Sexual Assault Survivors' Experiences of Self-Compassion

by

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Abstract

Sexual assault can have devastating psychological consequences for survivors. Feelings of self-loathing and shame may undermine survivors' sense of self and contribute to long-term distress. Self-compassion has been proposed to be a facilitator of healing from traumatic events and has been found to help individuals find hope and meaning when faced with difficult life circumstances. To date, no known studies have examined self-compassion and trauma from a qualitative perspective and there is an absence of studies focusing on self-compassion exclusively in relation to sexual assault. The present study explored how sexual assault survivors describe and ascribe meaning to experiences of self-compassion. In-depth, semi-structured interviews were conducted with 10 female survivors who experienced sexual assault in adulthood. Through Interpretative Phenomenological Analysis, eight major themes emerged: (a) affirming self-worth; (b) accepting oneself; (c) absolving oneself of blame; (d) honouring emotions; (e) taking time for self-care; (f) connecting with others; (g) claiming power; and (h) recognizing progress. Based on the findings, suggestions for the intentional implementation of compassion-focused practices as an adjunct to trauma treatment are discussed.

Preface

This thesis is an original work by Janice Maria Dicks. The research project, of which this thesis is part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “SEXUAL ASSAULT SURVIVORS’ EXPERIENCES OF SELF-COMPASSION”, No. Pro00027477, JANUARY 17, 2012.

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Finally, I would like to thank the courageous women who shared their experiences of self-compassion in the hopes of making a positive difference in the lives of other survivors of sexual assault. Without their contributions, this research would not have been possible.

Table of Contents

List of Tables

CHAPTER 1

INTRODUCTION

The past few decades have witnessed a growing public awareness of the widespread crimes of violence against women. Sexual assault against women appears to be pervasive and endemic in our culture (Herman, 1997). Defined as any forced, unwanted, or inappropriate sexual activity (Douglas, Burgess, Burgess, & Ressler, 2006; Sorenson, Stein, Siegel, Golding, & Burnam, 1987), the prevalence of sexual assault continues to be alarmingly high. According to the 2004 General Social Survey on Victimization, within a one-year period there were approximately 512,000 incidents of sexual assault in Canada, representing a rate of 1,977 incidents per 100,000 population aged 15 and older, with the rates of sexual victimization being five times higher for females than for males (Statistics Canada, 2005). The 2009 General Social Survey on Victimization indicated that rates of sexual assault in Canada have remained relatively unchanged between 2004 and 2009 (Statistics Canada, 2010). In the United States, approximately 14.8% of women over 17 years of age reported having been raped, with an additional 2.8% of women having experienced attempted rape (World Health Organization, 2002). Worldwide, an estimated 7% of women have been sexually assaulted by a stranger with as many as 23-26% (depending on the region) having experienced unwanted sex from an intimate partner (World Health Organization, 2013).

Sexual assault can have devastating consequences for its victims. Following an assault, survivors may experience significant levels of anger, fear, guilt, and sadness (Amstadter & Vernon, 2008). Many survivors develop symptoms of Posttraumatic Stress Disorder (PTSD; Van Ameringen, Manchini, Patterson, & Boyle, 2008), with 65% of survivors meeting full diagnostic criteria for PTSD one month post-assault (Rothbaum,

Foa, Riggs, Murdock, & Walsh, 1992). Persistent feelings of self-loathing and shame have been found to be significant sources of distress for survivors (Frazier, 2003) and have been found to maintain posttraumatic stress symptoms over time (Andrews, Brewin, Rose, & Kirk, 2000). Survivors may devalue themselves and fear that others will see them as bad, unworthy, or undesirable (Gilbert, 2003). Shame can be difficult to treat (Gilbert, 2003) and, if left unresolved, it can hinder survivors' recovery from trauma (Andrews et al., 2000; Van Vliet, 2010).

Buddhist philosophy identifies compassion as one of the most important and unique characteristics of the human mind and compassion towards oneself can be a great facilitator of healing from tumultuous and devastating events (Gilbert, 2009). While the concept of compassion has its roots in Buddhism and has been practiced within Eastern traditions for more than 3,000 years, it is a relatively new concept in Western psychology (Gilbert, 2009). Self-compassion involves being kind, accepting, and gentle with oneself (Gilbert, 2009; Neff, 2011). Feeling compassion toward oneself has been posited to tone down and relieve the self-loathing, self-blame, and shame that plague survivors of traumatic events, such as sexual assault (Gilbert, 2009). Self-compassion involves holding "one's feelings of suffering with a sense of warmth, connection, and concern" (Neff & McGehee, 2010, p. 226) and has been found to help individuals find hope and meaning when faced with difficult life circumstances (Neff, 2011; Neff, Rude, & Kirkpatrick, 2007).

Despite the potential for self-compassion to facilitate healing from trauma, there is currently a dearth of research exploring self-compassion in relation to traumatic events, and, to my knowledge, there is no study that explores self-compassion specifically in

relation to sexual assault. Given the lack of research in this area and the important implications that self-compassion may have for the healing process, the present study explored the phenomenon of self-compassion for survivors of sexual assault.

Purpose of the Present Study

In the present study, I explored the phenomenon of self-compassion for females who have been sexually assaulted. I was interested in hearing from adult female survivors of sexual assault about how they define self-compassion, ways in which they have been self-compassionate since the assault, as well as ways in which their self-compassion may have influenced their feelings or perspectives towards the assault.

With the exception of two quantitative studies (i.e., Beaumont, Galpin, & Jenkins, 2012; Thompson & Waltz, 2008), there is a lack of published research on self-compassion in relation to trauma, or more specifically sexual assault, and no research that provides an in-depth understanding of the relationship between sexual assault and self-compassion. My intention for this study was to shape a comprehensive description and interpretation of survivors' experiences of self-compassion, which will ultimately contribute to a greater understanding of the phenomenon of self-compassion. It is my hope that the present study will help inform mental health practice in working with survivors of sexual assault.

Researcher's Background

My research interests go back approximately 14 years when I first started volunteering with two different women's organizations – a transition house and a women's centre. The transition house provided shelter for women who experienced abuse in their romantic relationships. The women's centre was instrumental in the area of

advocacy for women's rights and operated as a referral agency whereby the centre connected women with various resources in the community. Through my extensive involvement with these organizations, I became privy to the widespread crimes of violence against women and the secrecy and silence that accompanies such crimes.

My volunteer experiences unveiled within me a feminist orientation to looking at the world. Throughout the years, I have reflected on feminism and struggled to determine within which belief system, or feminist theory, I fit. I found it difficult to confine myself to any one particular branch of feminism, which in turn made me question my authenticity as a feminist. Yet, I continued in my academic, personal, and professional life to become increasingly interested in helping marginalized populations and hold a strong belief in equal opportunities and rights for women and men. It did not feel acceptable for me to turn my back on feminism despite not fitting into one category of feminists or another; rather, I recognized that I share in the belief that is at the core of all feminist theories – women and men should be equal politically, socially, and economically. I believe in the uniqueness of women and that a woman's differences from man should be celebrated. I believe that women can hold multiple truths, multiple roles, and multiple realities. I also believe that nearly half a century after the women's liberation movement first brought to light the sexual atrocities experienced by women, women continue to face sexual oppression at the hands of men. The writings of third wave feminist, Rebecca Walker, resonate deep within me. In her article titled, "Becoming the Third Wave," Walker (1992, p. 41) captured the essence of my feminist being:

> To be a feminist is to integrate an ideology of equality and female empowerment into the very fiber of my life. It is to search for personal clarity in the midst of

> systemic destruction, to join in sisterhood with women when often we are divided, to understand power structures with the intention of challenging them.

My feminist orientation has been further shaped through the work of several scholars. On a professional level, the work of feminist psychologists such as Judith Worell and Pam Remer (2003) has helped to shape my counselling practice. Canadian researchers in the area of violence against women, such as my Master's research supervisor, Peter Jaffe, and other notable researchers including Robin Mason, Leslie Tutty, and Holly Johnson have been inspirational, particularly for their work in enhancing society's responses to crimes of violence against women.

My early volunteer experience shaped my academic and professional path. More specifically, this volunteer experience led me to wanting to work with women who had been victims of violence in helping them to heal from their traumatic experiences. Along with volunteer experience, my research experience has consistently been in the area of victims of violence. As an undergraduate student, I assisted a professor in writing a manuscript on the topic of dating violence and then went on to research this topic for my honours thesis. This research was focused on both men and women and it was not until I conducted research in my Master's that I was able to get closer to the population with whom I wanted to work. For my Master's thesis, I worked with a supervisor who was considered an expert in the area of woman abuse. I conducted research that looked at the relationship between the trauma women experienced as a result of being abused by their romantic partners and how that trauma impacted their experience in the family court system as well as whether or not they were able to obtain custody of their children. After this very positive experience, I knew that I would need to have a supervisor with similar

interests for my doctoral dissertation. My current supervisor has promoted my interest in the area of violence against women.

Qualitative research situated in the constructivist perspective fits well with who I am as a researcher and a clinician. I believe that people hold different realities that are shaped by their own life experiences, and I honour these different perspectives in my everyday work as a counsellor. To fully appreciate the diversity and depth of an individual's own personal accounts, I believe in giving women the opportunity to give voice to their experiences. The testimony of the sexual assault survivors in this study is the very heart of this dissertation.

Overview of Contents

This dissertation is divided into five main chapters. The next chapter will review the existing literature pertaining to sexual assault, survivors' coping post-assault, and self-compassion. The literature review will be followed by a chapter outlining the methodology, including the method used in the present study, participant recruitment and selection, data collection, and data analysis. Considerations for trustworthiness and ethics have also been offered in this chapter. The fourth chapter will present the findings. The final chapter will discuss the findings in the context of existent theory, address clinical implications of the findings, and discuss limitations and directions for future research.

CHAPTER 2

LITERATURE REVIEW

The following review explores research and theoretical literature pertaining to sexual assault, coping and self-compassion. This review will include potential psychological consequences of sexual assault, the ways in which survivors cope with trauma, and literature on the nature and benefits of self-compassion.

Psychological Impact of Sexual Assault on Survivors

The psychological effects of sexual assault on its victims have been extensively studied and have been found to be wide-ranging. Lowered self-esteem (Bryant-Davis, Chung, & Tillman, 2009; Ehlers & Clark, 2000; Guerette & Caron, 2007; Martin, Taft, & Resick, 2007), damaged body image (Martin et al, 2007), and feelings of isolation (Guerette & Caron, 2007) and anger (Guerette & Caron, 2007; Amstadter & Vernon, 2008) are just a few of the injurious sequelae that can be experienced by survivors.

Depression and suicidality. Depression has been found to be a common experience in the aftermath of sexual assault (Bryant-Davis et al., 2009; Gidycz & Koss, 1990; Guerette & Caron, 2007; Martin et al., 2006; Petrak, Doyle, Williams, Buchan, & Forster, 1997). One study that interviewed 23 female survivors on the psychological impact of sexual assault found that 95% of women experienced depression and low mood, with the time since the assault ranging from 1 to 364 weeks (Petrak et al., 1997). In a study that interviewed women about the impact of having been sexually assaulted an average of 3.5 years earlier, half the women reported feeling depressed (Guerette & Caron, 2007). The experience of depression was reported to be all-consuming, as one woman in the study recalled, “It was like I was functioning but I wasn’t there. I would go

through the motions of every single day wondering ‘what’s the point?’ My world crumbled.” (p. 41).

Depression has been found to be significantly associated with both suicidal ideation (Ullman & Najdowski, 2009) and suicide attempts in female survivors of sexual assault (Ullman & Brecklin, 2002). Following reports from psychologists who engaged in therapy with survivors, Petrack et al. (1997) noted that 30% of survivors engaged in suicidal thinking, with the median time since assault being 7.5 weeks. In a study that compared victims of individual sexual assault with victims of group sexual assault that occurred less than three months to greater than five years earlier, 21% of the victims of individual sexual assault and 44% of the victims of group sexual assault reported that they contemplated suicide (Gidycz & Koss, 1990). Another study found that in comparison to women who had experienced physical assault only, women reporting sexual assault were 5.3 times more likely to report threatening or attempting suicide within a 90-day period (McFarlane et al., 2005).

Mental pollution. Feelings of self-loathing and disgust are frequently experienced by survivors of sexual assault. A type of “mental pollution” is stated to occur for many victims of sexual assault where survivors have strong feelings of internal dirtiness that are usually felt within 24 hours of the occurrence of the assault (Fairbrother & Rachman, 2004). This dirtiness consists of feelings of contamination that persist regardless of any observable external dirt (Rachman, 2004). Fairbrother and Rachman (2004) assessed feelings of mental pollution in 50 women who had an unwanted sexual experience a minimum of three months prior to data collection. Through semi-structured interviews they explored the women’s urges to wash following the assault, the internal

and external nature of their feelings of dirtiness, as well as whether memories of the assault triggered the feelings of dirtiness. They found that 60% of participants reported having emotional feelings of dirtiness. Participants in their study frequently reported an increase in their showering or bathing habits following the assault. It was also not uncommon for participants to report that they would need to shower following any sexual activity or any memory of the assault in which feelings of dirtiness were invoked. One woman reported intense washing habits following the assault to the extent that she was diagnosed with obsessive-compulsive behaviour. It has been suggested that this mental pollution, or emotional feelings of dirtiness, arise from an internalization of disgust, or self-loathing. Olatunji, Elword, Williams, and Lohr (2008) assessed mental pollution and its relation to psychological sequelae in 48 female undergraduate students who had experienced either rape or attempted rape. It was suggested that the sexual behaviour of a sexual assault violates an individual's moral code of sexuality. In this sense, the mental pollution develops from the combination of physical contact with the perpetrator and the moral violation, which leads survivors to believe that they are internally spoiled.

Self-blame and shame. Following sexual assault, negative self-appraisals may undermine survivors' sense of self. Olatunji and colleagues (2008) found that negative cognitions arising from mental pollution (e.g., "I am dirty," "I am disgusting") were highly correlated with the self-blame experienced by survivors of sexual assault. In an effort to make sense of and control their distress, asking questions such as "What did I do to cause this?" is not uncommon for survivors (Frazier, Mortensen, & Steward, 2005). In a study that collected data from female sexual assault survivors at four points in time following the assault (i.e., two weeks to one year), it was found that survivors who

reported more self-blame reported feeling distress at all four time periods (Frazier, 2003). In contrast, a decrease in self-blame over time was related to a decrease in distress over time (Frazier, 2003).

Self-blame has been linked to shame where shame is defined as "a self-conscious moral emotion" that is evoked by self-evaluation and self-reflection (Tangney, Stuewig, & Mashek, 2007, p. 347); shame is often accompanied by self-blame (Gilbert & Miles, 2002; Van Vliet, 2009). Shame can be implicit or explicit and can manifest itself in consciousness or beneath awareness (Tangney et al., 2007). Having both an external and internal orientation, shame can involve perceived rejection from others, as well as being critical of the self and seeing oneself as damaged (Budden, 2009; Gilbert, 2003; Tangney et al., 2007). Shame has been contrasted with guilt, which has been said to result from a negative appraisal of one's behaviour towards others, as opposed to a negative appraisal of one's self (Gilbert, 2003; Tangney, 1991; Tangney et al., 2007). Similarly, shame has been noted to be "self-focused", whereas guilt is associated with concern for others, or "other-focused" (Gilbert, 2003).

Shame has been described from an evolutionary perspective. For many animals, the communicative signals of shame (e.g., withdrawal, submission, hanging one's head in defeat) can be enough to ward off an attack from a dominant opponent (Gilbert, 2003, 2009). It has thus been suggested that shame is rooted in "threat to self" and is activated when one's ability to preserve oneself is threatened (Gilbert, 2003, 2009). Healthy shame serves regulatory and protective functions, preventing exposure and loss of personal boundaries (Budden, 2009). In the context of sexual assault, the self comes under attack. Sexual assault involves the violation of moral values and shatters expectations about a

predictable world and the ability to defend against a perpetrator. As indicated by Budden (2009), traumatic experiences of this nature "strip individuals of their status, dignity, and all sense of personal control" (p. 1034).

If left unresolved, shame can interfere with survivors' recovery from trauma (Andrews et al., 2000; Van Vliet, 2010) and can be very difficult to treat (Gilbert, 2003). Survivors may be worried that by disclosing the assault, they will be seen in a negative light by others (Starzynski, Ullman, Townsend, Long, & Long, 2007; Ullman & Filipas, 2001). Even without knowing the perspectives of others, the self-reflective nature of shame can result in survivors devaluing themselves, activating feelings of anxiety, anger, disgust, contempt, or self-defeat (Gilbert, 2003). As Gilbert (2003) noted, "The sense of being undesirable and bad can be a source of terror since it cuts one off from hope and connectedness to others and casts a dark shadow over hope" (p. 6).

There is a growing body of research examining the relationship of shame and sexual assault. In a mixed methods study (Andrews et al., 2000) that examined the role of shame in victims of physical assault, sexual assault, or mugging, participants' experiences of shame were categorized into themes. Participants experienced shame associated with believing that they could have done something to prevent the crime. They worried about looking bad to others, and experienced shame about their emotional reactions and feelings of humiliation. Another study (Amstadter & Vernon, 2008) compared the emotional reactions of 165 undergraduate students during and after four different types of trauma exposure: sexual assault (n = 31), physical assault (n = 29), motor vehicle accident (n = 65), and illness/injury (n = 40). Participants' experiences of emotions during and after the trauma were assessed. Shame was found to increase significantly

post-trauma for the sexual assault victims (total emotion increased from M = 50.19 and SD = 13.67 to M = 58.62 and SD = 14.20), with the three other trauma groups reporting little change from peri- to post-trauma. Vidal and Petrak (2007) explored the experiences of shame for 25 survivors who were sexually assaulted in adulthood, with the length of time since the assault ranging from 2 weeks to 25 years. Participants reported according to how they felt within the past year. Seventy-five percent of participants reported feeling shame towards themselves following the sexual assault. Over 50% of survivors blamed themselves for the assault. Those who felt they were to blame scored significantly higher on behavioural shame (e.g., shame resulting from the belief that they behaved in a way that contributed to the occurrence of the assault). They also scored significantly higher on characterological shame (e.g., shame resulting from negative evaluations about the core of who they are as a person) and bodily shame (e.g., shame resulting from negative evaluations about physical aspects of the self) than those who did not feel self-blame. Survivors reported pervasive negative evaluations of themselves and their bodies, along with worry about how they were perceived by others following the assault. Noteworthy is that 13 of the 25 survivors kept the sexual assault a secret, feeling too much shame to disclose the traumatic experience.

Posttraumatic Stress Disorder. Posttraumatic Stress Disorder (PTSD) is a common reaction to sexual assault (Bryant-Davis et al., 2009; Ehlers & Clark, 2000; Martin et al., 2007; Van Ameringen et al., 2008) that may have a debilitating impact on survivors. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), PTSD is characterized by repeated and unwanted experiencing of a traumatic event whereby there are persistent symptoms

of hyperarousal, avoidance of stimuli associated with the traumatic event, and negative alterations in cognition and mood. Kilpatrick and Acierno (2003) provided further details on the primary symptoms of PTSD. The unwanted re-experiencing of the trauma can include recurring memories of the assault, nightmares, flashbacks, and sensitivity to stimuli that may be associated with the assault. Hyperarousal involves the survivor becoming increasingly hypervigilant about her surroundings and the possibility of further attacks, and can impair sleep as well as concentration. The avoidance component of PTSD involves avoiding any thoughts or feelings, individuals or places that serve as reminders of the assault. Also noted in the DSM-5 is that these symptoms are required to last for a minimum of four weeks and result in functional impairment for the individual in order for a diagnosis to be established.

Sexual assault has been found to be the type of trauma that is most likely to result in PTSD in women (Kilpatrick & Acierno, 2003; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), with females being twice as more likely than males to develop the disorder (Kilpatrick & Acierno, 2003). While the majority of survivors of sexual assault will experience symptoms of PTSD immediately following the assault, the symptoms will subside for some over the course of several months (Rothbaum et al., 1992). However, for a significant number of survivors, symptoms can persist for years (Rothbaum et al., 1992). Ehlers and Clark (2000) suggested:

> Persistent PTSD occurs only if individuals process the traumatic event and/or its sequelae in a way which produces a sense of a serious current threat…Once activated, the perception of current threat is accompanied by intrusions and other

re-experiencing symptoms, symptoms of arousal, anxiety, and other emotional responses (p. 320).

With the central feature of PTSD being fear of physical threats of injury and death (American Psychological Association, 2000), it is not surprising that one-third of rape victims are diagnosed with this cluster of symptoms at some time following the assault (Rothbaum et al., 1992). Ullman, Filipas, Townsend and Starzynski (2007) explored the psychosocial factors that contributed to the onset and maintenance of PTSD among sexual assault victims. Race, education and marital status were not predictive of PTSD; however, older age was related to fewer PTSD symptoms. Those who experienced previous trauma or had a history of childhood sexual assault reported more severe symptoms and those who perceived greater life threat also reported more severe symptoms. In a study involving 48 survivors of sexual assault, mental pollution was found to be significantly positively correlated with PTSD cognitions (Olatunji et al., 2008). Shame has also been found to be linked with PTSD, where a study of survivors of violent crime found that shame was the only emotion that predicted PTSD symptoms past the one-month diagnostic threshold and beyond six months (Andrews et al., 2000).

Coping with Sexual Assault

Following sexual assault, survivors employ a number of coping strategies, some of which may facilitate recovery and some of which may hinder recovery. Survivors' attempts to cope with, or control, the aftermath of the assault are influenced by their appraisals of the assault and/or its aftermath as well as their own beliefs about how to deal with the trauma (Ehlers & Clark, 2000).

Coping strategies have been broadly categorized in the literature as being effective or ineffective at reducing distress, and as being cognitive or behavioural in nature. Examples of cognitive coping include cognitive restructuring (e.g., attempting to change one's thinking about the assault), wishful thinking (e.g., hoping and wishing that things will get better), self-blame, and self-criticism (Gutner, Rizvi, Monson, & Resick, 2006). Behavioural coping includes observable actions such as withdrawal from others, problem avoidance, and seeking social support (Gutner et al., 2006). Najdowski and Ulman (2009) provided examples of adaptive (effective) and maladaptive (ineffective) ways of coping. Adaptive coping strategies can include actively trying to cope with the assault, obtaining emotional support from others, using instrumental support, venting, positive reframing, planning, humor, acceptance, and religion. Such examples of adaptive coping would be classified by Lawler, Ouimette, and Dahlstedt (2005) to be approach methods that involve actively trying to work through the trauma. Maladaptive coping strategies, like adaptive strategies, are employed by survivors in an effort to gain control over the impact of the sexual assault. Such strategies, however, can have a paradoxical effect by directly increasing unwanted psychological symptoms rather than eliminating them (Ehlers & Clark, 2000). Examples of maladaptive coping strategies include self-distraction, denial, and behavioural disengagement. Classified as avoidant approaches to coping (Lawler et al., 2005), these responses to trauma can be adaptive in the short-term in that the avoidance can aid in minimizing emotional arousal and help the survivor to process the trauma at a manageable pace (Van Vliet, 2010). In the longer term, avoidant approaches such as withdrawing from social situations have been associated with higher levels of distress (Bryant & Harvey, 1995; Frazier et al., 2005). It has been suggested that

coping strategies may vary in their adaptiveness depending upon the point at which victims utilize the strategies post-assault (Frazier, Klein, & Seales, 1995). In their longitudinal study of female rape victims, Frazier and colleagues (1995) found that those who used problem-avoidance coping experienced less distress initially but more distress at 6 to 12 months after the rape, and those who used social withdrawal experienced less distress at later time points.

A considerable amount of research has been conducted on how survivors cope with the aftermath of sexual assault. Gutner et al. (2006) examined the relationship between coping strategies and psychological distress among 122 female survivors of sexual assault (n=74) and physical assault who were assessed at one month (or less) and three months post-assault. It was found that survivors who employed wishful thinking and social withdrawal as coping methods demonstrated fewer improvements in trauma-related symptoms. As survivors increased their use of cognitive restructuring, emotional expression, and support from others over time, PTSD symptomology decreased. Frazier and colleagues (2005) assessed four types of coping among survivors of sexual assault: problem avoidance, social withdrawal, cognitive restructuring, and expressing emotions. They found that those who engaged in behavioural self-blame (attributions to controllable past behaviours) were more likely to cope using self-destructive (e.g., drinking) and avoidant (e.g., social withdrawal) methods. Furthermore, Frazier and colleagues found that survivors who perceived greater control over their recovery were more likely to engage in adaptive coping strategies and less likely to engage in maladaptive coping strategies. Other studies have also found that perceived control over recovery is associated with better adjustment in survivors (e.g., Frazier, 2003; Frazier, Steward, &

Mortensen, 2004; Ullman et al., 2007). Najdowski and Ullman (2009) found a similar association when they examined the role of coping strategies, self-blame, and perceived control over recovery on trauma-related symptoms and self-rated recovery for adult survivors who were sexually assaulted an average of 13 years earlier. Higher levels of self-blame were related to greater PTSD symptoms and less self-rated recovery. Higher perceived control over recovery was related to fewer PTSD symptoms and greater self-rated recovery.

Treatment for Survivors of Sexual Assault

A multitude of therapeutic models have been developed for the treatment of trauma, including sexual assault. Such models range from overarching stages that transcend the theoretical orientation of the therapist to orientation-specific interventions that require additional training and expertise. It is not uncommon for a therapist to use a combination of approaches in working with survivors of sexual assault; and, when tailoring individual treatment, clients' social and cultural backgrounds should be taken into consideration (Dass-Brailsford, 2007).

Herman (1997) proposed a three-stage model of trauma recovery that can be applied to working with women who have experienced sexual assault. In the first stage, there is a focus on building rapport within the therapeutic relationship and creating a climate of trust and safety. Clients are in control of the process and are actively involved in treatment planning. In the second stage, treatment is directed towards remembering and exploring the traumatic incident(s). This stage is also concerned with helping clients to mourn the losses associated with their experience of sexual assault, whereby the grieving process is considered a necessary aspect to healing. The third stage, known as

the reconnection stage, targets the creation of a new identity and reconciliation of the past. In this stage clients transition from victim to survivor; there is a focus on taking concrete steps to enhance a sense of power and control, learning to protect themselves from future harm, and building connections with positive and trustworthy others.

An alternate but similarly broad model for trauma treatment has been introduced by Briere (1996) in his Self-Trauma Model, which combines humanistic, psychodynamic, and cognitive-behavioural theories. The model delineates four main components to trauma treatment, including safety, support, therapeutic feedback, and working through the trauma. Likewise, Chu (1998) proposed a stage-orientated model for trauma treatment, represented by the acronym SAFER and includes the following stages: self-care, acknowledgement, functioning, expression, and relationships. In each of these proposed models, there is an immediate focus on establishing trust and safety as well as an effort on stabilization, or the provision of psychological first aid, prior to the processing of the trauma. It is also necessary to point out that while these models are delineated by stages, trauma recovery is not always linear, and there may be a back-and-forth movement between stages.

While the models outlined above can be considered to have sufficient flexibility to be applied within any theoretical orientation, orientation-specific interventions are also employed by therapists when treating survivors of sexual assault. Cognitive behavioural therapy (CBT) approaches have been well-supported in the literature for their ability to help clients process traumatic memories and associated emotions (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick & Schnicke, 1992). Cognitive Processing Therapy (CPT) was designed specifically to treat PTSD in survivors of sexual assault (Resick & Schnicke,

1992). Treatment involves education, exposure through reading and writing about the traumatic event, and cognitive interventions aimed at directly addressing maladaptive beliefs and causal attributions associated with a traumatic event (Resick & Schnicke, 1992). Prolonged exposure (PE) is a therapy designed to treat PTSD that involves education, breathing retraining, behavioural (in vivo) exposure to feared environmental reminders of the trauma, and imaginal exposure to the trauma memory (Foa, Steketee, & Rothbaum, 1989). Foa and colleagues (1991) conducted a comparison study of approaches for the treatment of rape victims. The treatments examined included supportive counselling and two cognitive behavioural approaches to trauma treatment, prolonged exposure and stress inoculation training (SIT). All individuals who received treatment experienced significant improvement compared to those assigned to the waitlist/control group. SIT was found to produce a significantly greater outcome than supportive counselling, and PE was found to be superior to the other two treatment groups. Resick, Nishith, Weaver, Astin, and Feuer (2002) compared the effectiveness of PE and CPT to a waitlist control for the treatment of PTSD in adult female rape victims. The women who received PE or CPT experienced a significant improvement in symptoms compared to the waitlisted women, but the two treatments did not differ significantly in level of improvement.

Self-Compassion

Compassion refers to "behaviour that aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging – in order to benefit another person" (Gilbert, 2009, p. 193). Essentially, self-compassion is compassion turned inward (Neff & McGehee, 2010) whereby there is a focus on the

desire to care for, nurture, and support oneself in order to promote well-being (Gilbert, 2009; Neff, 2011). Showing compassion towards oneself is an adaptive way of relating to the self in difficult circumstances (Neff & McGehee, 2010). It involves acknowledging that what one is going through is difficult and that one is struggling with the experience (Neff, 2004). Although the notion of compassion has existed within Eastern philosophies for thousands of years, self-compassion is a relatively new concept for Western psychology (Neff, 2003a) with two primary researchers, Kristen Neff and Paul Gilbert, leading the way. While there is only a decade of research thus far, self-compassion has consistently been found to promote psychological well-being (e.g., Neff, 2003a; Neff, 2003b; Neff & McGehee, 2010) and to play a particularly important role in how individuals deal with difficult life circumstances, such as sexual assault (Leary, Tate, Adams, Allen, & Hancock, 2007).

Neff's conceptualization of self-compassion. Neff's (2003a) conceptualization of self-compassion was derived in large part from Theravada Buddhism. According to Neff (2011), self-compassion requires that individuals recognize their own suffering and give themselves unconditional kindness and comfort, particularly at times when life is turbulent. Painful or distressing feelings are not avoided; instead, the human experience is embraced, no matter how difficult it may be (Neff, 2011). Self-compassion has been noted by Neff (2011) to be "a sparkling diamond that emerges from the coal" and "when we give ourselves compassion, the tight knot of self-judgment starts to dissolve, replaced by a feeling of peaceful, connected acceptance" (p.13).

Neff (2003a) defines self-compassion as consisting of three main components: self-kindness, common humanity, and mindfulness. Self-kindness involves understanding

one's shortcomings and failures instead of attacking them. It includes being caring, gentle, and patient with oneself rather than being critical or judgmental (e.g., treating oneself with tenderness when going through a difficult time). Common humanity refers to perceiving painful experiences, such as sexual assault, not in isolation but as part of the human experience. In this sense, suffering, failure, and inadequacies are recognized as being part of the human condition, rather than being seen as separating and isolating (e.g., acknowledging that many others feel similarly at times of distress). Mindfulness involves a taking a nonjudgmental stance towards painful thoughts and feelings. It involves trying to take a balanced view rather than becoming overwhelmed by an experience (e.g., approaching painful experiences with openness and curiosity).

Self-compassion has been contrasted with self-pity where individuals are said to become absorbed by their own pain and suffering (Neff, 2003b). In other words, they over-identify with their pain and can become so lost in their suffering that they are unable to see alternatives.

Gilbert's conceptualization of self-compassion. The basis of Gilbert's theory of compassion is that it is first necessary to understand how and why our minds are as they are with all of the emotions that can be experienced within us. Gilbert (2009) posited that it is only when individuals are equipped with knowledge and understanding about the origins and capabilities of their emotions that they are able to stand back from their emotions and observe them objectively and with self-compassion (Gilbert, 2009). Gilbert's theory of self-compassion borrows from Buddhist teaching; however, in contrast to Neff, Gilbert proposes a social mentality theory of self-compassion that employs principles of evolutionary biology, neurobiology, and attachment theory.

Social mentality theory describes how the mind works to seek out relationships with others in order to secure specific types of social relationships that are integral to promoting survival and reproduction (Gilbert, 2005, 2009, 2011). Gilbert described his theory as a blending of the concept of archetypes as proposed by Carl Jung and evolutionary psychology. Gilbert (2009) proposed that different mentalities activate different patterns in the brain and that such mentalities are "constantly arising and patterning our minds through our interactions" (p. 11). Social mentalities of mating, social rank, alliance and cooperation, care-eliciting and care-seeking are just a few of the many patterns of relating to others that humans may instinctually create (Gilbert, 2009). He proposed that the care-eliciting/care-seeking mentality is central to compassion as humans instinctually strive to feel protected and cared for by others, and a sense of belonging is integral to our well-being and safety. In contrast, the social rank mentality views relationships in terms of hierarchies and social comparisons. Humans want to be seen as talented, desirable and worthy, feel valued, and be successful. If when comparing themselves to others, they feel weak, powerless, or inferior, shame can arise from the disparity between who they feel they are and who they feel they ought to be.

In his theory of compassion, Gilbert (2009) normalizes difficult emotions and attributes them to the evolved mammalian brain. He proposed three types of affect regulation to describe how the brain gives rise to different emotions. The first is the threat and self-protection system, which is designed to recognize threats and quickly impel self-protection. This system is designed for fight or flight and activates the stress hormone cortisol. The second system is the incentive and resource-seeking system that is designed to seek out the resources, such as food, sex, and friendships, needed in order to thrive and

grow and guide individuals towards important life goals. Gilbert has suggested that this system activates the neurotransmitter dopamine, which has been proposed to be under-activated in individuals with depression. The third system proposed by Gilbert is the soothing and contentment system, which is most related to self-compassion. This system is developed in infants through secure attachments with parental figures. When parents consistently act in reassuring and calming ways towards their infants, such comforting experiences and emotional memories of safety form the foundation for self-soothing, allowing for the internalization of these first experiences of compassion within the young, which can later be accessed at times of distress. In contrast, those who do not have secure and loving experiences can develop self-criticism and shame as a result. According to Gilbert, the soothing and contentment system "enables us to bring a certain soothing, quiescence, and peacefulness to ourselves, which helps restore balance" (p. 24). Gilbert has suggested that this system has been found to activate endorphins and the hormone oxytocin, which leads to feelings of social safeness and well-being. The soothing and contentment system is activated when others are kind and understanding towards us; likewise, the system can be activated by relating to ourselves in a kind and caring manner.

According to Gilbert (2009, 2011), the soothing and contentment system can be easily overridden by the other two systems, as they are both designed for immediate survival. When the systems are out of balance, an individual will become stressed or even distressed. For example, in the face of social threat (i.e., activation of the threat and self-protection system), an individual experiences shame, which can cut one off from self-soothing and emotion regulation. Given that survivors of sexual assault are often plagued

with shame and self-loathing (e.g., Ehlers & Clark, 2000; Martin et al., 2007; Olatunji et al., 2008), it is possible that their threat systems become over-activated and in turn contribute to persistent levels of distress. Gilbert (2009) has suggested that compassion arises from a balance of the three emotion systems and, in particular, operates through the care-giving/care-eliciting social mentality that orients one toward alleviating distress and promoting thriving.

Compassion-focused therapy. A major outcome of Gilbert's theory is the development of compassion-focused therapy (CFT; Gilbert & Procter, 2006). CFT is a multimodal approach to working with clients, which uses interventions that incorporate components of cognitive behavioural and emotion-focused therapies, among many others (Gilbert, 2011). In its entirety, CFT involves "developing genuine concern for one's well-being; learning to be sensitive, sympathetic, and tolerant of distress; developing deep understanding and empathy for the roots and causes of distress; becoming non-judgmental; and, developing self-warmth" (Gilbert & Procter, 2006, p.358).

The basis of CFT is that some individuals can have difficulty activating the soothing and contentment system, which is designed to promote feelings of reassurance, safety, and contentedness (Gilbert, 2011). Gilbert (2011) noted that the clients for whom CFT was developed are those who experience high levels of shame and self-criticism, blame themselves for their problems, and feel as though they are internally flawed or damaged. He posited that having compassion for oneself can lessen threat-focused feelings, thoughts, and behaviours and that compassion is a "basic vitamin for the mind" (Gilbert, 2009, p. 44). The overarching goal of CFT is to help individuals who are limited in self-compassion to create brain states that are conducive to a calm and contented mind.

Through training in self-compassion, an individual can learn how to activate the brain patterns associated with caring and nurturing, which can in turn activate soothing and reduce distress.

Gilbert's theory that compassion activates specific patterns in the brain has been examined in studies addressing the neural correlates of self-compassion. In one study, Lutz, Brefezynski-Lewis, Johnstone, and Davidson (2008) examined the effects on the brain of voluntarily generated compassion. They had expert and novice meditation practitioners cultivate a loving-kindness (i.e., compassionate) meditation state to examine affect reactivity to emotional and neutral sounds. Brain activity was assessed using an fMRI and the results showed that concern for others in response to emotional sounds (e.g., sounds of distress) resulted in the activation of certain brain areas. Specifically, those practicing loving-kindness meditation (versus a control group) were found to have enhanced affective processing with activation of the insula and cingulate cortices of the limbic system, areas that had previously been implicated in feeling empathy (e.g., Singer, Seymour, O'Doherty, Kaube, Dolan, & Frith, 2004). Thus, the results of the study show that cultivating compassion and kindness can create large and systematic changes in brain function, which in turn enhances empathetic responses to one's social environment. In other work on the neural correlates of self-criticism and self-reassurance, Longe and colleagues (2010) instructed participants to imagine being either self-critical or self-reassuring in response to presented scenarios (e.g., personal setback scenario, negative emotion scenario, neutral scenario). Results indicated that self-reassurance is associated with activation of the left temporal pole and insula, suggesting that self-reassurance activates similar regions of the brain as compassion and empathy.

Self-compassion and well-being. Newly emerging literature has revealed many positive benefits to cultivating self-compassion. Self-compassion has been found to improve both physical health and psychological well-being.

One of the earliest studies to examine compassion in relation to physical well-being was conducted by Rein, Atkinson, and McCraty (1995). The purpose of that study was to examine the effects of positive and negative emotions on an indicator of immune functioning, salivary immunoglobulin A (S-IgA). Thirty participants were randomly assigned to four groups. Through either self-induction or external induction via video tape, two groups were instructed to experience care and/or compassion and two groups were asked to experience anger and/or frustration for five minutes. Those who engaged in compassionate imagery exhibited increases in S-IgA, suggesting that compassionate imagery may have positive effects on immune functioning. Pace et al. (2009) also found a relationship between compassion and immune system functioning. They found that individuals who participated in six weeks of compassion meditation improved their immune functioning, as well as their neuroendocrine and behavioural responses to stress. Rockliff, Gilbert, McEwan, Lightman, and Glover (2008) explored the impact of compassion focused imagery on heart rate variability and cortisol levels in participants. Compassion focused imagery was found to increase heart rate variability and reduce cortisol levels in some participants, thus providing evidence that compassionate imagery can activate the soothing affect system. Not all participants benefited physiologically from compassionate imagery, and the researchers proposed that these individual differences (e.g., low heart rate variability and no change in cortisol) may be related to the high self-criticism and insecure attachments in some participants, who may first

require therapeutic intervention in order to reap the benefits of compassion focused imagery.

Neff, Rude, and Kirkpatrick (2007) examined the relation of self-compassion to positive psychological health and the five-factor model of personality. Self-compassion, wisdom, personal growth, curiosity, exploration, happiness, optimism, positive and negative affect, and personality were assessed in 177 undergraduate students using a multitude of self-report scales. Self-compassion was found to be linked to self-reported measures of happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness. Self-compassionate people were found to experience significantly more positive mood and less negative mood, with greater overall happiness suggested to stem from the warmth and connectedness to others via common humanity. It was also suggested that a self-compassionate individual consciously makes changes for a more fulfilling life.

Neff, Hseih, and Dejitthirat (2005), in the first part of a two-part study, examined the relations between self-compassion, achievement goals, fear of failure, perceived competence, intrinsic motivation, anxiety, and self-reported grade point averages in 222 undergraduate students. Self-compassion was positively correlated with perceived competence and intrinsic motivation and negatively correlated with fear of failure and anxiety. Self-compassion was linked to mastery goals (i.e., motivated by curiosity, desire to enhance and master skills, and understand new material) in contrast to performance goals (i.e., motivated to defend or enhance self-worth), and it was suggested that self-compassionate students may be better able to see failure as a learning opportunity.

Numerous studies have found self-compassion to be related to effective or adaptive forms of coping. Neff and colleagues (2005), in the second part of their two-part study, examined the link between coping strategies when faced with academic failure for 214 undergraduate students. Self-compassion was found to be significantly positively correlated with emotion-focused strategies such as reframing the problem and acceptance but negatively correlated with a persistent focus on or venting of negative emotions. Self-compassion was also found to be negatively associated with maladaptive coping strategies such as denial and mental disengagement. Similar findings on self-compassion in relation to coping were discussed in by Allen and Leary (2010) who examined the construct of self-compassion in relation to research on coping. They noted that self-compassion had a strong relationship with positive cognitive restructuring, which involves changing one's view of a stressful situation in order to frame it in a more positive light; people who are high in self-compassion tend to interpret negative events in a less ominous manner. Following a study by Ehlers and Clark (2000) where experiences of trauma were commonly found to lead to negative appraisals of the self, Leary et al. (2007) found that people who were self-compassionate tended to make more accurate self-appraisals.

Not surprisingly, self-compassion has been found to be significantly negatively correlated with depression and anxiety (Neff, 2003b; Neff & McGehee, 2010; Neff, Rude, & Kirkpatrick, 2007), neuroticism (Neff, 2003b; Neff, Rude, & Kirkpatrick, 2007; Neff & Vonk, 2009), as well as self-criticism, rumination, and thought suppression (Neff, Kirkpatrick, & Rude, 2007). Gilbert, Baldwin, Irons, Baccus, and Palmer (2006) in their study of self-criticism and self-warmth had participants imagine a self-critical or self-

assuring part of themselves in the context of a setback. They found that those participants who were high in self-criticism had difficulties in generating images and feelings of self-compassion. In a pilot study conducted by Gilbert and Procter (2006), individuals with personality and/or mood disorders participated in a compassionate mind training (CMT) program. Whereas CFT refers to the theory and process of applying a compassion model to psychotherapy, CMT refers to specific activities designed to foster compassionate attributes and skills. Nurturing self-compassion in participants was found to have a significant effect on reducing depression, anxiety, self-criticism, feelings of inferiority, submissive behaviour, and shame. Overall, self-compassion has been found to be associated with psychological well-being and greater life satisfaction in both adolescents and adults (Neff & McGehee, 2010).

To date, there are very few published qualitative studies that attempt to elucidate the phenomenon of compassion from the perspectives of participants. One study, conducted by Pauley and McPherson (2010), explored the experiences and meaning of compassion and self-compassion for individuals diagnosed with depression or anxiety. Using phenomenological interpretative inquiry, findings revealed three themes regarding experiences of self-compassion for participants. First, participants saw compassion as being comprised of both kindness and action. Second, they expressed a positive view of self-compassion in that it may be useful or helpful with their experiences of depression of anxiety. Third, participants felt that demonstrating self-compassion can be difficult, either because the concept of self-compassion is challenging or because their experiences of depression or anxiety hinder their ability to be self-compassionate.

In addition to the shortage of qualitative research on self-compassion, there are only two known studies to date that examine self-compassion in relation to trauma. The first quantitative study, conducted by Thompson and Waltz (2008), explored the relationship between self-compassion and symptoms of post-traumatic stress in an effort to inform treatment of trauma. Participants were 100 undergraduate students who met criterion A (i.e., endorsed at least one trauma in which they fear physical injury or death for themselves or others and experienced feelings of helplessness and/or terror) for the diagnosis of PTSD as outlined in the DSM-IV-tr. The most commonly reported traumas were accidents, deaths or near-deaths of themselves or loved ones, and sexual assaults. Participants completed the Self-Compassion Scale (Neff, 2003a) and the Posttraumatic Stress Diagnostic Scale (Foa, Cashman, Jaycox, & Perry, 1997). Self-compassion was found to be significantly negatively correlated with participants' avoidance of distressing thoughts or feelings (Thompson and Waltz, 2008). It was suggested that those high in self-compassion may be less likely to be threatened by and avoid painful thoughts and emotions. The second quantitative study conducted by Beaumont and colleagues (2012), compared the effectiveness of 12 sessions of cognitive behavioural therapy (CBT) to 12 sessions of CBT coupled with compassionate mind training (CMT) for survivors of traumatic incidents. The most commonly reported traumas were work-related and motor vehicle accidents. Only one of the 32 participants experienced sexual assault. Data was collected pre- and post-therapy using three self-report questionnaires (i.e., Hospital Anxiety and Depression Scale; Impact of Events Scale; Self-Compassion Scale). Post-therapy, both groups experienced a statistically significant reduction in symptoms of anxiety, depression, avoidant behaviour, intrusive thoughts, and hyperarousal symptoms.

Participants who received the combined CBT/CMT developed significantly higher self-compassion scores post-therapy than those in the CBT-only group. While both treatments were effective, the authors discussed the added benefits of fostering the development of self-compassion in the treatment of trauma, whereby CMT in addition to CBT can lead to greater improvement in some symptoms than CBT alone.

Summary

As illustrated within the present chapter, sexual assault has deleterious consequences for victims. Shame, self-loathing, self-blame, and posttraumatic stress disorder are just several of the many injurious psychological sequelae experienced by survivors. A growing body of research has demonstrated the relationship between self-compassion and psychological well-being. As self-compassion has been proposed to help individuals find strength in coping with difficult life circumstances, it makes sense that self-compassion could play an important role in facilitating recovery for individuals who have been sexually assaulted. There is currently a dearth of research that examines self-compassion in relation to trauma and no known studies have examined self-compassion exclusively in relation to sexual assault. Through qualitative inquiry, it is hoped that the present study will illuminate the experiences of self-compassion for female survivors of sexual assault.

CHAPTER 3

METHODOLOGY

In order to study the experiences of self-compassion for female survivors of sexual assault, a qualitative methodology was used. Qualitative research, also known as qualitative inquiry, is an inductive approach characterized by sensitive and flexible methods (Creswell, 2007). It takes the philosophical stance that reality is *intra*subjectively and *inter*subjectively constructed through our participation in our social world. Furthermore, because many truths exist, our knowledge of the world is a continuous process of (re)negotiating our understanding of the world around us (McLeod, 2001). As such, qualitative inquiry seeks to uncover individual experiences and the varied meanings people attribute to their experiences (McLeod, 2001). It has been said that the notion of pluralism, or the appreciation of diversity and complexity of views, is intrinsic to qualitative inquiry (McLeod, 2001). In its totality, qualitative approaches are committed to exploring, describing, and interpreting the personal and social experiences of participants (Smith, Flowers, & Larkin, 2009).

While there are many methodologies that fall under the umbrella of qualitative inquiry, interpretative phenomenological analysis (IPA) was chosen to guide the present study design and analysis. IPA is particularly well-suited for the present study for a multitude of reasons. First, IPA is known for its appropriateness and wide use for studying the experiences and meaning-making of individuals. Second, IPA attends to the contextual factors (e.g., social, political, historical) that shape experiences, which is necessary for research associated with the societal problem of sexual assault. Third, IPA's commitment to the particular and giving voice to experiences is particularly fitting for survivors of sexual assault whose experiences continue to be silenced within our

society and throughout the world. Finally, as a doctoral student in counselling psychology and a counsellor, I am drawn to IPA's commitment to connect findings to my professional experience in psychology as well as the existent psychological literature. The following sections will outline the method and design of the present study, as well as including discussions of the philosophical assumptions and theoretical framework of IPA, participant selection, data collection, data analysis, trustworthiness, and ethical considerations.

Philosophical Assumptions

In order to undertake a qualitative study in the most effective manner, it is essential for the researcher to have a comprehensive understanding of the broader philosophical assumptions of the selected qualitative approach (Creswell, 2007). While IPA is a relatively new methodology that was introduced by Jonathan Smith (1996) in the mid-1990s, it draws on concepts and ideas with much longer histories. More specifically, IPA is informed by three primary areas of philosophical knowledge: phenomenology, hermeneutics, and idiography.

Phenomenology. Phenomenology has a strong philosophical component that dates back to the late 1800s and early 1900s and was founded by the philosopher Edmund Husserl (Creswell, 2007). The original aim of phenomenology was to describe basic concepts in all academic disciplines in a rigorous and unbiased way (Ashworth, 2008). For Husserl (1906/1907, 1927), an unbiased description of the subject matter was a necessary component of scientific knowledge. Phenomenology has become known as the philosophical approach to the study of experience in which its goal is to establish the essential features, or essence, of experiences (Smith et al., 2009). Husserl (1927) was

interested in experiences from the first-person perspective and, as such, conducted phenomenological inquiry on his own experiences. He believed that in order to get at the true essence of an experience, it was necessary for the researcher to "suspend the natural attitude" or develop a "phenomenological attitude" where the researcher works to prevent previous knowledge or preconceptions of the phenomena under investigation from interfering with the research.

Hermeneutics. The aim of Husserl's phenomenology was to describe experiences in their purest, unadulterated form, which he claimed could be done through the adoption of a phenomenological attitude. A student of Husserl's, Martin Heidegger, rejected Husserl's belief in Cartesian dualism (i.e., that the mind and body are separate entities) as well as his belief that the essence of experience can be captured in a way that is void of any presupposition (Heidegger, 1962). While informed by Husserl's phenomenological philosophy, Heidegger made his own path in phenomenology and is responsible for linking phenomenology with hermeneutics (Shinebourne, 2011). Heidegger was noted to believe that, "the phenomena of existence always required interpretation and hermeneutics is the art of interpretation" (Moran, 2000, p. 218). According to Heidegger (1962), all description is drawn from interpretation and all description involves interpretation.

Heidegger (1962) was interested in analyzing the experiences of others. He posited that humans are sense-making creatures and interpreting how people make sense of their experiences should be central to phenomenology. For Heidegger, phenomenology should not focus so much on individuals' perceptions of their lifeworld as it should on individuals' constructions of their lifeworld. Here, the notion of perception refers to being

able to directly access phenomena as it is perceived by the body in the world, whereas construction refers to one's representations or interpretations of phenomena. Heidegger believed that it was impossible to make an interpretation about a phenomenon without that interpretation being based on one's preconceptions of that same phenomenon. At the same time as acknowledging that one's presuppositions poses a challenge to the researcher, Heidegger emphasized that when engaging in hermeneutics, priority should be given to the phenomenon under investigation rather than one's preconceptions.

Idiography. At the heart of IPA is a commitment to idiography (Smith, 2004), where individual experience is considered to be the unit of study (Shinebourne, 2011). The term "idiographic" was first introduced into the English language with a contrasting term, "nomothetic," by Gordon Allport in the mid-1900s but was used as early as the late 1800s by the German philosopher Wilhelm Windelband (Shinebourne, 2011). Whereas a nomothetic approach, which is usually adopted in quantitative research, involves making generalizations about a population, an idiographic approach involves using a microscopic lens that allows the researcher to examine in detail the perceptions and understandings of individuals and their experiences (Chapman & Smith, 2002). IPA has two main commitments to idiography (Smith et al., 2009). The first is an allegiance to the particular, or the individual experience, and an adherence to the depth of analysis, which can be attained through a commitment to detail. The second is a commitment to understanding how particular experiential phenomena are understood from the perspectives of particular people, in a particular context. In this sense, IPA is said to focus upon the person-in-context and that person's relatedness to the phenomenon being studied (Larkin, Watts, & Clifton, 2006).

Epistemological Stance

Epistemology is the branch of philosophy concerned with the theory of knowledge and is inherent to a study's theoretical framework and methodology (Willig, 2001). This theory of knowledge asks the questions "How can we know?" and "What can we know?" (Crotty, 1998). As well, epistemology includes discussions about the relationship between the participants and researcher in the study (McLeod, 2001). Congruent with the qualitative research paradigm and, more specifically, IPA, this study will be based on a constructivist epistemology.

Constructivism assumes the standpoint that there is no objective truth or reality and that truth and meaning are not merely discovered but are constructed by each individual (Crotty, 1998). The constructivist epistemology posits that different people construct meaning in different ways, and as such, there is value in relying as much as possible on participants' views of their experiences, which are said to be formed through their interactions with others and through their historical, cultural, and linguistic contexts (Creswell, 2007; Willig, 2001). Researchers operating from a constructivist paradigm believe that they cannot separate themselves from the research; they recognize that their own background and experiences will shape any interpretation they make (Creswell, 2007).

IPA is situated within the constructivist paradigm (Smith et al., 2009). In IPA, the researcher's access to participants' experiences is dependent on, as well as complicated by, the researcher's own conceptions of the research topic (Smith & Osborn, 2008). It is assumed in IPA that "the data tell something about people's involvement in and orientation toward the world, and/or how they make sense of this" (Smith et al., 2009, p.

46). Smith and his colleagues (2009) suggested that while the subjective experience of a participant is never fully accessible to the researcher, the aim in IPA is to get "experience close" (p. 33).

Constructivist epistemology is congruent with my own beliefs about how we know what we know. As a counsellor, I have worked with numerous victims of violence, including survivors of sexual assault, and have witnessed how they cope with and recover from similar experiences differently. I have also found that it is difficult, if not impossible, to separate individuals from their environment, and that therapy must be considerate of one's historical, social, and linguistic contexts. I believe in multiple realities and that no one person's reality represents objective truth. It is this constructivist stance that influences how I work with and understand survivors as a clinician, as well as how I approached the present study.

Methodological Framework

IPA is a multi-faceted phenomenology that grew out of a desire to capture experiences qualitatively, while at the same time dialoguing with a discipline (i.e., psychology) that has a long tradition of utilizing quantitative approaches in research (Shinebourne, 2011). This integrative approach is attractive to researchers in the fields of clinical, counselling, and health psychology, as it allows for a rich description of participants' experiences as well as enabling the understanding and interpretation of such experiences to be linked to theories in mainstream psychology (Smith et al., 2009).

As highlighted above, IPA has its philosophical roots in phenomenology and hermeneutics. Borrowing from Husserl's approach to phenomenology, IPA is committed to examining the subjective experience of "something" (Smith et al., 2009) or studying an

individual's own perception of a personal experience (Smith, 1996). While IPA retains phenomenology's commitment to the study of everyday experience, experiences studied through IPA are, more often than not, experiences of importance that are often considered to be life-changing events for participants (Smith et al., 2009). Following Heidegger's hermeneutics, and in contrast to Husserl, IPA is based on the notion that human beings are continually interpreting their experiences, and any description is influenced by the participant's own interpretation of that experience (Smith et al., 2009). In this vein, IPA is not only interested in how participants describe their experiences, but also in how individuals understand and make sense of their experiences (Larkin et al., 2006). As noted by Smith et al. (2009), "With IPA, we are concerned with where ordinary everyday experience becomes 'an experience' of importance as the person reflects on the significance of what happened and engages in considerable 'hot cognition' in trying to make sense of it" (p. 33). Indeed, "without phenomenology, there would be nothing to interpret; without hermeneutics, the phenomenon would not be seen" (Smith et al., 2009, p. 37).

IPA shares with cognitive psychology and social cognition a commitment to understanding mental processes (Smith, 2004). It is said that IPA closely aligns with the original ideas of cognitive psychology, which was initially put forward as a science of meaning and meaning making (Smith, 2004). Larkin et al. (2006) delineate two primary goals for research following the IPA framework. First, there is a commitment to trying to understand participants' experiences of a particular phenomenon and describing in as much detail as is necessary to best capture their experiences. It is suggested that the objective of this first goal "is to produce a coherent, third-person, and psychologically

informed description, which tries to get as 'close' to the participant's view as possible" (p. 104). The second goal of IPA research is to engage in an interpretative analysis, which enables the initial description of the experience to be placed within a wider social, cultural, and theoretical context. To achieve this goal, the researcher is required to think about what it means for participants to have described their experiences, with all their feelings and assertions, in the manner that they have. Smith and Osborn (2008) describe IPA as a 'double hermeneutic' where the researcher is said to be making sense of the participant who is in turn making sense of her own experience. The researcher is said to be similar to the participant in that they are both human beings who draw on their personal resources in order to make sense of their experiences in the world (Smith et al., 2009). Researchers strive to understand what the experience of a particular phenomenon is like from the perspective of participants (Smith & Osborn, 2008) with the resulting IPA analysis taking the form of an "idiographic interpretative commentary, interwoven with extracts from the participants' accounts" of their experiences (Shinebourne, 2011, p. 200-201).

A phenomenological researcher is encouraged to maintain an "attitude of wonder that is highly empathic" (Wertz, 1995). IPA, in particular, has been said to be a combination of a hermeneutics of empathy and a hermeneutics of questioning (Smith et al., 2009). In choosing IPA for a research project, the researcher is committed to "exploring, describing, interpreting, and situating the means by which participants make sense of their experiences" (Larkin et al., 2006, p. 11). As the present study sought to explore the lived experiences of self-compassion for female survivors of sexual assault

and the meaning survivors attach to their experiences, IPA was an appropriate approach with which to undertake this research.

Selection Criteria

Sample sizes need not be large in qualitative studies, and it is recommended that a sample size of 3 to 10 participants is sufficient (Dukes, 1984). The present study included 10 adult females who were sexually assaulted in adulthood. The sample size was in the upper range of Dukes' (1984) recommendation in order to maximize variability. For the purposes of the present study, sexual assault was defined according to Canadian law, which does not distinguish between penetrating sexual assault (e.g., rape) or other forms of sexual assault but considers lack of consent to be the key indicator that assault has occurred (Martin's Annual Criminal Code, 2011). Therefore, sexual assault was defined as unwanted sexual activity of any nature (e.g., touching, kissing, intercourse) that occurred without the female's consent. In Canada, the age at which a person can legally consent to sexual activity is 16 years (Department of Justice Canada, 2010). For that reason, the present study operationalized adult sexual assault as occurring for individuals aged 16 and older.

In addition to age and sexual assault, a third inclusion criterion was that participants not be in a state of traumatic stress at the time of data collection. Past research has found that those individuals at early stages of healing from trauma may have difficulty conceptualizing self-compassion (Gilbert & Procter, 2006). The Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) was used to assess potential participants' levels of traumatic stress. The IES-R (Appendix A) is a self-report measure that assesses levels of distress within the past seven days for a specific event. It has been

found to have high uniformity with internal consistency alpha coefficients ranging from 0.79 to 0.92 and high reliability with test-retest correlations ranging from 0.57 to .94 (Weiss & Marmar, 1997). The Scale consists of 22 Likert-type items with responses ranging from 0 to 4 (not at all, a little bit, moderately, quite a bit, extremely) and is comprised of three subscales. The three subscales and sample items from each are as follows: (1) Intrusion Subscale (e.g., Any reminder brought back feelings about it); (2) Avoidance Subscale (e.g., I avoided letting myself get upset when I thought about it or was reminded of it); and (3) Hyperarousal Subscale (e.g., I was jumpy and easily startled). Total scores can range from 0 to 88 and the mean score is calculated for each subscale with overall mean scores ranging from 0 to 4. A cut-off score of 1.5 (equivalent to a total score of 33) was found to provide the best diagnostic accuracy for symptoms of traumatic stress (Creamer, Bell, & Failla, 2003). Therefore, as participants for the present study were required to not be in a current state of traumatic stress, individuals who scored at the lower end of the 0-4 range (i.e., 0 – 1.5) met the criteria for the present study. To act as a further safeguard against traumatic stress, only participants who were sexually assaulted a minimum of 12 months prior were selected for this study.

In addition to not being in a state of traumatic stress, it was critical that participants in the present study had disclosed the sexual assault to at least one other supportive person (formal or informal) prior to participating in the study. Disclosure of distressing events has been found to be related to improved psychological and physical well-being (Greenberg & Stone, 1992; Greenberg, Wortman, & Stone, 1996; Pennebaker, 1999); this has also been the case for survivors of adult sexual assault (Ahrens, Stansell, & Jennings, 2010; Burt & Katz, 1988; Cohen & Roth, 1987). Perceived negative social

reactions to survivors' disclosure of sexual assault may negate the positive effects for some survivors, leading to more depression, posttraumatic stress symptoms, and physical health outcomes (Ahrens et al., 2010). Given the implications that initial disclosure can have on a survivor's well-being and path to recovery, it was imperative that interviews in the present study were not used as a means for first disclosure of sexual assault.

In summary, criteria for participation was as follows: (a) participants consisted of females who were sexually assaulted in adulthood, with adulthood being operationally defined as 16 years of age or older; (b) participants were 18 years of age or older at the time of interviews; (c) participants were not in a state of posttraumatic stress, as determined by their score on the IES-R; (d) the sexual assault occurred a minimum of 12 months prior to data collection; (e) participants disclosed the assault to at least one other supportive person; and (f) participants reported experiencing at least one instance of self-compassion since the sexual assault, based on their conceptualization of self-compassion.

Participant Recruitment

Recruitment of participants took place in Edmonton, Alberta between February and April 2012. Participants were recruited through public advertisements and community organizations. Advertisements were placed in online community listservs (e.g., Kijiji, Craig's List). The researcher also liaised with the Sexual Assault Centre of Edmonton and the Sexual Assault Centre at the University of Alberta to communicate the undertaking of this study. Other organizations that may encounter women who have experienced sexual assault were also notified (e.g., Clinical Services at the University of Alberta). Posters (Appendix B) providing information about the study as well as contact

information for the researcher were dispersed within relevant organizations throughout the city.

Participant Selection

A total of 27 individuals contacted the principal researcher by telephone or email to indicate interest in participating in the study. As the principal researcher, I explained the purpose of the study to them and outlined the six criteria for participation. An information letter (Appendix C) was sent to potential participants through email and they were encouraged to ask questions about the consent process and the study through their preferred mode of communication (i.e., telephone or email). Eleven individuals acknowledged meeting the first five criteria and indicated agreement to proceed; the IES-R was sent by email to these 11 individuals for completion and return to the researcher. The completed IES-Rs were scored and all but one individual fell within the acceptable range. For the one individual who did not meet full criteria, great care was taken in explaining the meaning of her score on the IES-R as well as normalizing her continued experience of intrusive memories, hyperarousal, and avoidance. She was provided with a list of community resources for counselling and was offered the opportunity to discuss the results of the IES-R or the community resources in greater detail. The other 10 individuals were informed that they met all six criteria and interviews were scheduled. Participants were sent a copy of the Informed Consent Form as well as the Demographic Form and were told that at the start of the interview they would be asked to complete both forms.

Sample Demographics

Ten females participated in the present study. Ages of participants ranged from 21

to 34 (mean 26.2, median 25.5). Half of the participants identified themselves as single while the other half identified themselves as married. Nine participants identified their ethnic background as Caucasian and one participant identified as East Indian. Specified religions were: Christian (2), Atheist/Agnostic (5), Former/Non-Practicing Catholic (2), and Goddess-Based Spirituality (1). Education levels varied across participants: three participants had (or were completing) graduate university degrees, four participants had (or were completing) undergraduate university degrees, one participant was currently enrolled in a college program, one participant had a college certificate, and one participant partially completed high school.

The 10 adult females who participated in this study were all sexually assaulted by acquaintances that they had known for varying lengths of time. Several participants experienced childhood sexual abuse, in addition to being sexually assaulted in adulthood. Some participants were sexually assaulted multiple times in adulthood by the same or different perpetrators. Other participants had one experience of sexual assault in adulthood. The time elapsed since participants' last experience of sexual assault ranged from one to 13 years. A brief introduction to participants is presented in Table 1; pseudonyms have been used to protect the identity of participants.

Data Collection

The primary source of data was from individual, face-to-face interviews. All interviews took place at the University of Alberta (Clinical Services), a setting that ensured confidentiality and privacy. Prior to commencing the interview, participants were asked to choose a pseudonym to be used in place of their name in order to maintain confidentiality. Participants were also asked to fill out a demographic form (Appendix

Table 1

Participant Demographics and Sexual Assault Experiences

Participant	Demographics and Sexual Assault Experiences
Mandy	Late 20s; Caucasian; sexually assaulted multiple times by a boyfriend; last experience of sexual assault nine years ago
Dominique	Late 20s; Caucasian; experienced childhood sexual abuse; sexually assaulted by a work supervisor 11 years ago
Riley	Mid 20s; Caucasian; sexually assaulted by a boyfriend (while separated from husband) one year ago
Millie	Early 20s; Caucasian; sexually assaulted by a boyfriend (who was also a coworker) four years ago
Emma	Mid 30s; Caucasian; sexually assaulted by a (casual) boyfriend 13 years ago
Candace	Mid 30s; Caucasian; sexually assaulted by a friend 12 years ago
Ellen	Early 20s; Caucasian; sexually assaulted by a work supervisor five years ago
Nina	Early 20s; East Indian; sexually assaulted by a friend two years ago
Gwen	Mid 20s; Caucasian; experienced childhood sexual abuse; sexually assaulted by three different perpetrators since the age of 16; last experience of sexual assault eight years ago
Alex	Mid 20s; Caucasian; sexually assaulted by a man she had known for one day two years ago

D), which was used for descriptive purposes. Signed consent (Appendix E) was obtained, and limits of confidentiality were explained. Participants were provided with an overview of the interview process prior to commencing the interview and were encouraged to ask any questions they may have had. All interviews were recorded through a digital recording device.

Consistent with Smith's (2004) recommendation, participants were interviewed using a semi-structured format. Given the emergent nature of qualitative inquiry, an advantage to using semi-structured interviews is readily being able to follow-up on interesting and important issues that arise in the interview (Smith, 2004). Interviews varied in length from 30 minutes to one hour and unfolded at the pace of participants. It is recommended in IPA that researchers develop 8 to 10 questions, including a variety of prompts (Appendix F), to use as a guide for the interview (Smith et al., 2009). Interview questions were framed broadly in an effort to explore the phenomenon flexibly and in detail (Smith & Osborn, 2008). Interview questions included: What does compassion mean to you? What does self-compassion mean to you? In what ways have you been compassionate with yourself since the sexual assault? In what ways does treating yourself with compassion influence your feelings and/or perspectives towards the sexual assault? Consistent with the IPA framework, questions were occasionally modified in light of participants' responses and other interview questions emerged based on the unique circumstances and perspectives of the participants (Chapman & Smith, 2002). The overall tone of the interviews was conversational, and every effort was made to provide a comfortable and safe atmosphere for participants. Descriptive field notes outlining overt and nonverbal behaviours of participants were recorded during and after the interview, which served as a reference in the analysis of data.

Each interview was transcribed verbatim and initial follow-up questions were noted. Participants were informed both at the beginning and end of the interview that they would have the opportunity to review their transcribed interview and to make any additions, deletions, or corrections they felt necessary. All participants reviewed their

transcripts via a password-protected file through email. Deletions or additions were noted directly in the transcript by participants, and follow-up questions were addressed via participants' preferred mode of communication (i.e., telephone or email). Participants were informed that additional follow-up may be necessary and all were open to such possibility.

Throughout the research process, it was necessary for me, as the researcher, to set aside, or bracket, my own preconceptions and experiences of self-compassion, as it was essential to maintain focus on the experiences being described by participants. The practice of bracketing enables the researcher to put aside any preconceived notions about the research topic so as to minimize the impact of the researcher's own beliefs and biases (Creswell, 2007). In the present study, bracketing took the form of writing memos before and after each interview. Memos before each interview included any presuppositions I had going into the interview as well as any thoughts or reflections that I carried over from previous interviews or recent readings of literature on self-compassion. Memos at the end of interviews primarily included any reactions, reflections, or insights related specifically to the interview, as well as hunches related to overall themes in the data. It is important to note that while my preconceptions were acknowledged and recorded through the writing of memos, I believe that it is unrealistic to think that my biases and assumptions did not influence the research process.

Data Analysis

While Smith and Osborn (2008) contend that there is no definitive way to do analysis in IPA, Smith and his colleagues (e.g., Chapman & Smith, 2002; Smith et al., 2009) provided recommendations and guidelines for the analysis of data. Following

transcription, Smith et al. (2009) outlined six main steps to use as a guide for analyzing data within the IPA framework and each step was closely adhered to in the present study.

The first step requires that the researcher become immersed in the data by reading the transcript multiple times. It is essential that the participant becomes central to the analysis and any preconceptions on the part of the researcher or ideas about how the analysis should proceed are put aside. Repeated reading allows the researcher to actively engage with the interview and enables the researcher to notice sections where content is richer and more detailed, as well as noting any contradictions or paradoxes. In the present study, this step involved first listening to the audio-recorded interview a minimum of two times in an effort to re-connect with the participant's experiences. Repeated re-readings of the transcript followed, with some initial noting directly on the transcript regarding any thoughts or impressions that were forthcoming in this initial stage.

The second step involves examining the transcript for semantics and language use. In this step, it is suggested that the researcher note anything of interest in the margins of the transcript, particularly ways the participant speaks, understands, and thinks about the phenomenon. The result of this step is a comprehensive set of notes and comments on the data. For the present study, this step involved a careful examination of the transcript for any statements that appeared to capture a participant's experience of self-compassion. This process involved going line-by-line through the transcript; anything that stood out as relevant to the researcher was noted. The result of this phase of analysis was a hard-copy transcript with a series of statements/points-of interest written in the right-hand margin. Consistent with Smith et al.'s (2009) instructions, at this point, the data set had grown

substantially and not only included the interview but also all of the exploratory commenting on the part of the researcher.

The third step involves capturing the detailed set of notes into low-level themes (often referred to by other qualitative methods as codes); this was an iterative process of reducing the volume of detail while still striving for complexity. At this point in the analysis, the clean computer copy of the transcript was transferred to ATLAS.ti.7.0, a software program for qualitative data management to assist with the organization and analysis of data. Low-level themes (developed from the hard copy of statements/points of interest) were formulated and attached to their corresponding points in the transcript. These low-level themes consisted of concise statements about what was previously noted as important and were represented "as phrases which speak to the psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual" (p. 92). At this point in the analysis, and continuing onwards, the researcher engages in the hermeneutic circle as outlined by Heidegger (1962; Smith et al., 2009). In other words, in order to understand any specific part of a participant's interview, the researcher must look at the whole interview, and in order to understand the whole interview, the researcher must look at the parts (Smith et al., 2009). The low-level themes in the present study reflected both the participants' original words and captured the researcher's interpretation of the phenomenon.

The fourth step of IPA analysis involves organizing the low-level themes (or codes) that emerged in the previous step into higher order themes. This process involves looking for interrelationships, connections, and patterns among low-level themes. While some themes will naturally be drawn together and may be renamed to suit the connection,

other themes that no longer seem to fit may be discarded; the end result is a set of higher level themes that illustrate the most interesting and important aspects of the participant's interview. Smith et al. (2009) outlined several methods that can be employed when looking for patterns and connections between emergent themes. Abstraction was used in the present study and is a method whereby similar low-level themes are grouped together and a new name is developed for the cluster of low-level themes. Numeration was also employed and involves taking account of the frequency with which a low-level theme is supported and appears throughout a transcript.

The fifth step involves repeating the four previous steps with each new transcript. In working with new transcripts, it is essential for researchers to maintain the idiographic commitment of IPA whereby each new transcript should be "treated on its own terms, to do justice to its own individuality" (p. 100). In an effort to treat each transcript on its own terms, substantial time was spent with each transcript before moving on to the next, often encompassing a period of three or more weeks. As well, analysis of emergent themes occurred at a case level for each participant before searching for patterns and connections among participants.

The final step involves looking for patterns in themes across all interview transcripts. In the present study, this step involved identifying themes that were specific to a particular case versus themes that illustrated shared experiences among participants. This process involved considering not only the frequency of themes but also themes that could be considered potent or powerful in capturing the experience of self-compassion for participants. Smith et al. (2009) suggested setting criteria for measuring recurrence across cases when working with studies of larger sample sizes, where larger sample sizes

are typically greater than six participants. In the present study, themes were considered for super-ordinance only when present in at least half (5/10) of all the participant interviews.

Determining Trustworthiness

Smith et al. (2009) endorse Yardley's (2000) criteria for assessing the quality of an IPA study. Yardley offers four broad principles: sensitivity to context; commitment and rigor; transparency and coherence; and, impact and importance.

Sensitivity to context encompasses many different facets of a study. First, a researcher should be grounded within the philosophy of the qualitative approach. In the present study, this involved extensive familiarization with the philosophical assumptions of IPA. As the primary researcher, it was imperative for me to have an in-depth understanding of Husserlian phenomenology, Heiddegarian hermeneutics, and idiography, and the role each philosophy plays in the IPA approach. A second component of Yardley's first criteria involves sensitivity to the participants of the study. It was crucial to immerse myself in the sexual assault literature prior to undertaking this study in order to ensure an understanding of the difficulties survivors can experience post-assault. Sensitivity to context in this respect first came into play in my selection criteria for participants. I was committed to providing a positive experience for participants and this included being mindful of their healing thus far. As such, ensuring that participants were not experiencing traumatic stress at the time of data collection through the IES-R and being a minimum of 12 months post-assault, as well as taking care to ensure that I was not the first person to whom they disclosed the sexual assault, showed sensitivity to and respect for their healing process. Through reading and reflecting on my clinical

experience in working with survivors of sexual assault, I knew it was essential to maintain a climate of safety, warmth, and understanding. At all times, I was cognizant of helping my participants be at ease throughout the interview process. A third component to sensitivity to context is related to awareness and addressing of ethical issues. This involved choosing a setting that would ensure privacy and confidentiality of participants, being respectful of participants' schedules/time, ensuring participants' understanding of the consent process and limits of confidentiality, following through on commitments made to participants regarding the sharing of my understandings of their experiences, and providing participants with community resources in case they required assistance post-interview.

The second of Yardley's principles is commitment and rigour. Commitment refers to the degree of attentiveness to each participant during the data collection and was achieved by means of the first principle of sensitivity to context. Familiarity with the sexual assault literature and reflecting on my own clinical experience, contributed to my goal as a researcher to make participation in this study as positive of an experience as possible for participants. Bracketing in the form of memos before interviews helped to clear my mind of preconceptions going into the interview, which I believe enabled me to better focus on the participant during our time together and demonstrated reflexivity on my part as a researcher. In adhering to the idiographic focus of IPA, substantial care and time was spent working with the data for each participant. Furthermore, it was important to me as a researcher using the IPA method to ensure that participants were equally represented in the findings, as much as possible. Rigor refers to the thoroughness of the study. According to Yardley, this can refer to the appropriateness of the sample to the

research question, the quality of the interview, and completeness of the analysis. In the present study, the interview schedule was carefully designed to ease the participant into the study with open-ended questions to gain insight into their experiences of self-compassion post-assault. All questions were open-ended and I was careful not to lead participants in any direction other than where they had intended going themselves. This required great flexibility and openness on my part, a delicate balance of following the participant and remaining true to the interview schedule. In adherence to IPA's commitment to idiography, substantial time was spent working with each transcript and analyzing each participant's experience prior to moving on to the next participant. As Smith et al. (2009) commented, data analysis was sufficiently interpretative, "moving beyond a simple description of what is there to an interpretation of what it means" (p. 181).

Yardley's third principle for evaluating the quality of the study is transparency and coherence. Transparency refers to how clearly the stages of the research process are described and coherence refers to the goodness of fit between the theory, method, and findings. To ensure quality, data collection and analysis procedures were closely adhered to as outlined by Smith et al. (2009). As recommended by Smith et al. (2009), interviews were transcribed verbatim to ensure that the nuances of participants' language remained and participants' mannerisms and paralinguistic behaviours were captured through the use of descriptive field notes. As IPA attempts to comprehend phenomena based on participants' experiences with the phenomenon, it was essential to make interpretations that were grounded in the perspectives of participants. This was verified through two main methods. First, member checks were used to ensure that I was describing the

phenomenon from an emic perspective (Maxwell, 1992) and that the interpretations of the phenomenon being offered resonated with participants. As previously indicated, participants were provided with the opportunity to review transcripts to make any additions, deletions, or corrections. In addition, follow-up questions were asked of each participant in order to discuss any changes made to the transcript as well as to ask any clarification questions. A summary of analysis was sent to each participant to confirm understandings or discuss emerging interpretations at the individual level. To maximize rigour, a peer review process was implemented throughout the course of the research to act as an external check of the research process, findings, and implications (Creswell, 2007). This process involved a series of meetings with my research supervisor who independently assessed and confirmed that the findings of the present study were plausible based on the data. Transparency and coherence was further achieved by appropriate illustrations for each theme in the findings section.

Yardley's final principle is impact and importance; whether or not the study tells the reader something interesting, impactful, or useful. I see this final principle as relating to the transferability of the study whereby transferability refers to the extent to which the results of a study can be applied to other contexts (Merriam, 2002), such as clinical work with survivors of sexual assault. In the present study, transferability was maximized through "rich, thick descriptions" of the phenomenon of self-compassion in survivors of sexual assault (Merriam, 2002). Such descriptions provide the opportunity for audiences to determine to what extent the findings are useful (e.g., clinicians can determine what fits for a particular client based on how closely their situation matches to participants).

A final consideration for evaluating quality is the independent audit, which ensures the trustworthiness of this study (Merriam, 2002; Smith et al., 2009). A record has been kept of all memos, descriptive field notes, consent forms, ethical challenges, as well as digital audio recordings, transcribed and coded interviews. An independent audit ensures that "the final report is a credible one in terms of data which have been collected and that there is a logical step-by-step path through the chain of evidence" (Smith, 2009, p. 183).

Ethical Considerations

Prior to commencing this research, approval was obtained from the Research Ethics Board (REB 1) for studies of emergent design at the University of Alberta. This approval was granted in February 2012 and data collection commenced soon after. Throughout the entire study, I followed the ethical principles, values, and standards of practice for psychological researchers as outlined by both *the Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) and the Canadian Tri-Council Policy Statement *Ethical Conduct for Research Involving Humans* (CIHR, NSERC, & SSHRC, 2005). As research on sensitive topics, such as sexual assault, involves a potential threat to participants, in order to prevent the occurrence of harm to participants, their well-being was considered at each stage of the research process.

Informed consent was obtained from participants prior to the commencement of any interview and was sent to participants in advance of the scheduled interview to give participants time to review the form on their own. Within this consent, participants were informed of the sensitive nature of this study as their experiences of sexual assault would be brought into the discussion. Participants were informed that through the very nature of

qualitative research, there is a desire on the part of the researcher to retain as much of the participants' language as possible as quotes are integral to the richness of the study. To ensure the privacy, confidentiality, and anonymity of participants, pseudonyms were used and all potentially identifying information was removed. Electronic files were stored on a password-protected computer and any other documents were secured in a locked filing cabinet and will continue to be securely stored for five years following the completion of the research project. After this time they will be destroyed.

Reciprocity, or giving back to the participants, is a factor worthy of ethical consideration (Creswell, 2007; Marshall & Rossman, 2006). As participants were giving their free time to the interview process, I conveyed gratitude. Bottled water was provided for each participant during the interview. Following the interview, an honorarium in the form of a gift card for a store offering self-care products (i.e., $30 for Bath & Body Works or $30 for Chapters) was given to each participant. Participants were given the option of which gift card they preferred. Participants were informed that they can request a summary of the findings of the study once the research project was complete.

One necessary reflection was on my role as a researcher. It was essential that I retained my role as a researcher throughout the research process. Due to the sensitive nature of the study, I was cautious to maintain my professional boundaries as a researcher and not enter into the role of counsellor. Aside from initial nervousness, I detected no signs of distress from any participants in their interviews or interactions with me. At the conclusion of our interview, I provided participants with a list of contacts (Appendix G) for resources in the community as well as a 24-hour crisis line in case they found that the interview brought up feelings that they needed to work through. As an interviewer, I

emphasized strengths of participants at the end of the interview process in an effort to leave the interview on a positive note. In reflecting with participants about their experience during the interview, more than half of participants indicated that the interview stirred up thoughts about how they could be more self-compassionate and noted that they were happy to have been part of a study that looked at a "positive" side to sexual assault, rather than the trauma on which so many other studies focus.

CHAPTER 4

FINDINGS

Eight super-ordinate themes emerged from the semi-structured interviews with participants: (a) affirming self-worth; (b) accepting oneself; (c) absolving oneself of blame; (d) honouring emotions; (e) taking time for self-care; (f) connecting with others; (g) claiming power; and (h) recognizing progress. As previously noted, Smith et al. (2009) recommended defining "recurrent" themes as a way to enhance the validity of the findings when working with a larger sample; recurrent was set at 50% for the present study (i.e., the main themes occurred for at least half of participants). Table 2 illustrates which themes were relevant for each of the 10 participants.

The experience of self-compassion for the women in this study was undeniably a journey. For some women, it was evident that this journey was in its infancy and these women could point to few instances of self-compassion in their lives. For other women, self-compassion was well-engrained to their way of being and they could reference numerous experiences. No woman identified being self-compassionate immediately following sexual assault; and, irrespective of where these women were on their pathway, all women described struggling and identified barriers to self-compassion such as shame, self-loathing, self-blame, and the societal stigma associated with sexual assault. The eight super-ordinate themes presented within this section illuminate a process whereby there is no anticipated ending, with all participants reporting an ongoing commitment and desire to garner more self-compassion into their lives.

Affirming Self-Worth

For participants of this study, a sense of personal worthlessness was prevalent following the sexual assault(s). Many participants indicated that the post-assault

Table 2

Participants and Corresponding Themes

	Affirming Self-Worth	Accepting Oneself	Absolving Oneself of Blame	Honouring Emotions	Taking Time for Self-Care	Connecting with Others	Claiming Power	Recognizing Progress
Mandy	●	●	●	●	●	●	●	●
Dominique	●		●		●	●	●	●
Riley	●		●	●	●	●		●
Millie		●			●	●		●
Emma	●	●	●	●	●	●	●	●
Candace	●				●	●		
Ellen	●		●	●	●	●	●	●
Nina				●	●	●		●
Gwen	●	●	●		●	●	●	●
Alex	●	●	●	●	●	●	●	●

experience of self-compassion involved affirming their self-worth. This practice of affirming self-worth involved a range of processes, including asserting their worth as a human being, regarding themselves as deserving of self-compassion, giving themselves permission to treat themselves and their needs as important, and treating themselves according to how they would treat another person going through similar difficulties.

Affirming self-worth often involved an inner acknowledgment or assertion of such worth. For Dominique, who was sexually assault by a partner, being self-compassionate included being patient with herself and telling herself, "I am important" and "I matter." Not long after having been sexually assaulted by a supervisor at work, Ellen's experience with the judicial system left her with feelings of increased shame and self-blame. She reflected on coming to a point in her recovery where she believed that she was a worthwhile person:

> Five years ago I reached a point where I didn't really want to live anymore. That's when I realized that this is ridiculous. I am worth more than this and my life is worth more than this. Even though the cops thought I was this and the judge thought that, I realized it's not true. I am a good person.

For Alex, who was sexually assaulted while on vacation by a man she had met the same day, the very act of being self-compassionate communicated her self-worth:

> Self-compassion can be so frivolous. It is completely for yourself and sends the message that "I am awesome" and "I deserve something."

Many participants spoke of feeling undeserving or unworthy of self-compassion post-assault. Personally reinforcing their right to treat themselves compassionately was identified by participants as a key component of affirming their self-worth. Inseparable

from feeling deserving of self-compassion was granting oneself the permission to be self-compassionate. This was evident in participants' use of phrases such as "giving myself permission…," "allowing myself…," and "it's okay…" Candace was sexually assaulted by a friend and her use of this language highlighted her own push towards feeling deserving of self-compassion:

> Self-compassion involves allowing and giving myself permission to take time out for myself and to relax and not feel that I always have to be doing something for somebody else. Sometimes I have to tell myself that I deserve it and it's okay to spend $60 on a pedicure/manicure. I don't have to feel guilty about it and think that I could have used that money for something else other than myself.

Similarly, Gwen, who experienced sexual assault by three different perpetrators since the age of 16, reported that her practice of self-compassion involves a conscious giving of permission to be on the receiving end of compassion:

> I started recognizing that it's okay for other people to be compassionate to me and that it's even okay to be compassionate to myself. So I give myself permission to recognize that it's okay. I'm allowed to not be at work right now. I'm allowed to eat ice cream out of the bucket right now. I'm allowed to do all these things and then by giving myself permission it actually allows me to heal and get over hurdles much faster.

Dominique also reflected on this permission-giving process:

> For me, the way I am compassionate towards myself is letting myself do the little things. Allowing myself or giving myself permission to put myself first.

For some participants, the process of being self-compassionate involved reflecting on how they would treat another person who had comparable emotions, thoughts, or experiences. This reflection assisted participants to affirm their self-worth as they recognized and accepted that if others are deserving of compassion, they were too. Gwen illustrated how such reflection was helpful in facilitating self-compassion:

> Self-compassion is turning that compassion for others inwards and treating yourself how you would treat a very cared-for friend. So, sometimes it's a lot of phone calls and it's talking it through with someone else. It often involves saying to myself, "Okay, but if it was her, I wouldn't say that. I wouldn't say that you're failing or anything like that so then let's not do that to myself."

Similarly, Riley, who was sexually assaulted by a partner, highlighted how such reflection translates into self-compassion:

> If I've done something that I've messed up on or that I feel bad about, then I do to myself what I would do for somebody else in the same situation. So if I'm feeling bad and I'm starting to beat myself up, I'll say "Stop!" and reflect on what I would do for my daughter or my husband if they were feeling the same way. And then I do whatever it would be that I would do for them.

As Emma, who was also sexually assaulted by a partner, indicated,

> I practice compassion for self by trying as much as possible to treat myself as I would a best friend.

Accepting Oneself

Participants described moving away from harsh judgment and self-criticism post-assault towards a stance of self-acceptance. Self-compassion for these participants

involved accepting the self as a whole person, which included recognizing their strengths and limitations and forgiving themselves for imperfections.

Participants shared an attitude of non-judgment and openness towards themselves, including what they considered to be difficult parts of the self. Mandy, who was sexually assaulted by her partner, shared her experience of first stumbling upon self-compassion accidentally. She described being outside for a walk and coming across an alcove of trees. It was being in the safety and peacefulness of the alcove, in the present moment, and without judgment, that helped her recognize self-compassion:

> When I was in the alcove, I just let myself be, and I was okay with being there. A lot of times I would feel really bad about myself but then when I was there I let myself feel okay with being. I have those moments or allowances and it's like going to a different plane of myself, rather than just the surface. I guess going into the depths of the person, myself, and being at peace with that person, that level; so comfort rather than avoidance, being afraid of what you'll find there but also actually liking it and reveling in it.

Part of participants' experiences of self-acceptance included acknowledging imperfections of the self and forgiving the self for these imperfections. For Emma, self-compassion involved openness to the human experience, including its limitations and mistakes:

> I have empathy for others and am open and welcome of the fact that the human experience includes limitations, making mistakes. I find that it's easy to put myself above others but I remember that I, too, will make errors and can learn

> from those things and that doesn't make me a bad person. So, it's really an active mindfulness.

For Alex, self-compassion involved forgiving herself for perceived mistakes:

> Self-compassion in some ways is like forgiving yourself. I tend to beat myself up a lot about mistakes or perceived mistakes and so at least being self-compassionate is saying, "It's okay that this happened, it's okay.'

Millie, who was sexually assaulted by a partner, shared a similar view:

> Self-compassion is about embracing yourself, not punishing yourself for things that may have happened or things that may still bug you about yourself. Self-compassion is kind of like The Serenity Prayer – "Give me strength to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

Gwen shared a unique stance on self-acceptance in her recognition that she may never be fully self-compassionate and, for her, that acknowledgment in itself is self-compassionate:

> It's very hard to get out of that [shame] and so I have just started to accept that it will probably always be my default. Probably the single most healing thing was getting to the point where I said to myself, "It's okay if shame is your default setting, that's cool, just be aware of it and do what you need to do." So I've stopped hating myself for always turning to the self-loathing and the self-criticism and I've realized that's just going to be part of who I am.

Absolving Oneself of Blame

Internalized self-blame was a common experience for participants post-assault.

For these women, being self-compassionate involved absolving themselves of blame for the sexual assault(s). Mandy described how she came to free herself from blame and personal responsibility after repeated sexual assaults by her partner:

> It took me a couple of years to process what had happened in our relationship and realize why I was so angry about it, why I felt so lost in general. I realize that's when I was able to name it; I realized what had actually happened. I had blocked from my memory the first instance; it happened while I was asleep. It was when I realized how it first happened that I could absolve myself in a way. I knew that he was guilty at that point.

Ellen shared how reducing her self-blame was an act of self-compassion:

> Self-compassion definitely made me feel like it wasn't my fault. It took me a long time, but eventually I stopped feeling like it was my fault. Recognizing this was important because of the pain I went through and the pain my family went through. And I felt like I had done that deliberately, that, it's pretty awful for me to do to my parents, and just recognizing that it was a shitty situation and there's nothing I could have changed. Just because I trusted someone doesn't mean he had the right to assault me.

Several participants, like Riley, described how self-talk helped resolve their struggles around self-blame:

> I beat myself up about it, but after everything was said and done and I started having to deal with the sexual assault, I started looking at it as it wasn't my fault. It was his choice; I couldn't have done anything different. When you're being

> self-compassionate, you're not constantly saying it was your fault. I said to myself, "It's not your fault, you couldn't do anything different."

Similarly, Dominique indicated how she was able to strengthen her inner voice to challenge the self-blame:

> The hardest part is that self-sabotage that creeps up in your mind and tells you the sexual assault was your fault. For you to actually believe and say to yourself, "No, it wasn't my fault – you can say what you want but I know and believe this is not right. The sexual assault is not my fault and no matter what you say in the back of my mind, it's not going to change that; talk away but it's not going to change that."

For Emma, releasing herself from blame was integral to her experience of self-compassion post-assault:

> Self-compassion was probably the biggest part of healing. For me, the struggles were internalized self-blame, reinforced of course by social structures and reinforced by what I like to call injustice systems and medical systems. That was a huge part of the self-blame and it was through self-compassion that I was able to, first of all, notice it, second of all, normalize it as a typical response to trauma, particularly interpersonal trauma, but not necessarily one that I needed to own, and then move past that.

Honouring Emotions

Self-compassion for participants in this study involved honouring, or placing a high level of importance, on their emotional experiences. These sexual assault survivors

spoke of the necessity of recognizing, paying attention to, and expressing their emotions, especially the difficult emotions surrounding the sexual assault.

For some participants, honouring their emotions involved responding to their needs in the moment. Mandy reflected on being in the alcove where she first discovered self-compassion:

> I would like to go there and just meditate or think or cry or whatever I needed to do at the time.

Alex also described instances of giving herself space to express emotion:

> Some days I get tired, really tired, sooooo tired. It's like my spirit is tired or my bones are tired and so some days I cry. It's like sobbing, weeping. I don't even know where it comes from, this upwelling of emotion, and sometimes I say, "I just want to feel tired today and I just want to feel bad."

For other participants, responding to their emotional needs in the moment was not always feasible. Riley shared how honouring her emotions involved a negotiation between recognizing her need to express emotion and finding the appropriate time and space to do so:

> If, for example I've had a flashback or a moment where I thought about something that made me upset, instead of bursting out in tears in the middle of the day for no apparent reason to outsiders, I try to control myself at the time and give myself that time to deal with it later. I say to myself, "Okay, after work I'm gonna take time and I'm gonna talk it out with my husband, deal with it after work, but right now, it needs to be in, it needs to go away for the time being." So, yes, you can't do it in the middle of a job interview or when you're at work but when you

> get home you can close the doors, nobody else has to know, and you can cry it out. You can scream, yell, and throw pillows against the wall if you need to, just to deal with whatever you need to deal with. It's a lot easier to figure out what you're going to do or how you're going to think after you've taken care of the emotions.

Nina, who was sexually assaulted by a friend, described a similar experience of setting aside time to process thoughts or emotions that were bothering her:

> If I have something that's bothering me I'll actually take the time out to think about it and work through it. I'll take half an hour out before I go to sleep and just think about it and get it all out there. I know I'm going to think about it eventually, it's gonna stay in my mind and pop up at the worst time. So I'd rather set aside a time and think about whatever problem is bothering me, think about ways to work through it.

Some participants, such as Emma, compassionately tended to her feelings through journal writing:

> Writing allows me to honour all feelings that I have and all experiences that I have and express them in a way that doesn't bottle them up.

Riley also reflected on journaling as a way to express emotion:

> Sometimes talking to yourself doesn't work. Sometimes you actually have to write it out and it helps to just let it go.

Physical exercise was also identified by some of the participants as a means of expressing emotions. Several participants mentioned their participation in yoga as a self-

compassionate practice. For Emma, exercise allowed her to release difficult emotions, which she considered to be part of her experience of self-compassion post-assault:

> Exercise allows me to experience and express emotions, such as anger. Emotional expression is a huge part of self-compassion for me because there is a part of me that wants to stuff or ignore emotions such as anger and sadness. Running and lifting weights allows me to intentionally bring into my body various emotions that need to be felt.

Taking Time for Self-Care

All women identified taking time for self-care as a way in which they were self-compassionate. Self-care involved a broad range of activities that included nourishing oneself physically, relaxing, and pampering oneself. Irrespective of the activity, self-care for all women involved taking time for oneself and putting oneself first.

For some participants, like Mandy, being self-compassionate involved taking care of herself physically:

> I was realizing that I kind of dehydrated myself most of my life and I've been a very ill person, not in very good health. For instance, when I was in graduate school and I was writing my papers I would be like, "Oh I have to finish this page before I can take a sip of water." It was almost like anorexia with water. And I think a lot of people don't drink enough water probably but I'm on this bandwagon now so I started drinking a glass every hour. I had to force myself because I didn't like to do it. Now it's become more natural and while I don't drink one every hour it's ingrained in me so that when I'm thirsty I go get a drink

> of water. So, I think that drinking water now is being more compassionate toward myself and it's respecting my body.

For Millie, taking care of herself also included a physical component:

> I have been overweight as long as I can remember. I got to the point where I realized I was killing myself slowly; diabetes and heart disease runs in my family. I've always been good at doing stuff for other people but not necessarily for myself so being self-compassionate involves taking care of myself more. I have been working out and trying to tackle my weight.

For many participants, self-care included claiming pockets of time for themselves despite the busyness and demands of daily life. Nina described the importance of making it a priority to spend time with herself:

> Taking more time out for me is really necessary, especially being a survivor. This involved anything to get my mind off of school, off of work, off of volunteering, family, anything to get my mind off of other things and onto myself. To me, that's my form of self-care. I took yoga, a lot of hot yoga, and it was very peaceful, it was really nice, something I did for myself.

For Riley, self-care involved being creative given the competing demands of caring for her young child. Riley described taking time for herself while having a bath:

> [While having a bath] I can lock the rest of the world out. I lock the door, turn on the fan, turn off the lights. I do my thing, whatever I want to do, and nobody can get in. It gives me time that I know I'm not going to get interrupted and I can just relax.

Ellen pointed out that taking time for oneself need not be complicated at all:

> It's really important to be able to spend time with yourself. I'm not the kind of person who spends three hours getting ready in the morning but I think it's definitely important to take time just for me even if it's just for my appearances or taking my dog for a walk.

For some participants, like Candace, caring for themselves involved going the extra step and indulging in pleasurable activities:

> Self-compassion involves doing things for myself such as getting a massage, pedicures, and doing other things I enjoy like going to a book club once a month.

For other participants, a small pocket of time throughout the day was insufficient and self-care involved a more substantial period of time. Gwen described such time as, "taking a break from life." These breaks from life ranged from a few hours to a few months. Gwen described one such break as being self-compassionate after she experienced reminders of the sexual assault:

> I was having this really weird series of nightmares about sexual assault and being sexually assaulted and they were really quite vivid and awful. So, instead of getting up and powering through the day I took the morning for self-care and re-watched The Daily Show. I got up and started my day a few hours late and for me that was self-compassionate because it was recognizing that I needed to nurture myself rather than following the pseudo-pop psychology of push on and pretend this never happened or there's something wrong with you if you have it still affect you. I find it's much better to just be nurturing so I took a morning off.

Alex also described taking time out from daily life following the sexual assault:

> I took a week off from life about a year ago. I gave myself a little island of time. I gave myself time to stop because at that point in my recovery I was very go-go-go. People would tell me to relax or take some time to myself but I just couldn't. I couldn't just sit and just do nothing when I have school to do. It was always just relentless so I gave myself a week of not having to deal with the world.

Connecting with Others

Participants in this study reported connecting with others to be a major component of self-compassion post-assault. Not only did participants consider opening up about the sexual assault to others as a form of self-compassion but all participants reported that connecting with others in general, and not isolating themselves, was integral to their experience of self-compassion.

Participants spoke of the importance of reaching out and accepting help from others, where "others" included family, friends, and counsellors. For Ellen, talking about the sexual assault and being able to ask for help was self-compassionate:

> I talked about it a lot with my family, the counsellor and with a couple of close friends. Just being able to open up to someone and recognizing that I needed help was self-compassionate. I know that a lot of people just shove it in a box and don't ever talk about it but I knew that it would help and it really did.

Alex also considered reaching out to others for support as being self-compassionate:

> It's self-compassionate to call people when I'm really upset or I need to talk...Telling myself to reach out and recognizing that sometimes I need to do that.

All participants attended counselling post-assault and some participants had continued involvement in counselling at the time of data collection. Severeal participants shared their experiences of participating in group therapy where both participants considered it self-compassionate to be vulnerable to a group of people who had the potential to help with their recovery. Mandy described how allowing herself to open up helped to release her from her fear of judgment by others:

> Even just telling them [the group members] about the sexual assaults, it was almost affirmed by a group then, by 10 people. So I think that helped me a lot because there was always the underlying worry that family members love me so they're going to understand and empathize but then everybody else in my life - What would they think? Wouldn't they think it was my fault? So being able to share in a group really helped, that's had quite a big impact.

Riley shared a similarly powerful experience of group therapy:

> They [the group members] taught me to do the things that I needed to do for me and not worry about other people. They were a big impact and that's when I started turning everything around.

All participants made a conscious choice to surround themselves with positive people who supported them in their healing and generally in their daily life. For Emma, "Self-compassion involves surrounding myself with healthy people who respect and support me." Similarly, Nina reflected on her choice to surround herself with supportive people:

> I have surrounded myself with positive people, people who I can trust, who understand my mentality, and know my personality enough to know when I need

> support or know when I need to be left alone. I have been surrounding myself with better people.

Candace noted that for her, staying connected with friends is self-compassionate:

> It is important to stay connected with friends and not isolate yourself. It is important to find people who have things in common with so you are able to be in touch with others and not feel alone.

For Gwen, much of her learning about self-compassion was modeled by others. Having been sexually assaulted throughout much of her childhood and then experiencing sexual assault in adulthood, self-loathing and shame were more common to her than self-love and kindness. Gwen described how self-compassion was facilitated by the compassion of other people who she came to trust:

> I had to get used to compassion when it didn't involve me being exploited because previous to that it was in the family; kind acts were always followed by an expectation. I didn't understand that kind acts could happen all on their own, without any exploitation. It took years of me living with my adopted dad and having him be such a win of a dad and there was never expectation, I was never exploited, and I was always safe. This [self-compassion] was a new way of being for me and I had to experience compassion first from someone else before I could start doing it myself. It took three years of my adopted dad training me on compassion and then I was able to start being gentle and kind to myself. I wouldn't have been able to do it if I didn't have him to model that for me.

She went on to say:

> If you can surround yourself, or at least have a few key people who are treating you very compassionately then it's very hard to berate yourself all the time…those people keep me in check.

Claiming Power

A sense of powerlessness over themselves and within the world was a common reaction among participants during and after the sexual assault(s). Participants in this study reported acknowledging and embracing their inner strength as ways in which they were self-compassionate post-assault.

Several participants recalled reaching a point where they refused to be defined by the assault(s) any longer. Self-compassion for these participants involved taking control of their healing and their lives in general. For Dominique, this involved a sense of "fighting back":

> I had lived my life according to "this [the sexual assault] is what happened to me and everything I do is because of that." All my insecurities are because I was raped. My lack of self control was because I didn't deal with the assault. So, I always went back to that and related my bad behaviour or poor choices to the assault. I have realized that the sexual assault happened, but it doesn't define who I am. I'm not defined anymore as a situation. It's an empowerment of "I'm fighting back. This isn't going to control me. This isn't going to control my life. I can have the power that was taken. I can have it back."

Ellen shared a similar experience of reclaiming her personal power:

> I thought, "This is ridiculous. He's already ruined the last six months of my life. I'm miserable and why would I let him do this to me? He already has so much

> power over me." I think self-compassion involves recognizing that you need to take the power back in your life.

For Alex, it was important to identify that the sexual assault now has less influence on her life and that treating herself with compassion has been strengthening:

> When I'm being self-compassionate it gives me little pockets of time when I don't feel oppressed by the sexual assault or it doesn't have as much weight. Self-compassion gives me relief from it so that later on I can go back to it…Not to be melodramatic but the world isn't over. I'm not always going to feel horrible so I guess the better you get at being self-compassionate the less you feel like you are drowning.

For several participants, embracing their inner strength included recognition of their ability to influence change within society. These women shared a commitment to stand up to oppressive societal norms and to advocate for the rights of others. For Mandy, healing from the sexual assault included educating herself about her body and sex. She described periods of rebelliousness, which to her symbolized her anger and desire to fight back. Outwardly, this translated to her shaving her head, wearing baggy clothes, and attaching herself to feminist theory in university; each of which she described as being self-compassionate. Mandy reflected on her choice to free herself from being oppressed as a female in society:

> I recognized how hair is one of the sexual components of a woman through the gaze of a man and I was also interested in bending gender. The sexual assault made me question my sexuality more concretely than before and I was starting to see gender as more fluid. Being of ambivalent gender appealed because it

> provided me safety from the male gaze, like how I started wearing baggy clothes and shaved my head. Theoretically I don't agree with hiding who I am but it gave me some freedom from being an object.

Mandy described how powerful it was to re-conceptualize her notion of romantic relationships:

> Realizing that I didn't only have to be wedded to men in my life was huge for me. It was powerful to realize that men wouldn't always have power over me and that I wasn't stuck with them, especially since past relationships with men were not good for me. This realization was self-compassionate and another really big part of self-compassion for me is that I have gotten to the point where I can be in a romantic relationship and with a man.

For Emma, self-compassion involved standing up for her own rights as well as the rights of others:

> I identify as a feminist and I participate in a wide range of activist activities. By participating in everything from Take Back the Night to other feminist activities, I'm surrounding myself with individuals who are supportive and non-judgmental and fighting things like violence against women.

Gwen also shared her passion for advocacy in the context of self-compassion:

> Self-compassion allows me to become more of an activist, more of an ally, and much more involved in feminist politics. Without self-compassion, I wouldn't have been able to do all of this. I wouldn't have been able to do this interview, all the things that I do in terms of community organizing, or even just the courageous conversations that you have when someone tells a rape joke and you explain why

> that's not okay. Without self-compassion, it would just be too traumatizing. So, I think self-compassion gives you a little bit of armour.

Recognizing Progress

Recognizing the progress made towards improving their well-being since the sexual assault(s) was a key component of participants' experience of being self-compassionate. Participants identified their ability to reflect on positive changes in their lives as an act of self-compassion and acknowledged how self-compassion positively contributed to their well-being.

For Nina, life was very tumultuous following the sexual assault. She found herself relying on alcohol and prescription medication to cope. Her experience of self-compassion included acknowledging improvements she made in her life since the assault:

> I work out more often. I stopped drinking completely. I don't take any medication unless I am deathly ill and absolutely have to. I have stayed away from romantic relationships and I have gotten my priorities straight. I'm a stronger person for the sexual assault. I am dealing with my problems a lot better. If I can't work through problems on my own then I'll find somebody to help me. I'm not afraid of getting help at this point.

Dominique described feeling victorious at this point in her healing:

> I'm done. I won. I thrived. It's an achievement. I've dealt with the sexual assault and it's always going to be there but now it's about how I can make my life more positive. Is there somebody I can help? And working on myself, right? Because you're always going to do that the rest of your life and I am important.

For other participants, like Mandy, the experience of self-compassion was itself inextricable from their growth and progress. Mandy reflected on her progress but also attributed her ability to engage in self-reflection to self-compassion:

> When I look back to almost a year ago, I can see the progress that I have made. Looking at it from week to week it doesn't feel like anything major but I have made a ton of progress. Being self-compassionate allows me to reflect on myself, to better understand myself so that I can better care for myself and love myself.

Similarly, Gwen reflected on how far she has come since the last sexual assault and the role self-compassion had in her healing:

> When I think back to being 18, which was the last time I was sexually assaulted, I think my heart and my spirit were just a gigantic open wound and it made everything in life much harder to cope with because I just had this open wound and was very unprotected. Thinking about the assaults themselves I was so hurt and had so much pain that it was overwhelming. I think self-compassion actually helps build up some scar tissue so that when I can go back and think about them now at least I can talk about it. I can access some resources about it now because it's not this all-consuming, open and gaping wound.

Ellen expressed gratitude towards the positive changes in her life since the sexual assault and the role of self-compassion in these changes:

> I wouldn't be here today if I hadn't been compassionate to myself. I feel you are wasting your day if you are not going to be nice to yourself at all or give yourself a little kindness. I recognize that I feel much differently about myself than I did

> five years ago. I don't really think about the sexual assault that much anymore. I'm definitely a lot more confident.

Other participants, like Emma, reflected on their increased competence to cope with the experience of sexual assault and in managing the stressors of daily life:

> Self-compassion has become the biggest buffer I know against stress. A bomb can go off and there's a centered piece within me that I can deal with. This centre of peace is undisturbed by external events. I feel grounded and connected and while I may feel flustered at times, the core of myself is grounded. The rest is just small stuff.

CHAPTER 5

DISCUSSION

The purpose of the present study was to gain an in-depth understanding of the experience of self-compassion for women who were sexually assaulted in adulthood. While research in the area of self-compassion has grown exponentially within the past decade, few studies have examined self-compassion in relation to traumatic events and no known study has explored self-compassion specific to survivors of sexual assault. It was my hope that the present study would add to the existing knowledge in the area of self-compassion and trauma and provide foundational knowledge of the experience of self-compassion as it relates exclusively to survivors of sexual assault.

This study centered on 10 adult females who disclosed the experience of sexual assault in adulthood. Their individual accounts of self-compassion were compared and contrasted through the analysis of semi-structured interviews using Interpretative Phenomenological Analysis (IPA). Each woman's experience of self-compassion was undoubtedly individualistic; however, similarities in experiences of self-compassion emerged among participants. The present section includes a discussion of the key findings in relation to existent theory, clinical implications of the findings, methodological implications, and suggestions for future research.

Discussion of Key Findings

The main research question of this study asked, "How do female survivors of sexual assault in adulthood experience self-compassion?" For participants of this study, eight major themes emerged, with each theme capturing the experiences of at least half of all participants. The themes were: (a) affirming self-worth; (b) accepting one-self; (c)

absolving oneself of blame; (d) honouring emotions; (e) taking time for self-care; (f) connecting with others; (g) claiming power; and (h) recognizing progress.

Although not the primary focus of the present study, participants described the deleterious psychological consequences of sexual assault. Similar to the findings of other studies examining the psychological sequelae of sexual assault (e.g., Amstadter & Vernon, 2008; Olatunji et al., 2008; Petrak et al., 1997), these participants experienced diminished self-worth, self-loathing, shame, and self-blame, among other distressing feelings and cognitions. Given their reported high levels of self-criticism, it was not surprising to learn that the participants were not immediately self-compassionate following sexual assault. This is consistent with existent literature examining the relationship between self-compassion and trauma (e.g., Beaumont et al., 2012; Gilbert 2009; Thompson & Waltz, 2008), which suggests that posttraumatic stress symptomology is not conducive to a healthy way of relating to the self.

Participants shared how their sense of personal worth was challenged post-assault. The negative impact that trauma can have on one's schemas, cognitive worldviews, and attributions has been extensively studied in the literature, as has the process of repairing maladaptive ways of relating to the self and the world following trauma. Janoff-Bulman (1989) delineated three basic assumptions about the world and the self, including perceived benevolence of the world, meaningfulness of the world, and worthiness of the self. Following trauma, these basic assumptions become dissonant; they no longer make sense in the context of sexual assault. As Littleton and Grills-Taquechel (2011) explained, the experience of sexual assault challenges one's existent schemas, as it involves a serious violation of one's personal integrity and trust in the world. Victims are

faced with a cognitive dilemma, somehow needing to integrate their horrific experience with their prior assumptions.

When participants in the present study allowed self-compassion to enter their inner worlds, they moved towards more adaptive ways of relating to the self. In fact, self-compassion affirmed participants' self-worth. Affirming self-worth for participants in this study involved a multitude of processes. Participants shared how they asserted their worth through self-affirming statements, such as "I am important" or "I am enough." Neff (2003b, 2011) differentiated between self-esteem, or self-worth, and self-compassion. Although they are similar constructs, with both facilitating positive feelings towards the self and an inter-correlation ranging from 0.57-0.59 (Neff, 2003b), Neff argued that self-compassion is more stable and has more benefits and less risk than self-esteem, noting that there is increasing concern regarding the relationship between high self-esteem and narcissism (Neff, 2011). Neff does not denounce self-esteem entirely, however, noting that adaptive forms of self-esteem also exist. The affirmations of self-worth among participants in the present study appear to be of the healthy and non-narcissistic form. Rather than perceiving themselves as having worth that is superior to others, participants' affirmations of worth instead assisted them with rising from very low self-worth following sexual assault towards an equanimity, or balance, whereby these women feel equal to, rather than inferior or superior, to others. Participants described using how they would personally treat another person in a similar situation as a frame of reference for how they could treat themselves. Essentially, enhancing their self-worth involved seeing themselves as humans and, like everyone else, deserving of compassion. This is consistent with Neff's (2003a) conceptualization of self-compassion consisting, in

part, of a sense of common humanity. Participants' experiences of bolstering perceptions of the self can be likened to the concept of "rebuilding," which has been used in reference to repairing the shattered self and assumptions after a difficult or shame-eliciting event (e.g., Janoff-Bulman, 1989; Van Vliet, 2008). For some participants, this rebuilding of their assumptive worlds was a sort of restoration process, a re-establishment of their worth pre-assault. For other participants, this process operated at a grassroots level because there was little foundation of self-worth on which to build. Irrespective of their self-perceptions prior to the assault, moving towards improving self-perception post-assault involved recognizing their worth in the world, including their deservingness of self-compassion.

Not only did the experience of self-compassion include an enhancement in their sense of self, self-compassion for the women in this study also included an embracing, or welcoming of the self. In her conceptualization of self-compassion, Neff (2003a) noted that self-acceptance is at the heart of the experience. It is therefore not surprising that the experience of self-compassion for survivors of sexual assault in this study included an acceptance of oneself as a whole person, recognizing one's strengths and limitations and forgiving oneself for imperfections. Consistent with Neff (2003a), self-acceptance involved recognizing that the very nature of being human comes with feeling inadequate and flawed at times. Participants described self-compassion as being open to the human experience, being at peace with who they are as individuals, and appreciating themselves. One participant shared how coming to accept that she may never be fully self-compassionate was in itself an act of self-compassion. In consideration of the self-criticism and self-hatred that often plagues victims following an atrocity such as sexual

assault, this embracing of the self can be considered a stark contrast to participants' post-assault painful ways of self-relating.

Similar to the first two themes that involve achieving a more balanced perspective of the self, the third theme captured the self-compassionate adjustment in attributions of blame. The experience of self-blame for sexual assault survivors cannot be understood apart from a social context. Still today, there continues to be a societal propensity to fault victims of sexual assault, to search for characteristics in victims that can be presumed to have contributed to their own victimization (Herman, 1997; Worell & Remer, 2003). Koss, Goodman, Browne, Fitzgerald, Keita, and Russo (1994) asserted that societal beliefs perpetuate sexual assault and contribute to victim-blaming. Rape myths, or generally false beliefs about sexual assault, are pervasive within society. Such myths include the indication that the sexual assault was a trivial event, that the woman fabricated the assault, that the woman asked for or wanted the assault, and that the perpetrator did not intend to assault the woman (Koss et al., 1994). Given the myths and inaccurate messages perpetrated by society about sexual assault, it makes sense that survivors would struggle to arrive at an unbiased and reasonable assessment of their behaviour during the assault. Ullman (1997) proposed that self-blame is a way to make sense of the sexual assault, as one locates the explanation for the assault within oneself. Blaming the self is a way in which incongruent data (i.e., the sexual assault) can become assimilated. Janoff-Bulman (1979) proposed two types of self-blame attributions: characterological self-blame and behavioural self-blame. In characterological self-blame, victims blame their personal character for the assault (e.g., The sexual assault happened because I am an awful person). In behavioural self-blame, victims blame their actions for

the victimization (e.g., I did something to cause the sexual assault). Such self-directed attributions fuel the loathing and contempt experienced by survivors of sexual assault, all the while maintaining activation of the threat and self-protection system as described by Gilbert (2009). In her study exploring the role of attributions in the process of overcoming shame, Van Vliet (2009) found that participants were able to reduce self-blame by identifying external factors that explained why the event occurred. For participants in the present study, it was considered self-compassionate to recognize that no action on their part, in any way, excused the perpetrator of responsibility for their victimization.

Like beliefs or perceptions about the self, emotions are considered to be a central component of the self's configuration (Jopling, 2000). For the participants in the present study, negative emotional arousal was predominant in their lives following sexual assault. Participants identified being consumed by these negative emotions, a process known as over-identification (Neff, 2003a). Neff described over-identification as an immersion in one's emotional reactions that leaves an individual unable to see the experience in a balanced way. In the case of survivors of traumatic events such as sexual assault, it can be said that the emotional pain, including fear and shame, can be so intense that survivors feel ill-equipped to manage such emotions (Jaycox, Zoellner, & Foa, 2002) and may reject or avoid these difficult feelings. Such over-identification has the capacity to undermine functioning, with individuals experiencing difficulty with emotion regulation (Thompson, 1994). In contrast to over-identification, self-compassion, as described by Neff, involves being moved by and open to one's own suffering, not avoiding or disconnecting from painful feelings, and offering nonjudgmental understanding to one's

pain. In a similar vein, participants in this study were seen to compassionately honour their emotions in tending to their emotional needs with understanding and validation. Participants described engaging in behaviours that enabled them to respect and express such emotion in helpful ways. This involved noticing when emotion needed to be expressed, finding appropriate time and space to express emotion, as well as finding a means of expressing emotion tailored to individual preferences. For several participants, this involved expressing emotion as it arose, in the moment, and allowing whatever emotion that needed to be felt to surface. Some participants described noticing emotional arousal but recognizing that the time or place (e.g., at work) was not conducive to the expression of emotion, and they would comfort themselves by promising time after work to express the emotion. Other participants described finding appropriate outlets for emotional expression such as journal writing or vigorous exercise. Essentially, participants identified emotional regulation and tolerance as part of their experience of self-compassion after sexual assault. Participants gained control of their experience and expression of emotions, which has been identified as the goal of emotional regulation (Gross, 1998; Linehan, 1993). They learned to tolerate, or stay with their emotions as they happened, a process that has been noted by Gilbert (2009) as being linked but not equivalent to acceptance. In giving their emotions space and not avoiding them, particularly the difficult emotions surrounding their experiences of sexual assault, participants can be said to have developed compassion for their feelings in recognizing that what they are feeling in the context of sexual assault is understandable.

Within the first four themes, participants' experiences of self-compassion included engagement in cognitive and emotional processes that moved them towards

creating a more accurate and balanced perspective of the self and an inner sense of well-being. These experiences of self-compassion are reminiscent of the practice of mindfulness, which has been identified as one of the three main components of self-compassion according to Neff (2003a). Mindfulness, according to Kabat-Zinn (2003) is "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (p. 145-146). Siegel (2007) described mindful awareness as a form of "intrapersonal attunement" that provides one with the capacity to reflect on processes of the mind; enabling a person to regulate emotions, improve patterns of thinking, and make adaptive choices. Siegel noted that mindfulness involves discernment, a process that can be contrasted to the concept of over-identification as described by Neff (2003a), whereby the mind's activities do not define the person. This discernment can also be likened to the concept of self-as-context in Acceptance and Commitment Therapy whereby clients learn to observe their thoughts, feelings, and experiences, rather than evaluate or place judgment (Hayes, Luoma, Bond, Masuda, & Lillis, 2005; Neff & Tirch, 2013). Participants in the present study considered it self-compassionate to no longer define themselves by the sexual assault or by their post-assault experiences of self-criticism, worthlessness, and shame. It was evident in the present study that bringing awareness to their automatic negative thoughts and feelings helped participants to facilitate a more compassionate stance towards the self.

Self-compassion for the women in this study operated on a holistic level. Not only did their experiences take the form of compassionate thinking and feeling, but the women also described self-compassion on a behavioural level. Gilbert (2009) identified compassionate behaviour as acting in ways that will alleviate suffering and assist one

with moving forward. Compassionate behaviour can be likened to self-care, a concept that first emerged through the field of nursing in the 1950s (Denyes, Orem, & Bekel, 2001). Self-care, defined as self- or environment-directed behaviours aimed at regulating and improving one's functioning (Gast, Denyes, Campbell, Hartweg, Schott-Baer, & Isenberg, 1989), is differentiated from self-care agency, which is a person's capacity to engage in self-care (Gast et al., 1989). Following the experience of sexual assault, participants considered themselves unworthy or undeserving of self-compassion or even compassion from others. Their post-assault experiences of self-loathing and self-criticism contributed to a diminished capacity for self-care. As participants came to see themselves as worthwhile persons, deserving of care and attention, their capacity for self-care was enhanced and their repertoire of skills for self-care increased. Participants described being mindful of and tending to their physical needs in a kind and caring manner. For some participants, it was self-compassionate to care for the self even at the most basic level, which included physically taking care of the body in the form of nutrition or exercise. For other participants, self-care included carving out a regular period of time to be alone, free from the distractions of daily life. Still other participants identified indulging in pampering as a way of being self-compassionate. Within this theme, participants can be considered to be engaging in the care-giving and care-eliciting social mentalities as described by Gilbert (2009); but, instead of in relation to others, they occurred in relation to the self.

Participants' experiences of self-compassion extended outside of the self and into their relationships with others. All participants identified connecting with others as contributing to their experience of self-compassion post-assault, where "others" included

family and friends, counsellors, and other survivors. In disclosing the sexual assault to supportive others, participants learned that they could still be accepted and be seen as worthy in the eyes of another despite their victimization. Connecting with other survivors was particularly helpful for participants as it normalized their own experiences of and reactions to sexual assault. Through their connection with others, participants were able to deconstruct societal messages about women, sexuality, and sexual assault. Hearing other survivors share their experiences enabled the participants in this study to see the assault from another perspective; that one was violated and taken advantage of, rather than a contributor to the assault.

Examining the deleterious effects that sexual assault can have on relationships sheds light on how participants came to view connecting with others as contributing to their experience of self-compassion. Not only does sexual assault damage survivors' perceptions of self-worth, it also challenges survivors' perceived worth in relationships, including their ability to trust in and be vulnerable in relationship with others. Herman (1997) noted, "Traumatic events destroy the belief that one can be oneself in relations to others" (p. 53). Negative appraisals about the goodness of others or fairness and safety of the world become prevalent following traumatic events (Frazier, Conlon, & Glasser, 2001; Janoff-Bulman, 1989). Survivors question how they are viewed by others, resulting in a perceived threat to social standing (Gilbert, 2009). It is therefore not surprising that traumatic events and associated shame promote isolation (Troop & Hiskey, 2013; Van Vliet, 2008). In fact, Jobson and O'Kerney (2009) found that alienation following trauma was cross-cultural, spanning across individualistic and collectivist cultures.

Neff (2003a) noted that in seeing one's experiences with greater balance and clarity, it becomes easier to react to one's own suffering in a compassionate manner. It was through such connecting with others that participants were able to rebuild positive views of the self. Van Vliet (2008) identified "connecting" as one subprocess in her theory of recovery from shame events. She proposed that the movement away from alienation of the self towards improved connection with supportive others results in a greater acceptance of the self. In light of Gilbert's (2009) theory on social mentality and his three-part system of affect regulation, it can be proposed that when these survivors experience non-judgment and acceptance from supportive others, they gradually become less fearful of a loss of social standing as a result of their victimization. In their connection with caring others, participants can be said to be engaging their care-eliciting and care-receiving social mentalities, which in turn activates their own soothing and contentment system, making more space for self-compassion as activation of the threat and self-protection system is reduced. For many participants in the present study, it was necessary to experience compassion from others before being able to be compassionate toward the self.

Disempowerment is avowedly at the core of sexual assault and, for participants of this study, sexual assault and its ensuing psychological sequelae became an enemy worth fighting. The very nature of sexual assault renders its victims as helpless and violates "the autonomy of the person at a level of basic bodily integrity" (Herman, 1997, p. 52). Survivors feel little control and their attempts to regain control, as previously discussed, often lie within causal attributions about the assault, usually involving some level of self-blame. The literature on PTSD (e.g., Rothbaum & Foa, 1996) affirms that survivors of

traumatic events often feel incompetent and powerless to manage their symptoms. Self-compassion for the survivors of sexual assault in the present study included a claiming of their personal power whereby participants identified acknowledging and embracing their inner strength as being central to this theme. For some participants this included making a choice to no longer allow oneself to be defined by the sexual assault (e.g., not viewing themselves and their lives solely through the lens of victimization). For other participants, this involved recognizing their ability to influence change in society and subsequently standing up to oppressive societal norms and advocating for the rights of others (e.g., confronting rape jokes, participating in anti-violence events such as Take Back the Night). Participants' self-compassionate experiences of claiming a sense of personal power neatly aligns with Zimmerman's (2000) theory of psychological empowerment. According to his theory, there are three components to psychological empowerment. The first component is intrapersonal, or within the individual, and addresses one's perceived sense of control, competence, and motivation. The second component is interactional and involves developing a critical awareness and understanding of one's socio-political environment. The third component is behavioural and involves taking action within one's environment at the level of community organization and advocacy.

The literature on self-compassion is seemingly devoid of any mention of empowerment. One could argue, however, that Gilbert's (2009) recurrent use of the word "courage" in the context of allowing self-compassion into one's life is a similar construct. Gilbert (2009) noted that to be self-compassionate is to be courageous in confronting important life issues, to "face up to and work on psychological difficulties that we recognize are holding us back" (p. 364). In a similar vein, participants identified how

recognizing and acting on their inner strength enabled them stand up to the harmful effects of sexual assault and no longer define themselves by their victimization. Participants' experiences of empowerment can be said to fit squarely within the incentive and resource seeking system as defined by Gilbert (2009), which is designed to provide positive feelings (through the release of dopamine) that serve to motivate and energize. This system is stimulated when one wins something or is successful; it thrives on achievements and pushes one towards growth. Participants in the present study described their claiming of power as victorious and the shedding of defining themselves by the sexual assault as an achievement. Connecting with their inner strength served to motivate them towards progress and enhance their psychological well-being. For these participants, their self-compassionate experience of empowerment assisted with bringing balance to the accentuated loss of power that came with being sexually assaulted.

Empowerment is a key construct in feminist theory and practice. From a feminist perspective, sexual assault cannot be solved in isolation from the institutionalized politics of the larger societal structures and, in feminist-oriented therapies, women are encouraged to identify and challenge the external conditions of their lives that devalue and subordinate them as women (Worell & Remer, 2003). Claiming their power enabled the participants in this study to exert influence over the personal, interpersonal, and institutional factors that were impacting their psychological well-being. Reestablishing a sense of power and control within oneself and developing a critical awareness of the power imbalance that exists within society helped survivors to perceive the sexual assault in terms of a larger social context. It also brought clarity to their own ability to influence change within themselves and society as a whole.

It has been said that empowerment goes beyond improving the negative aspects of a situation by searching for those aspects that are positive (Cohen, 2000). For these survivors of sexual assault, the experience of self-compassion involved just that -- a recognition, or acknowledgment, of the positive changes that have occurred in their lives since the sexual assault. Participants identified the following ways in which their lives improved since the sexual assault: Being kinder to themselves (through increased self-acceptance and improved perception of self-worth), having increased empathy for their own experiences, providing better self-care, increasing self-confidence, and turning away from a reliance on maladaptive coping behaviours. According to the broaden-and-build theory of positive emotions, attaching positive meaning to a difficult experience can trigger positive emotion, which in turn has the capacity to build psychological resilience and emotional well-being (Fredrickson, 2001). Participants identified self-compassion as focusing on and celebrating the positive aspects of their lives, rather than continuing to dwell on the negative aspects of sexual assault and its psychological consequences.

While the literature on sexual assault predominantly addresses the negative impact of trauma, studies reporting on the positive changes following traumatic events have emerged within the past decade. The experiences of self-compassion for participants in the present study are reminiscent of an emerging concept in the trauma literature known as posttraumatic growth, which refers to the notion that an individual can psychologically grow or change for the better following a traumatic event, such as sexual assault (Grubagh & Resick, 2007; Linley & Joseph, 2004). The earliest research on posttraumatic growth and sexual assault was conducted by Veronen and Kilpatrick (1983) who developed four models by which rape could lead to positive life changes.

Since that time, several other studies have emerged that focus exclusively on survivors of sexual assault. Frazier and colleagues (2001) examined post-traumatic growth among sexual assault survivors at four points in time and proposed that those who grow following a trauma experience change in three main areas: changes in one's sense of self, changes in relationships, and changes in spirituality and life philosophy. A study that examined posttraumatic growth in a sample of 100 treatment-seeking female physical and sexual assault victims found that 45% of survivors experienced at least a moderate level of growth post-assault (Grubaugh & Resick, 2007). In a more recent study, 74% of survivors of sexual assault reported at least some perceived growth following the assault and 18% reported a considerable amount of perceived growth (Cole & Lynn, 2010). As reflected in the eight emergent themes of the present study, it can be suggested that all participants experienced growth post-trauma. Growth for these participants was embedded within their experiences of self-compassion as they described positive changes within themselves, including an improved sense of self, a rebuilding of trusting connections with others, a redefining of their lives as worth living, and a freeing from the sense of entrapment engendered in their lives by the sexual assault.

Clinical Implications

While the purpose of qualitative research is not to make generalizations, the findings of qualitative studies may be transferrable to other contexts. Grounded within the findings of the present study are therapeutic implications for engaging in psychological treatment with survivors of sexual assault.

All participants in the present study attended counselling following their experience of sexual assault and alluded to therapy as being integral to their recovery and

experience of self-compassion. Participants identified being consumed with negative emotional arousal post-assault and considered it self-compassionate to engage in ways that enabled them to respect and express their emotions. While there are a multitude of treatment modalities available for survivors of sexual assault, two CBT approaches have been well-supported in the literature in their ability to help clients approach (rather than avoid) traumatic memories and associated emotions. Both Cognitive Processing Therapy and Prolonged Exposure are designed to assist clients with emotional tolerance and regulation (Foa, Steketee, & Rothbaum, 1989; Resick & Schnicke, 1992), which was identified by participants in the present study as central to their experience of honouring their emotions. Although compassion-focused therapy (CFT) has not been demonstrated to provide effective treatment for PTSD on its own given a dearth of research on the topic, the existent research suggests that higher self-compassion is associated with a greater willingness to engage difficult thoughts and emotions and a lower need to avoid painful experiences (Leary et al., 2007; Thompson & Waltz, 2008). In CFT, clients learn healthier ways of relating to the self, such as developing the capacity for self-soothing, which in addition to the benefits of the CBT treatments noted above, can assist with sustainability of progress during and post-treatment. It can be suggested that CFT is well-suited to be used in conjunction with the effective treatments already being put into practice for survivors of sexual assault.

Participants in the present study were at differing stages in recovery from sexual assault and identified varying experiences of self-compassion. For some participants, self-compassion was already well-engrained into their way of relating to the self. For other participants, self-compassion was a relatively new concept and was difficult to put

into practice and articulate. Treatment for clients who are familiar with self-compassion may look very different than with clients for whom self-compassion is a foreign concept. It is therefore recommended that therapists assess a client's level of self-compassion near the beginning of treatment and then follow-up with assessments at regular intervals to track change and provide further direction for treatment. The use of psychometric measures to assess and track changes in traumatic stress, depression, and anxiety, among other symptomology, is a common practice among psychologists when working with survivors of traumatic events. Just as measures such as the Trauma Symptom Inventory (Second Edition; Briere, 1995) can inform treatment from a trauma symptom perspective, so can treatment be informed from a self-compassion perspective. To assess levels of self-compassion, Neff (2003b) developed a self-report questionnaire called the Self-Compassion Scale. The Self-Compassion Scale provides an overall rating of self-compassion for the individual being assessed, as well as a breakdown of scores in accordance with the three main components of self-compassion and their opposites as identified and extensively studied by Neff: Self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. The long and short versions of this questionnaire offer flexibility for use within a therapeutic setting and the breakdown of scores provide specific information on areas that can be targeted within treatment. Aside from providing direction for treatment, a further benefit to ongoing assessment is suggested by the findings of the present study. Participants identified that being able to recognize any progress towards improving their psychological well-being was a key component to their experience of self-compassion post-assault. Having participants

complete a measure of self-compassion at regular intervals over the course of treatment can serve to further reinforce such progress.

For the survivors of sexual assault in the present study, self-blame was a common experience post-assault, with self-compassion proving to be a helpful antidote to self-blame. Given the destructive nature of self-blame, as well as its high rate of occurrence among survivors of sexual assault, it is imperative that therapists assess for self-blame. When self-blame is evident, it will be important for therapists to help clients understand its origins and purposes. Based on the present study's findings on how self-compassion alleviated participants' self-blame, there may be some therapeutic benefit for the implementation of self-compassion as a remedy for self-blame. At the very beginning of treatment using a CFT approach, there is a focus on helping clients to see the origins and/or functions of their self-attacking behaviours (e.g., self-criticism, self-blame). This is not dissimilar to the approach taken in PE or CPT whereby one session is spent exploring the purpose of and normalizing traumatic stress symptoms. The difference with CFT, however, is the intention of fostering compassion within the client for her symptoms, seeing the symptoms as automatic safety strategies or behaviours (Gilbert & Procter, 2006). Helping clients to understand their self-attacking symptoms through the provision of psychoeducation on the threat and protection system is an essential foundational step in CFT. Assisting clients with understanding their attempts to make sense of their victimization is also necessary and can be achieved through an exploration of clients' causal attributions regarding the assault, as well as examining the external and societal factors that contributed to the sexual assault.

With participants' self-identified high levels of self-criticism, self-blame, and self-loathing, the act of treating themselves with compassion was, at times, unfathomable. When engaging in treatment with survivors of sexual assault, it is important for therapists to be aware that clients in the early throes of trauma may have difficulty conceptualizing self-compassion (Gilbert & Procter, 2006). Patience and persistence on the part of the therapist is encouraged. Therapists can be intentional in gently pointing out the harsh self-directed language used by clients, in an effort to assist with bringing the client's self-criticism into conscious awareness. Being intentional in using compassionate language throughout session can start the process of clients thinking about the possibility of being self-compassionate or that they are worthy of self-compassion. Words or phrases such as self-kindness, self-care, being gentle with oneself, or having patience with oneself, all have a supportive and encouraging tone and were used by participants in the present study. As indicated by Gilbert (2009), the essence of self-compassion involves soothing the self during moments of suffering and doing what is necessary to help oneself. To help stimulate clients' soothing and contentment system as it relates to this meeting of needs within clients, therapists can ask, "What do you need right now?" Perhaps the least threatening way into self-compassion is encouraging a survivor to engage in self-care, which can be as simple as nourishing one's body if the client has not been eating well. It could involve taking a small amount of time out of her day to do something that she finds enjoyable, such as playing with her pet or taking a relaxing bath, both identified as compassionate activities by participants in the present study. Or, it can involve an activity that she once found pleasurable but perhaps has not engaged in since the sexual assault,

such as having lunch with a close friend. When clients engage in enjoyable activities, they will likely experience positive feelings about themselves and the world around them.

Participants identified moving away from harsh judgment and self-criticism post-assault towards a stance of self-acceptance as being critical to their experience of self-compassion. As survivors of sexual assault may be especially sensitive to judgment from others, therapists should approach every session with a nonjudgmental openness and acceptance of their clients' experiences. In this sense, therapists can model acceptance, and ultimately compassion, through the therapeutic relationship. It can be argued that compassion for clients is inherent to any therapist-client relationship and holds particular resonance with Carl Rogers' (1961) concept of unconditional positive regard. While compassion among therapists towards clients is often intuitive, it is recommended that compassion be deliberate and intentional when working with survivors of sexual assault. Therapists are often survivors' first point of disclosure following sexual assault, when the psychological symptoms become too distressing and they feel no longer able to cope. It is important for therapists to be mindful of their verbal and nonverbal reactions to survivors' stories, working to ensure that their first disclosure of sexual assault is one that is supportive.

Surrounding themselves with supportive others was identified by participants in this study as contributing to their experience of self-compassion, whereby supportive others included family, friends, counsellors and other survivors. Knowing that there are others who have been sexually assaulted, hearing their stories, and recognizing that they are not alone in their difficult thoughts and feelings was a validating experience for participants in this study. Given that social support and connection was such an important

aspect of self-compassion post-assault, counsellors should encourage clients to make contact with other persons who can have a positive influence in their lives. One way of fostering such connection is through group counselling, which presented as a very powerful experience for several participants in the present study. Group therapy served to bring greater clarity to participants' victimization, helping them to see that they are not to blame for the assault. As Herman (1997) noted, groups serve as "collective empowerment" where "the group requisitions and nurtures the strengths of each of its members" (p. 216).

Participants identified learning how to tolerate difficult emotions as contributing to their experience of self-compassion; thus, assisting clients with developing emotional tolerance may be another way in which therapists can help to foster self-compassion. If clients are participating in CPT or PE, emotional tolerance and regulation will be achieved through treatment; clients will learn that they have the competence to cope with distressing experiences. Maintaining the gains of treatment can be facilitated through the development of compassion for one's emotional experiences. Therapists can assist clients with learning to be open and accepting of their emotional experiences, which participants in the present study identified as being self-compassionate. One way in which this can be achieved is through teaching mindfulness to clients; a practice that has been described as cultivating awareness of the present moment, where experiences are sensed directly, accepted for what they are without judgment, and acknowledged with kindness and respect (Kabat-Zinn, 2003; Siegel, 2007). In its very practice, mindfulness is an accepting and compassionate way of relating to the self; it promotes an inner sense of well-being and increases a person's capacity for rewarding relationships with others (Siegel, 2007).

Although derived from the Buddhist tradition, mindfulness skills have been effectively taught outside of religious practice or group memberships (Siegel, 2007) and are becoming increasingly common in psychological treatment as evidenced by its practice in well-developed therapies such as mindfulness-based stress reduction, mindfulness-based cognitive therapy, acceptance and commitment therapy, and more recently compassion-focused therapy. In addition to teaching mindfulness, therapists can assist clients with finding adaptive ways of honouring and expressing their emotions, whether it is through talking with others, overt expression such as crying, or behaviours such as vigorous exercise or journaling, all of which were identified by participants in the present study as being helpful.

There are a multitude of therapeutic interventions that would be helpful in fostering self-compassion in survivors of sexual assault. As previously noted, participants in the present study needed to reflect on how they treat close friends as a frame of reference for how they treat themselves. Neff (2012) described an intervention that would be particularly helpful for these survivors where the client thinks of a problem that makes her feel bad about herself, such as sexual assault, then imagines an unconditionally accepting and compassionate friend, and then writes a letter to the self from the perspective of that caring friend. The client is then encouraged to read the letter at times requiring soothing or comfort. While this provides just one example of a way to facilitate self-compassion within clients, Gilbert (2009) and Neff (2011) offer numerous other interventions designed to stimulate self-compassion within shame-prone and self-critical clients, including variations of compassionate letter writing, compassionate imagery, and compassionate chair work.

Finally, while the professional rewards are plenty in accompanying sexual assault survivors through the healing process, it is necessary to acknowledge the challenges that therapists may personally encounter when working in this area. Compassion fatigue and vicarious secondary trauma are increasingly documented among therapists who work in the area of trauma recovery and it is not uncommon for therapists to disregard their own needs when focusing and caring for the needs of their clients (Figley, 2002; Rothschild, 2006). This recommended path towards self-compassion can be difficult for clients with many notable barriers, which can feel like an insurmountable task not only to clients but to therapists as well. Therapists are encouraged to treat themselves compassionately as they engage with their clients in this journey towards self-compassion.

Methodological Considerations

While the present study has much strength with respect to methodology, findings, and implications for clinical practice, it is not without limitations. The most apparent limitation, as with most qualitative studies, lies within the sample size. In order to capture the rich, detailed experiences of participants, a small sample size was required; however, the sample size of 10 did not allow for maximum variability among participants across age, religion, or ethnic background. Also in relation to the homogeneity of the sample is that all participants in this study were sexually assaulted by perpetrators known to them, either as partners, co-workers, or friends. Thus, it remains uncertain if similarities in experiences of self-compassion exist for women who were sexually assaulted by acquaintances and women who were sexually assaulted by strangers.

The process of collecting data presents additional limitations for consideration in the present study. Initial communication with participants was completed via email

and/or telephone and no participant met the interviewer in-person prior to the main interview. Many participants expressed initial nervousness about the interview and although rapport was quickly established with all participants, it is likely that participants' identified anticipatory anxiety impacted their ability to fully capture their experiences of self-compassion. Follow-up interviews were used a means to achieve clarity rather than to seek out additional experiences of self-compassion, so participants' experiences were limited to what they were able to provide during the primary interview. Although participants were fully informed about the nature of the interview and the types of questions they would be asked, providing the interview schedule ahead of time to participants may have helped to put them more at ease for the primary interview and, in turn, may have promoted enhanced recall of experiences of self-compassion. A second limitation with respect to data collection lies within the retrospective nature of the present study. Participants were asked to reflect on their experiences of self-compassion. While some of the shared experiences were quite recent, other experiences occurred years prior to the interview. Given that some recollections were from many years ago, the data may not fully capture participants' experiences of self-compassion.

A further limitation of the present study lies within the subjective nature of qualitative research, and, in particular, research based upon constructivist epistemology. IPA is said to be a double hermeneutic whereby the researcher and participant are both striving to make sense of her experience. It is acknowledged that the researcher and participant are drawing on their own personal experiences to formulate these understandings. Within the present study, it is reasonable to conclude that my own background and experiences, biases and assumptions, as the researcher and a fellow

human being helped to shape interpretations that I made, and thus impacted the findings of the present study. The reader is encouraged to refer to the section on Researcher's Background and the chapter on Methodology for further information on these biases and how they were acknowledged and addressed through data collection and analysis.

Directions for Future Research

The findings of the present study demonstrated strong support for the link between self-compassion and psychological well-being for survivors of sexual assault in adulthood. Being the only known study to explore self-compassion exclusively in relation to sexual assault survivors, the present study makes way for a multitude of possibilities for future research.

The most obvious path for future research would be for additional qualitative studies that address the limitations of the present study. Given the homogeneity of the present sample and the awareness that sexual assault affects women of all ethno-cultural backgrounds, greater heterogeneity would be beneficial to the sexual assault survivor research. Specifically, there is a need for further research exploring the experiences of self-compassion following sexual assault for middle-aged and older women, for women who are from non-dominant cultures in Canada, as well as for women who are from different socioeconomic classes. It would also be advantageous to capture the experiences of self-compassion for women who were sexually assaulted by strangers, as all participants in the present study were sexually assaulted by persons known to them.

Sexual assault within the present study has been addressed as being largely a woman's issue but one would be remiss to state that men do not experience sexual assault. To date, little is known about whether or not self-compassion is experienced

differently by males and females. A valuable contribution to the self-compassion and trauma research would involve an exploration of the experience of self-compassion for males following sexual assault.

As alluded to by participants in the present study, having compassion for oneself can be difficult to grasp and often takes practice to assimilate into one's way of relating to the self. For the development of therapeutic interventions in this area, an exploration of how and under what circumstances self-compassion may develop is necessary. An exploration of the development of self-compassion for childhood sexual abuse survivors is also worthy of consideration as it may be that the experience of childhood sexual abuse can lead to a different pathway for developing self-compassion. Although not addressed in detail within the present study, all participants pointed to barriers that got in the way of their experience of self-compassion. Exploring these barriers to self-compassion would be beneficial for clinicians who will assist clients with navigating the path towards self-compassion.

While the present study highlights the need for more qualitative research, there is also a plethora of areas that can be examined through quantitative means. Future quantitative directions include pre- and post-treatment studies on how CFT impacts the trajectory of recovery from sexual assault. Research delineating whether or not CFT can stand on its own as an effective treatment for recovery from sexual assault should also be considered. As well, longitudinal studies would be helpful in revealing if self-compassion does indeed build resilience and strength for survivors of sexual assault when faced with future adversity.

Conclusion

The study and application of compassion has existed in Buddhism for thousands of years. More recently, the benefits of self-compassion have been recognized within the practice of western psychology. Through its specific focus on survivors of sexual assault, the present study entered new territory in the growing body of research on self-compassion. A further uniqueness of this study is in its qualitative exploration of self-compassion following the experience of a traumatic event. The experiences of self-compassion for the sexual assault survivors in this study were transformative in the way in which survivors related to themselves. Self-compassion was perceived as being strengthening for these survivors, thus providing further evidence for a relationship between self-compassion and psychological well-being. Given the paucity of research in this area, it is hoped that the present study will generate further inquiry into the potential for self-compassion to facilitate recovery from traumatic events. It is also hoped that the present study will stimulate research into new possibilities for the psychological treatment of sexual assault survivors.

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Appendix A

IMPACT OF EVENT SCALE - REVISED

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, how much were you distressed or bothered by these difficulties?

		Not at All	A little Bit	Moderately	Quite a Bit	Extremely
1.	Any reminder brought back feelings about it.	0	1	2	3	4
2.	I had trouble staying asleep.	0	1	2	3	4
3.	Other things kept making me think about it.	0	1	2	3	4
4.	I felt irritable and angry	0	1	2	3	4
5.	I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6.	I thought about it when I didn't mean to.	0	1	2	3	4
7.	I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8.	I stayed away from reminders about it.	0	1	2	3	4
9.	Pictures about it popped into my mind.	0	1	2	3	4
10.	I was jumpy and easily startled.	0	1	2	3	4
11.	I tried not to think about it.	0	1	2	3	4
12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13.	My feelings about it were kind of numb.	0	1	2	3	4
14.	I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15.	I had trouble falling asleep.	0	1	2	3	4
16.	I had waves of strong feelings about it.	0	1	2	3	4
17.	I tried to remove it from my memory.	0	1	2	3	4
18.	I had trouble concentrating.	0	1	2	3	4

	Not at All	A little Bit	Moderately	Quite a Bit	Extremely
19. Any reminder brought back feelings about it.	0	1	2	3	4
20. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
21. I had dreams about it.	0	1	2	3	4
22. I felt watchful and on guard.	0	1	2	3	4
23. I tried not to talk about it.	0	1	2	3	4

SCORING:

Avoidance Subscale: Mean of items 5, 7 ,8 ,11 ,12 ,13 ,17 ,22

Intrusions Subscale: Mean of items 1, 2, 3, 6, 9, 16, 20

Hyperarousal Subscale: Mean of items 4, 10, 14, 15, 18, 19, 21

Impact of Events - Revised score: Sum of the above three clinical scales.

Note that the Hyperarousal scale is made up of 7 new items (No's 4,10,14,15,18,19,21) added to the original Impact of Events Scale (IES). For valid comparisons with scores from the IES, use just the sum of the Avoidance and Intrusion items.

Appendix B

Adult Survivors of Sexual Assault

Are you a survivor of sexual assault?

Have you been compassionate with yourself since the assault?

Would you like to help other survivors by sharing your experiences with self-compassion?

My name is Janice Dicks and I am a doctoral student in the Counselling Psychology program at the University of Alberta. I am interested in talking with survivors of sexual assault about their experiences of self-compassion.

Participation will take approximately 2 ½ hours of your time.

If you are interested in hearing more about the study, please contact me at 780-***-**** or jdicks@ualberta.ca

Janice Dicks
780-***-****
jdicks@ualberta.ca

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780-***-****
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Appendix C

UNIVERSITY OF ALBERTA

Faculty of Graduate Studies
Department of Educational Psychology

Information Letter

Project Title: Sexual Assault Survivors' Experiences of Self-Compassion

Principal Researcher: Janice Dicks
Research Supervisor: Dr. K. Jessica Van Vliet

To *Research Participant*:

Thank you for your interest in participating in this study. The purpose of this research is to explore the experiences of self-compassion for female adult survivors of sexual assault. As such, it is necessary for you to have experienced at least one instance in which you were compassionate with yourself since the assault. This information could benefit other survivors, as well as counsellors and other helping professionals providing support services to survivors of sexual assault. I am doing this research as the dissertation component of my doctorate in Counselling Psychology at the University of Alberta.

A description of what your participation in this study would entail and the precautions that will be taken to protect your privacy are described below.

If you decide to participate, you understand that:

1. You will be given an explanation of the study and be provided with an opportunity to discuss any questions or concerns that you may have.

2. You will participate in an initial interview that will be audio-recorded and transcribed. A second interview may be required in order to provide the interviewer with an opportunity to follow-up on any lingering questions or to make clarifications.

3. After the initial interview, a transcript of the interview will be given to you for review in order to verify its accuracy. Preliminary findings will be shared with you and you will be invited to provide feedback on these findings.

4. The interviews will be held at the University of Alberta, Education Clinical Services, or in a setting that will be comfortable to you that will at the same time ensure your confidentiality, and will be approximately one and a half hours in duration. The style of the interviews will be conversational and the topic will be on your experiences of self-compassion since the sexual assault.

5. This research will provide new knowledge about the experiences of self-compassion for survivors of sexual assault. While it is not anticipated that you will experience distress, some people find discussing topics related to their sexual assault difficult. In case you become distressed, you will have access to a list of referrals to low or no cost counselling agencies in my community.

6. Given that some of the conversation may focus on your experience of sexual assault, if you disclose that a child (under the age of 18) is being abused or neglected or is at risk of being abused or neglected, you are aware that the researcher is required by law to report the abuse to the appropriate authorities.

7. If you indicate that you are suicidal or homicidal, the researcher is required to report this to the appropriate authorities to ensure your safety or the safety of others.

8. You can request that a summary of the final report be provided to you once the research project is complete.

9. All of your information that is collected (for example transcripts and audio-recordings of my interviews) will be labelled so that your name is not associated with them and all identifying information will be changed. Electronic files will be stored on a password-protected computer and any other documents from the study will be secured in a locked filing cabinet for five years following the completion of the research project. After this time they will be destroyed. This is all done to ensure your privacy, confidentiality, and anonymity.

10. Any research personnel, such as a transcriber, that may be involved in the study will sign a confidentiality agreement and will comply with the University of Alberta Standards for the Protection of Human Research Participants. http://www.uofaweb.ualberta.ca/gfcpolicymanual/policymanualsection66.cfm

11. The findings from this study will be compiled into a dissertation and they may be presented at conferences and reported in academic journals. However, none of your identifying information, including your name or identifying characteristics, will be used in any presentations or publications of the results.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Research Ethics Board (REB 1) for studies of emergent design at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Coordinator of the REB 1 at (780) 492-2614.

Your participation in this study is completely voluntary, and you am free to withdraw my participation at any time. You have the right to opt out of this study without prejudice, however any data included up to the point of withdrawal with be retained.

Thank you for considering participation in this study. ***If you choose to be involved in this study, please contact me at (780) 288-5124 or email me at jdicks@ualberta.ca to indicate your interest.*** *Also, if you have any questions or would like more information, please contact me or my research supervisor.*

Principal Researcher:
Janice Dicks
University of Alberta
Department of Educational Psychology
(780) ***-****
jdicks@ualberta.ca

Supervising Researcher:
Dr. K. Jessica Van Vliet
University of Alberta
Department of Educational Psychology
(780) ***-****
jvanvliet@ualberta.ca

Thank you for considering participating in this study.

Sincerely,

_____

Janice Dicks, M.Ed., CCC.
Doctoral Student, University of Alberta
Department of Educational Psychology

Appendix D

Participant Information Form

Today's Date _____ / _____ / _____
Month Day Year

Date of Birth _____ / _____ / _____
Month Day Year

Participant Pseudonym _____

Relationship Status (please check ✓ one)

- ☐ Single
- ☐ Married/Common-Law
- ☐ Separated/Divorced
- ☐ Widowed
- ☐ Other _____

Present Living Situation (please check ✓ one)

- ☐ On my own
- ☐ With a partner and/or children
- ☐ With my parent(s)
- ☐ With a roommate
- ☐ Other _____

Highest Level of Education (please check ✓ one)

- ☐ Partial high school
- ☐ Partial college or university
- ☐ High school
- ☐ College diploma
- ☐ Undergraduate degree
- ☐ Partial graduate school
- ☐ Graduate degree
- ☐ Other _____

Employment Status (please check ✓ one):

- ☐ Not employed
- ☐ Part-time employment
- ☐ Full-time employment
- ☐ Part-time student
- ☐ Full-time student
- ☐ Other _____

Occupation _____

Ethnic/Cultural Background _____

Religion _____

Appendix E

UNIVERSITY OF ALBERTA
Faculty of Graduate Studies
Department of Educational Psychology

Consent Form

Project Title: Sexual Assault Survivors' Experiences of Self-Compassion
Principal Researcher: Janice Dicks
Research Supervisor: Dr. K. Jessica Van Vliet

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

Thank you for your interest in participating in this study. The purpose of this research is to explore the experiences of self-compassion for female adult survivors of sexual assault. As such, it is necessary for you to have experienced at least one instance in which you were compassionate with yourself since the assault. This information could benefit other survivors, as well as counsellors and other helping professionals providing support services to survivors of sexual assault.

A description of your participation in this study and the precautions that will be taken to protect your privacy are described below.

My participation in this study will involve the following:

1. I will be given an explanation of the study and be provided with an opportunity to discuss any questions or concerns that I may have.

2. I will participate in an initial interview that will be audio-recorded and transcribed. A second interview may be required in order to provide the interviewer with an opportunity to follow-up on any lingering questions or to make clarifications.

3. After the initial interview, a transcript of the interview will be given to me for review in order to verify its accuracy. Preliminary findings will be shared with me and I will be invited to provide feedback on these findings.

4. The interviews will be held at the University of Alberta, Education Clinical Services, or in a setting that will be comfortable to me that will at the same time ensure my confidentiality, and will be approximately one and a half hours in duration. The style of the interviews will be conversational and the topic will be on my experiences of self-compassion since the sexual assault.

5. I am aware that this research will provide new knowledge about the experiences of self-compassion for survivors of sexual assault. While it is not anticipated that I will experience distress, some people find discussing topics related to their sexual assault difficult. In case I become distressed, I will have access to a list of referrals to low or no cost counselling agencies in my community.

6. Given that some of the conversation may focus on my experience of sexual assault, if I disclose that a child (under the age of 18) is being abused or neglected or is at risk of being abused or neglected, I am aware that the researcher is required by law to report the abuse to the appropriate authorities.

7. If I indicate that I am suicidal or homicidal, the researcher is required to report this to the appropriate authorities to ensure my safety or the safety of others.

8. I can request that a summary of the final report be provided to me once the research project is complete.

My privacy will be maintained in this study by the following procedures:

1. All of my information that is collected (for example transcripts and audio-recordings of my interviews) will be labelled so that my name is not associated with them and all identifying information will be changed. Electronic files will be stored on a password-protected computer and any other documents from the study will be secured in a locked filing cabinet for five years following the completion of the research project. After this time they will be destroyed. This is all done to ensure my privacy, confidentiality, and anonymity.

2. Any research personnel, such as a transcriber, that may be involved in the study will sign a confidentiality agreement and will comply with the University of Alberta Standards for the Protection of Human Research Participants. http://www.uofaweb.ualberta.ca/gfcpolicymanual/policymanualsection66.cfm

3. The findings from this study will be compiled into a dissertation and may be presented at conferences and reported in academic journals. However, none of my identifying information, including my name or identifying characteristics, will be used in any presentations or publications of the results.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Research Ethics Board (REB 1) for studies of emergent design at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Coordinator of the REB 1 at (780) 492-2614.

My participation in this study is completely voluntary, and I am free to withdraw my participation at any time. I have the right to opt out of this study without prejudice, and any of my collected data will not be included in the study.

Having read and understood all of the above, I _____ agree to participate freely and voluntarily in this study.

_____ _____
Signature of Participant Date

_____ _____
Signature of Researcher as Witness Date

Two copies of this consent form will be provided. One is to be kept by you for your records, and the other is to be returned to the researcher.

If you have any questions or concerns about this research, please contact:

Principal Researcher:
Janice Dicks
University of Alberta
Department of Educational Psychology
(780) ***-****
jdicks@ualberta.ca

Supervising Researcher:
Dr. K. Jessica Van Vliet
University of Alberta
Department of Educational Psychology
(780) ***-****
jvanvliet@ualberta.ca

Thank you for your participation in this study. Please feel free at any time to bring up any questions and/or concerns regarding your participation in this study.

Appendix F

Interview Guide

- Describe a time when you were compassionate with yourself.
- What does the word compassion mean to you?
- What does self-compassion mean to you?
- Very briefly, please describe the circumstances and context surrounding the sexual assault(s)

  Prompts:
  - When did it happen? What age(s) were you?
  - What was your relationship to the individual(s) involved?
  - Was it a one-time or repeated offence?
  - [If participant becomes immersed in sexual assault story, prompt to return to experiences of self-compassion] Was there any moment during this experience that you were compassionate with yourself?
- In what ways have you been compassionate with yourself since the sexual assault?
- Is there anything that gets in the way of being self-compassionate?
- In what ways does treating yourself with compassion influence how you feel and think about the assault?
- What impact does being self-compassionate have on your daily life?

Appendix G

Community Services

If you are experiencing distress, or need someone to talk to, please consider seeking support at one of the following support agencies. All of these agencies provide no-cost or low-cost counselling.

24-hour Crisis Line Numbers

Sexual Assault Centre of Edmonton	780-423-4121
The Support Network's Distress Line	780-482-4357

Sexual Assault Centre of Edmonton

Address:	#205, 14964 121A Avenue
Phone:	780-423-4102
Hours:	Monday – Thursday 9 a.m. – 5 p.m. Friday 9 a.m. – 4 p.m.

Catholic Social Services

Address:	Multiple locations in Edmonton
Phone:	780-432-1137

Cornerstone Counselling Centre

Address:	#302, 10140 117 Street
Phone:	780-482-6215

Jewish Family Services

Address:	#502, 10339 124 Street
Phone:	780-454-1194

Student Counselling Services (For U of A students only)

Address:	2-600 Students' Union Building
Phone:	780-492-5205
Hours:	Monday – Friday 8:30 a.m. – 4:30 p.m.

University of Alberta Education Clinical Services

Address:	1-135 Education North Building
Phone:	780-492-3746

University of Alberta Sexual Assault Centre (For U of A students only)

Address:	2-705 Students Union Building
Phone:	780-492-9771
Hours:	Monday – Friday 9 a.m. – 9 p.m. Saturday – Sunday 1 p.m. – 4 p.m.