to accept and "let things go." For her, this meant "practicing the empathy and the compassion and not setting myself up, like not letting my anxiety say, 'you are never going to do this this or this, or whatever,' just letting things go."

Similar to Robyn, letting go was a process Colleen also used to overcome perfectionism. She was able to "let go" of the person she thought she should be and accept who she really was: "I think perfectionism is hard. Sometimes I can get caught up in that like 'this is what I should be doing' and 'you know if I did this better, then this wouldn't be happening.'" When asked for a specific example of "letting go" in the context of her sexual problems, Collen described how she used to hold beliefs about "what a good wife should be doing," for instance, "even just down to having shaved legs and shaved bikini area and you know perfect and all that stuff." Letting go meant that now "I don't care."

Whereas "letting go" was a self-compassion approach that helped Robyn and Colleen quiet their inner critic, Clara's method involved adopting a new mindset that involved recognition and acceptance of her sexual issues. This approach also included realizing that her well-being was not defined by her sexual concerns:

> [Acceptance] is a long process and it can take years. But that doesn't matter because I've just kinda recognized that it's not the be all and end all to being, like, happy and stuff. And I think it is just that acceptance of the sexual problems and just not feeling annoyed by it.

Olivia was a participant who quieted her inner critic by becoming aware of and reframing her negative thoughts. Through therapy, she was able to reconsider old sexual thought patterns that she developed as a result of the sexual abuse that she sustained throughout adolescence and early adulthood. Examples of negative sexual beliefs included: "sex benefits one person", "sex is a secret", and "I'm a sexual object." Olivia created awareness of her inner critic by "taking a step back and examining what's really being said, and even turning that around if it's, like, a negative inner voice to a positive inner voice." Examples of new sexual beliefs that she established as part of reframing her negative thoughts are: "sex is an expression of love", "sex is mutual", and "sex is safe."

Whereas Olivia took a step back and reflected on her thoughts, Delilah stood up to herself by "noticing when that critical, inner critic part kicks in" and then challenging her thoughts:

> Part of that self-compassion is noticing it [inner critic] and then kind of finding a way to bring it back that fits better for me. Like, if it's a thought, well okay, kind of challenging that a little bit or like, "Is that really true?"

Despite standing up to her inner critic, Delilah still found she had "little hints" of or residual negative thought patterns. She would catch her inner critic telling herself that "you don't deserve it" or "it doesn't matter what you want anyways as long as you make sure the other person is happy, because if the other person is happy then the relationship will be stable." Delilah also participated in "a lot of self-betrayals in the past." More specifically, she would engage in

"things I didn't want to do" and noticed her "boundaries being violated and confused" which Delilah "connected to the abuse." In addition to challenging her inner critic, she attempted "to say affirmations to let those [negative thoughts] dissolve away so I can just be a channel and a conduit of Divine love and grace."

Connecting With Social Supports

For the majority of participants, self-compassion involved connecting with social supports as a way to cope with sexual problems. Social supports included people who participants considered to be supportive of their practices of self-compassion, and who helped normalize and validate their experiences. Such sources included intimate partners, friends, family, therapists, and social media. Also, the women found that being open and transparent with individuals within their social circle aided in them being more self-compassionate. These three aspects of the current theme, i.e., connecting with supportive people, having experiences normalized and validated, and communicating in an open and transparent manner, were part of the women's' self-compassion experiences and are discussed below in more detail.

Connecting with social supports for Oliva meant "having that non-judgement from people who I really care about; and love has been extremely helpful with the healing process." Her psychologist was one person who had helped with her sexual problems:

> My psychologist has helped me and continues to help me a lot. She has educated me about what sex could be and what a healthy sexual relationship is. I'm still working towards having that with my husband (and myself) because we're definitely not there yet.

Perhaps the largest source of support in Olivia's life was her husband:

> He's been so patient, and has been really open minded to lots of things. We do lots of couple's exercises and he's just been super, super patient, and I'm really grateful for that.

Similar to Olivia, Jay spent time with nurturing people. Her current partner, for example, would "comfort" and "reassure" her when she got triggered:

> Even though I'm not really traumatized by the assault any longer, sometimes there are instances where they just feel like déjà vu and eery. It just reminds me of the assault and I get scared. When this happens, he comforts me.

She included him in her self-compassionate practices, such as going out for dinner. Jay's younger sister was also caring, and would "hold me accountable to being self-compassionate." Additionally, Jay found it beneficial to be part of a support group for sexual assault survivors: "I think what I got out of the support group is, like, just say good things to each other in a meaningful way, boost each other up." Furthermore, she built a strong therapeutic alliance with her therapist. Jay sought counselling immediately after the assault and found that her therapist encouraged her to become more self-compassionate:

> [My therapist] always asks me at the end of the consultation, "Tell me one thing you are going to do for yourself and then the next time I see you, tell me what you did. It's just something really nice to talk about."

Like many other participants, self-compassion for Skylar meant building meaningful relationships with her partner and friends. She found that having a loving partner who was present when she was upset was important when overcoming her sexual problems:

> My current partner seems a little bit more comfortable with…me being upset and knowing that it is not his job to make it better. Like he certainly tries, but it's not his job to make me feel better. But he does see it as part of his job to *be* there while I make myself feel better.

Additionally, Skylar found it helpful to have a healthy sexual relationship with her partner where her boundaries were respected: "It helps to be in a supportive environment too. Like I can say to

him, yes, I want to come down to your place tonight and hang out. However, that's literally all we're doing. And he's like, 'Okay.'" She also connected with close friends where she felt heard and respected:

> What I've got is three or four people in my life who are exactly like that [supportive]. And when I'm with them, I may unload on [them] or talk about it again and they're not going to be like, 'Oh my God, I've heard this 100 times.' They're like, 'It sounds like it still really bothers you," or, 'It's really hard to think about.'"

Self-compassion for Delilah meant a partner who was understanding of her sexual needs: "We also made it really clear that he doesn't expect me to do things that I don't want to do." Having a secure intimate relationship allowed the couple to entertain the possibility of an open relationship:

> Even in this relationship I feel like I can't really one hundred percent be the sexual partner that I know he would like. So we've been having conversations about having an open relationship because at first it was more about him, because I didn't want him to miss out, because I can't always give him what he wants and needs.

Delilah felt that having an open relationship had strengthened her current intimate relationship. "You know, you'd think, like, 'Ooh an open relationship. That's like a recipe for disaster'. But it feels actually closer than ever, amazingly."

Moreover, connecting with social supports helped normalize and validate the women's experiences. Margaret found it "very nurturing and validating" talking to other women and discovering commonalities regarding their sexual problems and experiences. Likewise, it was beneficial for Clara to connect with both direct and indirect social supports. Direct social supports included her friendship group. She stated:

> Talking to people about how you feel, I think, has really helped me in, like, self-compassion because not only for myself to just say out loud, but then you kinda realize that other people have gone through similar things to you, or kind of understand where you are coming from.

More indirect sources of support for Clara included social media and "listening to podcasts and googling stuff." She discovered that on Twitter, "people have gone through the same things. They've really helped me to recognize, and just be more open with myself and with people." Another example of social media normalizing her experiences was the #Me Too Movement:

> It [#Me Too Movement] started at the similar time to when I was having to – not feelings of being lost, but I didn't know which direction I should go to, like, help myself. And it just kind of inspired me, all these, like, strong women were coming together to try and make a difference or to try to tell people they are not alone and things like that. That's really helped.

In contrast to other women in the study, Allie was curious if she could be more self-compassionate if she had a partner who would provide her a reason or validation for being compassionate towards herself: "Part of me feels like if I was seeing someone and getting some kind of external validation and had this, like, sort of other reason to try to be more gentle with myself that might help [me be more self-compassionate]." She wondered if she needed someone to convince her that she was worthy of self-compassion:

> But maybe it's just wishful thinking that maybe if there was someone else to, you know, try to convince me that I was worthy of it [self-compassion], that that might be something to kind of push me over the edge to be more kind to myself.

An important piece of connecting with social supports for participants meant being open and transparent within their interpersonal interactions with others. Olivia found that "being able to have open communication with my mom about things has been really, really good." Margaret shared similar experiences as Olivia, placing value on positive interpersonal connections with friends or with sexual partners. For instance, Margaret realized it was mutually beneficial to overtly communicate to friends about her sexual well-being and experiences:

> I feel like with my friends I come across as like a fairly honest and open person, so I think a lot of them never had a lot of chances to talk about this kind of stuff [sexual problems]. So it's a mutual benefit to being able to have those kinds of conversations, you know, just human connections.

With regard to her sexual partners, Margaret discovered "transparency and communication … in terms of having sex with a partner is the way I got better at having sex with myself." She also noted "over the next several years [I] got better at communicating that [what she liked sexually] to the men I was with."

Becoming more self-compassionate for Delilah meant reaching out to others and "not trying to do it all by myself." She found that being explicit and making her needs known helped in receiving emotional support from her friends:

> A lot of my friends and I are having these conversations now out in the open, like we are all supportive of one another. Like yes, don't do self-betrayal. Like yes, I don't need to talk to you about this right now. Or hey, what's going on with you? What do you need right now? Do you need to take a break? So kind of making that explicit in some of my relationships. Like this is what I'm working on and like, you know, can we work on it together. So that's been really great and helping for sure.

She also realized that self-compassion and compassion for others are interconnected, and "the compassion for others comes naturally after I offer it to myself."

Jay took a different approach than Olivia, Margaret, and Delilah, and learned that talking openly in therapy helped her cope quickly from her sexual problems: "I think I was pretty open in my therapy sessions about whatever I was experiencing or questions or queries I had. I think that's how I was able to bounce back quite quickly." She elaborated further by stating, "You have to do the work. You can't just listen in therapy because the professional can't know what's going on if you don't open up to them." She also found that maintaining "an open attitude" and "being open to receiving help" aided in her quick recovery.

Countering Societal Messages

As they coped with their sexual problems post-sexual assault, self-compassion for the participants in this study involved countering societal messages, especially with regard to sex and body image. Such messages influenced how participants thought they should think, feel, and behave in relation to their sexual selves, oftentimes interfering with the women's ability to cope effectively with their sexual problems. Self-compassion for participants included countering these societal messages and discovering what positive sexual well-being meant for themselves.

Pertaining to countering societal messages around sex, Sarah did not view her lack of sexual desire as a problem. However, she acknowledged that society pathologized her as having a sexual dysfunction:

> For me, I don't feel any desire at all. None. And to me, it's not that much of a problem, but it feels weird in society being a woman who, like, essentially doesn't have sex or date. But again, for me, that is not really a problem. But it is something that other people could label as a problem.

In contrast, Clara recognized her sexual issues as troubling, but did not want problematic discourses about sexuality to shape her own sexual experiences. As part of her self-compassion experience, she examined gender bias surrounding sex, as well as dominant discourses around masturbation, both which hindered her return to a healthy sexual life post-assault. Self-compassion for Clara meant being aware of, and not falling victim to, such bias and discourse, and constructing her own healthy sexual script that felt right for her. For instance, in her experience, it is not expected for women to end in orgasm during sex but it is for men:

> In some areas in our society, girls are kind of expected to just have sex, and they don't have to enjoy it, whereas, like, guys are supposed to enjoy it and kind of finish [orgasm] whereas it's not expected for girls to finish [orgasm] during sex.

She also had difficulty with masturbation after the sexual assault, stating: "If I do try to masturbate, it will be, like, about two minutes and then I would just stop because I just don't want to." She perceived that it was less acceptable in society for women to masturbate: "But girls, like, no one really talks about that [masturbation], or it is not seen as expected for girls to do that [masturbate] in society." As a result, Clara found that the lack of acceptance for women to masturbate impeded her in relearning to masturbate. For her, self-compassion meant learning to enjoy sex and masturbation again, resulting in orgasm when possible. An important step in this process for Clara was "not feeling pressured to achieve anything [orgasm]" and having confidence that she will "eventually overcome it [sexual problems]."

For Skylar, she debunked old sexual beliefs that she learned from personal experiences and social media. She had only two sexual partners over the course of her lifetime. What this meant is that much of her beliefs regarding sex came from what she learned from her previous sexual experiences with her ex-husband and from social media. Self-compassion for Skylar

involved checking-in with her current partner to debunk sexual myths that she has come to believe as true over the years. For example:

> I've only had two partners: my current one and my husband, ex-husband. And so anything he [my ex-husband] said [about sex], 100 percent of the guys I've been with have said that to me, do you know what I mean? So it must be true. And then you get the jokes, or the movies, or the TV shows that kind of support that thought process [what she learned about sex from her ex-husband] and you go 'okay'. And this guy's [her present partner] like, "What are you talking about? Like no, it's not like that. It [sex] can be different." And I'm like, "Oh, okay.'"

Allie and Oliva countered messages around body image. Allie stated: "I'm a size 18 kind of person, and there's a lot of societal messages around 'you better take what you can get.'" Such messages were reinforced with her first sexual assault:

> I think a lot of it goes back to the sexual assault, when people would say to me, "Well why would he do that to you? He can have anyone he wants. As if anyone would want to do that to you." And I think that's still very much ingrained in me.

Allie found herself believing in the negative messages that she received about her body weight. However, she discovered that self-compassion helped her to "respect myself enough" to realize when she was starting to believe in negative societal messages and then "say no, I'm not playing along with this anymore."

Part of self-compassion for Oliva was making the connection between body image, athletic performance, abuse, and ultimately her sexual problems:

> And so for a lot of it, your body image and performance sometimes get intertwined in a way that's not healthy. So as much as you try to tell yourself "My body is for

> performance," you're still a human and you're still a woman with all these messages being thrown at you every day.

She also realized that:

> A lot of my body image specifically has been maybe playing a bigger role than I initially thought [in my sexual problems], especially just the nature of what had happened and the coaching relationship that happened. A lot of it was placed on my body appearance and my athletic performance.

Asserting Personal Boundaries and Taking Control

Self-compassion for many participants in the study meant becoming more assertive in their sexual needs and elsewhere; setting personal boundaries; and taking back a sense of control that was taken away from the participants during the sexual assault(s). A major aspect of this theme was regaining power. Sexual assault often took away a sense of power and control, leaving participants feeling vulnerable. In contrast, self-compassion helped them regain their power and take back the control that was stolen from them. Sarah, for example, became more assertive in her needs around dating. Before the assaults, she experienced herself as being a "people pleaser" who was "very easily persuaded." She felt that she had to explain to family, friends and to those who asked her out on dates why she did not want to date: "I used to make up excuses, afraid that questions would lead to a place where I had to disclose [why she did not want to date]." However, self-compassion for Sarah meant greater assertiveness, where she realized that "I don't have to [make up excuses] and I can just state very simply that I don't want to date and I don't owe anyone an explanation."

In Clara's case, she recognized that she was in control of her body when it comes to sex and that she could say no:

> I wanna be in control and I don't want to be taken advantage of anymore. And it's recognizing that it's *my* body, and if I trust the person that I'm sleeping with that I should be in control of that. And it doesn't matter if I don't orgasm. But it's just recognizing that I'm in control, and it's fine. And I can just do what I want and I'm free to say no.

Margaret took a different approach than Sarah and Clara and removed orgasm as the goal during sexual activity. In her experience, there was a lot of pressure placed upon her, and women in general, to reach orgasm. Removing orgasm as the end result for Margaret was a form of self-compassion, as a positive way of coping with her sexual problems post- assault:

> It was putting on a lot of pressure. And also the female orgasm, we were taught that it is very performative. And as a survivor of sexual violence who had experiences where I either stopped crying out in pain so that the experience would be over more quickly, you know, that kind of 'grin and bear it' thing, can be involved in sexual activity at various degrees.

Self-compassion for Colleen involved "taking the lead or control of things" in sexual situations. For instance, having sex would include "me doing it [having sex] in a way that I would have power and control so that the other person didn't have control over me." Like Clara, she also began saying no to certain sexual acts, staying grounded in decisions around sex:

> Someone is not entitled—just because someone's a man doesn't mean they need to have sex or they need to whatever. Or like if my husband needs to find sex elsewhere, then that's his problem and not something that--not feeling guilty if I don't feel like having sex. "I'm not having sex. I don't really care what you're feeling right now." Whereas before I think I would have been very mindful of, you know, well I wouldn't want someone to

> cheat on me because they're not fulfilled. So I'm just going to do this to keep everyone happy.

Similar to other participants, Robyn became more assertive in her needs, and experienced stronger boundaries. She stated, "I know what I will tolerate and what I won't tolerate, and the way I want to be treated. The first sign of disrespect, that's it, you're gone. Knowing that I'm not going to suffer through it just for the sake of being with someone."

For Skylar, self-compassion consisted of finding her voice and speaking her mind. She shared an experience where she made the connection between shaving her pubic hair and the abuse she sustained as a child:

> Then all of a sudden all the hair was gone. And I was like, "Oh my God". And I did not like it. And I didn't realize, like, I never liked that look in general anyways, and I never really knew why. But then I saw him [her partner] a couple of days later and *dudidudida* and I actually had a complete and utter and total meltdown because things happened when I was a kid and I never realized that that hair was literally a shield like that was something like I am no longer a little girl, I'm a grown up, I have control, I can say things. So in the past, if something like that had have happened, like with my ex-husband, I would have checked-out and just waited for whatever to be done. But actually, we stopped, we had a conversation, and all that kind of stuff. So I do really feel like that was a moment of self-care or self-compassion because I spoke up for myself.

An analogous occurrence for Delilah meant respecting herself, setting boundaries, and exploring her sexuality. For instance, respecting herself involved honouring and remaining true to herself:

> So it's okay to continue to work on honouring myself and having more compassion for myself and noticing the micro self-betrayals. I mean these are things, like micro self-betrayals, like, having a phone call with a friend who is having a really bad day but I'm exhausted and I don't have anything else. And still doing it even though I don't! Like why didn't you just set a little boundary there?

She also had clear sexual boundaries from the beginning of her current relationship:

> What I did was I made sure that anytime we were intimate that it was okay for me to stop. It was okay for me to take a break. I could say no at any time without any guilt or shame or made to feel bad about that, you know? And I did. And when I didn't feel it was right, I didn't do it. So that's really big. Because I think I've done a lot of self-betrayals in the past, like, things I didn't want to do which I think it connected to the abuse and, you know, like with boundaries being violated and confused things like that. But it was really empowering to approach it like that in this relationship.

Exploring sexuality for Delilah was akin to a sexual awakening or entrance into a new sexual renaissance period where she felt more sexual aliveness, presence, and desire than ever before:

> I think I'm having like an enlightenment or a sexual awakening at this time, like at this time in my life when I'm figuring out a new relationship to my sexuality. And I don't know what that's exactly going to look like, but there's so much space in my current relationship that's so safe, so secure, and so stable, and so loving that I can figure out what it means to have a fulfilling sexual life while not doing self-betrayal and while having compassion for myself.

Engaging in Regular Self-Care

As part of their self-compassion experiences, many participants engaged in regular self-care to cope with their sexual problems. Self-care for these participants meant prioritizing themselves and attending to their personal needs. For some women, this meant frequently engaging in meaningful activities. Others routinely practiced what they learned in therapy or participated in spiritual practices. Regardless of the activity, participants often experienced a positive impact on their spiritual, mental, emotional, and physical health.

Sarah and Jay were two participants who regularly took part in enjoyable pursuits. For instance, Sarah participated in "non-academic reading" and found "play[ing] with my cat" on a regular basis beneficial. She also frequently listened to "music that is really sad and mournful, with deep female voices like Nina Simone," often resulting in crying. Furthermore, Sarah would "sleep a lot," commenting that "it is actually very helpful for your emotional and brain health." Jay would routinely treat herself to something she enjoyed, or bought herself "something" she liked. She stated:

> If I'm having a bad day and I need to relax, I will do something I enjoy doing, like listen to music. Or if I have the money to buy myself something enjoyable, like a nice snack, or go somewhere that I don't usually go but always wanted to, like vacation, if that was possible.

Self-care for Olivia and Robyn involved regularly practicing what they learned through self-education and in therapy. Olivia, for example, stated, "The more books and articles I can read, the more I feel like I'm not alone in my experience." One resource that she found especially helpful was *The Sexual Healing Journey* by Wendy Maltz (2012). Olivia particularly liked this book, as "it is a huge resource for survivors and partners of survivors or other people

affected by sexual assault (family, friends, etc.)." For Robyn, her counsellor suggested "adult colouring as a stress reliever to reconnect with the inner child." At first, she was "very apprehensive" as it was "something I never really got into" when she was younger. However, Robyn discovered she "actually liked it" once she tried it as an adult and decided to connect with her inner child through coloring on an ongoing basis. Robyn later found pieces of her artwork that she created in adulthood and thought they were "quite good."

Another aspect of self-care for participants was expressed in spiritual practices. For Skylar, this involved regularly engaging in mindfulness practice. She would often "take a step back" from the situation and "reflect on the moment", giving herself time to sort out her thoughts:

> If I'm not feeling 100 percent, or I'm not feeling completely in the moment, I don't ignore that anymore and keep pushing to get stuff done. And when I say that, I don't just mean in the bedroom. I mean stuff in general as well. So I'll step back and actually look at or think about what's going on. Why am I feeling this way? And give myself some time to figure that out a little bit.

Delilah routinely connected to her higher self. This included channeling divine energy through daily prayer or engaging in self-compassion visualizations:

> Like every morning I pray. I say these prayers which are all about accessing divine energy so that I can channel it and not have to manufacture it. So it comes in from above, and kind of generates in here, and then I get the benefit, and then kind of [makes an explosion sound]. Like there's even a visualization one of my therapists shared with me. It's a self-compassion exercise where you notice the sensation in the body. Put your hand over it. Notice the felt sense, you know, temperature, colour, weight, texture, movement, etc. And

> then you offer it tenderness and compassion – just the sensation, tenderness, compassion, kindness, like a baby, a kitten, or a small animal. And then the fourth step is to take that and radiate it out to the world.

Rebuilding a Relationship With One's Body

For the participants in this study, self-compassion was related to rebuilding a relationship with their own bodies. For some women, this meant connecting with their bodies through physical movement, such as dancing, yoga or sport. Doing so had a positive impact on participants' well-being, including developing a sense of calmness within the body, being mindful, respecting one's boundaries, and practicing non-judgement. For others, this included developing an enhanced awareness of their physical selves, helping with self-regulation and acceptance of personal limitations.

In Sarah's experience, connecting with her body meant showing herself physical affection. She would "hug myself and rub my arms and I'll tell myself you're doing a really good job., like you're doing the best you can." Sarah stated that she experienced "a warm feeling" when she showed herself compassion through touch. She also danced while listening to music, stating that it created a "sense of calmness through my body." Similarly, Clara engaged in yoga: "The most I felt like I've done something compassionate for myself is when I practice yoga. That's when I really feel like I've connected with myself."

Like Clara, Olivia incorporated yoga into her fitness schedule, benefiting from its effects: "Incorporating yoga into my fitness schedule has also been very helpful in becoming mindful in my body, respecting its boundaries instead of being frustrated by them, and practicing non-judgement towards myself." She also started playing her competitive sport for fun, which she

found contributed the most to her healing: "I think that has been probably one of the most healing things for me is just being able to play [sports] again and have fun."

Another way that participants rekindled a relationship with their bodies was through the development of an increased sense of awareness of their physical selves. Margaret found that self-compassion helped her to be more in tune with her body. She recognized how her sexual desire was related to ovulation: "I recognized an increase in desire associated with times when biologically my body was like 'yup, this is time to get it done' and it was kind of cool too." Margaret was also more conscious of with how her vagina responded during sex, acting as a gauge of her emotional well-being:

> It's very directly connected to how my vagina feels about things too. Because if she's [my vagina] not cooperating, then I'm not doing a good job listening to what my feelings are and what's going on in my life and stuff like that. So she's [my vagina] a pretty good guardian in that regard.

Similar to Margaret, Delilah became more in harmony with her nervous system. She found that regulating her nervous system helped quiet her mind:

> I find most of the time that my thoughts go awry because my nervous system is dysregulated. So self-compassion to me is like really wrapped up in looking after my nervous system. If my nervous system is activated, what do I need to bring it down? If it's too low down, what do I need to kinda bring it back up again? Then I find if I can do that, then sometimes that inner critic part will quiet down a little bit.

For Allie, learning to accept her body was an important aspect of self-compassion. She noticed she often compared her physiological body to others. Allie experienced severe depression off and on after her first sexual assault and felt her body let her down for not

producing enough serotonin. Self-compassion for her meant recognizing that everyone has different limits. She stated that she "couldn't keep comparing myself to other people. I'd drive myself crazy. I had to recognize my own limits." Allie also struggled with teasing apart the relationship amongst her sexual problems, sexual assault, negative body image, and the negative effects of antidepressants:

> I guess just that I wish I could tease this one out a little bit more, but my thoughts are also muddled about my body and everything with that. I think to a certain extent I don't have a lot of control over my body because with 15 years of antidepressants I've gained 100 pounds. But a lot of those antidepressants, and especially with increasing those antidepressants, were as a direct result of the assaults so it's really hard to tease these things apart.

Persevering Through Emotional Challenges

Half of the participants experienced emotions that made it challenging to practice self-compassion in relation to their sexual concerns. Emotions ranged from blaming themselves for the sexual assault to feeling panic during sexual intercourse. Irrespective of these feelings, participants persevered despite this obstacle, seeing it as just another barrier to overcome. The women developed an internal strength that propelled them into persevering through emotional challenges.

Like many sexual assault survivors, Clara blamed herself for not confronting her feelings or telling anyone about the assault. In addition to blame, she also experienced feelings of guilt and shame because of what happened:

> I knew deep down what had happened but I couldn't confront those feelings and felt guilty that I didn't say anything to anyone in that first month and kind of blamed myself. And then it was just guilt and feeling ashamed of what happened.

These intense feelings extended to her sexual life, where she experienced panic followed by numbness when pressured to orgasm with a partner:

> During sex I don't think about it until, say, I'm, like, with a guy and he wants to make me orgasm and then I just kind of panic and I think 'oh I just can't'. I don't get, like upset or anything like that. I think I just, my mind just goes a bit numb to it, and then I'm just, like, I can't because of that.

Clara pushed through these strong responses by realizing and reminding herself that there was nothing to feel guilty about and that it was "okay" not to feel anything after the assault.

For Margaret, shame arose in various aspects of her life. For instance, she experienced "shame that was placed on me as a woman in society, but then also that secondary shame from the sexual assaults." She also felt shame for "being attracted to men, and also having been sexually assaulted by men." Additionally, Margaret struggled with shame associated with "putting myself and my own pleasure at the forefront of sexual experiences." With determination, she attained the ability to "unpack" how this emotion permeated multiple areas of her life. This involved regularly exploring and being committed to "understanding" the origins of shame, "coming to terms with" it, and then "releasing" it. "Unpacking" shame helped her to remove it with being a woman, and putting herself and pleasure first.

To cope with strong emotions, Colleen started drinking excessively after her first sexual assault. She blamed herself for the assaults, stating "If I wasn't drinking then that [sexual assault]

wouldn't have happened." Additionally, Colleen would become angry and repulsed when she had sex with her sober husband when she was drunk:

> I would go out with girlfriends or whatever and come home drunk and we would have sex and it would automatically be like that's an imbalance of power. Like you shouldn't be having sex with me when I'm drunk. Whether I say I want it or not it shouldn't be happening.

A large part of Colleen's experience of self-compassion occurred once she quit drinking. Drinking kept her from "really letting myself feel" intense feelings such as blame and anger. Although her pursuit of sobriety was difficult, Colleen was persistent. Through self-compassion, she learned to say no to certain sexual acts with her husband and for not putting herself in compromising situations – both which helped her feel "less guilty."

Similar to Clara, Robyn blamed herself for the sexual assault. She would often think, "Oh this is my fault, like I shouldn't have done *this*, I should have done *that*." Robyn experienced self-doubt when it came to trusting herself and choosing a partner. She stated, "I don't trust myself. I don't trust the guy. I have a lot of self-doubt." Robyn also noticed she had "walls up" and "barriers up" when it came to trust in dating men again. Self-compassion for her meant continuously working through these challenging emotions and learning to "never give up." She started to see herself as a fighter and developed an attitude of "get off your ass and do something about it." She stated, "I didn't want to be called a victim."

Skylar was also committed to persevering through difficult emotions. She began to realize that it was healthier to feel her emotions than push them away: "As long as the environment allows me, I've learned it's much better to feel it and process it than it is to try and push it away." Skylar also understood the consequences of allowing herself to feel her feelings: "I mean

sometimes self-care/self-compassion gets messier before it gets cleaner because you're letting yourself feel the feelings and whatnot." She discovered that confronting her feelings as opposed to avoiding them aided in her moving forward in her life: "I do notice that since I've allowed myself to do that [feel feelings], I get to the other side way faster than if I had fought it."

Chapter 5: Discussion

The purpose of this study was to explore women's experiences of self-compassion in coping with sexual problems following a sexual assault. The main research question was: What are women's experiences of self-compassion in coping with sexual problems after a sexual assault? The following sub-questions were also explored: How do female survivors experience and practice self-compassion in response to sexual problems related to sexual assault? What facilitates the experiences and practice of self-compassion in coping with sexual concerns for female survivors of sexual assault? What barriers interfere with the practicing of self-compassion for women who are experiencing sexual problems after a sexual assault? In addition, how has practicing self-compassion in coping with sexual concerns after a sexual assault influenced other aspects of women's lives? To help answer these questions, 10 female sexual assault survivors who were recruited across Canada each participated in individual semi-structured interviews. Using an IPA methodology to analyze the interview data, I developed an in-depth understanding of participants' self-compassion experiences as each woman coped with sexual problems post-sexual assault. Data analysis revealed eight main themes across the women's accounts: (a) honouring time, (b) quieting the inner critic, (c) connecting with social supports, (d) countering societal messages, (e) asserting personal boundaries and taking control, (f) engaging in regular self-care, (g) rebuilding a relationship with one's body, and (h) persevering through emotional challenges.

This final chapter includes a discussion of key findings in relation to existing research. It also provides suggestions for therapists counselling sexual assault survivors who are experiencing sexual problems. Finally, I bring closure to this dissertation by describing the study's limitations and considering avenues for further study.

Discussion of Key Findings

Honouring Time

The saying *time heals all wounds* is often said to those who have experienced emotional, physical, mental, or spiritual pain. In its simplest terms, this advice indicates that the suffering a person is currently experiencing will diminish with the passage of time. Suffering is a universal human phenomenon. Indeed, Neff (2003a) included common humanity, or the concept that each individual is not alone in their suffering, as one of the main components in her definition of self-compassion. One area of suffering that participants experienced in this study was in the form of sexual problems that occurred after sexual assault. Part of the women's self-compassionate experiences included honouring time as they coped with the deleterious aftermath of such trauma.

Although self-compassion for many participants involved honouring time as they coped with sexual issues, the women's relationship to time varied amongst them. Whereas some participants found that self-compassion fluctuated over time based on factors such as busyness or appraisal of an event, others observed self-compassion as a process that occurred over time. The notion that self-compassion is a process is not new. This concept is salient in psychotherapeutic approaches for developing self-compassion, such as CMT (Gilbert, 2009) and mindful self-compassion (Neff & Germer, 2013). In these approaches, skills augmenting self-compassion are taught over a series of weeks. Individuals are expected to practice these teachings outside of sessions to help integrate and habituate to the practice.

Underlining the importance of time in the sexual healing process following a sexual assault, Van Berlo and Ensink (2000) stated that following CSA, ASA or both, sexual problems can occur and last for years, and healing can take time. Similarly, Maltz (2002) reported sexual

healing from sexual trauma can take "months, and, in some cases, years before clients report significant improvement in their sex lives" (p. 325). The current study's findings on honouring time are consistent with the above-mentioned literature. Issues with sexual pain, desire, arousal, orgasm, and trust were just some of the negative consequences that the women spoke of following sexual violence. Self-compassion for these participants meant giving themselves the necessary time to restore a positive sense of sexual well-being. It required patience on behalf of the women, oftentimes coping on a day-to-day basis. Participants saw time as being necessary in their healing, and it became an important part of their self-compassion experience.

Quieting the Inner Critic

Participants found that after experiencing sexual assault, their inner dialogue became harsh and judgemental, with the participants often blaming themselves for what happened. The women's negative self-talk became a dominant mindset, interfering with sexual recovery. Self-criticism amongst sexual assault survivors is a common phenomenon and has been cited extensively within the literature (Gilbert, 2009; Olatunji et al., 2008; Vidal & Petrak, 2007; Weiss, 2010). More specifically, the literature points to the role of the self-critic in coping with sexual problems post-sexual assault (Elliott, 1992). Elliott (1999) claimed it was not the sexual abuse itself that caused sexual problems later in life, but rather it was the survivor's negative self-evaluation or inner critic. In Elliott (1992), the inner critic is described as consisting of three types of negative messages: absolute shoulds, belittling statements about oneself, and ominous forecasts about the future. Absolute shoulds not only guide how we are "supposed" to live but also act as an emotional form of punishment if betrayed. Similarly, in the current study, some participants found that their inner dialogue told them that they "should" look a certain way for their intimate partners during sexual activities. Other women in the study engaged in belittling

self-talk by saying negative comments about themselves. Furthermore, each participant's inner critic may also have acted as a form of emotional punishment as she blamed herself for the sexual assault.

As a way of counteracting this harsh manner of self-relating, in the present study, many women found that self-compassion helped quiet their inner critic pertaining to sexual problems. Self-compassion involved the participants developing an awareness of their inner critic, as well as the ability to reappraise their negative thoughts. The women also learned that self-compassion assisted in "letting go" of what they believed they "should" be as a sexual being and embrace their true sexual selves. A novel contribution of the present study is how it helps bridge the literature on self-compassion, self-criticism, and the sexual difficulties that may result from sexual assault. The findings suggest that self-compassionate practices, such as those mentioned above, may aid female sexual assault survivors in quieting their inner critic pertaining to their sexual problems post-sexual assault. These findings are also consistent with Neff's (2003a) and Gilbert's (2009) emphasis on self-compassion as a means of reducing self-criticism.

Connecting With Social Supports

Connecting with social supports was a self-compassionate act that many participants engaged in as they coped with their sexual concerns. Women in the present study interacted with friends, family, intimate partners, therapists, and social media in an open and honest way, helping to normalize participants' experiences and facilitate recovery. The current study's findings of connecting with others as an expression of self-compassion is reflected in the extant literature. For instance, Maheux and Price (2016) found that in a sample of individuals who had experienced traumatic life events, having positive social relations increased self-compassion by minimizing psychopathology, such as PTSD, generalized anxiety disorder, and depression

symptoms. The authors pointed to the way in which external (social supports) and internal (self-compassion) resources interact to facilitate healing. Similar findings were also evident in the present study, specifically, participants reported how self-compassion was accompanied by a lessening of mental health issues since the sexual assault(s). It is possible that connecting with social supports, as part of what it meant to be self-compassionate, helped to reduce participants' mental health symptoms.

An important aspect of participants' experiences of self-compassion in the current study involved communicating with their intimate partners about their sexual difficulties in an open and clear manner. Communicating openly and honestly was a form of self-compassion that helped the women feel supported, heard, and valued. Existing literature supports the positive relationship between self-compassion and constructive communication. For instance, Schellekens and colleagues (2017) revealed that self-compassion was associated with improved communication about cancer in couples experiencing lung cancer, and that cancer was more openly discussed when the partner of the cancer patient was high in mindfulness. Additionally, Neff and Beretvas (2012) discovered that self-compassion within intimate relationships was positively linked to relationship well-being and better communication, and negatively associated with verbal aggression. Lastly, Yarnell and Neff (2013) reported that self-compassionate individuals were more likely to peacefully resolve interpersonal conflicts. Based on the connections made between the present study's findings and existing literature on self-compassion, female sexual assault survivors may profit from social supports as they cope with their sexual issues after sexual trauma.

Countering Societal Messages

Participants in the present study described how their experiences of self-compassion included the challenging of societal messages. Conceptualizations pertaining to what is expected during sex and negative comments surrounding body image were just a few dominant discourses women deconstructed as they coped with their sexual problems post sexual assault. Albeit sparse, the existing literature supports the positive relationship between self-compassion and coping with negative body image messages. For example, Puhl et al. (2020) investigated weight stigma and self-compassion amongst young adults. Self-kindness was reported as being lower in those who had experienced weight stigma, and lower levels of self-kindness for females was linked to experiencing inequality due to their weight and having received negative comments. Indeed, current study participants reported treating themselves unkindly after receiving negative societal messages pertaining to their weight and body image. Self-compassion for some women helped in preventing negative body image messages from becoming ingrained. For others, self-compassion assisted participants in making the connection between their abuse, distorted body image perceptions, and sexual problems.

The current study builds on Puhl et al.'s (2020) view that self-compassion may be helpful in coping with weight stigma. Furthermore, to my knowledge, the present study is the first to address the gap in the literature relevant to the role of self-compassion in countering negative societal messages pertaining to sex. Self-compassion for certain participants included examining and debunking sex-related societal messages that interfered with their sexual recovery. Additionally, women noticed that countering problematic sexual discourses gave them the freedom to explore what healthy sexual well-being meant to them. Discovering that self-compassion helped participants in the present study counter negative societal influences related

to body image and sex not only adds to the burgeoning field of self-compassion research but may benefit other female survivors of sexual violence experiencing similar occurrences.

Asserting Personal Boundaries and Taking Control

Sexual assault is about power and control, with most victims being women and the majority of perpetrators being men (Benoit et al., 2015). Women often feel powerless not only during the sexual assault but in subsequent sexual situations (Van Berlo & Ensink, 2000). Self-compassion for many participants in the present study helped them to become more assertive in their sexual needs and elsewhere, to set personal boundaries, and to take back a sense of control that was taken away from them during the sexual assault(s). For example, participants started saying no to certain sexual activities that made them feel uncomfortable, as well as repositioning themselves during particular sex acts to gain a greater sense of control. For others, regaining power and control involved removing orgasm as the end result of sex. This study's finding is consistent with feminist theory, in that survivors feel empowered as they regain control by setting personal boundaries and engaging in assertive behaviour (Courtois, 1991). In doing so, women overcome feelings of helplessness and submissiveness as a result of the abuse (Courtois, 1991). Asserting boundaries and taking control is also in alignment with Neff's (2018) *yang* definition of self-compassion, or the part of oneself that is protective, sets boundaries, and speaks one's truth. Along the same lines, Maltz (1988) stated that it is important for the survivor to feel that she has a choice in all sexual situations, and that the survivor knows that she can stop any form of sexual behaviour without negative consequences. Existing literature also points to a negative relationship between self-compassion and submissive behaviour (i.e., a lack of assertiveness). For instance, in their pre-trial study of the effectiveness of CMT with a sample of patients experiencing severe long-term mental health problems, Gilbert and Procter (2006) found

that participants naturally became more assertive as their self-compassion developed. Additionally, in their research investigating the relationship between self-compassion and submissive behaviour in university students, Akin (2009) found that the self-kindness, common humanity, and mindfulness components of self-compassion were negatively associated with submissiveness amongst participants. These findings in relation to existing literature suggest that self-compassion for female sexual assault survivors may mean setting personal boundaries and taking control as a way to help cope with sexual challenges post sexual assault.

Engaging in Regular Self-Care

Self-compassion for the women in the present study involved making themselves a priority and regularly attending to their needs in the form of self-care practices as they coped with their sexual challenges. Participants commented that habitually engaging in self-care was favorable to their mental, physical, emotional, spiritual, and sexual well-being. These findings are consistent with Gilbert's (2009) description of *compassionate behaviour* or behaving in ways that reduce suffering and that move a person towards their goals in life. For women in the current study, frequent self-care approaches included treating themselves with kindness, taking time for themselves, and engaging in enjoyable activities. Participants also recognized and honoured when they needed a holiday, taking vacation when possible. Lastly, the women routinely connected with themselves through mindfulness and spiritual practices. In addition, the current findings connect to the existing (albeit limited) literature on the beneficial role of self-care on sexual well-being in relation to certain health issues. For instance, Hoseini et al. (2018) investigated the impact of a self-care education program on sexual function and quality of life in patients with ischemic heart disease. Results revealed that quality of life and sexual function improved for the experimental group after the educational self-care intervention. These

outcomes, combined with the current study's findings, suggest that for female sexual assault survivors, self-compassion may mean engaging in frequent self-care to help them cope with sexual issues post-sexual assault.

Rebuilding a Relationship With One's Body

Self-compassion for several study participants, as they coped with sexual problems from a sexual assault(s), involved rebuilding a relationship with their bodies. Since the body is where the sexual assault took place, many women felt betrayed by their physical selves. Such betrayal was manifested, in part, through problems with sexual well-being. Repair for some women meant reconnecting with their bodies through physical movement. For example, women would dance with themselves, participate in yoga, or play sport for fun. Incorporating the body in the healing process from trauma has been used worldwide (Ogden et al., 2006). Yoga, chi gong, focusing, and somatic experiencing are just some examples of healing practices where physical movement is used (Ogden et al., 2006). Studies supporting the positive relationship between self-compassion and movement have also been conducted. For instance, Crews et al. (2016) explored whether trauma-sensitive yoga helped cultivate self-compassion in teen and adult female survivors of sexual violence. Indeed, their study revealed that trauma-sensitive yoga helped participants be more kind to themselves, confront negative emotional experiences, and reconnect with their body and mind using mindfulness.

For other participants in the current study, self-compassion involved developing a heightened awareness of their physical being. For example, self-compassion for some women helped them become more mindful of their bodies and practice non-judgement towards themselves. Other participants noticed that their bodily reactions acted as a gauge to their emotional well-being. Traditional sex therapies, such as sensate focus, have been known to help

individuals heal from sexual problems by increasing awareness of their body as well as their partners (Avery-Clark et al., 2017; Brotto, 2017). Similarly, Maltz (2012) includes a variety of touch exercises that can be performed solo or with a partner to help augment body awareness. Indeed, self-compassion for many participants in the present study included incorporating resources and approaches such as Sensate focus and Maltz's techniques. Based on the current study's findings, self-compassion for some female sexual assault survivors may involve rebuilding a relationship with their body as a way to cope with sexual problems post-sexual trauma.

Persevering Through Emotional Challenges

The emotional consequences of a sexual assault can be vast, with survivors often experiencing an overlapping of symptoms at once (Carey et al., 2018; Stein et al., 2004; van Berlo & Ensink, 2000). Anxiety, depression, shame, hopelessness, and blame are just a few feelings survivors report following sexual violence (Tarzia et al., 2017; Weiss, 2010). Compounding these deleterious emotional impacts can be negative feelings associated with sexual problems due to, or worsened by, the sexual assault(s). These feelings can include guilt, disgust, resentment, and numbness that can further impair a survivor's sexual experience (McCabe, 2009; Sims & Meana, 2010; Sutherland, 2012). The women in the present study communicated similar negative emotions in relation to their sexual problems after the sexual trauma(s). Furthermore, these participants realized that self-compassion helped them overcome emotional difficulties, allowing them to experience a more satisfying sex life. Neff's (2003a) research supports this positive relationship between self-compassion and emotional well-being. For example, she discovered that people high in self-compassion experienced less depression and anxiety, as well as better emotional regulation. Similarly, Scoglio et al.'s (2018) study revealed a

negative relationship between self-compassion and emotion dysregulation in their sample of female survivors of physical and sexual violence experiencing PTSD symptoms.

Perseverance was deemed an important self-compassionate experience for participants as they coped with overwhelming emotions impacting sexual well-being after the sexual assault(s). This finding is consistent with results of a mixed methods study (Ferguson et al., 2014) that explored self-compassion and positive psychological functioning in young female athletes. Participants viewed self-compassion as beneficial in helping them overcome struggles related to sport, focus on what the women *could* do as opposed to their weaknesses and inadequacies, and treat themselves with kindness and understanding during difficult times as opposed to surrendering. Similar results were also reported by Wilson et al. (2019) who explored the interrelationship of self-compassion and mental toughness among Canadian elite women athletes. These authors discovered that self-compassion and mental toughness were connected, with perseverance being the most common form of mental strength the female athletes utilized to cope with sport-related adversity. With its novel focus on sexual assault survivors with sexual concerns, the present study expands upon the literature on self-compassion and perseverance.

Clinical Implications and Recommendations

Based on this study's findings, there are a number of clinical implications and recommendations therapists may find helpful when working with female survivors of sexual assault who are experiencing sexual problems as a result. Suggestions are outlined below.

Given the salient role of time in participants' self-compassion experiences, therapists can remind survivors that using self-compassion to cope with their sexual problems can take time and effort, and that self-compassion is often an intentional and deliberate process that can become easier and more habitual with time. Clinicians may choose to assess where clients are in

their self-compassion journey and track progress over time by using self-report questionnaires, such as Kristen Neff's Self-Compassion Scale (Neff, 2003a). Assessing a woman's level of self-compassion may provide valuable information that can help inform treatment. For example, both the long and short versions of Neff's self-compassion questionnaire can pinpoint areas in need of attention and provide direction for future treatments. Furthermore, tracking progress over time may help empower clients, with empowerment being an important component of feminist theory and counselling psychology (Courtois, 1991; McWhirter, 1994; 1998). Additionally, counsellors may choose to monitor changes in a survivor's sexual well-being over time. For instance, the Female Sexual Function Index (Rosen et al., 2000) assesses four major categories of female sexual dysfunction: desire, arousal, orgasm, and pain, as well as general sexual satisfaction. The Female Sexual Function Index is considered psychometrically sound and easy to administer (Rosen et al., 2000). If therapists monitor changes in a client's sexual well-being over time, it could have similar advantages to tracking progress in self-compassion as mentioned above.

Just as honouring time was an important self-compassion experience amongst participants, so was quieting the inner critic. Some women in the present study found that the inner critic became their dominant mindset after the sexual assault, making it difficult for them to recognize self-criticism. Therefore, one of the therapist's roles may be to listen for negative self-talk that the client engages in and bring this awareness to the client's attention. Additionally, counsellors might take a psychoeducational approach, helping survivors understand symptoms as being the result of the brain developing an over-active threat system and that it is not the person's fault (Gilbert, 2009). Furthermore, according to Elliott (1999), sexual problems may be framed as the result of self-criticism and not the sexual assault. Understanding Gilbert's and Elliott's rationale for symptomology may enhance a client's self-compassion and move them

forward in their healing. Furthermore, clinicians could train in Neff and Germer's (2013) mindful self-compassion or Gilbert's (2009) CFT psychological interventions to help increase a survivor's self-compassion, as both approaches may help reduce self-criticism (Gilbert, 2009; Neff & Germer, 2013). Therapists may want to inform women of self-compassionate approaches used in the present study to soften self-criticism, such as reframing their negative thoughts. For example, a counsellor might help a survivor reframe the belief "I am a bad person" to "the sexual assault was not my fault" and "I am a valuable and good person."

As mentioned above, participants in the present study found that self-compassion assisted with *intrapersonal* problems (e.g., self-criticism) related to their sexual concerns after sexual trauma. From more of an *interpersonal* perspective, connecting with social supports was a core feature of women's self-compassion experiences. As part of a client's rehabilitation, therapists can suggest survivors talk openly and honestly with others whom they trust as a way to have survivors' sexual recovery experiences validated and normalized. Communicating openly and honestly can help women feel heard and valued, as well as alleviate mental health symptoms (Maheux & Price, 2016). The therapeutic alliance between counsellor and client can be viewed as a form of social support for clients, where clinicians can demonstrate compassionate behaviours in session, such as being caring, kind, empathic, and nonjudgmental. In addition, therapists may encourage survivors to attend a sexual assault support group, where the women may not only connect with other survivors, but also have their experiences normalized in a group setting. Lastly, engaging with positive social media platforms and social justice movements (e.g., #Me Too Movement) are other recommendations counsellors can suggest to have a client's experiences validated.

Another self-compassionate act that women in the current study found beneficial as they recovered from sexual problems after a sexual assault was countering negative societal messages pertaining to sex and body image. Based on this finding, therapists may consider helping clients debunk negative societal influences. For instance, counsellors could provide survivors with accurate sexual health information to ensure they are properly informed when making sexual decisions and engaging in sexual activity. Specifically, practitioners may choose to educate clients about the sexual response cycle, and how sexual desire is not always spontaneous but often responsive to sexual stimuli (Basson, 2001). Additionally, therapists can listen for and correct negative societal beliefs pertaining to sex and body image, such as the messages mentioned in the present study: "males are expected to end in orgasm but females are not" or "no one will find me attractive because I am a larger person." Furthermore, therapists may choose to provide specific psychological interventions, such as CBT, to help survivors identify and change negative thinking and behavioural patterns pertaining to sex and body perceptions (Kar, 2011). Additionally, clinicians can take a social activist role traditionally found in feminist therapy, such as educating the public about common sexual myths and leading positive body image workshops (Enns, 1993).

While self-compassion helped participants counter societal messages, the women also found that behaving compassionately towards themselves helped them assert personal boundaries and regain control in their sexual lives after their sexual trauma(s). Therapists may choose to work on assertiveness skills with clients, helping them find their voice. For example, counsellors may want to educate women about their *Bill of Sexual Rights*. This bill can be found in Maltz's (2012) book *The Sexual Healing Journey*, a useful resource clinicians may want to familiarize themselves with when helping survivors recover from sexual problems after sexual violence.

Examples of an individual's sexual rights include: "the right to say no to sexual behaviour, the right to control touch and sexual contact, the right to stop sexual arousal that feels inappropriate or uncomfortable, and the right to enjoy healthy sexual pleasure and satisfaction" (Maltz, 2012, p. 34). These civil liberties are often violated during a sexual assault, leaving survivors feeling confused about their sexuality. Informing women of these freedoms may empower them to re-build healthy sexual beliefs and behaviours as they regain their power post-sexual trauma. Additionally, clients may find it empowering to learn from practitioners how to integrate what Neff (2018) had described as the *yin* and *yang* parts of self-compassion, which refers to the soothing and kind aspects of self-compassion (yin) and the protective assertive aspects (yang). Balancing these two aspects of self-compassion may help clients care for themselves while standing in their truth.

From the perspective of participants in the present study, self-compassion in the form of regular self-care practices resulted in a positive impact on the women's mental, physical, spiritual, and sexual selves. Therefore, therapists may choose to teach survivors self-care strategies, as an expression of self-compassion. For instance, counsellors could instruct clients on how to perform Gilbert's (2009) mindful breathing and compassionate mind training techniques or Kristen Neff's self-compassion exercises and guided practices (https://self-compassion.org). Moreover, counsellors can encourage clients to participate in self-care activities deemed meaningful to them, such as playing with pets or reading.

In addition to self-care, rebuilding a relationship with one's body was a key self-compassionate experience in women's sexual recovery. Therapists could suggest survivors engage with their physical bodies in ways that feel right for them, such as showing oneself physical affection through hugging and touching, as well as dancing, yoga, and sport.

Counsellors may also choose to teach clients mindfulness skills to become more embodied and in-tune with their physical selves. For instance, mindfulness based cognitive therapy has been found helpful for women staying present during sexual encounters and reducing provoked vestibulodynia symptoms (Brotto et al., 2017; 2020). The body has also been included in traditional sex therapy, such as sensate focus (Avery-Clark et al., 2019), and healing from sexual trauma (Maltz, 2012). Therefore, clinicians could teach survivors the touching exercises involved in each step of sensate focus, as well as Maltz's sexual healing techniques, and then instruct clients to practice these new skills by themselves or with a partner. Providing women with a holistic approach in their healing that includes both mind and body interventions is important given the complicated and adverse sequelae of a sexual assault (s; Carey et al., 2018; Stein et al., 2004; van Berlo & Ensink, 2000). Moreover, therapists may choose to include sensorimotor interventions in therapy to assist clients in trauma recovery. For example, somatic resourcing can help survivors regulate their nervous system and movement can be used in therapy to challenge dysfunctional somatic patterns and process implicit memories (Ogden et al., 2006).

Including the body in the sexual recovery process was an essential self-compassionate experience for participants. Just as notable for women was challenging emotions related to the sexual assault(s) and their sexual issues. Therapists will want to normalize for clients that experiencing difficult emotions are common, and typical reactions, amongst survivors post-trauma (Carey et al., 2018; Courtois, 1991; Stein et al., 2004; van Berlo & Ensink 2000). In addition, clinicians can educate clients that although avoidance of symptoms, such as negative emotions, may be advantageous in the beginning stages of trauma recovery (Van Vliet, 2010), extended use of avoidant coping mechanisms can result in a worsening of symptoms (Frazier et al., 2005; Van Vliet, 2010). However, in alignment with Herman's (1997) tri-phasic approach to

working with trauma survivors, practitioners may want to ensure clients are well-resourced and stable prior to processing emotions to avoid re-traumatization. Therapeutic approaches, such as EFT, may help women become aware of, understand, and regulate emotions, as well as change unhealthy emotions and develop healthier emotional coping methods (Greenberg, 2004). Additionally, counsellors may inform survivors that EFT for couples has shown to improve sexual desire and decrease depressive symptoms in partnered women (Macphee et al., 1995). CFT is another well-known psychological approach used to aid clients in emotion regulation (Gilbert, 2009). Thus, therapists can work towards rebalancing the survivor's three affect regulation systems and assisting clients in accessing their soothing system using the skill-building components of CMT (Gilbert, 2009). Moreover, therapists may also want to highlight the role of perseverance when coping with sex-related emotional stress. For example, counsellors could reference the present study when reminding women that moving forward from sexual problems following a sexual assault can take commitment and persistence.

Limitations

I chose IPA as my qualitative research method in this study to capture an in-depth understanding of women's experiences with self-compassion as they coped with sexual concerns after a sexual assault. In my sample of 10 participants, however, only two women did not identify as being Caucasian. Including a more diverse sample, such as the voices from Indigenous women, sexually diverse individuals, those who identify with a disability, and females over the age of 50, could add to the transferability and usefulness of the study's findings. Additionally, absence of a member check for one participant, who did not provide feedback on her interview transcript, may have increased the potential for misrepresentation by the researcher of the participant's self-compassion experiences.

The subjective nature of qualitative research poses as a methodological consideration, as the researcher seeks to understand the participant's lived experience. In IPA, this two-step process, or double hermeneutics, involves the participant making sense of their experiences as well as the researcher interpreting what the participant is making sense of (Smith et al., 2009). In other words, double hermeneutics means that both the participant and the researcher influence the interpretation of the data. Although I attempted to bracket my biases, prejudices, and past experiences, double hermeneutics implies that my preconceptions undoubtedly affected the analysis and interpretation of the participants' experiences. Additionally, it is important to keep in mind that the findings from this study represents a social construction of the women's experiences of the phenomenon at this point in time, rather than serving as a universal *truth* meant to be generalized across populations.

Another limitation may have to do with the retrospective aspect of information retrieval. Participants were asked to recall their lived experiences pertaining to self-compassion. However, reclamation of these memories for some women predated the interview by many years. Therefore, the data may not accurately represent participants' relived experiences of self-compassion.

A unique methodological consideration in this study had to do with conducting participant interviews during the COVID-19 pandemic. Although face-to-face interviews are often the choice in qualitative studies (Rubin & Rubin, 2005), in-person meetings were not always possible given the pandemic's restrictions. While five of the 10 interviews were held in person, the remaining five were conducted over the phone based on the participant's comfort level and geographical location. Even when face-to-face interviews took place, masks were worn as per the pandemic guidelines, interfering with reading the women's facial expressions. Both

Pietkiewicz and Smith (2014) and Smith et al. (2009) state the importance of monitoring the interview's effect on participants. This includes reading participant's facial expressions and non-verbal behaviour (Smith et al., 2009). However, the wearing of masks for COVID protection and holding phone interviews made reading non-verbal signals challenging. It required frequent check-ins with participants to measure the impact the interview was having on them, if any. It also meant relying on the women's honesty to say if they were being negatively impacted and needed to stop the interview. Although I felt rapport had been built with each participant interviewed, it is possible that the women withheld pertinent information that could add to the richness of the data as a result of feeling uncomfortable talking about certain issues, feeling ashamed, or becoming emotionally dysregulated.

The last limitation discussed has to do with self-selection bias, or when individuals volunteer to participate in a study (Ganguli et al., 1998). Indeed, participants in the current study volunteered to share their experiences of self-compassion, possibly creating implications for the interpretation of the current study's findings. For instance, according to Ganguli et al., volunteer participants tend to be educated younger women, with higher functioning and cognitive abilities. Comparably, in the present study, women were relatively young, well-educated, and high functioning. Therefore, self-selection may have reduced the sample's diversity in terms of age, education, and level of functioning.

Future Directions

To my knowledge, this is the first study to explore women's experiences of self-compassion in coping with sexual problems after a sexual assault. Being the first to explore these constructs, at their intersection, opens up opportunities for future research. Below are directions future researchers may want to consider.

Firstly, holding in-person interviews, when possible, would allow the researcher to accurately read the participant's non-verbal body language and facial expressions, which is important when monitoring the impact an interview is having on participants. Furthermore, it would be recommended to hear the unique experiences and perspectives from a more diverse sample regarding this study's research questions, such as Indigenous women, sexually diverse individuals, those who identify with a disability, and females over the age of 50.

Secondly, exploring men's experience of self-compassion in coping with sexual problems after a sexual assault would also be beneficial, given that males can also be victims and have their own unique experiences. For instance, Iseley and Gehrenbeck-Shim (1997) found that men who were sexually assaulted commonly presented a high degree of depression and hostility. In addition, Maltz (2012) discussed that both men and women share similar sexual impacts after abuse, such as trouble with desire, arousal, orgasm, and trust. Given the similarities in impact between male and female sexual assault survivors, it would be interesting to hear men's unique experiences in relation to this topic, as well as the perspectives from other genders (e.g., people who self-identify as transgender, two-spirited, and intersexed people).

Thirdly, to my knowledge, no quantitative or mixed-methods designs have been completed within this domain of research. Quantitative researchers could investigate pre- and post-tests in self-compassion and/or sexual well-being after interventions in CFT, mindful self-compassion, and sexual healing techniques. Psychologically sound assessment tools used to assess these constructs could include Neff's (2003a) Self-Compassion Scale and Rosen et al.'s, (2000) Female Sexual Function Scale. Also, a mixed-method approach could provide both quantitative and qualitative data, offering both depth and breadth.

Fourthly, it would be fruitful for qualitative researchers to explore the understudied area of research relevant to how self-compassion may assist female sexual assault survivors in coping with self-criticism related to sexual issues. Exploring self-compassion's role in countering negative body image messages and beliefs around sex would also add to the burgeoning literature on self-compassion. In addition, future researchers may want to expand on the relationship found in the present study between self-compassion and self-care for survivors coping with sexual problems. Furthermore, prospective studies could provide further insight into the relationship between perseverance and sexual recovery.

Lastly, more research pertaining to sexual health, including sexual problems, is needed within the field of counselling psychology. Therapists feeling incompetent or uncomfortable discussing sexual issues with clients may choose to build competency in this area via independent readings. Other suggestions include taking courses in sex education or seeking consultation to ensure clients are receiving accurate sex information.

Conclusion

Female survivors of sexual assault often experience many negative psychological, physical, and interpersonal effects post-sexual violence. Women who have experienced sexual trauma may also encounter sexual concerns related to desire, arousal, pain, orgasm problems, and sexual well-being that can last for years after the assault. Given that self-compassion has been known to consistently advance psychological well-being and facilitate resilience, this study used IPA to explore women's experiences of self-compassion in coping with sexual problems following a sexual assault. IPA captured the essence of self-compassion through the lived experiences and perspectives of female sexual assault survivors, accentuating the women's resiliency. Not only does this research expand knowledge and understanding around women's

perceptions and experiences of self-compassion in relation to sexual well-being following sexual assault, but it also builds upon the emerging literature regarding the usefulness of self-compassion in addressing trauma among women. Furthermore, this study provides understanding and knowledge that may inform potential counselling approaches for helping survivors in their sexual recovery.

As this study helped give voice to survivors whose experiences navigating through subsequent sexual difficulties have been underrepresented in the literature on self-compassion, I conclude this dissertation with a quote from one of the participant's self-compassion experiences: "Who I am as a result of the healing is so much more than I could have been if the trauma never happened."

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Appendix A – Glossary of Terms and Definitions

Acceptance and commitment therapy (ACT): A model of therapy that stems from cognitive behaviour therapy (CBT) and that uses processes such as acceptance, mindfulness, commitment, and behaviour change to attain improved psychological flexibility. With ACT, individuals identify and accept difficult thoughts and emotions and commit to making behavioural changes that are in alignment with their individual values (Lappalainen et al., 2007).

Acute stress disorder (ASD): A short-term condition where an individual was exposed to actual or threatened death, serious injury, or sexual violence, and the duration of the disturbance lasts three days to one month (APA, 2013).

Adulthood sexual assault (ASA): A term used to imply any unwanted and non-consensual sexual act that occurs after the age of 16 years, regardless of the age difference between the survivor and perpetrator (Finkelhor, 1979; Russell, 1986).

Biomedical model: The biomedical model views health problems, including sexual functioning issues, from a purely biological standpoint, with minimal emphasis on psychosocial theories and interventions (Deacon, 2013; Engel, 1977).

Childhood sexual abuse (CSA): While the definitions of childhood sexual abuse vary across jurisdictions, there is wide agreement that this criminal act encompasses: sexual acts involving children who lack the maturity as well as the cognitive and emotional capacity to give consent; and a difference in power between the perpetrator and the victim related to age, physical strength, intelligence, authority, life experience, or social hierarchy (Schachter et al., 2009). The Government of Canada website (2014) states that the age of consent to engage in sexual activity is 16 years; however, this threshold rises to 18 years if sexual activity exploits the young person (e.g., prostitution or pornography).

Cognitive behavioral therapy (CBT): A psychotherapy approach that combines both cognitive and behaviour therapy to help clients see how their thoughts and/or behaviours may be contributing to how they feel, with the goal of returning the person to normal functioning (Dass-Brailsford, 2007).

Compassion focused therapy (CFT): An integrative form of psychotherapy that draws from social, developmental, and evolutionary psychology; neuroscience; and Buddhist thinking, and includes compassion as an important piece in the psychotherapy process (Gilbert, 2009).

Compassionate mind training (CMT): The skill-building component of compassion focused therapy (CFT), where clients are taught the attributes of compassion: care for well-being, sensitivity, sympathy, distress tolerance, empathy, and non-judgement (Gilbert, 2009). Specific skills used to teach the attributes of compassion are: imagery, attention, feeling, sensation, behaviour, and reasoning (Gilbert, 2009).

Descriptive phenomenology: A phenomenological approach to research that attempts to describe a phenomenon without meaning assigned to it (Smith et al., 2009).

Dyspareunia: Painful sexual intercourse (Masheb et al., 2009).

Emotionally focused therapy (EFT) for couples: A brief attachment-based counselling approach that aims to improve a couple's relationship by building secure attachment bonds within the couple's relationship. Within therapy, a couple's problem emotions and interaction patterns are identified, and the couple communicates with one another their relational needs, with the goal of improving their relationship (Wiebe & Johnson, 2016).

Empowerment: The process whereby marginalized individuals, groups, or organizations become aware of power differentials within various aspects of their lives; develop resources towards resiliency; and build the capacity to exercise these resilient skills in a way that is respectful and empowering of others (McWhirter, 1994).

Female Orgasmic Disorder: A condition whereby for a minimum duration of six months, a woman has had difficulty reaching orgasm or the sensations associated with the orgasm is reduced in intensity (APA, 2013).

Female Sexual Interest/Arousal Disorder: A condition where a women experiences little to no interest in at least three of the following indicators that lasts for at least six months: sexual activity; sexual thoughts/fantasies; initiation of sexual activity and is generally unreceptive to her partner's sexual attempts; excitement/pleasure during sexual activity; interest/arousal to any form of sexual cues (e.g., verbal, visual, written); genital or nongenital sensations during sexual activity (APA; 2013).

Feminist empiricism: An epistemological viewpoint stating that women's and girl's experiences should be added to research to avoid knowledge being seen only from a male perspective (Burns & Walker, 2005).

Feminist epistemology: A philosophical assumption concerned with how gender influences our conceptions of knowledge (Doucet & Mauthner, 2006).

Feminist metaphysics: A philosophical assumption that examines common beliefs and ideas that are taken for granted as being reality and investigates ways in which they may have been gendered (Haslanger & Sveinsdóttir, 2011).

Feminist postmodernism: An epistemological perspective asserting that since women will experience oppression differently based on factors such as race, ethnicity, sexuality, and disabilities, researchers need to examine the complex interaction between gender and all aspects of individual differences. Therefore, there are many forms of perceived realities (Burns & Walker, 2005).

Feminist standpoint: An epistemological stance claiming that a researcher's subjective perspective is important when creating and interpreting research (Burns & Walker, 2005).

Genito-Pelvic Pain/Penetration Disorder: A condition where a woman experiences problems with one or more of the following: intercourse; genitor-pelvic pain during intercourse or attempt of vaginal penetration; fear or anxiety of painful vaginal penetration; tightening of the pelvic floor muscles during attempted vaginal penetration. Symptoms can be persistent or recurrent, and have lasted at least six months (APA; 2013).

Idiography: An approach to knowledge production where individual differences are explored, providing a more complete understanding of that individual (Pietkiewicz & Smith, 2014).

Impact of Event Scale – Revised (IES-R): A self-report measure that assesses traumatic stress related to three major symptom clusters of PTSD (intrusion, avoidance, and hyperarousal; Creamer et al., 2003).

Interpretive phenomenology: A phenomenological approach to research where the researcher interprets and makes meaning of participant's experiences (Pietkiewicz & Smith, 2014).

Interpretative phenomenological analysis (IPA): A qualitative methodological approach that examines in-depth the meaning of a participant's lived experience (Smith et al., 2015).

Mindful Self-Compassion: A psychological intervention that includes mindfulness as a way to increase self-compassion (Neff & Germer 2013).

Phenomenology: A qualitative approach to research that studies the essential components of a phenomena or experience that makes it original or unique from others (Pietkiewicz & Smith, 2014).

Post-traumatic stress disorder (PTSD): A long-term condition where an individual was exposed to actual or threatened death, serious injury, or sexual violence, and the duration of the disturbance lasts more than one month (APA, 2013).

Provoked Vestibulodynia: Pain at the entrance of the vagina (Corsini-Munt et al., 2014).

Psychobiosocial model: The psychobiosocial model views women's sexual problems within a broader relational and cultural context (Tiefer, 2002).

Sexual abuse: Sexual violations against another individual by a person in a position of power or authority (e.g., parent, priest). Sexual abuse can occur only once or over a period of time (Government of Alberta, 2019).

Sexual assault: Defined as any non-consensual sexual act committed against a person (Fedina et al., 2018).

Sexual health: Based on WHO's (2006) definition, sexual health includes the emotional, mental, physical, and social components of an individual's sexual well-being, as well as the inclusion of

concepts such as respectful sexual relationships with the potential for enjoyable sexual experiences, and the absence of disease, dysfunction, discrimination, and sexual violence.

Sexual problems: Discontent or dissatisfaction with any emotional, physical, or relational aspect of women's subjective sexual experience. Sexual problems can arise from sociocultural, political or economic factors (e.g., lack of access to health services, pressure to meet ideal sexual cultural norms, lack of sexual interest due to family and work obligations), partner and relationship issues (e.g., betrayal, unequal power, communication problems), psychological factors (e.g., depression, anxiety, past experiences of physical, sexual, or emotional abuse), and medical problems (e.g., local or systemic medical conditions such as circulatory or neurological problems, pregnancy, STDs) (Tiefer, 2002).

Sexual violence: An umbrella term used to cover a wide range of unwanted sexual behaviour, in any setting (e.g., home, work), and regardless of the relationship to the survivor (e.g., long-term partner, stranger). Sexual assault and sexual abuse are terms often included under the term sexual violence (WHO, 2003).

Sexual well-being: An individual's behavioural (e.g., genital and non-genital sexual frequency, duration of sexual activities), motivational (e.g., sexual desire), and cognitive-affective (e.g., sexual satisfaction, esteem, thoughts during sexual engagements) sexual responses. This definition also includes the person's perspective of satisfaction as it pertains to their sexual relationship, sexuality, and sexual functioning, including their sexual response (e.g., desire, arousal, orgasm; Byers & Rehman, 2013; Crump & Byers, 2017). Byers and Rehman (2013) distinguish the meaning of sexual well-being from the WHO's (2006) description of sexual health, stating that the sexual health definition is expansive, and includes not only the individual's physical, mental, emotional, and social aspects of their sexual well-being, but concepts such as the person's sexual rights, as well as the freedom from disease, dysfunction, coercion, discrimination, and sexual violence.

Appendix B – Poster

FEMALE SEXUAL ASSAULT SURVIVORS

REQUIRED FOR RESEARCH STUDY

If you are a female survivor of sexual assault, 19 years of age or older, and experiencing sexual problems as a result, you are invited to participate in a research study.

Participation will involve about 2 hours of your time.

During this time, you will be interviewed about your experiences of self-compassion in coping with sexual problems following a sexual assault.

Your participation will be completely **confidential**.

For more information regarding this study, please contact:

Debbie Campbell, M.Ed., CCC.
Doctoral Student, University of Alberta
Department of Educational Psychology
debra1@ualberta.ca

Pro00094717approved by the Research Ethics Board of the University of Alberta

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Appendix C –Information Letter and Consent Form

Research Study Title: Women's experiences of self-compassion in coping with sexual problems following a sexual assault.

Principal Researcher: Debra Campbell, M.Ed., email: debra1@ualberta.ca
Research Supervisor: K. Jessica Van Vliet, Ph.D., R.Psych., email: jvanvliet@ualberta.ca

This study is for completion of the principal researcher's Doctorate of Counselling Psychology.

Background and Purpose of the Research Study: The purpose of this research is to explore women's experience of self-compassion in coping with sexual problems following a sexual assault. Information obtained from this study could inform counselling approaches for helping survivors overcome sexual concerns.

Eligibility: In order to participate in the study, you must (a) be female; (b) be 18 (in Alberta/Ontario/Prince Edward Island) or 19 (in Nova Scotia and New Brunswick) years or older; (c) be a survivor of sexual assault (whether in childhood, adulthood or both); (d) be experiencing sexual problems (e.g., difficulties with desire, arousal, pain, orgasm, or sexual well-being) as a result of the sexual assault(s); (e) have told at least one other person about the assault(s) prior to this research study; (f) have experienced and practiced self-compassion in response to sexual concerns post sexual assault; (g) be willing to talk about your experiences of self-compassion in relation to your sexual concerns; and (h) not be experiencing severe traumatic symptoms as a result of the assault(s). To assess severity of post-assault symptoms, you will be emailed and asked to complete the Impact of Event Scale – Revised (IES-R). If the severity of your symptoms are low, you will be invited to participate in the study. However, if your symptoms are high, you will not be eligible to participate in the study and will be provided a list of counselling resources to assist in any distress you may be experiencing.

What will I be asked to do? If you are eligible to participate in the study, I will contact you for an interview to be held either via telephone or in person at a confidential location, such as the sexual assault centre where you became aware of the study. However, in light of the COVID-19 pandemic, in-person interviews will only take place once the COVID-19 social distancing restrictions are lifted. You will be asked questions about your experiences of self-compassion in relation to sexual problems that started or got worse after the sexual assault(s). I anticipate about 90 minutes for the interview, with the possibility of a second brief interview (approximately 30 minutes) should follow-up questions arise. All interviews will be audio-recorded and transcribed. A transcript of your interview will be provided to you to review and provide feedback. Also, a summary of the report will be available to you at end of the study.

What are the risks of participating? The proposed research poses little risk of harm to you. However, some of the information that you will be asked about may be upsetting or stressful. You will be provided with a list of local resources for support and counselling services after the interview should you experience any distress. I am also a trauma-informed doctoral counselling student, and will be able to provide immediate assistance if necessary.

What are the benefits to me? You are not expected to get any direct benefit from being in this research study. However, there are potential indirect benefits for participants. Thinking and talking about times when you practiced self-compassion can be an empowering experience. Also, you may find it rewarding to know that you will contributing to research on how women experience self-compassion in coping with sexual concerns following a sexual assault.

Do I have to take part in the study? Participating in the study is your choice. If you decide to be in the study, you can withdraw at any time or refuse to answer any question(s) with no negative consequences. You have up to four weeks after receiving an emailed copy of your transcript to withdraw. Any information collected up to when you withdraw will also be withdrawn. After that point, your information will be kept and used in data analysis.

Will I be paid for the research? You will receive a $25 gift card of your choice (e.g., Starbucks) for participating in the research study. You are entitled to this gift card even if you choose to withdraw before the study is completed.

Will my information be kept private? All collected information will be kept confidential. For instance, you will choose a fake name so that no identifying information can be traced back to you. Also, any identifying information will be changed. Audio-recordings will be saved on an encrypted USB stick and stored securely in a locked filing cabinet in my office. Electronic data will be password protected on my computer in an encrypted file. My supervisor and I will be the only people who will have access to the data collected in the study. The IES-R will be deleted at the end of the study, audio-recordings will be deleted after 5 years, and all other anonymous information will be deleted after 15 years. The final project will be kept at the University of Alberta. Information from this study will be used in the write up of this final project and may be included in scholarly publications and conferences. I may use the information I get from this study in future research. However, if I do this it will have to be approved by the Research Ethics Board, and data will remain anonymous.

There are limits to confidentiality. If you disclose that a child (under the age of 19) is being abused or neglected or is at risk of being abused or neglected, and/or you indicate that you are suicidal or homicidal, I am obligated to report these to the appropriate authorities to ensure the safety of you and/or others.

If you have questions:
The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

If you decide to participate, have further questions, or require more information, feel free to contact me via phone (902) 751-1311, or email at debra1@ualberta.ca. You can also contact my research supervisor Dr. K. Jessica Van Vliet at (780) 492-5894 or via email at jvanvliet@ualberta.ca.

Name of Participant	Date
Debbie Campbell, M.Ed., CCC. Doctoral Student, University of Alberta Department of Educational Psychology	Date

Appendix D – Counselling Resources

Counselling Resources
Community Services

Should you experience distress, or need support, please consider contacting the following community services in your area. Many of these agencies provide free or low-cost counselling.

Across Canada

Hope for Wellness Helpline
Immediate mental health counselling and crisis intervention for all Indigenous people across Canada (available in some Indigenous languages)
Toll-free: 1-855-242-3310

Nova Scotia

24-hour crisis intervention line – Nova Scotia
1 (888) 429-8167

Halifax Area

Avalon Sexual Assault Centre
1526 Dresden Row, Suite 401, Halifax
Appointment Bookings: 902-422-4240
Service Email: counseling@avaloncentre.ca
Website: http://www.avaloncentre.ca

The People's Counselling Clinic
1701 Hollis Street, Suite 800, Halifax
General Inquiries: 902-491-4286
Service Website:
http://www.robertswright.ca/free-counselling-clinic
Email: thepeoplescounsellingclinic@gmail.com
Website: http://www.robertswright.ca

Counselling Services
6351 North Street, Suite 201, Halifax
General Inquiries: 902-802-3007
Email: channelofpeace@icloud.com
Website: http://www.channelofpeace.ca

Dalhousie University Student Health & Wellness
2nd Floor, LeMarchant Place
1246 LeMarchant Street, Halifax
Phone: 902-494-2171

Email: livewell@dal.ca

Mount Saint Vincent University
Counselling Services
E. Margaret Fulton Communications Centre (EMF) 108
166 Bedford Highway, Halifax
Phone: 902-457-6567
Email: counselling@msvu.ca

Saint Mary's University
The Counselling Centre
4th Floor Student Centre
923 Robie Street, Halifax
Phone: 902-420-5615
Email: counselling@smu.ca

Wolfville and surrounding areas

Mental Health and Addictions – Adult Program
23 Earnscliffe Avenue, Wolfville
Mental Health and Addictions: 1-855-273-7110
General Inquiries: 902-542-2266
Service Website:
http://www.nshealth.ca/service-details/Outpatient%20Mental%20Health%20(Adults)
Website:
http://www.nshealth.ca/locations-details/Eastern%20Kings%20Memorial%20Community%20Health%20Centre

Acadia University
Student Counselling Centre
30 Highland Avenue
Acadia Student's Union Centre, Old SUB complex, Wolfville
Phone: 902-585-1246
Email: counselling@acadiau.ca

Truro and surrounding areas
Colchester Sexual Assault Centre
35 Commercial St., Suite 403, Truro
Phone: 902-897-4366
Email: info@colchestersac.ca

Antigonish and surrounding areas

Antigonish Women's Resource Centre & Sexual Assault Services Association
204 Kirk Place, 219 Main Street, Antigonish

Phone: 902-863-6221
Email: info@awrcsasa.ca

St. Francis Xavier University
Health and Counselling Centre
Bloomfield Centre 305, Antigonish
Phone: (902) 867-2263

Alberta

Addiction Helpline (toll free within Alberta)
1-866-332-2322

Crisis Services Canada
Suicide prevention and support (Available 24/7/365)
1-833-456-4566
Text 'Start' to 45645 (Available 4pm – Midnight ET; Standard text messaging rates apply)

Mental Health Help Line (24/7 telephone service)
Location: Alberta Wide
1-877-303-2642 (Toll free)

Toll Free Crisis Line/Distress Centres
780 area code: 1-800-482-4357
403 area code: 1-800-784-2433

Calgary

24 Hour Crisis Helpline
(403) 266-4357

Calgary Communities Against Sexual Abuse (CCASA)
Northland Building
Suite 700, 910-7th Avenue S.W.,Calgary
Support and Information Line: (403) 237-5888
Toll Free (in Alberta): 1-877-237-5888

Calgary Counselling Centre
Suite 1000 105, 12 Avenue SE, Calgary
(403) 265-4980

Distress Centre Calgary (DCC)
24-hour crisis support in Calgary
(403) 266-HELP (4357)

Eastside Family Centre (free walk-in counselling)
Northgate Village Mall
255-495 36 Street NE, Calgary
(403) 299-9699

Indigenous Mental Health Program
7th Floor
1213 4 Street SW, Calgary
(403) 955-6645 (Intake)
Website: http://www.albertahealthservices.ca/info/Page2762.aspx

University of Calgary – Wellness Services
MacEwan Student Centre (MSC 370)
3rd Floor
2500 University Drive N.W., Calgary
(403) 210-9355

Edmonton

MacEwan University
7-103A, City Centre Campus
10700 – 104 Avenue, Edmonton
(780) 497-5063
WPS@macewan.ca

AND

621, Alberta College Campus
10050 MacDonald Drive, Edmonton
(780) 497-5063
WPS@macewan.ca

Sexual Assault Center of Edmonton (SACE)
Suite 205
14964 121A Avenue, Edmonton
(780) 423-4102 (Office)
Hotline: (780) 423-4121
www.sace.ab.ca

University of Alberta – Counselling & Clinical Services
2-600 Students' Union Building (SUB), Edmonton
(780) 492-5205

University of Alberta – Sexual Assault Centre

2-795 Students Union Building (SUB), Edmonton
(780) 492-9771 (Office / Hotline)
SexualAssaultCentre@ulaberta.ca

YWCA – Edmonton
#400, 10080 Jasper Avenue, NW, Edmonton
(780) 423-9922 (YWCA)
Email: info@ywcaedm.org

Ontario

If you are experiencing a mental health or addictions related crisis:

- Contact your doctor
- Go to the nearest hospital
- Find resources at ConnexOntario
- Call 911 or Telehealth Ontario at 1-866-797-0000

Mental Health Helpline
Toll-free: 1-866-531-2600

Talk 4 Healing
Indigenous women can get help, support and resources seven days a week, 24 hours a day, with services in 14 languages
Toll-free: 1-855-554-4325

Ottawa

The Sexual Assault Support Centre of Ottawa
Support Line: 613-234-2266
Office Line: 613-725-2160
Email: info@sascottawa.com

The Walk-in Counselling Clinic
2255 Carling Avenue, Ottawa
Area served: LHIN Champlain
613-722-2225
http://www.walkincounselling.com

The Counselling Group
2255 Carling Ave Suite 300, Ottawa
Intake Worker: 613-722-2225 (352)
Email: rfromowitz@thecounsellinggroup.com

Family Services Ottawa
312 Parkdale Ave., Ottawa

613-725-3601
Email: fscoc@familyservicesottawa.org

Toronto

Christian Counselling Services
1009-2 Carlton St., Toronto
416-489-3350
Email: admin@christiancounsellingservices.com

Family Service Toronto (FST)
128A Sterling Rd., Toronto, ON
Area served: Toronto
416-595-9618
www.familyservicetoronto.org/

Hard Feelings Mental Health
848 Bloor Street West, Toronto
(416) 792-4393
Email: info@hardfeelings.org or kate@hardfeelings.org

Toronto Psychotherapy Group (tpg)
120 Carlton Street, Suite 413, Toronto
Area Served: Greater Toronto area
(647) 794-6519
Email: info@torontopsychotherapygroup.com

TorontoPsychotherapists.ca
An online directory for finding quality, well-trained psychotherapists in the Toronto area
101-330 Dupont St., Toronto, ON
Area served: Toronto
1-416-580-0771
www.torontopsychotherapists.ca

Toronto Rape Crisis Centre/Multicultural Women Against Rape
24 Hour Crisis Line: (416) 597-8808
(416) 597-1171
Email: info@trccmwar.ca

Prince Edward Island

The Island Helpline
1-800-218-2885

Charlottetown

McGill Community Mental Health

55 McGill Avenue
Charlottetown, PE
(902) 368-4911
(no fee)

Richmond Centre Charlottetown
1 Rochford Street
Charlottetown, PE
(902) 368-4430
(no fee)

PEI Rape & Sexual Assault Centre
1 Rochford St., Charlottetown
(902) 368-8055
www.peisac.org
(no fee)

PEI Rape & Sexual Assault Centre
Satellite Offices: Alberton & Summerside
(902) 368-8055
www.peirsac.org

Victim Services: Queens and Kings County
1 Harbourside Access Road
Charlottetown, PE
(902) 368-4582
(no fee)

Summerside

Victim Services: Prince County
263 Heather Moyse Drive
Suite 19, 2nd Floor
Summerside, PE
(902) 888-8218
(no fee)

Prince County Hospital
65 Roy Boates Ave.
(902) 888-8180

Montague

Montague Mental Health Centre
162 Douses Rd.
(902) 838-0960

Souris

Community Mental Health and Addictions
17 Knights Ave., Souris
(902) 687-7110

Mental Health & Addictions Online, Phone, and Text-based Supports
Montague: Community Mental Health (902) 838-0960
Charlottetown: Richmond Centre (902) 368-4430 and McGill Centre (902) 368-4911
Summerside: Prince County Hospital (902) 888-8180
O'Leary: O'Leary Health Centre (902) 853-8670

New Brunswick

24 Hour Sexual Assault Support Line
Fredericton and Saint John: (506) 454-0437

CHIMO Help Line Inc.
Toll-free line: 1-800-667-5005
Provides 24/7 crisis intervention, referrals, and vital information.

Fredericton

Fredericton City Police: (506)-460-2300

Dr. Everett Chalmers Hospital: (506)-452-5400

Sexual Violence New Brunswick
Fredericton
Support Line: (506)-454-0437
Email: info@svnb.ca

SHE Counselling and Consulting Services
919 Prospect Street
Suite 90
Fredericton, NB
Phone: (506) 455-1777
Email: shecounselling@gmail.com

Saint John

UNB Student Health Centre
100 Tucker Park Road
(506)-648-5656
behealthy@unb.ca

UNB Saint John Counselling Services
Oland Hall G18/19
(506)-648-2308/(506)-648-2309
sjcounsellor@unb.ca

Saint John City Police
(506)-648-3333

Saint John Regional Hospital
(506)-648-6000

Moncton

South East Sexual Assault Centre (SESAC)
Counselling and accompaniment services: (506)-857-8028
Email: sesac.casse@crossroadsforwomen.ca
Support line: 1-844-853-0811 (24/7)

Sage Solutions Inc.
70 King Street
Moncton, NB
Phone: (506) 857-3258 or 1-800-390-3258
Email: info@SAGEinc.ca

Touchstone
The Red Lion Complex
23 High Street
Moncton, NB
Phone: (506) 857-3007
Email: tchstone@gmail.com

Appendix E – Demographic Questionnaire

For each of the following questions, please check the box and/or fill in the answer that best describes you. Only answer questions that you feel comfortable in answering. Answers to these questions will be used to describe the population I am studying.

Today's Date: _____

Participant Pseudonym: _____

Age: _____

Ethnic/cultural background: _____

1. Please check the highest level of education you have completed:
   - o Some high school
   - o High school graduate
   - o Trade/technical/vocational training
   - o Some college
   - o College graduate
   - o Graduate (e.g., Master's or Doctoral work)

2. Employment Status (Check all that apply)
   - o Not employed
   - o Part-time employment
   - o Full-time employment
   - o Part-time student
   - o Full-time student
   - o Other _____

3. Relationship status:
   - o Single
   - o Separated/Divorced
   - o Married/Common-Law
   - o Widowed
   - o Other _____

Appendix F - Interview Guide

1) What does self-compassion mean to you?

   Prompts:
   - What does kindness mean to you?
   - Can you provide specific examples?

2) Describe a time when you showed compassion towards yourself.

   Prompts:
   - What were you thinking/feeling/doing at the time?
   - What does treating yourself with kindness/compassion look like?

3) I'd like to ask a few brief questions about the nature of the sexual assault. (Note: if the participant starts to focus on details of the assault, redirect the interview to other interview questions.)

   Prompts:
   - What was the nature of the assault (for example, unwanted touching or rape)?
   - How long ago did the assault(s) take place?
   - Did you know the person who assaulted you?

4) Briefly describe any sexual concerns or problems that you have experienced or that have worsened since the sexual assault(s).

   Prompts:
   - How soon after the assault did you experience sexual problems/concerns?

5) In what ways have you practiced self-compassion to help you cope with your sexual problems after the sexual assault(s)?
   Prompts:
   - Can you provide specific examples of a time when you showed compassion towards yourself that helped with your sexual problems?
   - How did showing yourself compassion help you deal with these concerns?
   - Was there ever a time when self-compassion did not help you cope with these concerns?

6) Are there any barriers that get in the way of practicing self-compassion in relation to your sexual concerns?

   Prompts:
   - Has anything prevented you from practicing self-compassion?
   - What are you thinking/feeling/doing?
   - Can you provide specific examples?

7) Has practicing self-compassion in relation to your sexual problems after the sexual assault helped you in other areas of your life?

   Prompts:
   - Has other areas of your life improved since using self-compassion to cope with your sexual problems?

8) What, if anything, helps you be more self-compassionate in relation to your sexual concerns?

   Prompts:
   - Who, if anyone, helps you be more self-compassionate in relation to your sexual concerns?
   - Are there times that are easier than others?
   - Can you provide specific examples?