SELF-COMPASSION AND RECOVERY FROM SEXUAL ASSAULT

by

Angele Close

A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Graduate Department of Applied Psychology & Human Development
Ontario Institute for Studies in Education
University of Toronto

© Copyright by Angele Close (2013)
SELF-COMPASSION AND RECOVERY FROM SEXUAL ASSAULT

Doctor of Philosophy 2013

Angele Close

Department of Applied Psychology & Human Development
University of Toronto

Abstract

Despite concerted efforts to eradicate violence against women and challenge victim-blaming attitudes towards survivors of sexual assault, women continue to be sexually victimized and encounter negative and accusatory reactions by family, friends, and society at large. For many survivors, the consequences are internalizing blame and feelings of shame, which has been shown to be related to increased psychological distress, self-destructive coping mechanisms, depression, generalized anxiety, and post-traumatic stress (Arata, 1999; Davis & Breslau, 1994; Feiring, Taska, & Lewis, 2002; Frazier, 1990, 2000; Frazier & Schauben, 1994; Wyatt et al., 1990). New research in the area of self-compassion suggests that this way of self-relating can counter shame (Gilbert, 2005) and serve as a resiliency factor for coping with daily stressors (Leary, Tate, Adams, Allen, & Hancock, 2007) and contribute to well-being (Neff, 2003a). No study has yet empirically evaluated self-compassion among survivors of trauma, nor more specifically, victims of sexual assault. The present study investigated the relationships between self-compassion and various indicators of psychological health that have been associated with posttrauma adjustment. One hundred and forty-one women in North America who experienced a sexual assault in the past 5 years (aged 18 to 61, M age = 27 years) completed measures assessing trauma history (sexual trauma history, childhood trauma and stressful life experiences), posttrauma adjustment (psychological
distress, negative posttraumatic cognitions, and shame), self-compassion, self-criticism, and life satisfaction. The results of the study showed that self-compassion was significantly negatively related to psychological distress, negative posttraumatic cognitions, shame and self-criticism, and was positively related to life satisfaction. Hierarchical linear regressions revealed that when controlling for earlier childhood trauma and other stressful life experiences, self-compassion was a strong and significant predictor, explaining between 19 to 42% of the variance in psychological distress, negative posttraumatic cognitions, shame, and self-criticism. Comparing groups based on severity of sexual assault revealed that women who experienced attempted rape reported significantly higher levels of self-criticism compared with women who experienced sexual coercion. These findings bolster recent studies that equate self-compassion with psychological resilience. The negative relationships revealed between self-compassion and measures reflecting posttrauma adjustment and self-criticism, along with the positive association with life satisfaction clearly demonstrate validity in the pursuit of self-compassion as an important psychological construct that may help women recover from sexual trauma.
Acknowledgements

This dissertation would not have been successfully completed had it not been for the guidance of my committee members, help from friends, and support and encouragement from my family and husband.

First and foremost, I would like to thank my supervisor, Dr. Lana Stermac for her unwavering support and guidance throughout this 4-year project. I had three children coinciding with the work of this thesis, and her support, excitement, and warmth with each new ‘interruption’ from my research was unprecedented. Her kindness and availability during particular challenges in this process exceeded the supervisory role, and I am forever grateful. I wish to extend this gratitude to my committee members, Dr. Jeanne Watson, Dr. Kathryn Belicki, Dr. Catherine Classen, and Dr. Margaret Schneider. Thank you for your time and keen attention to my writing and to your helpful suggestions along the way.

Of course, a study such as this would not be possible without the brave, honest and courageous women who took the time to answer the many questions involved in this study. To those women: thank you. I am most deeply honored and grateful to be privy to your experiences and perceptions of how sexual victimization has affected your life. I would also like to extend my gratitude to the community organizations that assisted me in the recruitment process.

I would not be where I am today without the persistent unrelenting support and faith of my mother and father, Louise and Robert Palmer. My scholarly career has been a long journey and I know my father is happy to be here to witness its successful completion! I must also extend my deepest gratitude and appreciation to the love and
support I have received from my mother and father-in-law, Sandra and Randy Close. Throughout these past six years working towards my doctorate, they have listened, encouraged and helped me accomplish my goals in more ways than I can count.

Lastly, but in no way of least importance, I would like to acknowledge the unwavering confidence, support (both emotional and financial), and encouragement provided by my husband, Ryan Close. I would not have been able to meet my career and academic goals while having and raising our three amazing children without his patience, help, and humor along the way. You are the best life partner a woman can have.
# Table of Contents

Abstract ii  
Acknowledgements iv  
Table of Contents vi  
List of Tables viii  
Introduction 1  
Theories and Conceptions of Self-Compassion 5  
Empirical Research on Self-Compassion 14  
Sexual Assault 24  
Incidents 24  
Impacts 25  
Psychological distress 25  
Negative Posttraumatic Cognitions 26  
Shame 29  
Self-criticism 33  
Satisfaction with Life 35  
Feminist Analysis of Posttraumatic Impacts and Adjustment 39  
Components of Self-Compassion and Trauma Recovery Theory 42  
Need for the Present Study 44  
Method 47  
Study Sample 47  
Measures 50  
*Sexual trauma history* 50  
*Childhood trauma* 52  
*Stressful life experiences* 52  
*Negative posttraumatic cognitions* 53  
*Shame* 53  
*Psychological distress* 54  
*Self-compassion* 54  
*Self-criticism* 55  
*Life Satisfaction* 56  
Procedure 56  
Results 59  
Data Analysis 59  
Descriptive Analyses 60  
*Participant trauma history* 60  
*Posttrauma adjustment* 64  
*Self-compassion* 64  
*Self-criticism* 64  
*Life Satisfaction* 64  
Results of Hypothesis Testing 65  
Main research questions 65  
Exploratory research questions 70  
Discussion 73  
Main Research Questions 73
Self-compassion and posttrauma adjustment 73
Self-compassion and life satisfaction 77
Unique contributions of self-compassion 78
Severity of trauma 79
Implications for Clinical Practice 82
Strengths and Limitations 83
Strengths 84
Limitations 85
Summary and Conclusions 86
Directions for Future Research 89
References 91
Appendices
Appendix A – Study Poster 114
Appendix B – Letter of Information: Mail in 115
Appendix C – List of Community Crisis and Counselling Resources 117
Appendix D – Letter of Information: On-line 118
Appendix E – Letter of Information: Drop Box 120
Appendix F – Demographics Questionnaire 122
Appendix G – Sexual Experiences Survey Short Form Victimization (SES-SFV) 124
Appendix H – Self-Compassion Scale (SCS) 126
Appendix I – Posttraumatic Cognitions Inventory (PTCI) 128
Appendix J – Trauma Symptom Checklist (TSC) 130
Appendix K – Satisfaction with Life Scale (SWLS) 131
Appendix L – Childhood Trauma Questionnaire (CTQ) 132
Appendix M – Experience of Shame Scale (ESS) 135
Appendix N – Levels of Self-Criticism Scale (LOSC) 137
Appendix O – Stressful Life Experiences Screening (SLES) 138
List of Tables

Table 1 - Descriptive Statistics for Participant Demographics and Background 48

Table 2 - Frequencies of Sexual Assault History 61

Table 3 - Descriptive Data of Study Variables 63

Table 4 - Correlation Matrix for Psychological Distress (TSC),

Negative Posttraumatic Cognitions (PTCI), Shame (ESS),

Self-Criticism (LOSC) and Self-Compassion (SCS). 66

Table 5 - Summary of Multiple Regression Analyses for Variables

Predicting Psychological Distress (TSC), Shame (ESS),

Negative Posttraumatic Cognitions (PTCI) and Self-Criticism (LOSC)

using Self-Compassion (SCS) as the Independent Variable and

Controlling for Stressful Life Events (SLES), and

Childhood Trauma (CTQ). 68

Table 6 - Results of Analysis of Variance using sexual assault history (SES)

as the independent variable and psychological distress (TSC), negative

posttraumatic cognitions (PTCI), shame (ESS), self-compassion (SCS),

and self-criticism (LOSC) as dependent variables 72
A promising new area of psychological research has begun to explore the benefit of taking a compassionate stance towards the self with a range of psychological indicators. The majority of the burgeoning studies on self-compassion incorporate Neff’s (2003a) operationalization, characterized by three specific components, namely, self-kindness, mindfulness, and common humanity. In other words, to be compassionate towards the self means regarding one’s self with patience, kindness, and non-judgmental understanding, acknowledging that all humans are fallible, and worthy of compassion (Neff, 2003a).

Self-compassion has been shown to be related to positive changes in relationship to self and enhanced sense of connection with others (Corcoran, 2007), positive coping with academic failure (Neff, Hsieh, & Dejithirat, 2005), happiness and satisfaction with life (Hollis-Walker & Colosimo, 2011; Neely, Schallert, Mohammed, Robers, & Chen, 2009), and optimism and well-being (Neff et al., 2005).

Self-compassion may also help buffer against psychological stress in day-to-day life (Leary, Tate, Adams, Allen, & Hancock, 2007), and has been negatively associated with problematic cognitive processes like pessimistic thinking, rumination (Leary et al., 2007), and other negative self-evaluative cognitions, such as shame proneness, social physique anxiety, objectified body consciousness, fear of failure and fear of negative evaluations (Mosewich et al., 2011). While self-compassion has been shown to help buffer feelings like shame and counter self-criticism (e.g., Gilbert & Irons, 2004, 2005; Gilbert & Procter, 2006), it has also been negatively related to more severe clinical psychopathologies such as depression and anxiety (Leary et al., 2007; Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007; Raes, 2011). Further, in the only study examining self-compassion and trauma symptomatology (Thomson & Waltz, 2007)
self-compassion was found to be significantly negatively correlated with avoidance strategies, which have been shown to maintain symptoms of post-traumatic stress disorder (PTSD).

Although theory and early study findings are showing promise that self-compassion may offer health-enhancing qualities, including helping to buffer against feelings like shame and minimize distress, to date, none of the studies investigating self-compassion has examined if this dynamic holds true among survivors of trauma. This is surprising, given that mention of the importance of self-compassion as well as the three individual components that are empirically factored into Neff’s operationalization are identified either directly or indirectly in the feminist and psychology trauma recovery literature.

With knowledge of the multiple negative impacts of trauma on survivors’ psychological health, and the complex negative impacts of sexual assault in particular, self-compassion may be a valuable construct in the recovery for women who are sexually assaulted. From concerted research efforts, we know with confidence the many severe impacts on women rape survivors, such as depression, anxiety, PTSD, low self-esteem, and suicidality (see Resick, 1993 for a review). Such negative psychological outcomes and high levels of distress certainly impact survivors’ functioning and quality of life as well as impede prospects for recovery (Koss & Burkhart, 1989).

Unlike other crimes or traumas, sexual assault carries with it assumptions and prejudices that are carried by individuals and operate within systems throughout many areas of society, such as judicial and legal systems (DuMont & Myhr, 2000; Gunn & Minch, 1988; Lees, 1993), mental health and medical systems (Best, Dansky, & Kilpatrick, 1992), as well as broader social norms maintained by friends, family, and community (Ullman, 1996). These discriminatory beliefs and
attitudes, known as ‘rape myths’, perpetuate victim-blaming attitudes that predicate women as responsible for their own rape or assault (Burt, 1980).

As a consequence of rape myths and others’ blaming attributions to disclosures of sexual assault, many survivors internalize victim-blaming attitudes and harmful beliefs about self and the world (Miller, Markman, & Handley, 2007; Ullman, 1996, 1997). Internalized blame and negatively impacted beliefs can lead to intense feelings of shame, which has been linked with poor psychological functioning and to the presentation of disorders, such as PTSD (Lee, 2005; M. Lewis, 1998) and depression and anxiety (e.g., Gilbert & Irons, 2005). It seems then that survivors who take on societal victim-blaming attitudes become at an increased risk for psychological distress and poorer functioning and recovery.

Given the all-too common painful experiences of shame amid the rape survivor’s experience, treatment interventions that include awareness of internalized blame and which target the resulting feelings of shame are undoubtedly important. While some treatment models of trauma recovery have included attention to internalized blame (Kilpatrick & Veronen, 1983; Koss & Burkhart, 1989), the majority of treatments have incorporated exposure and cognitive-behavioural interventions (Foa, Rothbaum, Riggs, & Murdock, 1991; Frank, Anderson, Stewart, Dancu, Hughes, & West, 1988; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988) and targeted symptoms that reflect the immediate response to rape (Koss & Burkhart, 1989); thus, treatments to date have, for the most part, underestimated the role of survivors’ self-relating and ability to self-soothe and heal. While clinical feminist literature has long since acknowledged the importance of empathy and survivors’ developing self-compassion in the process of recovery (e.g., Herman, 1992), recent research with survivors of sexual abuse and assault using emotion-
focused therapy has revealed that minimizing self-blame and shame, and enhancing self-compassion is essential for survivors on the road to recovery (Paivio & Pascual-Leone, 2010).

While many qualities equated with self-compassion (e.g., empathy, distress tolerance, non-judgment, and warmth; Gilbert & Procter, 2006) are integrated within mindfulness-based interventions, such as Dialectical Behaviour Therapy (Linehan, 1993), Mindfulness-based stress reduction (Kabat-Zinn, 1990), Mindfulness-based Cognitive therapy (Segal, Williams, & Teasdale, 2002), and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), no study has yet empirically evaluated self-compassion among trauma survivors, nor more specifically, victims of sexual assault. Based on preliminary findings and theory, some researchers have proposed that self-compassion may be a skill that can be learned to help counter survivors’ feelings of shame and self-criticism, enhancing their ability to self-soothe (Gilbert & Procter, 2006; Paivio & Pascual-Leone, 2010), while possibly aiding with psychological inflexibility and avoidant behaviours common among this client group (Follette, Palm, & Pearson, 2006).

Given recent findings showing negative relationships between self-compassion and self-criticism (Neff, et al., 2007) and self-conscious emotions such as shame (Leary et al, 2007; Mosewich et al., 2011), together with our awareness that many survivors of sexual trauma internalize blame and suffer with feelings of shame, it would seem that an examination of the potential benefits of self-compassion with sexual assault survivors is an important endeavor. Moreover, the finding that self-compassion may be a teachable skill, allowing one to self-soothe (Gilbert & Procter, 2006), points to the value in exploring self-compassion as it relates to survivors of sexual violence, a population which is certainly in need of effective treatment interventions. Without exploratory studies that identify the role of self-compassion among
trauma survivors, however, an intervention focused on self-compassion with rape survivors cannot responsibly be implemented. First, an in-depth study of the relationships of self-compassion and other correlates related to posttraumatic adjustment, such as shame and psychological distress, is needed. Moreover, examination of the relationship of self-criticism among a trauma population would be a beneficial contribution to the both the trauma and self-compassion literatures.

This dissertation is aimed at addressing this gap of knowledge. First, an in-depth discussion of the theories and conceptions of self-compassion will be presented, followed by interesting empirical findings to date. The lack of studies examining self-compassion among a trauma population will be noted as a precursor to the presentation of theoretical underpinnings that elucidate the benefit of such a research pursuit. For example, tying the high incidence and multiple negative impacts of sexual violence on women with relevant features of self-compassion mentioned in the feminist and clinical psychology trauma recovery literature will logically explain the value in conducting research that specifically examines self-compassion among survivors of sexual assault.

Finally, an in-depth outline of the procedures and methodology used in this study will be presented, including relevant demographics of the participants, followed by the study results. Discussion of the study findings will follow, along with recognition of the strengths and limitations of the current study. This dissertation will wrap up with an outline of the most relevant conclusions of this project and with suggestions for future research in this area.

**Theories and Conceptions of Self-Compassion**

Though in its infancy, the number of investigations into the psychological benefits of self-compassion is quickly expanding. Much of this surge is due in part to Kristin Neff and her
development of a scale to empirically measure this ‘new’ construct, namely, the Self-Compassion Scale (SCS; 2003a). By her definition, self-compassion entails regarding one’s self with patience, kindness, and non-judgmental understanding, acknowledging that all humans are fallible, and worthy of compassion (Neff, 2003a). Specifically, the Self-Compassion Scale measures the extent to which people engage in self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification (Neff, 2003a). Though conceptually distinct, the three components of self-compassion are inter-related and they interact and engender one another (Neff, 2003a).

Specifically, the self-kindness component of self-compassion “entails being warm and understanding toward oneself when encountering suffering, inadequacy, or failure, instead of ignoring one’s pain or flagellating oneself with self-criticism” (Neff, 2008, p. 97). Self-compassionate people are kind and gentle toward themselves as opposed to being self-critical, harsh and judgmental. Second, represented in the component of common humanity, being self-compassionate consists of seeing one’s failings or suffering as part of the broader human experience (Neff, 2003a). Thus, there is a de-emphasis on the self and a connection to humanity; as Neff explains, “paradoxically, healthy and constructive self-attitudes stem in part from de-emphasizing the separate self, rather than merely building up and solidifying one’s separate and unique identity” (2003b, p. 96). Finally, a concept that has been given increasing attention in the clinical and health psychology literature is mindfulness. Its role in self-compassion lies in the balancing of emotions and equanimity to all of one’s experiencing (thoughts, feelings, sensations), which allows for an ability to face, rather than avoid painful thoughts, feelings, and sensations (Neff, Rude & Kirkpatrick, 2007). Mindfulness allows a willingness and openness to all of one’s experiences, allowing for greater clarity and ability to not suppress or exaggerate
negative emotions (Bishop et al., 2004; Neff, 2008) and to not be over-identified with mental or emotional phenomena, so that one is not swept away or caught up in one’s aversive reaction. Greater emotional well-being is brought about through this openness and mental space that leads to a dis-identification and impersonal approach to one’s experiences (Baer, 2003; Shapiro, Carlson, Astin & Freedman, 2006).

Neff (2008) emphasizes the interconnectedness and interdependence grasped through mindfulness, with the example of Hahn’s notion of interbeing, such that part of mindfulness is “recognizing that personal thoughts, feelings, and actions are affected by factors not typically included in one’s self-concept, such as parenting history, culture, and genetic and environmental conditions, as well as the behaviour and expectations of others” (p. 98). This lens of awareness of the complicated network of reciprocal cause and effect minimizes self-judgment of personal failings and awareness of how many things are not in our conscious control, thus we can let go of taking such things personally. When holding an attitude of self-compassion then, “problems can be approached with a compassionate, accepting mind-set that maximizes the emotional equanimity needed to recognize and act on possible ways to improve the situation (or at least our response to it)” (Neff, 2008, p. 98).

Knowledge of the relations among the components of self-compassion is less clear, as research in this area is scant. Neff (2003a) proposes that self-kindness, common humanity, and mindfulness are interrelated and engender one another. Recent theorizations further propose that development of each element has the potential to strengthen the other components (Barnard & Curry, 2011). This was demonstrated in a recent study examining mindfulness, happiness and self-compassion among undergraduate students (n = 73) and demographically similar community members (n = 50; Hollis-Walker & Colosimo, 2011). The findings showed that self-compassion
served as a partial mediator of the relationship between mindfulness and happiness, thus suggesting the capacity for strengthening one component by developing the other. Although an interesting finding, further research regarding the function and directionality of individual relationships of the components of self-compassion is certainly needed.

Self-compassion is hypothesized to minimize feelings of self-criticism and self-loathing (Neff, Kirkpatrick, & Rude, 2007) without having to adopt a skewed or unrealistically positive view of oneself (Leary et al, 2007). Unlike self-esteem, self-compassion entails feelings of loving-kindness towards oneself without requiring external validation and approval (Neff, Hseih, & Dejitthirat, 2005) and recognizing one’s personal failings as part of the human experience (Neff, 2003a). Self-compassion has been differentiated from concepts such as self-esteem, self-pity and self-complacency (Barnard & Curry, 2011) and has been empirically shown to contribute unique variance to indicators of psychological health apart from self-esteem (Neff, 2009). Through mindfulness, self-compassion acts as a type of emotion regulation strategy through which painful feelings are not avoided but are held in one’s awareness with gentleness and understanding (Neff, 2003a).

Neff (2008) presents self-compassion as a vehicle to greater emotional equanimity within a framework of lessening suffering from the knowledge that one “cannot always be, or get exactly, what (one) want(s)” (p. 97). Neff and McGehee state that “compassion can be extended towards the self when suffering occurs through no fault of one’s own – when the external circumstances of life are simply painful or difficult to bear” (2010, p. 226). They further add that self-compassion is just as applicable “when suffering stems from one’s own foolish actions, failures, or personal inadequacies”. However, whether self-compassion is an equally helpful approach for helping survivors cope with and heal from the impacts of sexual violence, and not
solely as a way to just deal with ‘not getting what you want’ or from “personal failures” goes unmentioned in Neff’s work to date. Still, by providing a reliable and valid measure with which to measure self-compassion, Neff has helped lay much of the groundwork for future investigations of self-compassion.

Another contributor to our current understanding of self-compassion is Paul Gilbert and colleagues (2005, 2006). Coming from an evolutionary-biopsychosocial framework, Gilbert (2005) includes compassion as a valuable component in his Social Mentality Theory, wherein social mentalities are “gene-learning emergent co-assemblies of motives, emotions, cognitive processing routines and behaviours that are ecologically sensitive, and enable the enactment of strategies via the creation of specific forms of partnerships and social roles” (p. 17). The awareness of the others’ humanity, as well as our own (i.e. compassion), is said to enable the maintenance of organization of the species-preservative system (Gilbert, 2005; Wang, 2005).

Within Gilbert’s framework then, self-compassion is theorized as part of neurological mechanisms of safety and defensive strategies within a ‘species-preservation’ system. For instance, according to Social Mentality Theory, a child who is loved and nurtured will develop a neuropathway for a self-soothing system (of which compassion is deemed a part), which can in turn help regulate the threat system when under duress (Gilbert, 2005). Thus, the ‘species-preservation’ system associated with prosocial behaviour and compassion that predominates in a safe environment is short-circuited under unsafe conditions of threat, isolation, or chronic stress (Wang, 2005). Experiences of traumatic stress have been found to produce deficits that interfere with feelings of affiliation and compassion (Herman, 1992; Wang, 2005).

Gilbert (2005) proposes that when an individual is neglected or abused as a child, he/she is unlikely to have learned how to self-soothe, or have accumulated memories of a caring other
from which to draw in times of threat or difficulty. Such individuals are also more likely to feel shame (Andrews, 1998; Gilbert & Miles, 2000) and engage in self-criticism, having internalized messages of being flawed, unworthy or bad (Gilbert & Irons, 2004; Gilbert & Procter, 2006).

Thus, according to Gilbert and Procter (2006), the pathogenic qualities of shame and self-criticism are both the degree of self-directed hostility, contempt and self-loathing that permeates self-criticism, and secondly, the relative inability to generate feelings of self-directed warmth, soothing, reassurance and self-compassion (Gilbert, 2000; Linehan, 1993; Neff, 2003a). For individuals who were neglected, shamed, or abused as children, they may not have developed self-reassurance (self-compassion) as a way to handle negative events and setbacks (Gilbert et al., 2006). Thus, while there may be an overstimulation of brain pathways that mediate threat and defense systems, there may simultaneously be an “understimulation of the soothing, warmth, positive affect system, with limited articulation of interpersonal schemas of self and other as helpful, soothing, and reassuring” (Gilbert et al., 2006, p. 184). Gilbert and colleagues (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006), therefore, propose that treatment interventions that focus only on diminishing negative self-criticism may be insufficient, as clients high in self-blame, shame and self-criticism may require a learning of skill or a developed pathway for engaging in self-compassion toward the self when faced with an internal or external threat to self. While Gilbert’s evolutionary-biopsychosocial framework theorizing the process of compassionate versus critical self-relating is interesting and theoretically rich, it lacks a feminist lens to explain study findings that have found gender differences, with women scoring lower in self-compassion (e.g., Neff 2003a, Neff, Kirkpatrick & Rude, 2007).

A recent emotion-focused model with trauma survivors (EFTT; Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010) clearly outlines how an experiential, person-centered
approach with trauma survivors can specifically target and reduce maladaptive emotion schemes such as shame, while nurturing survivors’ compassion towards the self. Experiential tasks are incorporated in therapy sessions to access clients’ underlying maladaptive schemas, reprocess them and alter their meaning construction. As a person-centered approach, the therapeutic relationship is deemed primary and curative in disconfirming negative relational experiences (Paivio & Nieuwenhuis), with an additional focus on the emotional processing of trauma memories (Paivio & Pascual-Leone). EFTT addresses affect regulation as part of treatment interventions for survivors (e.g., gradual trauma exposure) along with particular attention to self-related disturbances, such as fear, avoidance, and self-blame, as their research has shown that clients were unable to resolve past interpersonal issues until these self-related disturbances were first reduced (Paivio & Pascual-Leone). Addressing these self-related disturbances while increasing self-compassion is considered crucial for survivors, as Paivio & Pascual-Leone state: “Clients cannot move forward and resolve issues with perpetrators and hold them accountable for harm until they stop blaming themselves; they cannot sustain healthy relationships in general until they feel more compassionate towards themselves” (p. 203). EFTT has been shown to lead to reduced symptoms of distress, increased self-esteem and improvements in global personal functioning (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone). It is to date the only empirically investigated and validated treatment for survivors of interpersonal violence that incorporates attention to decreasing shame and self-blame while enhancing self-compassion.

A final relevant framework for self-compassion comes from a recent theory concerning positive emotions and the relationship to resiliency, namely, Frederickson’s (1998, 2001) broaden-and-build theory of positive emotions. Within this theory, positive emotion (e.g., joy, interest, contentment, pride and love) is thought to broaden people’s ‘thought-action repertoires’,
which, in turn increases the likelihood of building personal resources, whereas, negative emotions narrow one’s ‘thought-action repertoire’ in limiting one’s response to act in certain ways (e.g., fight when angry or flight when afraid). Personal resources gained through positive emotions may include cognitive (e.g., mindfulness), psychological (e.g., sense of mastery in the face of challenges), social (e.g., capacity to give and receive emotional support), and physical (e.g., immunity to ailments) (Frederickson, Cohn, Coffey, Pek, & Finkel, 2008). Several laboratory studies (e.g., Frederickson & Joiner, 2000; Frederickson & Levenson, 1998; Tugade & Frederickson, 2004) and a recent randomized, longitudinal field experiment incorporating lovingkindness meditation (Frederickson et al., 2008) have shown support for the broaden-and-build model of positive emotion relating to psychological resiliency. For example, after 7 weeks of practicing daily lovingkindness meditation practice (n=56 compared with n=73 in a waitlist control group), which entails intentional focus and extension of “warm feelings first to themselves and then to an ever-widening circle of others” (Frederickson et al., 2008, p. 1046), participants’ experiences of positive emotions evoked through the meditation were linked to shifts in personal resources, such as mindful attention, self-acceptance, positive relations with others, and good physical health, which in turn lead to life satisfaction and decreased depression symptoms.

A recent study evaluating the benefits of interventions designed to develop self-compassion and optimistic thinking on the internet for individuals at risk for depression provides some support for Frederickson’s theory (Shapira & Mongrain, 2010). Results of individuals assigned to the self-compassion group (n = 63) and optimism group (n = 55) were compared with a control group (n = 70) in which participants wrote about an early memory. A battery of tests was completed at 1 week following the intervention period and at 1-, 3-, and 6-month follow-
ups. Both active interventions resulted in significant improvement for participants in terms of self-reported happiness at 6 months as well as significant decreases in depression at 3 months follow-up. Further, the authors examined the efficacy of the interventions in relation to individual differences in personality, such as self-criticism and dependency. Through their data analyses they found that individuals higher in connectedness experienced increased gains in happiness and greater reductions in depression at the 6-month follow-up when assigned to the self-compassion group versus the optimism or early memory writing group. The researchers note that both interventions involved having participants engender hope through thinking more positively about their current distress and their future, thus, there are likely common elements among the interventions may have contributed to their efficacy. Methodological issues with this study may be a concern, however, as the application of the internet as the basis of the intervention leaves questions regarding potential truthfulness and accuracy of reporting on the part of participants.

Nonetheless, within the broaden and build theory then, of which the above and other studies are showing promising support, “when people open their hearts to positive motions, they seed their own growth in ways that transform them for the better” (Frederickson et al., 2008, p. 1060). While research exploring Frederickson’s broaden and build theory expands the area of positive psychology, continued research is needed, as the processes and mediating factors that may contribute to study findings raise additional questions for further study.

To summarize, while Neff draws from Buddhist concepts in her conceptualization of self-compassion, Gilbert and colleagues place self-compassion within an evolutionary-based cognitive-behavioural framework. Both researchers, however, have blazed a trail in psychology of new and innovative explorations into self-compassion as a form of self-to-self relating and
attitude that has healing possibilities, particularly for individuals high in shame and self-criticism. Important recent research from Paivio and Pascual-Leone specifically reveals how emotion-focused therapy treatment with survivors of interpersonal violence has the potential to diminish self-interrupting factors like shame and self-blame, while promoting the development of self-compassion through the fostering of a strong mutually empathic therapeutic relationship. Finally, while Frederickson’s (1998, 2001) broaden-and-build theory of positive emotion has yet to specifically identify self-compassion, recent studies have offered strong support that positive emotions (i.e. love, joy, contentment and interest) promote the enhancement of personal resources, which has been linked with increased life satisfaction and reduced depressive symptoms (Frederickson et al., 2008) and shown to lead to emotion regulation and finding positive meaning in negative circumstance (Tugade & Frederickson, 2004). These findings allude to the potential for self-compassion as a mediator of personal resources, which may be particularly important in the context of coping with the aftermaths of sexual assault.

**Empirical Research on Self-Compassion**

Though there is still a great deal to learn, a number of recent studies have begun to demonstrate the potential psychological benefits of self-compassion (e.g., Gilbert & Irons, 2005; Leary et al., 2007; Neff, 2003a, Neff, Rude & Kirkpatrick, 2007; Shapiro et al., 2005). For example, in the first of two studies, Neff et al (2007) found that increases in self-compassion occurring over a one-month period were associated with increased psychological well-being, such as lower levels of anxiety. Their second study investigating the relation of self-compassion to the five-factor model of personality revealed that self-compassion was significantly positively associated with self-reported measures of happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness, and
significantly negatively associated with negative affect and neuroticism. Neff et al (2005) found that self-compassion moderated impacts of perceived academic failure among undergraduate students.

Leary et al (2007) conducted 5 studies investigating the cognitive and emotional processes by which self-compassionate people deal with unpleasant life events. Study participants consisted of male (n=59) and female (n=58) undergraduate students (ages 17-21) receiving course credit for participation. In the first study, participants reported on negative events in their daily lives and were measured on a number of psychological health indexes. The results showed that overall, self-compassion predicted emotional and cognitive reactions to negative events in everyday life. Specifically, self-compassion was related to reactions of treating oneself kindly and was associated with fewer negative, pessimistic and self-critical thoughts, and was negatively related to anxiety, sadness, and self-conscious emotions (e.g., humiliation, shame, and embarrassment). Self-compassion was also associated with ratings of the overall day more positively, suggesting a resiliency factor, such as an improved attitude/appraisal of negative events.

Another interest finding was that self-compassion moderated participants’ reactions when the stressful event of the day was perceived as their fault. When perceiving themselves to blame for the stressful event, participants high in self-compassion tended to take greater efforts to be kind towards the self and to understand their emotions, but not so when they perceived themselves as not responsible for the event. Thus, self-conscious emotions, such as shame, embarrassment and humiliation were moderated by self-compassion when the events were perceived as the fault of the participant, but were inversely related in the case of no-fault events.
This finding suggests that perception of fault may be an important factor in the service of self-compassion.

The second study entailed having participants respond to three hypothetical scenarios and complete measures of self-compassion, self-esteem and narcissism. The findings showed that self-compassion buffered against negative self-feelings when imagining distressing social events, such as less catastrophizing, less personalizing, and greater equanimity. Self-compassion was also associated with less extreme behavioural inclinations in response to imagined events, perhaps suggesting improved behavioural coping. Finally, it was also found that self-compassion was related to measures of emotional, cognitive and behavioural reactivity independently of self-esteem; regression analyses indicated that self-compassion accounted for unique variance to outcome variables while self-esteem did not.

Leary et al’s third study involved evaluating participants’ reactions to negative feedback. Results showed that self-compassion moderated participant reactions to neutral feedback and buffered people against the psychological impact of negative events, and chiefly, attenuated reactions to both positive and negative events. Their fourth study evaluated self-compassion related to participants’ ratings of videotaped performances in an awkward situation. Findings showed that individuals low in self-compassion undervalued their videotaped performances compared with observers. Also, self-compassion predicted positive affect when watching one’s own videotape, but not when watching others’ tapes, thus providing support for the concept of equanimity in unpleasant stressful and awkward situations and that self-compassion is a unique construct, distinct from broader feelings of compassion toward others.

Lastly, in Leary et al’s fifth study, after self-compassion was induced as a dominant mindset, participants were asked to reflect on negative past experiences and complete relevant
measures to evaluate the extent to which self-compassion moderates people’s reaction to remembered life events. The findings suggested that self-compassion leads people to acknowledge their role in negative events without feeling overwhelmed. Therefore, people high in self-compassion appear to accept responsibility within difficult circumstances (e.g., openness inherent in Neff’s mindfulness component), feel less negatively about self (perhaps influenced by self-kindness), and perceive their experiences as similar to others (common humanity).

To summarize, Leary et al.’s (2007) five studies revealed that self-compassion predicted emotional and cognitive reactions to negative events in everyday life, buffered people against negative self-feelings when imagining distressing social events, and moderated negative emotions after receiving ambivalent feedback, particularly for participants who were low in self-esteem. Leary et al.’s findings demonstrate support for the emotional regulatory capacities wrought within self-compassion, as the studies clearly showed that individuals higher in self-compassion were better able to cope with negative life experiences, such as unfavorable evaluations and personal rejection.

Caution is noted, however, in the limitations of this study to the generalizability of these findings to other populations, such as community samples and trauma survivors, as the young adult undergraduate student sample may be unique and not representative of self-compassion among other populations. Moreover, while the sample size used across these five studies was sufficient, replication with large sample sizes is needed to strengthen the study results. Even with these methodological limitations, however, the findings show promise that self-compassion helps people buffer the negative impacts from daily stressors, which offers hope that this may also ring true for women coping with the aftermath of sexual trauma.
Interesting findings relating to disordered eating are found in the self-compassion literature (Adams & Leary, 2007). A sample of 84 undergraduate women completed measures evaluating restrictive eating (a desire and effort to avoid eating unhealthy foods) and eating guilt, defined as a tendency to feel guilty after eating unhealthily. Afterwards, participants were invited to either an unhealthy food preload (i.e., the disinhibition effect, which refers to occasions of overeating among highly restrained eaters) or not and were induced to evoke self-compassion towards their eating behaviour or given no intervening treatment. Results showed that those who experienced the self-compassion induction experienced reduced distress and attenuated their eating following the preload among those identified as highly restrictive eaters. These findings highlight a positive association of inducing a self-compassionate mind frame and reducing restrictive eating for women. This result demonstrates the potential for self-compassion as an adaptive form of coping with distress and disappointment, which was also demonstrated in Neff, Hsieh and Dejitterate’s (2005) study of undergraduate students coping with academic failure. Their results showed that self-compassion was positively associated with emotion-focused coping strategies and negatively associated with avoidance-oriented strategies. These findings provide support for the adaptive coping qualities that may be fostered through nurturing self-compassion, which may also have implications for the treatment of trauma.

In the only study to date that investigates self-compassion in relation to the specific criteria of post-traumatic stress disorder (PTSD) as outlined in the *Diagnostics and Statistical Manual of Mental Disorders* (DSM-IV-R; 1994), Thompson and Waltz (2008) sampled 210 undergraduates who experienced a Criterion A trauma (22 of whom met criteria for PTSD and 14 of whom identified as having experienced a sexual assault) and administered the SCS (Neff, 2003a) and the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry,
Their findings showed that the SCS total scores significant correlated with the PTSD avoidance subscale of the PDS, but not with the reexperiencing and hyperarousal subscales. Thus, higher self-compassion was associated with a stronger ability to engage with painful thoughts and emotions and less of a need to avoid and disengage from painful affect associated with the outcomes of traumatic experience (Lear et al., 2007; Neff et al., 2007). This finding bears important promise for our interest in self-compassion and recovery from trauma. Although the study findings are limited in the small sample size of sexual assault survivors (14) and the non-clinical undergraduate student population, the results nonetheless provide support for the potential of self-compassion as a positive contribution to post-assault recovery resources. They show promise in individuals higher in self-compassion as having an advanced ability to approach painful emotional experiences, which, in turn, may make them “more likely to experience a natural process of exposure to trauma-related stimuli” (Thompson & Waltz, p. 558).

A number of studies on self-compassion have shown a positive relationship with various indicators of psychological health and wellness. For example, in their study with 91 undergraduates, Neff, Kirkpatrick, and Rude (2007) looked at self-compassion through writing about one’s greatest weakness. Specifically, to evaluate the proposition that self-compassion helps protect against self-evaluative anxiety (which may also include shame), this study involved a laboratory experiment of a mock job interview where participants were to provide a written answer to their “greatest weakness”. As predicted, self-compassion was associated with significantly less anxiety after the task of considering one’s greatest weakness, while self-esteem was not. Analysis of the writings indicated that participants’ references to self and others in the writing task differed as a function of self-compassion; the writing of those high in self-compassion involved a more interconnected and less separate view of self, even when
considering one’s personal weakness. Further, there was no correlation between self-compassion and negative emotion words, thus suggesting that self-compassion does not merely represent a lack of negative affect. Though contributing to our knowledge and understanding of self-compassion using the SCS and supporting Neff’s definition, this study’s findings would be strengthened if replicated using an experimental design (e.g., randomly assigning an experimental group with training in self-compassion and comparing to a control group) and with non-student populations.

Other recent studies have demonstrated a relationship between self-compassion and life satisfaction and happiness. For example, based on analyses of two studies incorporating the self-report measures of 203 undergraduate students evaluating goal regulation, stress, perceived support, and self-compassion, Neely and colleagues (2009) found that self-compassion was a significant predictor of students’ well-being, where it was defined as having a sense of purpose in life, sense of self-mastery, low perceived stress, low negative affect and high satisfaction in life. The sole reliance on quantitative data and the cross-sectional nature of the data, however, limit the strength of the studies’ findings, as does the exclusivity of using a student sample (all participants < age 22).

Other studies have found that self-compassion correlates with self-reported happiness and optimism (Neff et al., 2007) and it predicts variation in happiness and optimism beyond what is accounted for by self-esteem, age, and gender (Neff & Vonk, 2009). As Barnard and Curry (2011) point out, however, positive indicators such as life satisfaction, happiness and well-being may stem from and/or facilitate self-compassion, or other associations may be implicated in these findings, thus, more research is needed to explain these relationships.
In one study involving 69 Christian clergy, self-compassion was found to be negatively related with shame and with emotional exhaustion associated with working in ministry and positively correlated with satisfaction in the ministry (Barnard & Curry, 2011). Here, emotional exhaustion was characterized by fatigue, irritation, sadness, cynicism and social withdrawal, while satisfaction in ministry referred to feeling valued and finding one’s work meaningful and having a positive influence on others.

Two recent studies with adolescents have shown that self-compassion may serve as a form of psychological resilience (Neff & McGehee, 2010) and as an adaptive coping buffer for young women athletes grappling with self-conscious emotions, including shame, guilt and pride (Mosewich et al., 2011). In the latter study, 151 young female athletes (M Age = 15.1 years) completed measures of self-compassion, self-esteem, self-conscious emotions, social physique anxiety, obligatory exercise, objectified body consciousness, fear of failure, and fear of negative evaluation. Self-compassion was found to be negatively related to shame proneness, social physique anxiety, objectified body consciousness, fear of failure, and fear of negative evaluation. Self-compassion was significantly positively related to shame-free guilt proneness and authentic pride, emotions which are considered adaptive. Overall, the study findings support self-compassion as a potential resource for young women, particularly in dealing with negative self-evaluative thoughts and feelings. Such a study offers important evidence to promote continued exploration of self-compassion as it is relates to the challenges of blaming attributions and painful emotions surrounding sexual assault and victimization for women.

Neff and McGehee examined self-compassion among a group of adolescents (N = 235, M Age = 15.2 years) compared with a group of young adults (N = 287, M Age = 21.1 years). Their findings showed that self-compassion was strongly related with well-being among both the
adolescent group and the young adult group. More specifically, self-compassion was significantly negatively correlated with depression and anxiety scales and significantly positively correlated with feelings of social connectedness. Further, the researchers also investigated individual differences in self-compassion based on developmental models of attachment and personality. They found that self-compassion scores were strongly predicted by maternal support and family functioning more generally, with lower levels of maternal support linked with lower self-compassion. The authors interpreted their findings as demonstrating the relationship between self-compassion and attachment styles, suggesting that adolescents or young adults with fearful attachment styles from childhood – characterized by low trust in others and doubts in one’s personal worth – may lack the emotional foundation necessary in order to turn compassion towards themselves in difficult times. Results also showed that self-compassion partially mediated the relationship between maternal support and well-being, and self-compassion was also a significant partial mediator between family functioning and well-being, as well as secure, preoccupied or fearful attachment and well-being. Based on these findings, the researchers suggested that self-compassion may be a reflection of the internalized parent-child relationship; thus, implying that parents bare a strong role in influencing one’s development of one’s inner dialogues, whether it is one of self-compassion or an inner critic.

Another recent study with adolescents (N = 117; aged 16-20 years) within the child welfare system in Canada (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011) showed that higher levels of childhood emotional abuse, emotional neglect, and physical abuse were associated with lower self-compassion. Further, when controlling for age and gender, emotional abuse was significantly linked with reduced self-compassion, even when the effects of neglect and physical abuse were accounted for. Participants lower in self-compassion were found to be
more likely to experience psychological distress, have problems with alcohol and report a previous suicide attempt compared with those with higher self-compassion. These study findings provide strong support for the continued exploration of self-compassion during development and the potential relationships between experiences of abuse and neglect and the associations with self-compassion.

Amid the many aforementioned studies looking at various factors and correlates related to self-compassion, not one study has examined this construct with an adult trauma population, or more specifically, women survivors of sexual assault. This reflects a significant gap in the research for two main reasons. First, knowledge of high incidence and significant negative psychological impacts of sexual assault on women has been consistently revealed in the trauma literature. We know, for example, that experiences of shame (Davis & Breslau, 1994; Greenberg & Paivio, 1997; Vidal & Petrak, 2007), psychological distress (Briere & Runtz, 1989) and negative impacts to cognitions in beliefs about self, the world and self-blame (Foa et al., 1999), as well as the development of disorders such as depression (Briere & Runtz, 1989; Higgins & Follette, 2002), suicidality (Ellis, Atkeson, & Calhoun, 1981), anxiety and PTSD (Resick, 1993) and Complex PTSD (Herman, 1992) can be outcomes of sexual assault and victimization. Given that self-compassion has been theorized as a way of self-relating that offers resiliency and buffering features against experiences such as shame (Gilbert, 2005) and is negatively related to various negative psychological health indicators, such as depression and anxiety (Leary et al., 2007; Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007; Raes, 2011) and to the development of PTSD (Thomspoon & Waltz, 2008), it would seem germane to empirically investigate the relevance of this construct among survivors of sexual assault.
Second, the three components that comprise Neff’s (2003a) operationalization of self-compassion have each been named - either indirectly or directly - in the trauma recovery literature. Thus, in addition to relevant psychological concepts and health indicators empirically connected with self-compassion that would be relevant among a trauma survivor population, the specific components of self-compassion are theoretically relevant to trauma recovery when considering the clinical and feminist literature addressing women’s healing from sexual victimization. These two perspectives, which justify an investigation of the relationship of self-compassion among women coping with the aftermaths of sexual assault, are now each presented in greater detail.

**Sexual Assault**

**Incidents**

High incidents and prevalence of sexual violence experienced by girls and women in North America and around the world are a troubling and well-documented reality. For example, 51% of Canadian women have experienced at least one incident of sexual or physical violence in their lifetime, with 60% of these women encountering more than one violent assault (Statistics Canada, 1993). Other surveys have found that 39% of Canadian women have experienced a sexual assault from the age of 16 (Violence Against Women Survey; Johnson, 1996). Statistical estimates by the World Bank (2007) and the World Health Organization (2008) have projected that 1 in 3 girls will experience a forced sexual assault or other sexual encounter before reaching adulthood.

While women are often assaulted by strangers, the large majority of survivors are raped\(^1\) by someone they know. Statistics Canada, for instance, has found that 19% of women reported

---

\(^1\) While some of the literature differentiates “rape” and “sexual assault”, for the purpose of this dissertation, they are used interchangeably.
being raped by a stranger, with 69% of women identifying an acquaintance as the perpetrator (OWD, 1995). Incidence of verbal sexual coercion is also high, with one survey finding 11.7% of college women reporting sexual coercion in one academic term (Messman-Moore, Coates, Gaffey, & Johnson, 2008).

Impacts

**Psychological distress.** While some of the rape literature has noted a pattern of women rape victims experiencing a brief traumatic response with eventual attenuating of symptoms over time (Arata, 1999), numerous studies have consistently found that a large portion of women continue to experience chronic distress (Koss, 1993; Resick, 1993). These aftereffects of trauma are both numerous and complex; they may include depression, anxiety, somatization, and physical ailments. The women who experienced at least two types of interpersonal trauma in Higgins and Follette’s (2002) study, for example, were more depressed, exhibited more global distress, had more trauma-related symptoms (e.g., anxiety, intrusive thoughts), health problems, and took more medications than other women. In another study, the 15% of 278 university women in Briere and Runtz’s (1989) study who reported having had sexual contact with a significantly older person before age 15 reported higher levels of dissociation, somatization, anxiety, and depression than non-abused women. Fifty percent of participants in Ellis, Atkeson and Calhoun’s (1981) study (N = 27 adult rape victims) reported suicidal thoughts after the sexual assault, with 48% seeking treatment to help deal with assault-related problems. Although the sample size of Ellis et al’s study was relatively small, that half experienced suicidal thoughts is a striking finding that reflects the potentially devastating impact of sexual victimization.
Based on her comprehensive review, Resick (1993) concluded that rape survivors experience significant long-term problems in fear/PTSD, social adjustment, depression, and sexual disorders. In their longitudinal study with female rape victims, Murphy et al (1988) found that compared with non-victims, rape victims reported significantly more problems in interpersonal relationships at 1-year post-assault, significantly lower self-esteem at 18-months post-assault, and lower satisfaction in relations with parents at 2-years post-assault. These findings, thus, confirm the long-term psychological disturbances that can result as a consequence of sexual assault.

**Negative Posttraumatic Cognitions.** Trauma theorists and researchers have recognized and empirically investigated the negative impacts on survivors’ cognitions about self and the world as a result of a traumatic experience as well as on the recovery process. Foa and colleagues (Foa & Riggs, 1993; Foa, Steketee, & Rothbaum, 1989; Foa, Zinbarg, & Rothbaum, 1992), for example, have proposed that the development of PTSD is a result of disruptions in normal processes of recovery for survivors of trauma. Along with colleagues (Ehlers & Clark), they developed the Posttraumatic Cognitions Inventory (Foa et al., 1999) to empirically analyze and validate the theory that two dysfunctional cognitions, such as the belief that the world is completely dangerous and that one’s self is totally incompetent mediate the development and maintenance of PTSD. These dysfunctional cognitions are thought to arise when prior to a traumatic experience the individual believed the world is safe and he/she is highly competent, resulting in difficulty assimilating the traumatic experience and, thus, over-accommodating schemas about the self and the world. Alternatively, the trauma primes existing schemas about the world as a dangerous place and oneself as incompetent for individuals who have previous traumatic exposures or experiences. Hence, the presence of rigid beliefs about self and the world,
whether positive or negative, are considered to contribute to the individual’s development of PTSD, while individuals with finer discrimination of levels of safety and competence are better able to perceive the trauma as a unique experience without broad implications for the nature of the world and their ability to cope with it. Individuals who can perceive the trauma as a time-limited, awful experience that does not necessarily have implications for the future and perhaps even derive some element of personal growth are considered more likely to recover from the trauma and not develop or maintain chronic PTSD. On the other hand, individuals who experience chronic PTSD are characterized as excessively engaging in negative appraisals of the event, its sequela, or both.

Empirical studies have shown support for the relevance of cognitive factors in the development and maintenance of PTSD as theorized by the Foa, Ehlers, Clark and colleagues. In studies with motor vehicle accident survivors and assault victims, for example, negative cognitions and appraisals about initial PTSD symptoms were shown to predict chronic PTSD (Dunmore et al., 1999; Ehlers, Mayou, & Bryant, 1989). For 81 political prisoners who endured assault and torture, recovery was significantly impeded when survivors perceived permanent change to personalities and life aspirations and experienced mental defeat and feelings of alienation from others as a result of the trauma (Ehlers, Maercker, & Boos, 2000). Similarly, in their study of 253 rape survivors, self-blame and maladaptive beliefs predicted levels of psychological distress among survivors, which was also shown to strongly influence all health outcomes for participants.

Persistent PTSD was revealed to be mediated by excessive negative appraisals of traumatic events among a sample of 92 assault victims (Dunmore, Clark, & Ehlers, 1997, 1999). Dunmore and colleagues found that specific cognitive factors were related to both the onset and
maintenance of PTSD, namely, appraisals of aspects of the assault (e.g., mental defeat and mental confusion, and appraisal of emotions), appraisal of symptoms, perceived negative responses from others and a sense of permanent change as a result of the assault, as well as dysfunctional strategies and global beliefs negatively impacts from the assault. Associated with only the onset of PTSD for study participants were cognitive factors such as detachment during the assault, failure to perceive positive responses from others and mental undoing. Significance of the associations between cognitive factors remained when severity of assault was controlled. These study findings along with those mentioned above demonstrate the important role that cognition plays in the aftermaths of trauma for survivors and for many, the development and maintenance of PTSD.

Self-compassion may be related to survivors’ experience of cognitive appraisals post-assault. For example, in Thompson and Waltz’s (2008) study, self-compassion scores (SCS) were significantly negatively correlated with the avoidance subscale of the PDS, suggesting that individuals higher in self-compassion were more able to engage with painful thoughts and emotions rather than avoid them, which is likely implicated in the development and/or maintenance of PTSD given Criterion C of PTSD as outlined in the DSM-IV-R (1994), which accounts for avoidance of stimuli associated with the trauma. Further research on self-compassion and specific correlates of trauma is certainly needed, as this study’s findings promote more empirical questions than answers, such as what components and processes specifically underlie the contributions of self-compassion and its relationship to trauma criteria, and do the relationships vary depending on the type of trauma experienced? Nonetheless, Thompson and Waltz’s study serves as an important platform on which to continue to explore the relationship of self-compassion and the criteria that characterize PTSD; research
incorporating the revised definition of PTSD (in DSM-5) will be particularly fruitful and important.

**Shame.** One of the most noted outcomes for victims of sexual violence who blame themselves for their assault/abuse is the internalization of being/feeling dirty, unlovable, or worthless, which in turn produces intense feeling of shame (Davis & Breslau, 1994; Greenberg & Paivio, 1997; M. Lewis, 1998). For example, Vidal and Petrak (2007) found that in their sample of 25 women rape survivors, those who reported higher self-blame showed significantly higher levels of shame, which was in turn significantly associated with higher level of traumatic stress. Shame has been defined as “the feeling we have when we evaluate our actions, feeling, or behaviour, and conclude that we have done wrong. It encompasses the whole of ourselves; it generates a wish to hide, to disappear, or even to die” (M. Lewis, 1992, p. 2). Shame reflects a sense of “self-blame following an important failure of the self” (M. Lewis, 1992, p.195), which is determined by societal evaluations and expectations (Jordan, 1989). Jordan (1989) argues that being shamed “leaves one feeling disconnected and disempowered” (p. 1); it is a “felt sense of unworthiness to be in connection, a deep sense of unlovability” (p. 6).

Research attention to shame as an outcome of experiences of rape is scant. Studies that have evaluated shame, however, have revealed that women survivors commonly experience shame following sexual assault (e.g., Sable, Danis, Mauzy, & Gallagher, 2006; Vidal & Petrak, 2007; Weiss, 2010). As an example, based on the coding of 136 narratives taken from the American National Crime Victim Survey (NCVS), 13% of respondents reported experiencing some form of shame as a result of sexual assault (n=116 women), where shame was defined to include narratives of self-blame, humiliation, or fear of public scrutiny.
In their study of 25 women survivors of sexual assault, Vidal and Petrak (2007) found that 75% of the women reported feeling ashamed about themselves after experiencing a sexual assault. They also noted that history of previous sexual victimization, physical impacts, self-blame, not disclosing the assault, and knowing the assailant significantly increased the level of shame reported. Although the sample of women in Vidal and Petrak’s study is small, this study is a relatively recent study that closely examines the experience of shame among sexual assault survivors in a London community, and, as such, highlights shame as a pivotal outcome of sexual assault many survivors experience.

The negative impacts of shame for trauma survivors are far reaching. For example, shame has been found to play an important role in the onset and course of depression (Andrews, Qian, & Valentine, 2002). Moreover, shame has been implicated as an essential emotional process related to the development of sexual-abuse-related PTSD symptoms (Feiring, Taska, & Lewis, 2002) and has been found to exacerbate post-rape distress (Vidal & Petrak, 2007). Shame has also been identified as a barrier to treatment (Jordan, 1989; Paivio & Pascual-Leone, 2010) and was found to seriously disrupt the effects of imaginal exposure in treatment for PTSD (Lee, Scragg, & Turner, 2001). Intense feelings of shame may influence early treatment drop or cause women to refuse to seek treatment for symptoms of PTSD (Lee et al., 2001). Further, shame can negatively influence experience of the self and social behaviour, lead to longer-term psychopathology, affect help-seeking (Andrews, 1998) and leaving abusive relationships (Buchbinder & Eisikovits, 2003). Further, shame leads to secrecy and hiding, disconnection from others, and to women not trusting their own views of reality (Jordan, 1989). Indeed, Vidal and Petrak (2007) found that women who reported more shame were more likely to conceal their sexual assault from others. Such isolation and self-doubt in turn lead many women to be more
vulnerable to accepting others’ perceptions of reality claims, which, for survivors of sexual violence, may place them at risk of revictimization (Jordan, 1989).

Gilbert (1997, 1998) has proposed that shame can be differentiated as ‘external’ and ‘internal’. External shame refers to the influence of one’s social presentation, such as feeling unattractive and devalued in others’ perceptions, and is concerned with beliefs that others see one as inferior, inadequate or repulsive in some way. Internal shame, on the other hand, reflects negative evaluations about oneself, thus, seeing oneself as inadequate and inferior. While external and internal shame may overlap, one can exist without the other (Lee et al., 2001). Lee et al (2001) note that for treatment it is imperative to identify whether the individual holds the self as shameful, or if the shaming is solely external, as this distinction affects challenging of core beliefs associated with one’s perceptions.

Lee et al (2001) propose that another important distinction to make regarding trauma survivors’ experiences of shame is the enactment of shame as a primary or secondary emotion. Sexual assault may involve both primary and secondary shame, as interpersonal violence may evoke primary shame associated with the trauma, which triggers fear along with disempowerment. Survivors of sexual assault may also experience secondary shame, as it stems from learned evaluations within the family, culture and society of what is considered shameful, which in our current sociocultural context entail devaluations and shameful associations with sexual victimization (Lebowitz & Roth, 1994). Thus, shame can be experienced as an “innate hard-wired response” when the trauma occurs and can be linked with the meaning of the traumatic event and/or with symptoms of PTSD (Lee et al., 2001, p. 455). Further, Lee et al differentiate the experience of humiliation from shame in the case of experiencing rape. For example, they note that if the woman does not blame herself for the rape, she may still find the
experience humiliating; however, if when she discloses her rape to others and perceives herself as devalued in their eyes (i.e., and blamed), she may develop an internal sense of shame that leads to worsening of the impacts of the rape with associated feelings of being damaged (Gilbert, 1998).

Lee et al (2001) propose a model for shame-based PTSD developed through schema congruence or schema incongruence. Schema congruence refers to shame arising from the meaning of the traumatic events as compatible with underlying “shame schemas” about the self, whereas schema incongruence occurs when there is an incongruence of information of meaning from the traumatic event and preexisting schema (beliefs about the self and the world). Shame associated with self-blame for one’s sexual assault would, thus, likely reflect schema congruence wherein deeper held beliefs about one’s inadequacy or deservingness of harm are triggered by the event and often supported within the sociocultural context in the presentation of ‘external shame’. Not blaming oneself would support schema incongruence such that the self is able to deflect blame to the responsible others and not be defeated by the assault. Lee et al. note Gilbert’s (1997) example of a victim of torture who may feel humiliated, terrified and degraded by the perpetrator, but would not necessarily experience a devaluing or tarnishing of his identity. Still, even in schema incongruence, shame may arise as a result of a broken self identity, with the substitution of premorbid adaptive belief systems into shame-based beliefs about the self developed through the traumatic experience (Lee et al, 2001). In their study with 25 women survivors of adult sexual assault, Vidal and Petrak (2007) found support for Lee et al’s (2001) model of shame-based PTSD, namely, the women who reported higher self-blame showed significantly higher levels of shame, which, in turn, was significantly associated with higher
level of traumatic stress. Although a small study, their findings serve to bolster support for Lee et al.’s model of shame-based PTSD and encourage continued research in this area.

**Self-criticism**

A distressing self-relating style described as a “reflexive psychological behaviour” (Whelton & Greenberg, p. 1583), self-criticism has been deemed one of two dysfunctional configurations that make up Blatt’s (1974) model of depressive vulnerability. The self-critical personality type is described as one that carries an incessant need for self-sufficiency and is plagued with feelings of failure, worthlessness, self-doubt and inferiority (Blatt & Homann, 1992; Blatt & Zuroff, 1992). Self-criticism is a form of ‘inner harassment’ characterized by self-critical thoughts and feelings that can be intensely stress producing (Gilbert, 1992). In a recent study to evaluate their new scale called the sensitivity to put-down scale, Gilbert and Miles (2000) found that self-blame for criticism was associated with social anxiety, depression and shame. A self-critical cognitive style has also been found to mediate the relation between emotional abuse and non-suicidal self-injury among adolescents (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007).

In their process of developing a scale to measure self-criticism, Gilbert, Clarke, Hempel, Miles, and Irons (2004) identified two components of self-criticism, namely, dwelling on one’s mistakes and experiences of inadequacy and second, a desire to hurt or harm the self and feeling self-disgust and self-hate. The functions for this self-criticism were also differentiated into two factors, self-improvement/correction and self-harming/persecution. Evaluating their scales with a sample of 246 college women, Gilbert et al. found that a desire to harm the self positively mediated the effects of self-hate and was negatively mediated through the ability to self-reassure and attend to one’s positive traits. The authors concluded that the forms and functions of
individuals’ self-attacking must be included in assessment and treatment to more effectively alter this pathogenic self-relating style. Further, they noted that developing compassion for the self and the ability to self-soothe may play a major role in recovery from self-attacking behaviour. While an important contribution to the self-compassion literature and our understanding of self-criticism, this study failed to inquire or include participants’ experiences of trauma or sexual victimization. Thus, the potential relationship of self-criticism to experiences of sexual violation is unaddressed in this research.

Greenberg, Watson, and Goldman (1998) also emphasize the role of the incapacity of the self to counter self-critical attacks as paramount in the depressogenic process, along with the importance in attending to the harsh negative affect, such as shame and helplessness that results from self-criticism (Greenberg & Paivio, 1997). Indeed, Whelton and Greenberg’s (2005) study with 60 undergraduates who took part in a gestalt two-chair exercise involving enactment of their self-critical “inner voices” showed that self-critics were more contemptuous and less self-resilient than controls. Their study supports their proposed model that the emotional tone of contempt and disgust in addition to negative content are part of the internalized processes of self-criticism and should, therefore, be included in models of recovery and treatment of self-criticism.

Within the rape literature, however, self-criticism has been given little attention. The two rape studies that incorporate self-criticism, namely Brietenbecher (2006) and Filipas and Ullman (2006), are concerned with relationships among self-blame, sexual victimization and psychological distress, yet no specific measures of self-criticism were incorporated. In the rape literature, self-criticism appears to be couched within the domain of self-blame, which clouds its potentially unique role and any important relationships implicated in women’s recovery from sexual assault.
In other studies, self-criticism has been shown to play a role in a number of psychological difficulties, such as mood disorder (Marshall, Zuroff, McBride, & Bagby, 2008; Gilbert, 1998), suicide (O’Connor & Noyce, 2008), and PTSD (Brewin, 2003; Lee, 2005). One prospective study exploring risk factors for rape and sexual coercion among college women found that self-criticism and depression increased risk for verbal sexual coercion only, while marijuana and alcohol use increased risk only for rape (Messman-Moore, et al., 2008). These findings thus suggest that being self-critical may place women at an increased risk for sexual coercion, however, continued research is needed to clarify and confirm these relationships.

Studies of self-compassion to date have found significant correlations with self-criticism (e.g., Gilbert & Irons, 2004, 2005; Gilbert & Procter, 2006; Leary et al., 2007; Mosewich et al., 2011), suggesting a strong negative relationship that may offer promise in clinical applicability for survivors particularly high in self-criticism. A feminist analysis of the occurrence of sexual assault in our society suggests a problematical experience of self-blame among survivors, which may similarly evoke victims’ critical responses to self post assault. Due to the limited studies examining self-criticism among survivors of sexual assault, and the contrasting of self-criticism to self-compassion in the self-compassion literature, in the present study, self-criticism is considered apart from posttraumatic adjustment and framed as a pre-existing characteristic.

**Satisfaction with life**

The assessment of life satisfaction in counselling and clinical psychology and mental health research is growing alongside strengths-based approaches in evaluating clinical interventions (Duckworth, Steen, & Seligman, 2005), in discriminating among psychiatric populations (Arrindell, van Nieuwenhuizen, & Luteijn, 2001), assessing risk for
psychopathology and self-destructive behaviour (Suldo & Huebner, 2004), and evaluating psychotherapy treatment outcome (Friedman & Toussaint, 2006).

A large majority of studies examining life satisfaction have used the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), which has been found to have strong reliability and validity (Pavot & Diener, 1993, 2008). The construct of satisfaction with life has received strong empirical support for its unique contribution as a concept describing positive psychological health consisting of cognitive and global evaluation of one’s quality of life overall, both apart from and related to the broader construct of Subjective Well-Being (SWB) (Pavot & Diener, 1993). As one of three components to SWB (e.g., along with positive and negative affect; Diener, 1984), life satisfaction has been identified as an evaluative judgment of one’s life and has been heavily relied on among studies examining wellness and mental health.

A longstanding debate grappled in the literature exploring this construct is concerned with what factors underlie judgments that lead to satisfaction with life, and the possible variations that may influence its reliability and validity (Pavot & Diener, 2008). Discussions have resulted in differing models of the process underlying life satisfaction, such as the promotion of top-down structures emphasizing personality and temperament as the primary sources of judgment (Heller, Watson, & Ilies, 2004; Stubbe, Posthuma, Boomsma, & De Geus, 2005) and bottom-up models wherein factors such as current mood and immediate life circumstances are thought to be primary in formulating judgments regarding satisfaction with life (Pavot & Diener, 2008).

The notion of adaptation has dominated discussions of life satisfaction, proposing that life events or changes in life domains, while initially influencing one’s level of life satisfaction or overall SWB, only temporarily influence overall satisfaction with life (Pavot & Diener, 2008).
Adaptation proposes that people quickly adapt to new circumstances, and their level of SWB returns to a level similar to that before the event or experience. Headey and Wearing (1992) proposed a dynamic equilibrium model whereby a chronic baseline level of SWB is regulated by temperament or personality and overall SWB and satisfaction with life is relatively unchanged by life events or personal changes.

A number of studies, however, have shown that some life events and domain changes may result in lasting change in satisfaction in life and SWB. For example, unemployment (Lucas, Clark, Georgellis, and Diener, 2003), caring for a person with Alzheimer’s disease (Vitaliano, Russo, Young, Becker, & Maiuro, 1991), or becoming a widow (Lucas et al., 2003; Stroebe, Stroebe, Abakoumkin, & Schut, 1996) can produce long-term negative impacts on SWB. In light of emerging evidence that SWB and satisfaction with life levels do sometimes change over time, Heady (2006) proposed a modification of dynamic equilibrium theory, identifying personality traits and life events that are associated with such change. Thus, events in at least some life domains appear to have the power to bring about long-term variations in an individual’s level of SWB.

Based on their review of the various models discussed in the literature, Pavot and Diener (2008) argue that life satisfaction likely reflects a complex combination of both top-down and bottom-up factors. While personality traits such as extroversion and introversion form a foundation of subjective experiences of life satisfaction, components such as personal strivings also bear influence. Both individual and cultural norms are also found to exert influence on one’s judgments that lead to life satisfaction, as are feelings of self-esteem and self-efficacy, and experiences of mental illness and health (Pavot & Diener, 2008).
While these discussions have brought forward our understanding of life satisfaction as a factor of wellness, further research is needed, particularly that which continues to elucidate the cognitive processes involved in the formulation of life satisfaction judgment, as well as a deeper understanding of the process of adaptation (Diener et al., 2006).

Studies examining sexual assault and rape have commonly found lowered levels of life satisfaction among victims of sexual violence (e.g., Choudhary, Coben, & Bossarte, 2008) as well as in specific life domains, such as work (Murphy, Amick-McMullan, Kilpatrick, Haskett, Veronen, et al., 1988), and sexuality (McCall-Hosenfeld, Liebschutz, Spiro, Avron, & Seaver, 2009; Rynd, 1988). While some studies that explore the impact of sexual assault and rape incorporate a measure of quality of life or life satisfaction, typically in such studies the construct is included only as an indicator of mental health and happiness. For example, in their study examining perceived control and adjustment in a sample of survivors of sexual assault (n=135) and women who experienced sudden bereavement (n=159), Frazier, Stewart and Mortensen (2004) simply reported the finding that regarding satisfaction with life both groups of women reported being ‘satisfied’ (e.g., Frazier, Stewart, & Mortensen, 2004), without any additional explanation.

Studies that investigate this construct more deeply in terms of processes and influences on trauma recovery are scant. Thus, further studies that examine this construct among survivors of sexual assault and other traumas are needed. The application of predictive studies, for example, may be useful with a trauma population in investigating longer-term outcomes that may be predicted by satisfaction with life. Studies that closely examine the notion of adaptation and its role in posttraumatic adjustment and recovery for women who experience sexual trauma would
also provide important and interesting knowledge to both the trauma and recovery literature and positive psychology more broadly.

**Feminist Analysis of Posttraumatic Impacts and Adjustment**

While there is some commonality among reactions for victims common to all traumas (e.g., fear, terror, humiliations and imminent risk of serious injury or death), sexual assault is a violent act on another that reflects broader societal and political constructions of power and gender. A number of feminist theorists (e.g., Brownmiller, 1975; Burt, 1980) and psychological studies (e.g., Anderson, 1999; Pollard, 1992; Ullman, 1996; Wyatt et al., 1990), for instance, have highlighted societal attitudes of blame aimed at the female rape victim, while an attitude of neutrality and exoneration is directed towards the male perpetrator (Doherty & Anderson, 1998). Studies have revealed the influential role of others’ negative and accusatory responses and attitudes linked with patterns of symptoms and poorer recovery of survivors that is unique to rape survivors versus victims of other crimes (Kilpatrick, Best, Veronen, Amick, Villeponteaux, & Ruff, 1985; Resick, 1993; Ullman, 1996).

A critical feminist analysis of the role and impacts of messages of blaming women for their sexual assault provides an important theoretical underpinning for the promotion of examining self-compassion as part of women survivors’ posttrauma experience and recovery, as victim blaming attitudes perpetuate a ‘rape supporting culture’ (Doherty & Anderson, 1998) that impacts women’s posttrauma adjustment. Rape myths, defined as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists (that) create a climate hostile to rape victims” (Burt, 1980, p. 217) play a pivotal role in women survivors’ experiences of assault and recovery. Examples of rape myths include the belief that women lie about rape, that only ‘certain’ women are raped, and that because rape is sex, it is not damaging to the woman (Garland, 2005;
Lonsway & Fitzgerald, 1994). One recent national population survey in Ireland, for example, found that 30% of the sample of men and women (N = 3120) agreed that women wearing short skirts or tight tops were “inviting rape” and, thus, in some ways accountable for their victimization (McGee, O’Higgins, Garavan, & Conroy, 2011).

These rape myths and victim-blaming attitudes are held and perpetuated by police (Burt, 1980; Garland, 2005), medical and healthcare practitioners (Best, Dansky, & Kilpatrick, 1992), and legal and judicial systems (DuMont & Myhr, 2000; Gunn & Minch, 1988; Lees, 1993), the very systems on which a rape victim must rely if she chooses to report and receive treatment. In fact, rape victims have been described as experiencing a form of “secondary victimization” through feeling guilt and shame as a result of blaming attitudes held by such professionals (Campbell et al., 2001; Doherty & Anderson, 1998).

As a result of pervasive rape myths and victim blaming attitudes, a majority of sexual assault survivors internalize blame for their assaults (Burt, 1980). High incidence of self-blame among victims of sexual violence has been shown across various studies (e.g., Jehu, 1989; Koss, Figueredo, & Prince, 2002; Meyer & Taylor, 1986; Miller et al., 2007; Ullman, 1996, 1997; Wiehe & Richards, 1995). In Jehu’s (1989) study of female survivors of sexual violence, 86% believed they were responsible for their sexual abuse. In Vidal and Petrak’s (2007) study of 25 women survivors of rape, 64% reported feeling to blame for their assault, and Meyer and Taylor (1986) noted 50% of their sample of 58 rape victims endorsed a self-blaming attitude. While these studies may rely on small sample sizes, the findings nonetheless reveal that many survivors of sexual assault blame themselves. Studies have shown that victims of acquaintance rape experience more self-blame (Katz, 1991; Katz & Burt, 1988), which has been associated with lower reporting and delayed treatment seeking (Stewart et al., 1987). Victims of drug-facilitated
rape also feel a high degree of guilt and self-blame because they had been drinking alcohol when they were drugged (Fitzgerald & Riley, 2000).

Findings within the rape literature and research clearly show that self-blame impacts adjustment and recovery from rape. Of the 80 survivors interviewed in Katz & Burt’s (1988) study, for example, survivors with greater self-blame reported higher levels of psychological distress, longer recovery time, and lower levels of self-esteem. In Meyer and Taylor’s (1986) study, both characterological self-blame and behavioural self-blame were associated with poorer post-rape adjustment. Frazier (1990) found a greater likelihood of post rape depression among survivors with higher self-blame. Self-blame has also been linked to increased risk for victimization (Miller, Markman, & Handley, 2007), lower self-esteem (Kilpatrick & Veronen, 1983), maladaptive coping strategies (Arata & Burkhart, 1998), poorer recovery for women assaulted in both childhood and adulthood (Ullman, 1997), and increased levels of shame relating to self-blame (Vidal & Petrak, 2007).

To summarize, a critical feminist analysis thus implicates the pervasive occurrence of victim-blaming attitudes perpetuated through rape myths in the negative psychological impacts on women survivors of sexual victimization. Through victim-blaming attitudes that minimize the culpability of male perpetrators while exemplifying women victims’ responsibility for sexual assault and victimization, survivors - not surprisingly - often struggle with self-blame and, as a consequence, feelings of shame, which have been implicated in the occurrence and development of negative views of self and the world, increased psychological distress and even manifestations of more severe clinical disorders (e.g., PTSD), as well as impediments to healing and recovery. Challenging and healing such shame-based beliefs is, therefore, vital for survivors’ recovery and transformation.
Components of Self-Compassion and Trauma Recovery Theory

The cultivation of self-compassion has been proposed as a type of resolution to shame, thus, as a potential valuable component to enhancing survivors’ psychological health and well-being (Lee, 2005). Yet, a lack of attention to the relationship of traumatic experiences in recent self-compassion research by Neff and others highlights a gap where further exploration is needed.

Some of the work of feminist theorists (Herman, 1992) and psychologists (e.g., Lee, 2005; Paivio & Pascual-Leone, 2010) has emphasized the importance of survivors developing self-compassion to counter internalization of victim-blaming tones perpetuated in society that contribute to feelings of shame. Examining the three components of Neff’s definition of self-compassion in the context of this literature provides further impetus to investigate compassionate self-relating among a population of women sexual assault survivors.

The first component of Neff’s definition of self-compassion is self-kindness, which is deemed preferable over an attitude of self-judgment. Undoubtedly, a self-attitude of kindness over one of self-judgment is more adaptive and less harmful in providing self-nurturing, empathy, and love. In women’s therapy groups, for instance, self-empathy is considered one of four curative factors according to Fedele and Harrington (1990) and is noted by Herman (1992) as a key quality for survivors in the process of recovery.

The second component of self-compassion is common humanity versus isolation. Neff’s definition of common humanity encapsulates taking a broader view of one’s failings and problems within the realm of the human experience. It involves seeing oneself as having less of a separate identity and more of a connection with human experience as healthy and healing. Terry and Leary (2011) propose that this element of self-compassion would be particularly important
in helping trauma survivors cope with feelings of self-blame and shame, surmising that self-compassionate people, by focusing on feelings of common humanity, should focus less on how they were uniquely to blame for what happened to them.

World-renowned trauma expert Herman (1992) cites commonality as one of the essential processes of recovery from trauma. She points to the healing experiences within group therapy wherein trauma survivors are freed from isolation and secrecy, and able to reconnect and envision their suffering alongside others. Herman explains that once cohesion and intimacy are attained in the group, an intricate mirroring process occurs for each woman in which “the tolerance, compassion, and love she grants to others begin to rebound upon herself” (1992, p. 215-216).

Another example is found in Ingram and Perlesz’s (2007) clinical research with trauma survivors titled ‘The Wisdom’s Project’, in which participants experienced the therapist reading back theirs and others’ stories of pain and trauma, which “reinforces for us the power of human connection in engendering hope” (p. 84). Hearing others’ stories of wisdom and struggle helped them to feel connected with others, no longer isolated in their own suffering. An outcome of this process of telling, writing, reading, listening to and bearing witness to one’s own and others’ stories was enhanced self-compassion. This enhanced self-compassion created through the bearing witness to others’ stories (i.e. connection) seems comparable to Neff’s component of common humanity.

The final component in Neff’s definition of self-compassion is mindfulness, which has previously been linked with the treatment of trauma (e.g., Follette et al., 2006; Linehan, 1993). For example, Follette et al (2006) integrate Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT), and Functional Analytic Psychotherapy (FAP) to target
mindfulness in the treatment of trauma survivors. They argue that mindfulness enables a “psychological flexibility” that can coincide with targeting the reduction of emotional avoidance and suppression that is common among survivors of trauma. They believe that mindfulness allows openness to negative affect and experiencing, and helps diminish avoidant coping behaviour. Follette et al also note “the process of noticing and contacting private experiences without judgment is a part of the path to self-acceptance, which is a fundamental issue for many trauma survivors” (p. 58). Given that being in connection as a means towards healing requires an ability to be emotionally accessible and vulnerable (Stiver, Pierce, & Miller Baker, 1995), mindfulness may be the skill or ability to enable a trauma survivor to hold and sit with the intensely uncomfortable emotions that is necessary in trauma healing and recovery.

**Need for the Present Study**

Studies on self-compassion to date have shown promising findings positioning self-compassion as a psychological construct with health enhancing qualities. In particular, theorizations of self-compassion as an ‘anti-dote’ to shame (Gilbert, 2005) and as a form of psychological resilience against negative psychological manifestations, such as depression and anxiety (Leary et al., 2007; Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007; Raes, 2011), and PTSD (Thompson & Waltz, 2008) have been supported through empirical investigations. These sequelae have been noted as some of the negative impacts of sexual assault in the trauma literature.

Moreover, Neff’s three components of self-compassion (self kindness, common humanity, and mindfulness) have each been alluded to in the trauma literature. Connecting Neff’s components of self-compassion with the recovery of trauma suggests that this conceptualization of self-compassion may be applicable, if not quite valuable, for sexual assault
survivors. However, given that no studies on self-compassion have specifically examined its relevance in the experiences of women coping with the aftermaths of sexual assault points to a present gap in our understanding of this important concept.

An additional limitation to studies on self-compassion to date is a heavy reliance on undergraduate student populations, with an absence of representation from broader community-based samples. Further, while recent studies of self-compassion have found that females tend to score lower on self-compassion than their male counterparts (Neff, 2003a; Neff & McGehee, 2010), suggesting that self-compassion may be experienced differently, or be more difficult for women, the majority of studies on self-compassion have not investigated women’s experiences exclusively. Given that the majority of victims of sexual assault and childhood sexual abuse are female (Wilken, 2002), women are at an increased risk of internalizing blame and feeling shame, guilt, and worthlessness as a result of victimization (Greenberg & Paivio, 1997). Studies that evaluate women’s experience of self-compassion are, therefore, particularly important for our understanding of this psychological construct, and how it relates to women’s experiences in the aftermaths of trauma. It is anticipated that the current study will offer a much-needed contribution to this disparity of knowledge.

Based on our current knowledge and understanding of the role of self-compassion in trauma recovery, this study examined self-compassion among a sample of women survivors of sexual assault. The overarching question this study sought to address is whether self-compassion is related to sexual assault survivors’ psychological health and recovery? Specifically, this study examined the relationships between self-compassion and posttrauma adjustment (psychological distress, negative posttraumatic cognitions, and shame)\(^2\), self-criticism, and satisfaction with life.

\(^2\) Henceforth in this dissertation, unless otherwise specified “posttrauma adjustment” refers to three of the constructs examined in the study: psychological distress, negative posttraumatic cognitions, and shame.
We were also interested in evaluating the relationships between self-compassion and posttrauma adjustment and self-criticism when controlling for childhood trauma and other stressful life events. Based on theory and research on self-compassion thus far, along with previous knowledge of rape and its psychological correlates, a number of predictions were made. They were:

1. Self-compassion will be negatively related to posttrauma adjustment and self-criticism.
2. Self-compassion will be positively related to life satisfaction.
3. Self-compassion will be a significant contributor to posttrauma adjustment and self-criticism independent of contributions of childhood trauma and stressful life events.

Further exploratory analyses of self-compassion and additional variables (e.g., severity of sexual assault history) were also conducted in order to maximize our understanding of self-compassion and any other relevant relationships related to coping with the aftermaths of sexual assault.
Method

Study Sample

One hundred and forty-one women living in North America who have experienced a sexual assault in the past 5 years participated in this study (aged 18 to 61, M age = 27 years). Inclusion criteria for this study consisted of women aged 18 or older who experienced a sexual assault in the past 5 years and were able to provide informed consent. Participants had to have a sufficient command of the English language in order to comprehend and complete the questionnaires. Almost the entire sample identified as living in Canada (140 women), with a vast majority of the participants residing in Ontario (56.7%). While participants were asked about the time since their assault(s), only 47 individuals responded, thus, the descriptive statistics on this variable are not included. Details regarding demographical characteristics of participants can be found in Table 1.

Almost half of the sample identified as “Euro-Canadian”, a result that is not surprising when compared with other studies conducted in Canada. The number of participants who identified as “Other” (e.g., 30.5%) appeared high given the choice to select from nine different ethnocultural designations. The wording of “Euro-Canadian”, without a clarifier of “Caucasian” may have been unclear or problematic to many people who may have interpreted this option as signifying first- or second-generation European. This lack of clarity in the demographics questionnaire may have contributed to the high number of participants reporting “Other” as ethnocultural background.

---

3 Given that that it is the woman’s perceptions of the sexual victimization that are the most significant determinants of her psychological responses, this study will include both women who have and have not experienced rape and will not be limited by or concerned with legal definitions of “rape”. As such, the term “sexual assault” is used throughout this dissertation.
Table 1

*Descriptive Statistics for Participant Demographics and Background*

<table>
<thead>
<tr>
<th>Ethnocultural background</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian-Canadian</td>
<td>10</td>
<td>7.1</td>
</tr>
<tr>
<td>Indo-Canadian</td>
<td>4</td>
<td>2.8</td>
</tr>
<tr>
<td>African-Canadian</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>2.8</td>
</tr>
<tr>
<td>Caribbean-Canadian</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Euro-Canadian</td>
<td>69</td>
<td>48.9</td>
</tr>
<tr>
<td>Métis</td>
<td>5</td>
<td>3.5</td>
</tr>
<tr>
<td>First-Nations</td>
<td>4</td>
<td>2.8</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>30.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>87</td>
<td>61.7</td>
</tr>
<tr>
<td>Common-law</td>
<td>18</td>
<td>12.8</td>
</tr>
<tr>
<td>Married</td>
<td>15</td>
<td>10.6</td>
</tr>
<tr>
<td>Divorced</td>
<td>13</td>
<td>9.2</td>
</tr>
<tr>
<td>Separated</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>Student</td>
<td>77</td>
<td>54.6</td>
</tr>
<tr>
<td>Not presently working</td>
<td>49</td>
<td>34.8</td>
</tr>
<tr>
<td>Living circumstances</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>With family</td>
<td>43</td>
<td>30.5</td>
</tr>
<tr>
<td>With roommate(s)</td>
<td>34</td>
<td>24.1</td>
</tr>
<tr>
<td>Alone</td>
<td>33</td>
<td>23.4</td>
</tr>
<tr>
<td>With spouse</td>
<td>33</td>
<td>23.4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to perpetrator</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown (stranger)</td>
<td>37</td>
<td>26.2</td>
</tr>
<tr>
<td>Ex-boyfriend</td>
<td>31</td>
<td>22</td>
</tr>
<tr>
<td>Acquaintance/friend</td>
<td>27</td>
<td>19.1</td>
</tr>
<tr>
<td>Family friend</td>
<td>11</td>
<td>7.8</td>
</tr>
<tr>
<td>Co-worker/boss</td>
<td>10</td>
<td>7.1</td>
</tr>
<tr>
<td>Neighbor</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Father</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Dating</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Boyfriend</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>Teacher/coach</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>25.4</td>
</tr>
</tbody>
</table>

| Counselling past            | 68 | 48.2|
| Counselling current         | 36 | 25.5|
| Had/has a support person    | 71 | 50.4|
More than half of the current sample (61.7%) identified as “single”, which may not be atypical given the mean age of the study sample (e.g., 27 years). Over half of the sample (54.6%) reported being a student and approximately one third identified as unemployed. Percentages of living circumstances were comparable across the board.

Regarding relationship to the perpetrator, the highest percentage reported was by known assailants. Strangers accounted for 26.2%, while the ‘other’ category consisted of 25.4% of participants. Participants who used the space to write what for them was “other” identified their relationship to the perpetrator as: Minister, doctor, uncle, cousin, brother-in-law, mother’s boyfriend, girl friend, and foster-father, thus, the perpetrators in this category are also known to the victim. These rates of the perpetrator being known to the victim are similar to those reported by Statistics Canada (OWD, 1995). Almost three quarters of the study sample reported some experience receiving counselling related to their assault(s) and half (50.4%) of the sample identified having had/having a support person in her life whom she felt she could consistently turn to and rely on.

**Measures**

Standardized measures assessing participant trauma history, posttrauma adjustment, self-compassion, self-criticism, and life satisfaction were used. In addition, a brief demographics questionnaire was developed for the purpose of this study (Appendix F). Variables included were age, ethnocultural background, relationship status, student and employment status, living circumstances, relationship to the perpetrator(s), previous and current experience in counselling/therapy, and the experience of a support person.

**Sexual trauma history.** Following from Koss and colleagues’ earlier work on the Sexual Experiences Survey (E.g., Koss & Gidycz, 1985; Koss, Gidycz, & Wisniewski, 1987; Koss &
Oros, 1982), an adaptation of the revised and most recent short-form victimization version (SES-SFV; Koss, Abbey, Campbell, Cook, Norris, Testa et al., 2007) was used to assess adult sexual victimization experiences (Appendix G)\(^4\). Two minor modifications were made, namely, questions concerning the age since trauma (i.e. “since the age of 14” in the SES) were omitted as they were outside of the inclusion criteria and time elapsed since sexual victimization (e.g., “how many times in the past five years” was included in lieu of “the past 12 months” in the SES). The SES-SFV consists of 10 questions regarding sexual victimization and experiences of unwanted sex acts associated with various levels of coercion, threat, and force. Participants rate each item (1-7) that includes 5 detailed descriptions of sexual experiences (from a to e) on two separate frequency scales (from 0 to 3+) that identify “how many times in the past ‘five years’?” Questions refer to coercive sexual experiences, such as both coerced and forced sex acts, pressured sex acts and intercourse, intercourse or forced sex acts due to a man’s use of position or authority, unwanted sex acts because a man gave the woman alcohol or drugs, attempted rape, and forced penetration or sex acts not including intercourse and forced intercourse. Items 8-10 evaluate demographic information, frequency of experiences, relationship to the perpetrator and whether or not the participant reports an experience of rape. To score the SES-SFV, ordinal scoring was executed through placing each participant into an exclusive category based on their most severe experience. Guidelines for such grouping are provided in Koss et al (2007).

Regarding reliability and validity, Koss et al (2007) contend that since the SES is an induced model, wherein observed variables combine to form a new variable that represents a category of sexual experiences (e.g., noncontact, sexual coercion, rape), correlations between categories are not relevant, as “no reason exists for two or more of women’s experiences of sexual assault to

\(^4\) Revisions of the SES include more behavioural specificity, conversion to gender neutrality, full crossing of unwanted sexual acts and coercive tactics and revised and updated wording regarding the assessment of consent, alcohol-related incidents, unwanted acts, and coercive tactics.
necessarily be related to one another” (p. 363). Thus, measures of internal reliability are not suitable with the induced variable model (Koss et al., 2007).

**Childhood trauma.** The 28-item short-form of the Childhood Trauma Questionnaire (CTQ-SF; Bernstein & Fink, 1998; Bernstein et al., 2003) was employed to identify participants’ previous experiences with abuse and neglect in childhood (Appendix L). Participants responded to items that ask about experiences in childhood and adolescence using a 5-point Likert-type scale (Never True = 1 to Very Often True = 5). The five clinical subscales of the CTQ are physical, sexual, and emotional abuse and physical and emotional neglect (see Bernstein et al., 2003 for definitions of maltreatment types), which are each represented by five items. The remaining three items in the CTQ make up a Minimization/Denial validity scale that was designed to detect underreporting of maltreatment. A high score indicates more frequent past experiences with childhood abuses/traumas. Internal consistencies of the five subscales based on a study with a large community sample in Los Angeles County were as follows: .87 Emotional Abuse; .83 Physical Abuse; .92 Sexual Abuse; .91; Emotional Neglect; and .61 Physical Neglect (Bernstein et al., 2003). These statistics are consistent with previous psychometric qualities of the 70-item CTQ that demonstrated high internal consistencies ranging from .79 to .94 (Bernstein et al., 1994).

**Stressful life experiences.** To identify the number of stressful or traumatic experiences participants may have experienced in addition to sexual assault, participants were asked to complete the 20-item Stressful Life Experiences Screening Questionnaire (SLESQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998; see Appendix O). Participants were asked to circle YES if they experienced the event described in the item, or NO if they have not experienced the particular incident. Sample items include: “I have witnessed or experienced a serious accident or
injury”, “I have felt responsible for the serious injury or death of another person”, and “As an adult, I was hit, choked or pushed hard enough to cause injury”. Scores are summed, where an answer of ‘yes’ counts as ‘1’; higher total scores indicate more experiences with previous stressful life events.

**Negative posttraumatic cognitions.** Negative impacts of trauma on thoughts and beliefs was measured with the Posttraumatic Cognitions Inventory (PTCI; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999), a 36-item scale designed to measure thoughts and beliefs about self and the world related to posttraumatic adjustment with a 7-point Likert format where 1 = “Totally disagree” to 7 = “Totally agree” (Appendix I). The PTCI has been shown to consist of three factors, negative cognitions about self, the world and self-blame. Sample items include: “The event happened because of the way I acted”, “People can’t be trusted”, and “I have to be on guard all the time”. Higher scores indicate greater endorsement of pathological cognitions. Internal consistency is excellent, with Cronbach’s alphas for total score and PTCI scales as follows: .97 (total score), .97 (Negative Cognitions About Self), .88 (Negative Cognitions About the World), and .86 (Self-Blame). Test-retest reliability at 1-week and 3-week intervals was also good (Foa et al., 1999). All factors indicated moderate to strong correlations with measures of PTSD, depression, and general anxiety, and the PTCI was found to discriminate between individuals with and without PTSD (Foa et al., 1999).

**Shame.** The 25-item Experience of Shame Scale (ESS; Andrews, et al., 2002) was used to assess participants’ levels of shame (Appendix M). The ESS measures shame related to self (character and body) and performance (behaviour) on a 4-point scale (1 = “not at all” to 4 = “very much”), resulting in a total score in the range of 25-100. Three separate scores can be calculated for characterological shame (e.g., manner with others and personal habits),
behavioural (e.g., doing something wrong) and bodily shame. Higher scores reflect a higher level of shame. Sample items include: “Have you felt ashamed of your manner with others?”, “Have you worried about what other people think of your ability to do things?”, and “Have you avoided looking at yourself in the mirror?” Internal consistency for the ESS is reported to be .90 for characterological shame, .87 for behavioural shame, and .83 for bodily shame (Andrews et al., 2002). Test re-test reliability for the total scale is excellent at .83 (Andrews et al., 2002).

**Psychological distress.** To assess participants’ trauma-related symptoms, the Trauma Symptom Checklist (TSC-40; Brier & Runtz, 1989) was used (Appendix J). On the TSC-40, participants rate the frequency and extent to which they have experienced each symptom on a four point scale (1 = Never to 4 = Very Often) over the past two months. Sample items include: “Restless sleep”, “Dizziness”, “Loneliness”, and Uncontrollable crying”. To score the TSC-40, items are summed to produce a total score of six symptom scales, namely, Dissociation, Anxiety, Depression, Sexual Abuse Trauma Index [SATI], Sexual Problems, and Sleep Disturbance, or individual subscale scores. High scores reflect endorsement of more symptoms, hence, higher distress. The TSC-40 is an extended version of the TSC-33, a brief instrument with “reasonable psychometric quality which can be used in clinical research as a measure of traumatic impact” (Briere & Runtz, 1989, p. 153). With reliability cited as .90, The TSC-40 has been shown to be a reliable measure that discriminates well between sexually abused and non-abused women (Elliott & Briere, 1992)

**Self-compassion.** Participants were given the 26-item Self-compassion Scale (SCS; Neff, 2003a), which consists of six subscales (Appendix H): the 5-item self-kindness subscale (e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need”), the 5-item self-judgment subscale (e.g., I can be a bit cold-hearted towards myself when I’m
experiencing suffering”), the 4-item common humanity subscale (e.g., When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am”), the 4-item isolation subscale (e.g., “When I’m really struggling I tend to feel like other people must be having an easier time of it”), the 4-item mindfulness subscale (e.g., “When something upsets me I try to keep my emotions in balance”), and the 4-item over-identification subscale (e.g., When I’m feeling down I tend to obsess and fixate on everything that’s wrong”). Responses are given on a 5-point Likert-type scale from 1 = “almost never” to 5 = “almost always”. Mean scores on the six subscales are summed (once the negative items have been reverse-coded) to create an overall self-compassion total score. Higher total scores reflect higher levels of self-compassion.

The SCS has shown good internal and test-retest reliability in previous studies, and has been shown to differentiate between groups in a therapeutically consistent manner (Neff, 2003a). The internal consistency reliability in previous studies has been .94 (Neff et al., 2005) and .73 (Leary et al., 2007).

**Self-criticism.** To evaluate participants’ self-criticism, the 22-item Levels of Self-criticism Scale (LOSC; Thompson & Zuroff, 2004) was used (Appendix N). The LOSC consists of two subscales, the 12-item Comparative Self-Criticism (CSC) subscale (e.g., I fear that if people get to know me too well, they will not respect me”) and the 10-item Internalized Self-Criticism (ISC) subscale (e.g., “Failure is a very painful experience for me”). CSC reflects a negative perception of self in comparison to others, whereas, the ISC scale denotes a negative view of the self based on internal, personal standards. Participants were asked to rate the extent to which each statement describes them on a 7-point Likert scale (1 = “not at all” to 7 = “very well”). After reverse scoring identified items, a total score is derived from summing all items. Higher scores indicate higher levels of self-criticism. Internal consistency for the two scales has
been reported to be .81 (CSC) and .87 (ISC) (Thompson & Zuroff, 2004) and .71 (CSC) and .90 (ISC) (Gilbert et al., 2004).

**Life satisfaction.** The Satisfaction with Life Scale (SWLS; Deiner, Emmons, Larsen, & Griffin, 1985) was used to evaluate participants’ level of global life satisfaction (Appendix K). This brief 5-item instrument measures an individual’s global cognitive judgments about her life using a 7-point Likert scale (1 = “Strongly agree” to 7 = “Strongly disagree). Sample items include: “In most ways my life is close to my ideal” and “If I could live my life over, I would change almost nothing”. Total scores are calculated by summing responses to all items and are evaluated based on 7 groupings of levels (e.g., 35-31 = “Extremely satisfied” to 5-9 = “Extremely dissatisfied”). Thus, higher scores suggest higher levels of satisfaction with life, whereas lower scores indicate the reverse. The SWLS shows good convergent validity with other measures of subjective well-being, as well as good discriminant validity from other measures (Pavot & Diener, 1993). Internal consistency has been cited as .85 (with American college students) and test re-test reliability was .84 at a one-month interval (Pavot, Diener, Colvin, Sandvik, 1991).

**Procedure**

Three recruitment strategies were employed for this study. In the first strategy, paper fliers and/or posters were made available or posted/distributed at community counselling and mental health centres and rape/sexual assault crisis centres in small urban cities in Southwestern Ontario (e.g., Kitchener, Waterloo, London, and Cambridge). The advertisement provided details on the topic of the study, the anticipated amount of time to participate, contact information of the primary researcher, and a notice that for every 10 participants, a draw for a one hundred dollar gift card for Chapters/Indigo Booksellers would be made (see Appendix A). The poster/flier also
included an on-line link to a web-based survey, which was the second recruitment strategy. Participants, therefore, either emailed or telephoned the researcher to receive a questionnaire package mailed to them that included the information letter that outlined the purpose of the study, the procedure, protection of and limits to confidentiality, potential risks and benefits, the voluntary nature of participation, the intended uses and storage of the data collected, the contact information of the researcher, the research questionnaires (see Appendix B), and a list of local counselling resources (Appendix C), or they could use the link provided on the advertisement and complete the questionnaires via the internet, which also included a letter of information with the above information (see Appendix D). Women learned about the study by seeing such advertisements. If a woman contacted the researcher directly, she was either mailed a package (if she did not have internet access or preferred a paper copy of the questionnaires) or was directed to the web-based survey. The returning of the completed measures implied participants’ consent. Participants who accessed the survey on-line provided their consent to participate by submitting their responses.

In the third recruitment strategy, counsellors in rape crisis/counselling centers in Waterloo and London, Ontario (e.g., the Sexual Assault Support Centre of Waterloo Region and The Sexual Assault Centre of London) informed their clients who fit the study participant criteria about the research project and distributed research packages to women who were interested in participating. Participants were provided with a research package that included a letter of information that included the above information as well as specific directions for handling the completed protocols (Appendix E). In the few cases of such recruitment, the participants returned the completed research packages to their counsellors who then forwarded the packages.
to the principal researcher. The vast majority of the participants accessed the study through the Internet and participated on-line (93%).
Results

This study examined the relationships between self-compassion and indicators of negative posttraumatic adjustment, self-criticism, and life satisfaction in a population of women who experienced one or more sexual assaults in the past five years. Of the three recruitment strategies employed (e.g., poster seen at a counselling centre, flier distributed by a counsellor, advertisement seen on the Internet), the most successful strategy was the on-line survey, with 93% of the study participants completed on-line. The number of participants who learned about the study through a poster at a counselling/crisis centre or other institution (e.g., adult learning centre) versus through the internet is unknown, as this question was not asked as part of the survey. What seems apparent, however, is that making the survey available on-line greatly increased the number of participants. The large number of student participants in their 20’s in the study may be related to the high percentage of participants responding via the internet, as internet access and use is likely more typically found among this aged population. The ease and convenience of ‘going on-line’ to complete the survey also likely contributed to the higher rate of web-participation, compared with completing a paper copy of the questionnaires and having to mail the completed package back to the researcher.

Data Analysis

SPSS, Version 20 was used to manage and analyze the study data. First, the data were evaluated for missing and skewed data and to ensure that the assumptions for regressions were met. Descriptive statistics were calculated for all variables. Multicollinearity was checked for all correlations and found to be within adequate parameters (e.g., SPSS output for correlational analyses indicate collinearity check where Tolerance is below .1 and VIF is above 10). Given
that variables were normally distributed (those that were skewed were transformed to a normal distribution), Pearson correlations were conducted and interpreted for the research questions seeking to ascertain relationships between the study variables. When evaluating the contribution of self-compassion to other study variables, relevant variables were entered into multiple hierarchical linear regressions. Finally, to evaluate whether severity of sexual assault predicts posttrauma adjustment, self-compassion, and self-criticism, multivariate analyses of variance (MANOVA) and univariate analyses of variance (ANOVA) were executed.

**Descriptive Analyses**

**Participant trauma history.** Analyses of the Sexual Experience Survey – Short Form Victimization (SES-SFV) data showed that the distribution was negatively skewed (using the standard criterion of skewness to standard error ratio <2; e.g., 6.22), suggesting that the study sample consisted of significant sexual assault experiences among the participants. Kurtosis of the distribution was in the normal range (<2). Table 2 shows the frequencies of data collected with regard to sexual assault history of the sample. As can be seen in this table, the majority of the women in the sample experienced attempted rape (42.6%), with the second largest grouping having reported experiencing rape (26.2%). The third largest number of women reported experiencing sexual coercion (19.1%), while a very small percent of the women did not fit into any of the classification categories according to Koss et al’s (2007) scoring criteria (6.3%). Four of the nine participants who did not fit would have been identified as “non-victim” and the remaining five participants endorsed experiencing a form of sexual contact; however, the pattern of responding did not correspond to be included in one of the categories as outlined in Koss et al. (2007).
Table 2

*Frequencies of Sexual Assault History*

<table>
<thead>
<tr>
<th>Sexual Assault Experiences</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not fit any of the categories&lt;sup&gt;a&lt;/sup&gt;</td>
<td>9</td>
<td>6.3</td>
</tr>
<tr>
<td>Sexual Contact</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>27</td>
<td>19.1</td>
</tr>
<tr>
<td>Attempted Rape</td>
<td>60</td>
<td>42.6</td>
</tr>
<tr>
<td>Rape</td>
<td>37</td>
<td>26.2</td>
</tr>
</tbody>
</table>

<sup>a</sup> Category for participants whose endorsement of items in the SES did not fit into any of the categories according to the scoring formula as outlined by Koss, Abbey, Campbell, Cook, Norris, Testa et al., 2007.
For correlational and regression analyses, all participants were included regardless of classification on the SES, as women who participated identified themselves as fitting the research criteria (i.e. “experienced a sexual assault in the past five years”) and we chose to respect their perception of sexual assault and not exclude them from the study for the purposes of not “fitting” into Koss et al’s particular scoring criteria. When performing ANOVAs and MANOVAs, two groups were removed from the statistical analyses (e.g., Does not fit any of the categories and Sexual Contact) due to an insufficient number of participants in each group. Thus, in ANOVAs and MANOVAs, the sexual history data were treated as categorical.

Table 3 details the descriptive data of the remaining study variables (e.g., participant trauma history, posttraumatic adjustment, self-compassion, self-criticism, and satisfaction with life. The distribution of childhood trauma (CTQ) was slightly positively skewed (a skewness ratio of 2.33 and kurtosis of 1.76), indicating that overall the sample reported a low number of experiences of trauma in childhood. The data were transformed to a normal distribution using the square root of x in order to execute statistical analyses. Following transformation the skewness ratio fell within the acceptable range of a normal distribution (.091) and the kurtosis ratio was just slightly over 2 (e.g., 2.38). Scores indicating median and dispersion for the CTQ reflects a relatively low number of experiences of childhood trauma reported among the sample. Cronbach’s alpha for the CTQ was good at .90.

The distribution of the Stressful Life Events scores (SLES-Q) was also slightly positively skewed, indicating that the study sample reported low numbers of other stressful life experiences. Attempts at transforming the data were unsuccessful, as performing a log transformation was not possible with scores of zero in variables. The residual plot was examined and showed no patterns in the data (e.g., random cloud), which implied no negative impact on
Table 3

*Descriptive Data of Study Variables*

<table>
<thead>
<tr>
<th></th>
<th>M (Median(^a))</th>
<th>SD (25% - 75%(^a))</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participant Trauma History</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Trauma (CTQ)(^a)</td>
<td>53</td>
<td>39 - 78</td>
<td>23</td>
<td>121</td>
</tr>
<tr>
<td>Stressful Life Events (SLE)</td>
<td>6.66</td>
<td>3.31</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td><strong>Posttrauma Adjustment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Posttraumatic Cognitions (PTCI)</td>
<td>134.39</td>
<td>41.87</td>
<td>48</td>
<td>221</td>
</tr>
<tr>
<td>Shame (ESS)</td>
<td>73.27</td>
<td>18.8</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Psychological Distress (TSC)</td>
<td>92.5</td>
<td>24.98</td>
<td>39</td>
<td>156</td>
</tr>
<tr>
<td>Self-compassion (SCS)</td>
<td>15.54</td>
<td>3.67</td>
<td>7.45</td>
<td>26.1</td>
</tr>
<tr>
<td>Self-criticism (LOSC)</td>
<td>100.46</td>
<td>22.12</td>
<td>49</td>
<td>145</td>
</tr>
<tr>
<td>Satisfaction with Life (SWLS)(^a)</td>
<td>15</td>
<td>9-21</td>
<td>5</td>
<td>35</td>
</tr>
</tbody>
</table>

\(^a\) For non-normally distributed variable
data results. Therefore, all analyses were run with the variable data as is. Mean and standard deviation scores for the SLES-Q similarly show that overall, the sample reported minimal stressful life experiences. Reliability and internal consistency for the SLES-Q was adequate (Cronbach’s alpha .70).

**Posttrauma adjustment.** The data for PTCI and TSC were normally distributed. The skewness ratio for ESS was acceptable (1.59), however, the kurtosis ratio was slightly over 2 (2.11). Given that transformation to adjust kurtosis is not possible, the statistical analyses were run with this data as is. The slightly high kurtosis ratio may bias the p value, which may be a limitation of the study. Indicators of mid-point and dispersion reflect relatively high rates of experiences of negative posttraumatic cognitions (PTCI) and shame (ESS) in the study sample. Cronbach’s alphas were calculated for all variables indicating posttrauma adjustment, showing strong reliability and internal consistency (PTCI = .95, ESS = .96, and TSC = .95).

**Self-compassion.** The distribution for self-compassion was normally distributed. Cronbach’s alpha for the SCS was .92. The present study sample scores in self-compassion were notably lower than those reported by Neff’s (2003a) sample of undergraduates from a southwestern university in the United States (225 women; M age = 20.91 years; Mean = 17.72, SD 3.74), thus, indicating that overall, this study sample is less self-compassionate than Neff’s sample.

**Self-criticism.** The distribution for self-criticism was normally distributed. Cronbach’s alpha was good at .90.

**Life Satisfaction.** The distribution of the SWLS was slightly positively skewed, suggesting that more participants reported lower levels of satisfaction with life (skewness ratio of 2.18; kurtosis ratio of 1.79). The data were transformed to a normal distribution prior to
conducting statistical analyses using the square root of x. After transformation, skewness ratio was adjusted to within an acceptable range (<2, e.g., .20). Cronbach’s alpha for SWLS was satisfactory at .89.

**Results of Hypotheses Testing**

**Main research questions**

In light of the conceptualization of self-compassion as a feature of positive psychological health and resilience found in the literature (Leary et al., 2007; Neff, 2003a, 2003b), the following research predictions were made with regard to women survivors of sexual violence:

*Hypothesis # 1:* Self-compassion will be negatively related to posttrauma adjustment and self-criticism.

Results of correlations between self-compassion and posttrauma adjustment and self-criticism in the present study can be viewed in the correlation matrix in Table 4. As predicted, in all correlations, self-compassion was significantly negatively related (at the $p < .01$ level) to each of the variables considered negatives outcomes of sexual assault, namely, psychological distress, negative posttraumatic cognitions, and shame as well as with self-criticism.

*Hypothesis # 2:* Self-compassion will be positively related to life satisfaction.

This hypothesis was confirmed, as using a Pearson correlation after transforming the SWLS data showed that self-compassion scores were positively, moderately related to global satisfaction with life at the $p < .01$ level (e.g., $r = .46^{**}$), suggesting a positive relationship between self-compassion and satisfaction with life.

*Hypothesis # 3:* Self-compassion will be a significant contributor to posttrauma adjustment and self-criticism independent of contributions of childhood trauma and stressful life events.
Table 4

Correlation Matrix for Psychological Distress (TSC), Negative Posttraumatic Cognitions (PTCI), Shame (ESS), Self-Criticism (LOSC) and Self-Compassion (SCS).

<table>
<thead>
<tr>
<th></th>
<th>TSC</th>
<th>PTCI</th>
<th>ESS</th>
<th>LOSC</th>
<th>SCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSC</td>
<td>1.00</td>
<td>.70**</td>
<td>.65**</td>
<td>.58**</td>
<td>-.56**</td>
</tr>
<tr>
<td>PTCI</td>
<td></td>
<td>1.00</td>
<td>.55**</td>
<td>.64**</td>
<td>-.60**</td>
</tr>
<tr>
<td>ESS</td>
<td></td>
<td></td>
<td>1.00</td>
<td>.71**</td>
<td>-.51**</td>
</tr>
<tr>
<td>LOSC</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>-.71**</td>
</tr>
<tr>
<td>SCS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Note. TSC = Trauma Symptom Checklist (Brier & Runtz, 1989), PTCI = Posttraumatic Cognitions Inventory (Foia, Ehlers, Clark, Tolin, & Orsillo, 1999), ESS = Experience of Shame Scale (Andrews, et al., 2002), LOSC = Levels of Self-Criticism (Thompson & Zuroff, 2004), and SCS = Self-Compassion Scale (Neff, 2003a). *p = < .05. **p < .01.
To analyze this research question, multiple hierarchical linear regressions were completed using self-compassion as the independent variable in order to ascertain whether self-compassion can predict posttrauma adjustment (defined by psychological distress, negative posttraumatic cognitions, and shame) and self-criticism when controlling for earlier childhood trauma and stressful life events. As can be seen in Table 5, regressions showed that self-compassion is a moderate to strong significant predictor in explaining the variance in posttrauma adjustment and self-criticism.

**Psychological distress.** Childhood trauma and stressful life events were found to explain almost 12% of the variance in psychological distress scores ($R^2 = .119^{**}$), a significant finding that indicates that childhood trauma and stressful life events are strong predictors of it. Self-compassion adds another 24% to explaining the variance in psychological distress scores, a moderate and significant contribution ($p = .000$).

**Negative posttraumatic cognitions.** Childhood trauma and stressful life events were found to explain approximately 8% of the variance in negative posttraumatic cognitions ($R^2 = .082^{**}$), a significant finding that indicates that childhood trauma and stressful life events are strong predictors of negative posttraumatic cognitions. Adding self-compassion resulted in an additional 30% in explaining the variance in negative posttraumatic cognitions, a strong and significant contribution ($p = .000$).

**Shame.** Childhood trauma and stressful life events were shown to explain almost 10% of the variance in shame scores ($R^2 = .094^{**}$), a significant finding that indicates that childhood trauma and stressful life events are strong predictors of it. Self-compassion added almost 20% in explaining the variance in shame scores, a moderate and significant contribution ($p = .000$).
Table 5

Summary of Multiple Regression Analyses for Variables Predicting Psychological Distress (TSC), Negative Posttraumatic Cognitions (PTCI), Shame (ESS), and Self-Criticism (LOSC) using Self-Compassion (SCS) as the Independent Variable and Controlling for Stressful Life Events (SLES), and Childhood Trauma (CTQ).

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Hierarchical Step</th>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Distress (TSC)</td>
<td>Step 1</td>
<td>Stressful Life Events</td>
<td>1.62</td>
<td>.65</td>
<td>.216*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Trauma</td>
<td>3.36</td>
<td>1.45</td>
<td>.2*</td>
</tr>
<tr>
<td></td>
<td>Step 2</td>
<td>Stressful Life Events</td>
<td>1.49</td>
<td>.55</td>
<td>.199**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Trauma</td>
<td>1.02</td>
<td>1.29</td>
<td>.061</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-Compassion</td>
<td>-3.47</td>
<td>.49</td>
<td>-.511**</td>
</tr>
<tr>
<td>Negative Posttraumatic Cognitions (PTCI)</td>
<td>Step 1</td>
<td>Stressful Life Events</td>
<td>2.13</td>
<td>1.11</td>
<td>.169</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Trauma</td>
<td>.325</td>
<td>.162</td>
<td>.177*</td>
</tr>
<tr>
<td></td>
<td>Step 2</td>
<td>Stressful Life Events</td>
<td>1.9</td>
<td>.914</td>
<td>.150*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Trauma</td>
<td>.036</td>
<td>.137</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-Compassion</td>
<td>-6.57</td>
<td>.796</td>
<td>-.576**</td>
</tr>
<tr>
<td>Shame (ESS)</td>
<td>Step 1</td>
<td>Stressful Life Events</td>
<td>.52</td>
<td>.49</td>
<td>.092</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Trauma</td>
<td>.22</td>
<td>.07</td>
<td>.26**</td>
</tr>
<tr>
<td></td>
<td>Step 2</td>
<td>Stressful Life Events</td>
<td>.439</td>
<td>.44</td>
<td>.077</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Trauma</td>
<td>.11</td>
<td>.066</td>
<td>.134</td>
</tr>
<tr>
<td>Variable</td>
<td>Step 1</td>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Criticism (LOSC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stressful Life Events</td>
<td>.245 .588 .037</td>
<td>.101 .434 .015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Trauma</td>
<td>.272 .085 .28**</td>
<td>.093 .065 .095</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Compassion</td>
<td>-2.35 .385 -.46**</td>
<td>-4.08 .378 -.676**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. $R^2 = .358$ and $R^2_\Delta = .239$ for TSC; $R^2 = .387$ and $R^2_\Delta = .305$ for PTCI; $R^2 = .288$ and $R^2_\Delta = .194$ for ESS; $R^2 = .507$ and $R^2_\Delta = .420$ for LOSC.

*p = < .05. **p < .001.
**Self-criticism.** Childhood trauma and stressful life events were found to explain almost 9% of self-criticism ($R^2 = .087**$), which is significant. Adding self-compassion helped to predict an additional 42%, which revealed self-compassion to be a strong and significant ($p = .000$) predictor of self-criticism.

**Exploratory Research Questions**

In addition to the above main research questions, we wanted to explore the relationships between self-compassion and severity of sexual assault history in order to maximize our understanding of self-compassion and any other relevant relationships related to coping with the aftermaths of sexual assault. Specifically, we asked:

3. **Does severity of sexual assault predict posttrauma adjustment, self-compassion and self-criticism?**

To answer the above question and identify any main and interaction effects among the variables, multivariate analyses of variance were conducted. Based on group differences according to severity of sexual assault history, a MANOVA was conducted with three sexual history groups as the independent variable (Sexual Coercion, Attempted Rape, and Rape) on the dependent or outcome variables, namely, posttrauma adjustment (negative posttraumatic cognitions, shame, and psychological distress), self-criticism and self-compassion. Using Wilks’ Lambda as a testing method, no multivariate effect was detected.

While MANOVA provides a robust analysis of multiple group differences simultaneously, in a small study such as this, it may be less powerful in finding significant group differences, particularly when examining a specific dependent variable or when dependent variables are moderately correlated (Tabachnick & Fidell, 2007). Therefore, follow-up ANOVAs were executed to more closely examine the relationships between the groups according to severity of sexual assault and the outcome variables. Using only the three most severe categories
of sexual assault history as the independent variable, ANOVAs were executed with posttrauma adjustment (psychological distress, negative posttraumatic cognitions, and shame), self-compassion and self-criticism as the dependent variables, using a Bonferroni correction to account for multiple tests and possible Type I error (when selected, SPSS automatically adjusts the p-level to account for the number of analyses conducted). Table 6 displays the results of the ANOVAs, noting that a small but significant difference was found in self-criticism (p = .04).

To identify specific differences in comparing the three levels of severity of sexual assault history on the dependent variables, post hoc Bonferroni and Dunnett C tests were executed. Given that the results of Levene’s test of equality of error variance were not significant, indicating that assumption of equal variances was not violated, the Bonferroni post hoc test results were used (Dunnett C results would have been used had equal variances been violated). Findings from the post hoc tests showed a small but significant difference between the Sexual Coercion group and the Attempted Rape group (mean difference -12.81). This significant difference was unexpected, and while significant at the p=.05 level, the partial eta squared result indicated a minimal effect size (.051), which may explain why the MANOVA results did not reveal significant effects.

The Sexual Coercion group showed the lowest level of self-criticism, followed by the Rape group, with the highest self-criticism found in the Attempted Rape group; however, the Rape and Attempted Rape group did not significantly differ. A similar pattern was found for negative posttraumatic cognitions, however these differences were not significant. Rape victims fare worse with regards to psychological distress and all groups show comparable means in regards to shame and self-compassion.
Table 6

*Results of Analysis of Variance using sexual assault history as the independent variable (SES) and psychological distress (TSC), negative posttraumatic cognitions (PTCI), shame (ESS), self-compassion (SCS), and self-criticism (LOSC) as dependent variables*

<table>
<thead>
<tr>
<th>SES</th>
<th>M(SD)</th>
<th>F(df1, df2)</th>
<th>p-sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sexual Coercion</td>
<td>Attempted Rape</td>
<td>Rape</td>
</tr>
<tr>
<td>TSC</td>
<td>85.96(21.1)</td>
<td>94.63(26.27)</td>
<td>95.68(24.1)</td>
</tr>
<tr>
<td>PTCI</td>
<td>123.37(39.91)</td>
<td>139.35(41.8)</td>
<td>135.97(41.35)</td>
</tr>
<tr>
<td>ESS</td>
<td>67(19.25)</td>
<td>75.82(17.73)</td>
<td>75.35(20.31)</td>
</tr>
<tr>
<td>SCS</td>
<td>16.93(4.25)</td>
<td>14.99(3.57)</td>
<td>15.35(3.34)</td>
</tr>
<tr>
<td>LOSCa</td>
<td>91.85(22.47)</td>
<td>104.67(22.15)</td>
<td>101.51(20.3)</td>
</tr>
</tbody>
</table>

*Note. TSC = Trauma Symptom Checklist (Brier & Runtz, 1989), PTCI = Posttraumatic Cognitions Inventory (Foa et al., 1999), ESS = Experience of Shame Scale (Andrews, et al., 2002), LOSC = Levels of Self-Criticism (Thompson & Zuroff, 2004), SCS = Self-Compassion Scale (Neff, 2003a). SES (Koss et al., 2007) is grouped in 3 categories: Sexual Coercion, Attempted Rape and Rape. *p = < .05

*a Bonferroni post hoc tests indicated significant difference between Sexual Coercion and Attempted Rape groups (mean differences -12.81; Partial eta squared = .051).
Discussion

The overarching question this study sought to address is whether self-compassion is related to sexual assault survivors’ psychological health and recovery. More specifically, this study investigated the relationships between self-compassion and various indicators of psychological health that have been associated with posttraumatic adjustment, such as psychological distress, negative posttraumatic cognitions, and shame, as well as self-criticism and overall satisfaction with life in a sample of 141 women who experienced one or more sexual assaults in the past five years.

Main Research Questions

Self-compassion and posttrauma adjustment

This study was guided by three chief concerns for investigation. The first research question examined the relationships between self-compassion and self-criticism and posttrauma adjustment (e.g., psychological distress, negative posttraumatic cognitions, and shame). Consistent with the literature that suggests self-compassion is a positive emotive way of self-relating with health enhancing qualities (e.g., Barnard & Curry, 2011; Germer, 2009; Gilbert, 2005; Gilbert & Procter, 2006; Leary et al., 2007; Neff, 2003a, 2003b, 2011), our results confirmed moderate to strong negative relationships between self-compassion and psychological distress symptoms, negative posttraumatic cognitions, and shame. Further, a significant negative relationship between self-compassion and self-criticism was shown to be particularly strong, which is consistent with previous study findings (e.g., Leary et al., 2007; Mills et al., 2007) and with the operationalization of self-compassion as contrasting with self-criticism (Gilbert, 2005). These findings, thus, provide additional evidence for the recent promotion of health enhancing benefits fostered by a self-compassionate style of relating. Further, they uniquely contribute to
the gap in the literature by revealing the value of a compassionate way of self-relating when recovering from significant sexual trauma, which is much different than simply coping with the stresses of daily living (e.g., Leary et al.) or academic failures (Neff et al., 2007).

The finding that having a high level of self-compassion is associated with lower psychological distress provides support for promoting self-compassion as potentially helping to minimize the development of symptoms of psychological distress and perhaps fostering resiliency in the aftermaths of a traumatic experience(s). Given the important role of mindfulness in the operationalization of self-compassion (i.e. Neff, 2003a), this finding may be considered alongside previous research affirming the benefit of integrating mindfulness into the treatment of trauma (e.g., Follette, Palm, & Pearson, 2006). However, it goes further in specifically affirming the potential benefit of the development of self-compassion. Thus, as with previous studies on self-compassion (e.g., Birnie, Speca, & Carlson, 2010; Shapiro et al., 2005; Shapiro et al., 2007; Robins, Shian Ling, Ekblad, & Brantley, 2012), the role of mindfulness as an active factor in self-compassion is strongly supported. The directionality or particular nature of this role in self-compassion, however, continues to remain unclear and calls for the need for further research into the specific components of self-compassion and the interrelations among them.

The finding that self-compassionate individuals experienced less shame is consistent with previous study findings that showed a negative relationship between self-compassion and shame (Barnard & Curry, 2011; Mosewich et al., 2011), thereby confirming Gilbert’s (2005) proposition that self-compassion may be an “anti-dote” to shame. The importance of this particular study finding lies in the recognition of the high incidence (Sable, Danis, Mauzy, & Gallagher, 2006; Vidal & Petrak, 2007; Weiss, 2010) and negative impacts of shame as part of
the survivor’s experience (Greenberg & Paivio, 1997; Herman, 1992) and its necessary reduction/abolishment in the process of recovery (Paivio & Pascual-Leone, 2010). Our study, thus, compliments recent research in the area of emotion-focused therapy for the treatment of trauma (EFTT) wherein the development of self-compassion is considered paramount to reducing feelings of shame and self-blame that are frequently found to cause psychotherapeutic impasse in the treatment of survivors of sexual victimization (Paivio & Pascual-Leone, 2010).

Finding a negative relationship between self-compassion and negative posttraumatic cognitions among survivors of sexual assault suggests that having a self-compassionate attitude about oneself and one’s traumatic experiences may help shield against the negative outcomes of victimization, namely, altered and negative views about self and the world and self-blame. While previous research has argued that self-compassion may act as a buffer against negative psychological impacts and stress (Leary et al., 2007; Neff, 2003a, 2003b, 2011), this particular study finding reveals that this conceptualization of self-compassion rings true for women survivors of sexual trauma who experience negative changes to beliefs and thoughts about self and the world. This is an interesting finding taken together with studies validating Foa and colleagues’ work (e.g., Foa et al., 1999; Foa & Riggs, 1993; Foa, Steketee, & Rothbaum, 1989; Foa, Zinbarg, & Rothbaum, 1992) proposing the role of dysfunctional cognitions in the development and maintenance of PTSD, namely, the belief that the world is completely dangerous and that one’s self is totally incompetent. These dysfunctional cognitions either exist prior to a traumatic experience or arise as a result of the trauma. Individuals who can perceive the trauma as a time-limited, awful experience that does not necessarily have implications for the future and perhaps even derive some element of personal growth are considered more likely to recover from the trauma and not develop or maintain chronic PTSD, whereas those who
experience chronic PTSD are characterized as excessively engaging in negative appraisals of the event, its sequelae, or both. Studies have shown that negative cognitions and appraisals about initial PTSD symptoms predicted chronic PTSD (Dunmore et al., 1999; Ehlers, Mayou, & Bryant, 1989); thus, taking a compassionate stance towards oneself post-assault may have important implications for adjustment and recovery, including, perhaps buffering from developing more severe psychopathology, such as PTSD.

The common humanity component in Neff’s definition of self-compassion may be particularly relevant in light of one study that found that recovery for political prisoners who endured assault and torture was significantly impeded when survivors experienced mental defeat and feelings of alienation from others as a result of the trauma (Ehlers, Maercker, & Boos, 2000). The value of recognizing one’s pain (or failing) as part of the human experience is similarly suggested in Neff and McGehee’s (2010) study which demonstrated the role of attachment and family functioning in the development of self-compassion - or lack thereof. Their findings suggested that if an individual experienced a non-supportive and dysfunctional family upbringing, they may be able to heal their pain related to family problems through viewing their family members as “human beings who are also imperfect and struggling, and to recognize that interpersonal conflict is universal and shared aspect of human experience” (p. 237). This may be important for survivors who receive blaming or accusatory reactions from family members related to their assault(s), given that much of the negative outcomes of assault are confounded by others’ negative and blaming reactions (e.g., Anderson, 1999; Doherty & Anderson, 1998; Pollard, 1992; Ullman, 1996; Wyatt et al., 1990). Thus, the inclusion of self-compassion in one’s therapeutic treatment or recovery process may appropriately help buffer feelings of anger and
confusion towards others’ reactions, recognizing their behaviours in a realm of human fault rather than feeling chained to painful associated emotions.

That self-compassion was negatively related to self-criticism is not surprising and is consistent with previous studies that have contextualized a self-compassionate attitude as directly inverse to one of self-criticism (Gilbert, 2005). Given results of previous studies revealing the detrimental impacts of shame-based self-criticism and the strong associations with poor psychological functioning and the presentation of disorders, such as PTSD (Lee, 2005; M. Lewis, 1998) and depression and anxiety (e.g., Gilbert & Irons, 2005), this study finding sheds light on the positive health benefit in promoting self-compassion for individuals high in self-criticism and in particular for trauma survivors who engage in negativistic and self-critical thinking. Moreover, our findings are consistent with those of Neff and colleagues (2005), which showed that undergraduates scoring higher in self-compassion were less likely to suppress their negative emotions experienced as a result of an academic failure, and were more likely to engage in adaptive emotion-approach coping strategies, such as acceptance and reinterpretation, as opposed to being self-critical. Similarly, Shapira and Mongrain’s (2010) study of interventions in self-compassion and optimism showed that individuals higher in self-criticism were at risk for depression and benefitted from focused learning of self-compassion exercises on the Internet, with improvements in happiness and reductions in depression symptoms at a 6-month follow-up. These results together suggest that self-compassion may be an important feature of adaptive coping that may offer benefits for survivors coping with the impacts of sexual trauma.

**Self-compassion and life satisfaction**

The second main research question in this study sought to clarify whether self-compassion would relate positively to a sense of satisfaction and happiness in life in survivors of
sexual assault. This hypothesis was confirmed, as results showed that self-compassion scores and overall life satisfaction scores were positively related. This result places our findings alongside previous studies that have shown positive relationships between self-compassion and positive indicators of well-being, such as positive attitudes in the face of stress (Leary et al., 2007) improvements in relationship with self and enhanced sense of connection with others (Corcoran, 1997), happiness and optimism (Neff et al., 2007) and overall well-being (Neely et al., 2009). This finding, therefore, provides further support for self-compassion as a positive and potentially health-enhancing form of self-relating. This result is important when couched alongside studies in positive psychology that promote the benefit of enhancing positive emotions (Davidson, 2000; Frederickson, 2001). Given the correlational method used to evaluate this hypothesis, however, causality cannot be established, therefore, it is unclear whether self-compassion stems from life satisfaction and well-being and/or facilitates these indicators, thus, further research is needed in this area.

**Unique contributions of self-compassion**

Our third main research question concerned the role that self-compassion would play in the posttrauma outcomes of sexual assault when controlling for the proportion explained by earlier childhood trauma and other stressful life events. Our findings revealed that self-compassion was a moderate to strong significant contributor to the variance in the negative psychological impacts associated with mental health and posttrauma adjustment (e.g., psychological distress, negative posttraumatic cognitions, and shame) as well as with self-criticism. Past stressful life events was found to explain a minimal portion of the variance in psychological distress and negative posttraumatic cognitions only, and was not a significant predictor for shame or self-criticism. Adding self-compassion to the model resulted in
strengthening the predictive value exponentially. More specifically, self-compassion was a much stronger predictor for scores in posttrauma adjustment and self-criticism than was past stressful life events. This finding illustrates the unique role that self-compassion plays in predicting the negative effects of trauma for survivors of sexual violence and self-criticism among a population of survivors of sexual assault.

Though significant, childhood trauma was shown to be a minimal to modest contributor to posttrauma adjustment and self-criticism. The contribution of self-compassion, however, resulted in significantly strengthening the predictive value. Moderate to strong effect sizes (19 – 42%) were found for self-compassion with all posttrauma adjustment variables (psychological distress, negative posttraumatic cognitions, and shame) and self-criticism, thus, indicating that self-compassion plays an important and independent role in the psychological health of trauma survivors unique from the roles of childhood trauma and other stressful life events in one’s life.

Severity of trauma

In order to ascertain if one’s sexual history was related to outcome measures, our analyses included evaluating whether severity of sexual assault would predict posttrauma adjustment, self-compassion and self-criticism. Our study found that the only significant difference between the different levels of severity of sexual assault was in regards to self-criticism, with posthoc tests highlighting a small but significant difference between the attempted rape group and sexual coercion. It should be noted, however, that initial MANOVA tests did not reveal any significant effects; the significant difference between the Attempted Rape group and Sexual Coercion group was indicated in follow-up ANOVAs that were conducted as a further examination of relationships of interest between the study variables. With a minimal effect size, this finding was unexpected and is not easily interpreted.
It may be that women who experience attempted rape are more self-critical in making themselves more accountable for the sexual assault. For instance, a similar pattern of women in the Attempted Rape group showed a higher degree of engagement in negative posttraumatic cognitions (e.g., negative beliefs about self, the world, and self-blame) than women in the other groups, which may reflect the role of self-blame, hence self-criticism.

The groups of women according to most severe sexual assault experience were small (e.g., only 27 participants in the Sexual Coercion group), therefore, future research with larger sample sizes may better elucidate potential impacts of severity of assault on posttrauma adjustment, self-criticism and self-compassion. Thus, this particular study finding, though nominal, hints to potentially important and interesting relationships regarding severity of sexual assault and suggests that additional studies to help clarify these relationships are warranted.

The finding that rape victims fare worse with regards to psychological distress is consistent with studies that have documented the prevalence of psychological distress/symptoms in the aftermath of rape (Brier & Runtz, 1988; Higgins & Follette, 2002; Koss, 1993; Resick, 1993). Thus, while women who experienced attempted rape fare worse in regard to self-criticism, women who reported rape as part of their sexual trauma history appear to experience a higher level of psycho-physiological symptoms of trauma.

Regarding shame and self-compassion, in the present study all participants showed comparable means. Thus, while our findings corroborate previous research on sexual trauma that shows the occurrence of shame as a frequent outcome (e.g., Davis & Breslau, 1994; Greenberg & Paivio, 1997; Sable, Danis, Mauzy, & Gallagher, 2006; Vidal & Petrak, 2007; Weiss, 2010), they further our understanding of the ubiquitous experience of shame as a result of sexual trauma largely irrelevant to the level or degree of invasiveness of the trauma. These findings also
support the conceptualization of self-compassion as the anti-thesis to shame (Gilbert, 2005) and suggest that shame and self-compassion both appear to be immune to the level or degree of severity of assault. These findings reflect the importance of one’s internalization of assault and way of relating to self in their post-trauma experience, and less so the particular degree of violence or level of invasion of sexual assault experienced. However, our analyses included only three categories of sexual experience, therefore, with the inclusion of the sexual contact group in the data analyses, and with larger group sizes, it is possible that stronger or more notable differences may have been found.

These findings reflect a resiliency quality within self-compassion that has been previously proposed in the literature (Leary et al., 2007; Neff, 2003b, Neff & McGehee, 2010). For example, our findings suggest that a woman’s ability to be self-compassionate is not dependent on her experience of rape, attempted rape or whether she was coerced to engage in unwanted sexual acts, thus implying that the negative psychological and emotional impacts of the assaults experienced may be buffered if one is self-compassionate. This implication is consistent with Leary and colleagues’ (2007) study findings suggesting the resiliency qualities within self-compassion where individuals high in self-compassion were found to better cope with daily stressors. Recent studies with adolescents have similarly shown that self-compassion may serve as a form of psychological resilience (Neff & McGehee, 2010) and may help individuals cope with distress and disappointment in perceived academic failure (Neff, Hsieh & Dejitterate, 2005), minimize disordered eating (Adams & Leary, 2007), and buffer from self-conscious emotions, including shame, guilt and pride for young women athletes (Mosewich et al., 2011). Thus, the findings from this study concur with the potential of self-compassion as possessing a resiliency feature that may assist women recovering from sexual victimization.
Implications for Clinical Practice

It is our hope that findings from this study will provide insight to the potential benefit of integrating focused development of self-compassion in the treatment of trauma survivors. As such, discerning the clinical application in the study findings is paramount. Certainly, our results confirm those of previous studies that emphasize the role of shame (e.g., Arata, 1999; Davis & Breslau, 1994; Frazier, 1990; Frazier & Schauben, 1994; Lee, 2005; Wyatt, Notgrass, & Newcombe, 1990), negative alterations in views of self and the world and self-blame (Foa et al., 1999) and distress symptoms (Briere & Runtz, 1989; Ellis, Atkeson, & Calhoun, 1981; Higgins & Follette, 2002; Resick, 1993) as outcomes in survivors’ experiences post assault. Our study also contributes to the paucity of articles addressing self-criticism among survivors of sexual trauma. Given the negative psychological health issues associated with self-criticism (Gilbert & Procter, 2006; Lee, 2005; M. Lewis, 1998), and its negative relationship with self-compassion, our results point to the potential benefit of teaching self-compassion with survivors high in self-criticism in a clinical setting or in a psycho-educational format to help counter the negative impacts of sexual assault.

In fact, Messman-Moore et al.’s (2008) study findings that sexuality variables (e.g., dysfunctional sexual behaviours) and self-criticism served as risk factors for rape and sexual coercion among college women alludes to the potential benefit of including self-compassion ‘training’ for women on college campuses with the aims of preventing rape and sexual coercion. For example, where dysfunctional sexual behaviour is conceptualized as women’s efforts to meet non-sexual needs by reducing negative affect or feelings of loneliness or isolation (Briere, 1995), enhancing self-compassion through harnessing mindfulness (which nurtures one’s ability to approach negative affect rather than avoid) and common humanity (seeing oneself as part of the
human experience) may be particularly effective in helping women prevent or avoid experiences that place them at risk of sexual assault. Additional research in this area is important and certainly needed.

Moreover, our findings connect with previous research that propose self-compassion as an anti-thesis to shame. This offers a possibility for the treatment of trauma survivors, as we know shame is a common experience among survivors of sexual assault (Campbell et al., 2001; Doherty & Anderson, 1998; Paivio & Pascual-Leone, 2010). Moreover, this awareness suggests that a focused treatment fostering the development of self-compassion may be beneficial for individuals who are not necessarily survivors of trauma, but for whom shame is a powerful experience. As we know from previous research, shame can be a roadblock in the therapeutic process both for trauma survivors (Paivio & Pascual-Leone, 2010) as well as individuals with other personal issues (Greenberg & Paivio, 1997). Given the importance of reducing shame as a therapy goal together with the findings from this study, which clearly demonstrates the negative relationship between shame and self-compassion, developing self-compassion appears to be a worthwhile therapeutic objective.

Our finding that level of severity of assault had no effect on level of self-compassion supports the benefit of resiliency in developing self-compassion and suggests that relating to self with compassion may help individuals cope more effectively with their issues, which may include sexual victimization, some other form of trauma or other interpersonal issues.

**Strengths and Limitations**

The findings from this study comprise a number of important contributions to the limited literature on self-compassion as it relates to posttrauma recovery for women. However, this study
serves as a first step, as there is still much to learn and understand about the potential healing benefits of - or limits to - self-compassion in the aftermaths of trauma.

**Strengths**

To date, this study is unique in its specific focus on self-compassion as it relates to the recovery of sexual assault in women trauma survivors. While the number of studies documenting the positive therapeutic and psychological potential of self-compassion is burgeoning, no published study has specifically explored the role of self-compassion and factors commonly found as part of post-rape adjustment. Moreover, studies of self-compassion to date have largely been limited to undergraduate student populations or clinical samples, while this study examines a broader community based sample. Although the inclusion or mention of self-compassion in the healing of trauma has been cited by a number of psychologists (e.g., Paivio & Pascuale-Leone, 2010; Greenberg & Paivio, 1997; Herman, 1997), no study has been found that specifically measures self-compassion among women survivors of sexual trauma and evaluates the relationships with other measures associated with the aftermaths of trauma.

Moreover, the findings from this study strongly illustrate support for recent theorizations of self-compassion as an “anti-dote” to shame (e.g., Gilbert, 2005), which offers important clinical implications for survivors of sexual trauma and possibly other trauma survivors, who commonly struggle with feelings of shame and self-blame as a result of victimization. Further, this study offers a modest contribution to the paucity of studies that examine self-criticism among women survivors of sexual assault.

That the sample size was sufficient and was drawn from the community is also an important strength of this study, as the findings may be adequately generalizable to women survivors of sexual assault in North America. Moreover, while a large number of participants
were younger, Caucasian women, women of all ethnic backgrounds and ages participated, thus, indicating that the findings from this study are generalizable to women with diverse ethnic backgrounds and ages across the lifespan.

**Limitations**

Although the sample size was sufficient to allow for statistical power, another study with a larger sample would allow us to look at our variables and relationships between them with greater clarity and confidence. For example, given the small sample sizes of women who fit into two of the sexual history categories, these two categories were omitted for analyses, allowing only for the more severe categories to be analyzed, which themselves were small. This is a limitation of the study, as with greater numbers within all of the categories of sexual assault history, differences undiscovered in the current analyses may have been revealed.

Second, the correlational design of this study hinders our ability to understand the directionality or to establish causality in the relationships between self-compassion and variables indicative of psychological health and wellness. Still, correlations provide foundational evidence that interventions that nurture the development of self-compassion may also help effect positive change in other domains of psychological health and wellness.

Third, as this study was concerned with examining self-compassion scores with a number of indicators of psychological health, only the total self-compassion scores were analyzed rather than the specific subscales and separate components, which is a limitation of the study. The naissance of research in the area of self-compassion, and the dominant reliance on Neff’s (2003a) definition and operationalization of self-compassion means that a greater number of studies are needed to clarify and validate the construct of self-compassion, its particular components, the associations and interrelationships with various psychological health indicators,
which may shed light on how self-compassion and its multiple elements can best be fostered and developed in treatment.

Finally, that the vast majority of the study sample participated on-line may be a limitation of the study, as without verification of the participants, there is no guarantee that the eligibility criteria of the study were met, or that participants did not falsify or misrepresent themselves in some way unawares to the researcher. At the same time, on-line surveys are increasing in popularity in light of convenience and anonymity/confidentiality benefits for participants. Still, additional studies with different samples would be interesting and would serve to strengthen the findings of this study.

**Summary and Conclusions**

The findings from this study shed light onto the therapeutic potential of focused development of self-compassion in the recovery of sexual assault. Results of this study strongly support recent theorizations of self-compassion as an ‘anti-dote’ to shame and self-criticism (Gilbert, 2005), a positive emotive way of self-relating (e.g., Frederickson; Neff 2003a), and a factor that may enhance resiliency to – not only daily life stresses (Leary et al., 2007) or disappointments (Neff, Hsieh & Dejitterat, 2005). - but also the negative impacts of sexual assault.

Given the high number of women who experience sexual assault, and our awareness of the rampant and destructive internalizations of blame and feelings of shame that results from these traumatic experiences, this study provides encouragement for the pursuit of clinical applications of self-compassion in helping women survivors of sexual assault buffer the negative psychological outcomes of sexual victimization, such as psychological distress, negative cognitions about self and the world, and shame, and challenge self-critical approaches to self.
The relationship between self-compassion and shame highlighted in the analyses showed no differences between levels of severity of assault, which highlights the depth and ubiquitous impact of shame for survivors of sexual victimization and suggests that regardless of the particular act of assault, self-compassion may help the recovery process in its contraindication to shame.

Further, findings support the hypothesis that posttrauma adjustment, such as psychological distress and negative posttraumatic cognitions may also be diminished with focused enhancement of self-compassion, and, as such, survivors who experience alterations in thoughts about self, the world and self-blame and various negative trauma symptoms as a result of their sexual victimization would likely benefit from enhancing their ability to be compassionate towards the self.

This study showed that women who experience attempted rape tend to be more self-critical than women who encountered rape or sexual coercion, with similar patterns in regards to negative posttraumatic cognitions. Thus, in light of the negative relationship of self-compassion and self-criticism, self-compassion may be particularly important for survivors who have experienced attempted rape.

In sum, the purpose of this study was to explore relationships between self-compassion and negative and positive psychological states among women who experienced sexual assault. The findings provide strong support for the recent promotion of self-compassion as a concept that fosters health enhancing psychological resilience. The negative relationships revealed between self-compassion and measures reflecting some of the most common negative psychological outcomes of trauma, such as psychological distress, negative posttraumatic cognitions, and shame, as well as critical self-relating, and the positive association with life
satisfaction clearly demonstrate validity in pursuing self-compassion as an important psychological construct with promise for survivors of sexual trauma.

Further, our findings illustrate a strong negative relationship between shame and self-compassion and showed that different levels of severity of sexual assault bore no influence on shame or self-compassion scores. These findings highlight the contradictory relationship of shame and self-compassion and suggest that level of invasiveness or severity of assault may not be as relevant to the impacts of assault on survivors; rather the victim’s approach to self may be more relevant to her aftermath experience. This finding gleans promise into the promotion of self-compassion as potentially ‘curative’ for painful emotions like shame regardless of severity of assault or trauma experienced. Moreover, it supports the positioning of a self-compassionate way of self-relating in a framework of resiliency and positive psychology.

Another nominal, though interesting finding from our study is that women who experienced attempted rape appear to suffer from self-criticism significantly more so than women who experience sexual coercion, and show higher levels of negative posttraumatic cognitions (though not significant) than women who experience rape or coercion. Though the effect size was minimal, this finding stands nonetheless as a unique contribution to the rape/sexual assault literature, which is limited in scope in regards to the role of self-criticism among sexual assault survivors. While the finding that rape victims experience higher psychological distress than women who do not report rape as part of their experience is not new, still, it positions this research among many that illustrate the ubiquitous negative psychological impacts of rape and sexual assault on women, and, therefore, stands as an valuable contribution.
Directions for Future Research

While this study offers important insight into the role of self-compassion in the recovery of trauma, and, as such, contributes to the literature in the area of sexual assault and self-compassion, its conclusions highlight a number of unanswered questions left for further study.

First, repeating this study using a broader definition of trauma may be fruitful in revealing different and/or similar findings, such as examining specifically sexual assault versus surviving war trauma, traumatic grief, childhood sexual abuse or battering. Such studies examining different traumatic experiences may strengthen our understanding of self-compassion as beneficial for survivors of numerous or multiple forms of traumas, or it may reveal unique qualities related only to sexual assault survivors.

Second, although the nature of this study precludes drawing causality within the relationships between self-compassion, posttrauma adjustment and satisfaction with life, it provides substantial support for the execution of pilot studies examining treatment interventions with a focus on the development of self-compassion for survivors of trauma specifically. Studies that elucidate the specific role self-compassion plays in moderating the effects of trauma would also be useful contributions to the literature.

Third, future studies of self-compassion with survivors of sexual victimization would benefit from looking more specifically at the role of attributions of rape/assault. While this study measured the impact of negative posttraumatic cognitions with self-compassion, which included self-blame as one aspect of change in beliefs, incorporating a measure that looks more specifically at attributions of sexual assault and victimization might elucidate with greater clarity the relationships between self-blame, self-compassion, and shame, as well as other relevant variables indicative of posttrauma adjustment.
Fourth, given previous studies which have found different self-compassion scores based on gender (Neff, 2003b), future studies that include men and examine potential gender differences in relation to self-compassion and trauma may be interesting, particularly in regards to clinical applications and treatment recommendations.

Previous literature has proposed the development of self-compassion through imagery and thought records (Lee, 2005), writing (Gilbert & Proctor, 2006) and through the therapeutic relationship (e.g., Greenberg & Paivio, 1997; Paivio & Pascuale-Leone, 2010), however, no study has specifically examined how women survivors develop or nurture self-compassion. A qualitative study towards this aim would be a worthy pursuit; the findings of which would nicely complement and build on the results of this study.

Self-compassion is theorized to elicit an “ameliorative effect of self-understanding, patience, and balance during difficult experiences, and (to) remind us that suffering is common to all” (Hollis-Walker & Colosimo, 2011, p. 223). The impetus for this study was grounded in the presumption that the qualities and attitude in this way of relating to self would be helpful and would promote healing and wellness for women survivors of sexual violence. We believe that this study strongly shows that the development of self-compassion would assist women in their process of recovery from sexual assault. Thus, the important next step is to develop a treatment for sexual assault survivors that would focus on nurturing self-compassion and empirically validating its utility and therapeutic benefit. We believe that the findings of the present study provide the necessary evidence to show that doing so would be an exciting and worthwhile endeavor.
References


Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the
"second rape": Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence, 16*, 1239-1259.


FEMALE PARTICIPANTS NEEDED FOR RESEARCH IN SELF-COMPASSION AND RECOVERY FROM SEXUAL ASSAULT

If you have experienced a sexual assault in the last 5 years and are over 18 years of age, you are invited to take part in a study of self-compassion related to recovery of sexual assault.

As a participant in this study, you would be asked to complete some questionnaires that ask questions about:

- How do you generally treat yourself in difficult times?
- What are your experiences of sexual violence?
- What are some of your thoughts related to sexual violence?
- How has this experience(s) impacted you?

Your participation is completely confidential.

Every 10 participants will have a chance to win a $100 gift card for Chapters/Indigo bookstores.

For more information or to volunteer for this study, please contact:

Angèle Close, M.Ed.
Department of Adult Education and Counselling Psychology
226-220-0991 or angele.close@utoronto.ca
~ OR ~
Access the study on-line at:

This study is being funded through the Social Sciences and Humanities Research Council of Canada.
Consent Information

The purpose of this consent information letter is to ensure that you understand the purpose of the study and the nature of your involvement. Please contact the researcher to clarify any questions you have.

My name is Angèle Close. I am a Doctoral Student in the Counselling Psychology Program at the University of Toronto (Ontario Institute for Studies in Education) and am carrying out a study for my dissertation research that is looking at how treating oneself with kindness and compassion may help people who have experienced a traumatic event, such as sexual assault, heal and recover. This research is being funded by the Social Sciences and Humanities Research Council of Canada.

Purpose of the Research:
The purpose of this research study is to learn about how self-compassion may help individuals respond to traumatic incidents and to help us understand better the processes that affect their mental health and recovery.

We know that people have a number of psychological responses to highly stressful situations including different reactions to sexual assault. We also know that different individuals may cope with their assault and treat themselves differently, some perhaps critically, while others more so with kindness and compassion. We are interested in studying how different ways of treating one’s self may influence how one experiences the effects of trauma and the process of healing and recovery. We believe that this will allow us to design ways to help sexual assault survivors reduce psychological distress and better recover from sexual assault.

Participants in this Study:
You are invited to participate in this study because you experienced a sexual assault within the past two years. As part of this study you will be asked to complete a number of questionnaires. You will be asked questions about your background, experience(s) of sexual assault and other stressful events, psychological and physical heath, and different ways of treating yourself. It is expected that the study will be completed in approximately one hour. You do not give up any legal rights by choosing to participate in this research.

What Happens to the Information You Provide?
All of the information you provide is confidential, meaning that no one other than the researchers will have access to your information. Your name will not be required on any of the questionnaires; therefore, your participation in this research is completely anonymous. The information collected will be kept in a secure location in our research office at the University of Toronto for five years, after which time they will be destroyed. Any publications or presentations made on the basis of the information provided in this study will not identify you in any way.
Possible Risks of Participation:
Some of the information that you will be asked about may be upsetting or stressful. Your participation in this study is completely voluntary. You are free to refuse to answer any question(s), and you may end your participation at anytime without any negative consequences. You will be provided with a list of local resources for support and counselling services.

Possible Benefits of Participation:
There are no personal benefits to you for participating in this study, however, your participation will help us gain a better understanding of how people respond to experiences of sexual assault, and in turn may lead to the development of psychotherapeutic interventions for survivors of sexual assault. You will not be paid to take part in this study, however, for every ten participants, a draw for a $100 gift card for Chapters/Indigo Booksellers will be made. A summary of the research findings will be sent to you at your request.

Your involvement in this research is appreciated. If you choose to complete and return the questionnaires, this will signify your consent to participate in the study. Once you have completed the questionnaires, please mail in the self-addressed completed questionnaire package. This letter of information is yours to keep.

Should you have any further questions regarding this study, please feel welcome to contact Angèle Close at (226) 220-0991 or angele.close@utoronto.ca or Dr. Lana Stermac at (416) 978-0722 or I.stermac@utoronto.ca. If you have any ethical concerns regarding the study, you may contact the Ethics Review Office of the University of Toronto at ethics.reivew@utoronto.ca or (416) 946-3273. Please note also that if you find yourself feeling some distress or discomfort from answering some of the questionnaires, a list of local community crisis and counselling resources that can provide you with immediate assistance and support is included in this package.

Thank you for your participation,

Angèle Close, M.Ed., Doctoral Student and Lana Stermac, Ph.D.
Counselling Psychology Program
Ontario Institute for Studies in Education, University of Toronto
Local Community Crisis and Counselling Resources

Sexual Assault Centre London (SACL)
24-hour Crisis Line: (519) 438-2272

London & District Distress Centre
Crisis Line: (519) 667-6711

London Mental Health Crisis Service
24-hour Crisis-Line (519) 433-2023

Daya Counselling Centre
141 Dundas Street, 6\textsuperscript{th} floor
London, ON
(519) 434-3370

Sexual Assault Support Centre of Waterloo Region
24-hour Crisis Line: (519) 741-8633

Crisis Services of Waterloo Region
24-hour Crisis Line: (519) 744-1813
Toll Free: 1-866-366-4566 (TTY accessible)

KW Counselling Services
480 Charles St E., Kitchener
(519) 884-0000

Catholic Family Counselling Centre
400 Queen St. S. Kitchener
(519) 743-6333

Center of Mental Health Research
University of Waterloo
(519) 888-4567 ext. 33842

Cambridge Telecare Distress Centre
Crisis Line: (519) 658-6805
Consent Information

The purpose of this consent information letter is to ensure that you understand the purpose of the study and the nature of your involvement. Please contact the researcher to clarify any questions you have.

My name is Angèle Close. I am a Doctoral Student in the Counselling Psychology Program at the University of Toronto (Ontario Institute for Studies in Education) and am carrying out a study for my dissertation research that is looking at how treating oneself with kindness and compassion may help people who have experienced a traumatic event, such as sexual assault, heal and recover. This research is being funded by the Social Sciences and Humanities Research Council of Canada.

Purpose of the Research:
The purpose of this research study is to learn about how self-compassion may help individuals respond to traumatic incidents and to help us understand better the processes that affect their mental health and recovery.

We know that people have a number of psychological responses to highly stressful situations including different reactions to sexual assault. We also know that different individuals may cope with their assault and treat themselves differently, some perhaps critically, while others more so with kindness and compassion. We are interested in studying how different ways of treating one’s self may influence how one experiences the effects of trauma and the process of healing and recovery. We believe that this will allow us to design ways to help sexual assault survivors reduce psychological distress and better recover from sexual assault.

Participants in this Study:
You are invited to participate in this study because you experienced a sexual assault within the past two years. As part of this study you will be asked to complete a number of questionnaires. You will be asked questions about your background, experience(s) of sexual assault and other stressful events, psychological and physical health, and different ways of treating yourself. It is expected that the study will be completed in approximately one hour. You do not give up any legal rights by choosing to participate in this research.

What Happens to the Information You Provide?
All of the information you provide is confidential, meaning that no one other than the researchers will have access to your information. Your name will not be required on any of the questionnaires; therefore, your participation in this research is completely anonymous. The information collected will be kept in a secure location in our research office at the University of Toronto for five years, after which time they will be destroyed. Any publications or presentations made on the basis of the information provided in this study will not identify you in any way.
**Possible Risks of Participation:**
Some of the information that you will be asked about may be upsetting or stressful. Your participation in this study is completely voluntary. You are free to refuse to answer any question(s), and you may end your participation at anytime without any negative consequences. At the end of the on-line questionnaires you will find a list of local resources for support and counselling services that can be printed off for you to keep.

**Possible Benefits of Participation:**
There are no personal benefits to you for participating in this study, however, your participation will help us gain a better understanding of how people respond to experiences of sexual assault, and in turn may lead to the development of psychotherapeutic interventions for survivors of sexual assault. You will not be paid to take part in this study, however, for every ten participants, a draw for a $100 gift card for Chapters/Indigo Booksellers will be made. At the end of the survey you will have the opportunity to check a box indicating a desire to have a summary of the research findings sent to you at the completion of the study.

Your involvement in this research is appreciated. If you choose to complete and submit your responses on the on-line questionnaires, this will signify your consent to participate in the study. This letter of information can be printed off for you to keep.

Should you have any further questions regarding this study, please feel welcome to contact Angèle Close at (226) 220-0991 or aclose@oise.utoronto.ca or Dr. Lana Stermac at (416) 978-0722 or lstermac@oise.utoronto.ca. If you have any ethical concerns regarding the study, you may contact the Ethics Review Office of the University of Toronto at ethics.reivew@utoronto.ca or (416) 946-3273. Please note also that if you find yourself feeling some distress or discomfort from answering some of the questionnaires, a list of local community crisis and counselling resources that can provide you with immediate assistance and support is included in this package.

Thank you for your participation,

Angèle Close, M.Ed., Doctoral Student and
Lana Stermac, Ph.D.
Counselling Psychology Program
Ontario Institute for Studies in Education, University of Toronto
Consent Information

The purpose of this consent information letter is to ensure that you understand the purpose of the study and the nature of your involvement. Please contact the researcher to clarify any questions you have.

My name is Angèle Close. I am a Doctoral Student in the Counselling Psychology Program at the University of Toronto (Ontario Institute for Studies in Education) and am carrying out a study for my dissertation research that is looking at how treating oneself with kindness and compassion may help people who have experienced a traumatic event, such as sexual assault, heal and recover. This research is being funded by the Social Sciences and Humanities Research Council of Canada.

Purpose of the Research:
The purpose of this research study is to learn about how self-compassion may help individuals respond to traumatic incidents and to help us understand better the processes that affect their mental health and recovery.

We know that people have a number of psychological responses to highly stressful situations including different reactions to sexual assault. We also know that different individuals may cope with their assault and treat themselves differently, some perhaps critically, while others more so with kindness and compassion. We are interested in studying how different ways of treating one’s self may influence how one experiences the effects of trauma and the process of healing and recovery. We believe that this will allow us to design ways to help sexual assault survivors reduce psychological distress and better recover from sexual assault.

Participants in this Study:
You are invited to participate in this study because you experienced a sexual assault within the past three years. As part of this study you will be asked to complete a number of questionnaires. You will be asked questions about your background, experience(s) of sexual assault and other stressful events, psychological and physical heath, and different ways of treating yourself. It is expected that the study will be completed in approximately one hour. You do not give up any legal rights by choosing to participate in this research.

What Happens to the Information You Provide?
All of the information you provide is confidential, meaning that no one other than the researchers will have access to your information. Your name will not be required on any of the questionnaires; therefore, your participation in this research is completely anonymous. The information collected will be kept in a secure location in our research office at the University of Toronto for five years, after which time they will be destroyed. Any publications or presentations made on the basis of the information provided in this study will not identify you in any way.
Possible Risks of Participation:
Some of the information that you will be asked about may be upsetting or stressful. Your participation in this study is completely voluntary. You are free to refuse to answer any question(s), and you may end your participation at anytime without any negative consequences. You will be provided with a list of local resources for support and counselling services.

Possible Benefits of Participation:
There are no personal benefits to you for participating in this study, however, your participation will help us gain a better understanding of how people respond to experiences of sexual assault, and in turn may lead to the development of psychotherapeutic interventions for survivors of sexual assault. You will not be paid to take part in this study, however, for every ten participants, a draw for a $100 gift card for Chapters/Indigo Booksellers will be made. A summary of the research findings will be sent to you at your request.

Your involvement in this research is appreciated. If you choose to participate, you can find the questionnaire packages in a box at reception with a sign that reads: “Research Study – New Participants”. Once you have completed the questionnaires, please leave the completed questionnaire package in the second box noted with a sign that reads: “Research Study - Completed”, also found at reception. This letter of information is yours to keep. If you choose to complete and return the questionnaires, this will signify your consent to participate in the study.

Should you have any further questions regarding this study, please feel welcome to contact Angèle Close at (226) 220-0991 or angele.close@utoronto.ca or Dr. Lana Stermac at (416) 978-0722 or l.stermac@utoronto.ca. If you have any ethical concerns regarding the study, you may contact the Ethics Review Office of the University of Toronto at ethics.reivew@utoronto.ca or (416) 946-3273. Please note also that if you find yourself feeling some distress or discomfort from answering some of the questionnaires, a list of local community crisis and counselling resources that can provide you with immediate assistance and support is included in this package.

Thank you for your participation,

Angèle Close, M.Ed., Doctoral Student and
Lana Stermac, Ph.D.
Counselling Psychology Program
Ontario Institute for Studies in Education, University of Toronto
Demographic Information

Please answer the following questions by checking the box and/or filling in the answer that best describes you.

1. Age: ____________

2. Ethnic background
   - Asian-Canadian
   - Indo-Canadian
   - African-Canadian
   - Hispanic
   - Caribbean-Canadian
   - Euro-Canadian
   - Métis
   - First Nations
   - Inuit
   - Other: ____________

2. Place of Birth: ____________________________

3. Is English your first language?
   - Yes
   - No

4. Relationship Status:
   - Married
   - Divorced
   - Single
   - Separated
   - Widowed
   - Common Law

5. Education:
   - Student:
     - Adult Education
     - College
     - University
   - Full Time
   - Part Time
6. Employment:

- Employed:  
- Full Time  
- Part Time  
- Unemployed

7. Current Living Circumstances:

- Alone  
- With husband/partner  
- Other  
- With Roomate(s)  
- With Family

8. History of Sexual Trauma (since the age of 16):

Time elapsed since sexual assault:

___________ Months

___________ Years

Relationship to the perpetrator(s) (E.g., stranger, current or former boyfriend, father, co-worker, etc.):

________________________________________________________________________

9. Have you received counselling related to the assault(s)? Yes/No

Are you currently in counselling? Yes/No

10. Was there someone in your childhood who you could consistently turn to for support and reassurance?

- Yes

- No

Who was that person to you? (E.g., parent, brother/sister, teacher, coach, neighbor, friend, etc.):

________________________________________________________________________
Sexual Experiences Survey Short Form Victimization (SES-SFV)

The following questions concern sexual experiences that you may have had that were unwanted. We know that these are personal questions, so we do not ask your name or other identifying information. Your information is completely confidential. We hope that this helps you to feel comfortable answering each question honestly. Place a check mark in the box (☑) showing the number of times each experience has happened to you. If several experiences occurred on the same occasion – for example, if one night someone told you some lies and had sex with you when you were drunk, you would check both boxed a and e.

<table>
<thead>
<tr>
<th>Sexual Experiences</th>
<th>HOW MANY TIMES IN THE PAST FIVE YEARS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or butt) or removed some of my clothes without my consent (but did not attempt sexual penetration) by:</td>
<td>0 1 2 3+</td>
</tr>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>2. Someone had oral sex with me or made me have oral sex with them without my consent by:</td>
<td>0 1 2 3+</td>
</tr>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>3. A man put his penis into my vagina, or someone inserted fingers or objects without my consent by:</td>
<td>0 1 2 3+</td>
</tr>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>4. A man put his penis into my butt, or someone inserted fingers or objects without my consent by:</td>
<td>0 1 2 3+</td>
</tr>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>
what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

5. even though it did not happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by:

   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.

   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.

   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

   d. Threatening to physically harm me or someone close to me.

   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

6. Even though it did not happen, a man TRIED to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by:

   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.

   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.

   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

   d. Threatening to physically harm me or someone close to me.

   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

7. Even though it did not happen, a man TRIED to put his penis into my butt, or someone tried to stick in objects or fingers without my consent by:

   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.

   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.

   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

   d. Threatening to physically harm me or someone close to me.

   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

8. I am: Female ☐ Male ☐ My age is ___ years and ___ months.

9. Did any of the experiences described in this survey happen to you one or more times?

   Yes ☐

   No ☐

   What was the sex of the person or persons who did them to you?

   I reported no experiences ☐

   Female only ☐

   Male only ☐

   Both females and males ☐

10. Have you ever been raped? Yes ☐ No ☐
Self-Compassion Scale

Please indicate how often you act in the manner stated in each of the statements below according to the following scale:

1 = Almost never
2 = Very little
3 = Sometimes
4 = Very often
5 = Almost always

1. I try to be understanding and patient towards those aspects of my personality I don’t like.
   1 2 3 4 5

2. When I see aspects of myself that I don’t like, I get down on myself.
   1 2 3 4 5

3. I try to see my failings as part of the human condition.
   1 2 3 4 5

4. When something upsets me I get carried away with my feelings.
   1 2 3 4 5

5. When times are really difficult, I tend to be tough on myself.
   1 2 3 4 5

6. I try to be loving towards myself when I’m feeling emotional pain.
   1 2 3 4 5

7. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
   1 2 3 4 5

8. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
   1 2 3 4 5

9. When something upsets me I try to keep my emotions in balance.
   1 2 3 4 5

10. When I fail at something important to me I become consumed by feelings of inadequacy.
    1 2 3 4 5

11. When I fail at something that’s important to me I tend to feel alone in my failure.
    1 2 3 4 5

12. When I’m feeling down I tend to feel like most other people are probably happier than I am.
    1 2 3 4 5

13. When I’m feeling down I try to approach my feelings with curiosity and openness.
    1 2 3 4 5
14. I can be a bit cold-hearted towards myself when I’m experiencing suffering.

15. When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world.

16. When something painful happens I tend to blow the incident out of proportion.

17. When I fail at something important to me I try to keep things in perspective.

18. When I’m really struggling I tend to feel like other people must be having an easier time of it.

19. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.

20. I’m tolerant of my own flaws and inadequacies.

21. When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am.

22. When I’m going through a very hard time, I give myself the caring and tenderness I need.

23. I’m disapproving and judgmental about my own flaws and inadequacies.

24. I’m kind to myself when I’m experiencing suffering.

25. I’m intolerant and impatient towards those aspects of my personality I don’t like.

26. When something painful happens I try to take a balanced view of the situation.
Posttraumatic Cognitions Inventory (PTCI)

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking.

Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

1 = Totally disagree  
2 = Disagree very much  
3 = Disagree slightly  
4 = Neutral  
5 = Agree slightly  
6 = Agree very much  
7 = Totally agree

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The event happened because of the way I acted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. I can’t trust that I will do the right thing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. I am a weak person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. I will not be able to control my anger and will do something terrible.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. I can’t deal with even the slightest upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. I used to be a happy person but now I am always miserable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. People can’t be trusted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. I have to be on guard all the time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. I feel dead inside.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. You can never know who will harm you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. I have to be especially careful because you never know what can happen next.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. I am inadequate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13. I will not be able to control my emotions, and something terrible will happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. If I think about the event, I will not be able to handle it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>15. The event happened to me because of the sort of person I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. My reactions since the event mean that I am going crazy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. I will never be able to feel normal emotions again.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>18. The world is a dangerous place.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>19. Somebody else would have stopped the event from happening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>20. I have permanently changed for the worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>21. I feel like an object, not like a person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>22. Somebody else would not have gotten into this situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>23. I can’t rely on other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>24. I feel isolated and set apart from others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>25. I have no future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>26. I can’t stop bad things from happening to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>27. People are not what they seem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>28. My life has been destroyed by the trauma.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>29. There is something wrong with me as a person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>30. My reactions since the event show that I am a lousy coper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>31. There is something about me that made the event happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>32. I will not be able to tolerate my thoughts about the event, and I will fall apart.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>33. I fell like I don’t know myself anymore.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>34. You never know when something terrible will happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>35. I can’t rely on myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>36. Nothing good can happen to me anymore.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
# The Trauma Symptom Checklist (TSC-40)

How often have you experienced each of the following in the last two months?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Fairly Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insomnia (trouble getting to sleep)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Restless sleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Not feeling rested in the morning</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Waking up early in the morning and can’t get back to sleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Weight loss (without dieting)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling isolated from others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Waking up in the middle of the night</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Low sex drive</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Sadness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. “Flashbacks” (sudden, vivid, distracting memories)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. “Spacing out” (going away in your mind)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Headaches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Stomach problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Uncontrollable crying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Not feeling satisfied with your sex life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Trouble controlling temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Trouble getting along with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Passing out</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Desire to physically hurt yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Desire to physically hurt others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Having sex that you didn’t enjoy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Sexual problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Sexual overactivity</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Fear of men</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Fear of women</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Unnecessary or over-frequent washing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Feelings of inferiority</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Feelings of guilt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Bad thoughts or feelings during sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Feelings that things are “unreal”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Memory problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. Feelings that you are not always in your body.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Feeling tense all the time</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Being confused about your sexual feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. Having trouble breathing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. Nightmares</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Sexual feelings when you shouldn’t have them</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Loneliness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Anxiety attacks</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Satisfaction with Life Scale

Survey Form

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 = Strongly agree
6 = Agree
5 = Slightly agree
4 = Neither agree nor disagree
3 = Slightly disagree
2 = Disagree
1 = Strongly disagree

___ In most ways my life is close to my ideal.
___ The conditions of my life are excellent.
___ I am satisfied with my life.
___ So far I have gotten the important things I want in life.
___ If I could live my life over, I would change almost nothing.
**Childhood Trauma Questionnaire - Short Form**

**Instructions:** These questions ask about some of your experiences growing up as a child and a teenager. For each question, circle the number that best describes how you feel. Although some of these questions are of a personal nature, please try to answer as honestly as you can. Your answers will be kept confidential.

<table>
<thead>
<tr>
<th>When I was growing up…</th>
<th>Never True</th>
<th>Rarely True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Very Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I didn’t have enough to eat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I knew there was someone to take care of me and protect me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. People in my family called me things like “stupid”, “lazy”, or “ugly”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My parents were too drunk or high to take care of the family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. There was someone in my family who helped me feel important or special</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I had to wear dirty clothes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I felt loved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I thought that my parents wished I had never been born</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>When I was growing up…</td>
<td>Never True</td>
<td>Rarely True</td>
<td>Sometimes True</td>
<td>Often True</td>
<td>Very Often True</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
<td>-------------</td>
<td>----------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>When I was growing up…</td>
<td>Never True</td>
<td>Rarely True</td>
<td>Sometimes True</td>
<td>Often True</td>
<td>Very Often True</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
<td>----------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>20. Someone tried to touch me in a sexual way, or tried to make me touch them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. I had the best family in the world</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. Someone tried to make me do sexual things or watch sexual things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. Someone molested me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. I believe that I was emotionally abused</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. There was someone to take me to the doctor if I needed it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. I believe that I was sexually abused</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. My family was a source of strength and support</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Experience of Shame Scale

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred at any time in the past year. There are no ‘right’ or ‘wrong’ answers. Please indicate the response which applies to you with a checkmark.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all (1)</th>
<th>A little (2)</th>
<th>Moderately (3)</th>
<th>Very much (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Have you felt ashamed of any of your personal habits?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Have you worried about what other people think of any of your personal habits?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Have you tried to cover up or conceal any of your personal habits?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Have you felt ashamed of your manner with others?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Have you worried about what other people think of you manner with others?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Have you avoided people because of your manner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Have you felt ashamed of the sort of person you are?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Have you worried about what other people think of the sort of person you are?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Have you tried to conceal from others the sort of person you are?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Have you felt ashamed of your ability to do things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Have you worried about what other people think of your ability to do things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Have you avoided people because of your inability to do things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Do you feel ashamed when you do something wrong?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Have you worried about what other people think of you when you do something wrong?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Have you tried to cover up or conceal things you felt ashamed of having done?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Have you felt ashamed when you said something stupid?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Have you worried about what other people think of you when you said something stupid?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Have you avoided contact with anyone who knew you said something stupid?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Have you felt ashamed when you failed in a competitive situation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Have you worried about what other people think of you when you failed in a competitive situation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Have you avoided people who have seen you fail?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Have you felt ashamed of your body or any part of it?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Have you worried about what other people think of your appearance?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Have you avoided looking at yourself in the mirror?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Have you wanted to hide or conceal your body or any part of it?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX N

The Levels of Self-Criticism Scale

Please indicate with a number from 1 – 7 the extent to which you think each statement describes you. There is no ‘right’ or ‘wrong’ answer. Please answer honestly.

1 = Not at all  
2 = Usually not at all  
3 = Sometimes, but infrequently  
4 = Occasionally  
5 = Often  
6 = Usually  
7 = Very well

1. I am very irritable when I have failed.  
2. I have a nagging sense of inferiority.  
3. I am very frustrated with myself when I don’t meet the standards I have for myself.  
4. I am usually uncomfortable in social situations where I don’t know what to expect.  
5. I often get very angry with myself when I fail.  
6. I don’t spend much time worrying about what other people will think of me.  
7. I get very upset when I fail.  
8. If you are open with other people about your weaknesses, they are likely to still respect you.  
9. Failure is a very painful experience for me.  
10. I often worry that other people will find out what I’m really like and be upset with me.  
11. I don’t’ often worry about the possibility of failure.  
12. I am confident that most of the people I care about will accept me for who I am.  
13. When I don’t succeed, I find myself wondering how worthwhile I am.  
14. If you give people the benefit of the doubt, they are likely to take advantage of you.  
15. I feel like a failure when I don’t do as well as I would like.  
16. I am usually comfortable with people asking me about myself.  
17. If I fail in one area, it reflects poorly on me as a person.  
18. I fear that if people get to know me too well, they will not respect me.  
19. I frequently compare myself with my goals and ideals.  
20. I seldom feel ashamed of myself.  
21. Being open and honest is usually the best way to keep others’ respect.  
22. There are times that it is necessary to be somewhat dishonest in order to get what you want.
### STRESSFUL LIFE EXPERIENCES SCREENING

Below is a list of situations that some people have experienced. Please circle **YES** if you have experienced this type of situation or circle **NO** if you have **not** experienced this type of situation. If you would like help to complete this survey, please let us know.

<table>
<thead>
<tr>
<th>Situation</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have witnessed or experienced a natural disaster; like a hurricane or earthquake.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or experienced a serious accident or injury.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have been exposed to radiation or chemicals or this has happened to a close friend or family member.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or experienced the death of my spouse or child.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I or a close friend or family member has been kidnapped or taken hostage.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I or a close friend or family member has been the victim of a terrorist attack or torture.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have been involved in combat or a war or lived in a war affected area.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have seen or handled dead bodies other than at a funeral.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have felt responsible for the serious injury or death of another person.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or been attacked with a weapon other than in combat or in a family setting.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>As a child/adolescent I was hit, spanked, choked or pushed hard enough to cause injury.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>As an adult, I was hit, choked or pushed hard enough to cause injury.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>As a child/adolescent I was forced to have unwanted sexual contact.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>As an adult I was forced to have unwanted sexual contact.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>As a child or adult I have witnessed someone else being forced to have unwanted sexual contact.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have witnessed or experienced an extremely stressful event not already mentioned.</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Please explain: ______________________________________________________