Sexual violence and mental health: An analysis of the mediating role of self-compassion using a feminist lens

by

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Abstract

Using the feminist critique of the cognitive model of trauma, this study explored the potential mediating effects of self-compassion (self-warmth and self-criticism) on the association between experiencing sexual violence and negative mental health outcomes. Race and sexual orientation were explored as contextual variables. The sample consisted of 368 women (88.6% white, 94.6% heterosexual/straight) recruited from two semesters of a large undergraduate class who completed an online survey at three time points throughout the semester. A path analysis revealed that having experienced sexual violence prior to the beginning of the semester was positively associated with self-criticism, anxiety, depression, and PTSD symptoms at the end of the semester directly and indirectly through self-compassion mid-semester. Specifically, while there was evidence that self-criticism amplified the negative effect of sexual violence on mental health outcomes, there was limited evidence that self-warmth buffered these effects. Future research is needed on how survivors of sexual violence are conceptualizing the core concepts of self-compassion in order to improve both measurement and treatment.

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Dedication

This project is dedicated to survivors of sexual violence. I see you; I believe you. My passion for this project stemmed from a desire to ask questions, conduct research, and publish findings in a way that survivors could see themselves and their stories in my work. This is also my commitment to true feminist practice that actively challenges the status quo rather than explicitly or implicitly endorsing it. It is time we stop talking about sexual violence like it happens in a vacuum. It is time to stop talking about individuals making violent choices and start talking about when and how and where they learned they could be violent without accountability or did not learn their actions were violent. It is time to stop talking about identities as risk factors and start talking about how the lived experience of sexism, racism, homophobia, transphobia, and all the other isms is violence. We must do better if want to see the world be better.

Chapter 1 - Introduction

Unfortunately, sexual violence is common, especially for people with marginalized identities. The lifetime prevalence rate for rape is 18.3% for women and only 1.4% for men (Black et al., 2011). Moreover, other forms of sexual violence including sexual coercion, unwanted sexual contact, and unwanted sexual experiences that did not involve physical contact were reported by 44.6% of women (Black et al., 2011). Rates are higher for women who identify as a racial/ethnic or sexual orientation minority (Black et al., 2011; Rothman, Exner, & Baughman, 2011). The effects of sexual violence can be long-lasting and include suicidal ideation and attempts (Ullman & Najdowski, 2009), emotional and physical distress (Langton & Truman, 2014), and post-traumatic stress disorder (PTSD; Cortina & Kubiak, 2006).

Cognitive trauma theory asserts that trauma symptoms occur, or are amplified, after sexual violence because individuals' views of the world are transformed from safe to dangerous, leading individuals to adopt maladaptive behaviors in an attempt to increase safety (Ehlers & Clark, 2000). This assumption, however, might not accurately describe the experiences of women who live daily with a greater threat of sexual violence than men (Black et al., 2011). For women, sexual violence might instead confirm that the world is an unsafe place rather than transforming the world from safe to unsafe (Wasco, 2000). Specifically, according to feminist critiques of cognitive trauma theory, the trauma following sexual violence for women is marked by unique symptoms, such as shame and self-blame, and unique explanations of symptoms because women often already perceive the world as dangerous. Many feel they should have done something different to prevent their assault or should not be in as much distress afterwards (Tseris, 2013).

Accordingly, feminist critiques argue that current treatment modalities that use the

cognitive model of trauma might not be sufficient for survivors of sexual violence (Wasco, 2000). Self-compassion ("compassion directed inward"; Germer & Neff, 2013, p. 856) might be particularly powerful for female survivors of sexual violence because it combats these unique symptoms of trauma by focusing on non-judgment and increasing kindness towards oneself (McLean, Steindl, & Bambling, 2018). However, few studies that have looked at how self-compassion operates in the context of sexual violence specifically (Hamrick & Owens, 2018; Scoglio, Rudat, Garvert, Jarmolowski, Jackson, & Herman, 2018). Therefore, the purpose of this study is to evaluate if self-compassion mediates the effects of sexual violence on mental health outcomes (anxiety, depression, suicidal ideation, and PTSD symptoms) in order to inform clinical interventions with female survivors of sexual violence.

Chapter 2 - Review of Literature

Understanding the Impacts of Sexual Violence on Women's Mental Health

Men do experience sexual victimization; however, women experience it at much higher rates meaning it is women, and not men, who carry the burden of collective sexual trauma (Black et al., 2011). Further, rates of sexual violence among women vary substantially by racial/ethnic identity and sexual orientation. Although 18.8% of White women report experiencing rape at some point in their lives, this is lower than the 33.5% of Multiracial women, 26.9% of American Indian or Native Alaskan women, and 22.0% of Black women who have experienced rape (Black et al., 2011). Sexual violence other than rape has been reported by 58.0% of Multiracial women, 49.0% of American Indian or Native Alaskan women over their lifetime compared to 47.6% of White women (Black et al., 2011). Additionally, between 11% and 53% of women who identify as lesbian or bisexual will experience some form of sexual violence in their lifetime (Rothman et al., 2011) compared to 17.4% of heterosexual women who experience rape and 43.4% of heterosexual women who experience other types of sexual violence (Walters, Chen, & Brieding, 2013). Further, 46.1% of bisexual women experience rape, while 74.9% of bisexual women experience other forms of sexual violence (Walters et al., 2013). Although these prevalence rates do not fully capture the experience of women who hold multiple marginalized identities (e.g., class, ability status, citizenship status, etc), they do indicate that sexual violence or the threat of sexual violence is a reality for many women, particularly those who hold a racial/ethnic or sexual orientation minority identity.

Trauma Theories

A traumatic event is one that involves "exposure to actual or threatened death, serious injury, or sexual violence" (p. 266; American Psychiatric Association, 2013), and trauma

symptoms are the emotional and mental reactions to traumatic events as listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013). Sexual violence is considered a traumatic event according to this definition, and the psychological distress following sexual violence is well documented. In fact, anxious arousal, depression, anger, suicidal ideation and attempts, and other mental illnesses are common (Campbell, Dworkin, & Cabral, 2009; Elliot, Mok, & Briere, 2004; Ng, Yong, Ho, Lim, & Yeo, 2018; Ullman & Najdowski, 2009). Survivors of sexual violence also report physical illnesses and complaints, substance use and abuse, and sexual difficulties as well (Bonomi, Anderson, Campbell et al., 2009; O'Driscoll & Flanagan, 2015; Rivara, & Thompson, 2007).

Cognitive trauma theory. The cognitive model of trauma theory, which specifically looks at the development of PTSD, posits that those who process the traumatic event and the neurobiological reactions to it "in a way that produces a sense of current threat" develop PTSD (Ehlers & Clark, 2000, p. 320). This suggests that it is the cognitive processing after the event, rather than the event itself, that leads to PTSD (Lancaster, Rodriquez, & Weston, 2011). Further, because their safe worldview has been shattered, survivors of a traumatic event engage in maladaptive behaviors (e.g., thought suppression and engaging in safety behaviors) in an attempt to increase safety which increases symptoms of PTSD (Ehlers & Clark, 2000). This theory has influenced the choice of symptoms listed in the DSM (American Psychiatric Association, 2013), which are insufficient to describe the symptoms of people who, because of their marginalized identities, do not ever experience the world as completely safe due to consistent discrimination and devaluation in addition to identifiable traumatic events. Specifically, cognitive trauma theory does not account for the ongoing traumatizing impacts of oppression and marginalization based on identities survivors hold that shape their everyday experiences and responses to traumatic

events (Root, 1992).

Feminist critiques of cognitive trauma theory. A main tenet of the feminist critiques of cognitive trauma theory is that sexual violence does not happen independent of sexism: the patriarchal structures that privilege certain identities over others thereby deciding who has value (men) and who does not (women; Richmond, Geiger, & Reed, 2013). Much of the discrimination stemming from sexism is sexual in nature (e.g., sexual objectification, reproductive control; Beckman, 2017; Miles-McLean et al, 2015) and leads to increased rates of sexual violence against women (Black et al., 2011). Further, the lived experience of sexism is amplified by racism, heterosexism, and other systems of oppression for women with additional marginalized identities. Thus, contrary to the core assumption of cognitive trauma theory, many women experience the world as a consistently *un*safe place due to higher rates of violence, discrimination, and objectification, and clinicians and researchers should be looking for unique explanations of symptoms (outside a shattered worldview) for survivors of sexual violence (Tseris, 2013).

Living in fear of violence and discrimination, or being told consistently, both overtly and covertly, that you are not valued because of your gender, race, or sexual orientation, does not qualify as a traumatic event according to cognitive trauma theory, but has real consequences for well-being. Root (1992) calls this insidious trauma and explains "Insidious trauma is usually associated with the social status of an individual being devalued because a characteristic intrinsic to their identity is different from what is valued by those in power…it is often present throughout a lifetime" (p. 240). Some of this insidious trauma might be direct, such as experiencing microaggressions, while some of it might be less direct such as a lack of representation in media (Root, 1992). The cumulative effects of insidious trauma are lifelong and often result in survival

mechanisms (such as egocentrism and splitting the world into "good" and "bad" people) that might be misinterpreted as selfishness or cognitive distortions by a mental health professional rather than being recognized as symptoms of trauma (Root, 1992). Further, dominant cultural narratives about survivors of sexual violence make it more difficult or impossible for survivors to find safe spaces to heal because they increase shame, self-blame, disconnection, and isolation (Palmer, 1991; Tseris, 2013; Wasco, 2003). Any treatment that will help survivors of sexual violence heal will need to address the effects of insidious trauma and include intentional work on the part of the clinician to provide care that addresses the cultural narratives about sexual violence that might become internalized by the survivor (Palmer, 1991). Therefore, clinicians and research should be evaluating both for unique *explanations* for trauma symptoms and unique *symptoms* of trauma that are not listed in the DSM (American Psychiatric Association, 2013).

Self-Compassion and Treatment of Sexual Trauma

Treatment modalities developed with an understanding of cognitive trauma theory might not treat all aspects of trauma for a female survivor of sexual violence. For example, treatment to address distress following a traumatic event typically includes some form of processing of the traumatic event with the goal of reducing both reactivity to traumatic memories and avoidance behaviors in order to restore a sense of safety (Strand, Hansen, & Courtney, 2013). Feminist critiques of trauma theory would argue that it is critical that treatment for trauma following sexual violence also include space and power to confront cultural narratives about female sexuality, victim blaming, and violence in general (Tseris, 2013; Wasco, 2003).

Theoretically, self-compassion (composed of self-warmth and self-criticism) has the potential to account for the unique symptoms identified by feminist critiques of cognitive trauma theory and provide a specific focus for skill-building with clients to address these symptoms and

buffer psychological distress after sexual violence (McLean et al., 2018). Self-compassion describes the kindness we offer ourselves in difficult times and has been explored as a component of therapy in general, though the literature on self-compassion as an aspect of trauma treatment is very limited (McLean et al., 2018; Neff & Germer, 2012). Self-compassion theory is comprised of three main elements: loving-kindness, mindfulness, and common humanity. Specifically, loving-kindness is showing oneself understanding rather than judgment, mindfulness is nonjudgmental awareness of emotions and experiences rather than over-identifying with emotions, and common humanity is connecting personal suffering to the human experience rather than feeling isolated in suffering (Neff, 2003). Although Neff (2016) has argued for the validity of a unidimensional self-compassion construct, a two-factor structure representing positive aspects of these elements (self-warmth) and negative aspects of these elements (self-criticism) has been found by other researchers (López, et al., 2015). Because self-compassion describes both refraining from self-criticism and promoting self-warmth in times of difficulty (Neff, 2003), it might be that the two-dimensional conceptualization captures the importance of both increasing the positive aspects (loving-kindness, mindfulness, and common humanity) and decreasing the negative aspects (self-judgment, over-identification, and isolation) as the negative aspects are not just the absence of the positive aspects.

Self-criticism describes some of the unique symptoms identified by the feminist critiques of cognitive trauma theory such as shame and self-blame, isolation and disconnection from others, and powerlessness to change emotional responses (Tseris, 2013; Wasco, 2003). Self-warmth might combat these symptoms (McLean et al., 2018). For example, relating to the experiences of others who have experienced sexual violence and learning to view trauma responses as natural and normal in light of what has happened might help survivors replace

avoidance with compassion, reduce shame and self-blame, and increase the ability to notice and sit with trauma responses (McLean et al., 2018).

Along these lines, self-compassion has been found to be associated with positive psychological (Neff, Rude, & Kirkpatrick, 2006) and mental health outcomes (MacBeth & Gumley, 2012). Additionally, Maheux and Price (2015) found that self-compassion mediated the positive effects social support had on depression and anxiety symptoms for survivors of traumatic events. Self-compassion has also been found to be positively associated with mental health outcomes in adult survivors of childhood abuse (Barlow, Turow, & Gerhart, 2017). Further, self-compassion has been linked to less severe PTSD symptomology and more resilience for women who have experienced interpersonal violence (physical or sexual; Scoglio et al., 2018). Hamrick and Owens (2018) found that self-compassion reduced PTSD symptoms by decreasing self-blame and disengagement coping for survivors of sexual violence. These findings suggest that self-compassion could be helpful for survivors of sexual violence to improve mental health outcomes and address unique symptoms identified by the feminist critique of cognitive trauma theory. Currently, however, there is no literature evaluating the potentially mediating role of self-compassion (self-criticism and self-warmth) in the relationship between experiencing sexual violence and mental health outcomes for females.

Present Study

Treatments for sexual violence survivors based on cognitive trauma theory might not fully address the impact of the context in which sexual violence occurs, and there is a lack of research looking at constructs that might be specifically relevant for addressing the impact of internalized cultural narratives that affect mental health outcomes for women after sexual violence. Therefore, the current study seeks to use a feminist lens to explore how self-

compassion (self-criticism and self-warmth) mediates the associations between experiencing sexual violence and women's mental health outcomes (depression, anxiety, suicidal ideation, and PTSD symptoms). Race and sexual orientation will be evaluated as contextual variables that contribute to our understanding of how marginalized identities influence the experience of sexual trauma.

Hypotheses

H1: Women who have experienced sexual violence will report greater self-criticism, lower self-warmth, and worse mental health outcomes (anxiety, depression, suicidal ideation, and PTSD symptoms) than women who have not experienced sexual violence.

H2: Greater self-criticism and lower self-warmth will be associated with worse mental health outcomes.

H3: Sexual violence will be directly and indirectly associated with mental health outcomes through self-criticism and self-warmth.

Chapter 3 - Methods

Participants were recruited from two sections of an introductory human development course at a large Midwestern university across two semesters. Informed consent was collected from each participant. Participants completed surveys online through Qualtrics.com at three time points: a couple weeks into the semester (T1), midway through the semester (T2), and a couple weeks before the end of the semester (T3). Those who chose to complete the study were offered extra credit at each time point, while those who chose not to participate were offered other forms of extra credit in the class.

Sample

Data from two semesters (spring 2018 and fall 2018) were merged resulting in a sample of 531 participants; however, for the purposes of this study, only females were included (368 females, 70.1%). My final sample was predominantly White (88.6% White, 5.7% Latino/Latina, 3.8% African American, 3.3% Asian, 1.9% Native American/American Indian, 2.2% Other) and Heterosexual/straight (94.6% straight, 2.7% bisexual, 1.6% other, and 1.1% lesbian).

Measures

Sexual violence. Two items from the Life Events Checklist (LEC-5; Weathers et al, 2013a) were used to assess for the experience of sexual violence at T1. These items were *"I have been sexually abused, assaulted or raped"* and "*I have had other unwanted or uncomfortable sexual experiences."* Participants were assigned a 0 (*no sexual violence*) if they chose "*no*" to both items and a 1 (*sexual violence*) if they indicated "*yes*" to either or both items. Of the 368 participants in the sample, 141 had experienced some form of sexual violence (38.3%).

Self-compassion. Self-compassion was measured at T2 with the Self-Compassion Scale (SCS, Neff, 2003). The original 26-item measure consists of six subscales: self-kindness, self-

judgment, common humanity, isolation, mindfulness, and over-identification. However, an exploratory factor analysis with oblique rotation only resulted in three factors that accounted for 64.02% of the variance in the items remaining after two items that heavily cross-loaded were removed. There was only one item in the third factor, but it cleanly loaded on factor two as well, so I only considered two factors. I named these two factors self-warmth (11 items; $\alpha = .92$) and self-criticism (13 items; $\alpha = .95$) based on whether items came from the self-kindness, common humanity, and mindfulness subscales (self-warmth) or the self-judgment, isolation, and over-identification subscales (self-criticism).

The self-warmth factor included items such as "*I'm kind to myself when I'm experiencing suffering*" and "*When I'm going through a very hard time, I give myself the caring and tenderness I need.*" The self-criticism factor included items such as "*I can be a bit cold-hearted towards myself when I'm experiencing suffering*" and "*When times are really difficult, I tend to be tough on myself*." Participants rated each item on a scale from 1 (*Almost Never*) to 5 (*Almost Always*) and the mean score for each factor was calculated where higher scores indicating more self-warmth or more self-criticism.

Mental health. Anxious symptoms were measured at T3 with the 7-item Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) that asked participants to consider how often they have experienced symptoms of generalized anxiety disorder over the past two weeks, such as feeling nervous and trouble relaxing, on a scale ranging from 1 (*Not at all*) to 4 (*Nearly every day*). The mean score for this scale was calculated with higher scores indicating higher levels of anxious symptoms ($\alpha = .94$).

Depressive symptoms were measured with the 9-item Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) which asked participants to report on how often in

the past two weeks they had experienced symptoms of major depressive disorder, such as having trouble concentrating on things or feeling down, depressed, or hopeless, on a scale from 1 (*Not at all*) to 4 (*Nearly every day*). The mean of these items was calculated with higher scores indicating higher levels of depressive symptoms ($\alpha = .92$). To assess suicidal ideation, participants answered how true the following statement was for them on a scale from 1 (*Never*) to 5 (*Always*): *"In the past 30 days, I have seriously considered suicide."*

PTSD symptoms were measured with the PTSD Checklist for DSM-5 (PCL-5; Weathers et al, 2013b) which includes 20 symptoms of post-traumatic stress disorder, such as *"Trouble remembering important parts of a stressful experience from the past."* Response options ranged from 1 (*Not at all*) to 5 (*Extremely*). The mean score for this scale was calculated with higher scores indicating higher levels of PTSD symptoms ($\alpha = .97$).

Contextual variables. Race and sexual orientation were considered as contextual variables. One question was used to identify race/ethnicity "*Please indicate your ethnicity below (If you identify as multi-ethnic or mixed race check ALL that apply).*" Participants chose their racialethnic identity from a list: *White (Non-Hispanic), African American, Latino/Latina, Asian, Native American/American Indian, Other*. Participants were also asked to choose their sexual orientation from a list with the prompt, "*I consider myself to be…*" followed by the choices: *heterosexual or straight, gay, lesbian, bisexual, other*. Because the majority of the sample were White and heterosexual/straight, these variables were coded dichotomously where 1 = "*majority identity*" and 0 = "*minority identity.*" This resulted in 311 participants in the majority and 57 in the minority racial category and 348 in the majority and 20 in the minority sexual orientation category.

Analytic Plan

Correlations were run for the continuous variables (Table 3.1). One-way ANOVAs were run to examine whether race, sexual orientation, and sexual violence were associated with self-criticism, self-warmth, and mental health outcomes (anxiety, depression, suicidal ideation, and PTSD symptoms). Levene's statistic was used to test for homogeneity of variances when conducting the ANOVAs. In the case that variances were not equal across groups being compared, Welch's *F*-statistic was reported as it is robust when the homogeneity of variances assumption is violated (Field, 2005).

Table 3.1 Correlations for Variables (*N* = 368)

Variables	1	2	3	4	5	*M*	*SD*
1. Self-Warmth	–					2.85	.82
2. Self-Criticism	-.05	–				2.82	.95
3. Suicidal Ideation	-.01	.15*	–			1.10	.36
4. Anxiety	-.14*	.54**	.34**	–		1.92	.78
5. Depression	-.18**	.48**	.39**	.76**	–	1.64	.66
6. PTSD Symptoms	-.13*	.42**	.32**	.67**	.66**	1.76	.90

*Correlation is significant at the .05 level (2-tailed)

** Correlation is significant at the .01 level (2-tailed)

The direct and indirect associations between sexual violence and mental health outcomes (anxiety, depression, suicidal ideation, and PTSD symptoms) through self-compassion (self-warmth and self-criticism) were assessed with a mediated path analysis in M*plus* (Muthén & Muthén, 1998-2011; see Figure 1). Model fit was assessed with Pearson's chi-square test (χ^2), the comparative fit index (CFI), the root mean square error of approximation (RMSEA), and the standardized root mean square residual (SRMR). Indirect effects were evaluated with 95% confidence intervals from 2,000 bootstrapped samples (Bollen & Stine, 1992). Although all the

variables are continuous, one variable (suicidal ideation), was too skewed and kurtotic to be considered normal (skewness > 2; kurtosis >7; Kline, 2016), so I used the maximum likelihood estimator with S-B scaling (Satorra & Bentler, 2010).

Chapter 4 - Results

Preliminary Analyses

First, rates of sexual violence reported by participants were examined. About 44% (n = 25) of participants in the racial minority identity group reported sexual violence compared to 37.3% (n = 116) of participants in the racial majority identity group, although these differences were not significant ($\chi^2[1] = .88$, $p = .35$). For sexual orientation, 55% (n = 11) of participants in the minority identity group reported sexual violence compared to 37.4% (n = 130) of participants in the majority identity group, and these differences were also not significant ($\chi^2[1] = 2.50$, $p = .11$). Additionally, there were no significant differences between the majority and minority racial identity groups for any of the key variables in the model (see Table 4.1); therefore, race was not included in the path model. Some significant differences on key variables between the majority and minority sexual orientation group (see Table 4.2) and for those who had and had not experienced sexual violence (see Table 4.3) were found, accordingly, sexual orientation was included in the path model.

Table 4.1 ANOVA Comparing Means of Self-Criticism, Self-Warmth and Mental Health Outcomes for the Majority Group (n = 311) and Minority Group (n = 57) for Race

	Majority Identity		*Minority Identity*				
	M	*SD*	*M*	*SD*	*F*	*df*	*p*
Self-Criticism	2.81	.96	2.85	.91	.05	1	.82
Self-Warmth	2.86	.83	2.80	.87	.27	1	.60
Anxiety	1.91	.77	1.99	.83	.42	1	.52
Depression	1.63	.65	1.72	.70	.74	1	.39
Suicidal Ideation	1.08	.33	1.18	.50	1.71[w]	1	.20
PTSD Symptoms	1.77	.92	1.72	.81	.09	1	.77

[w] = Welch's statistic used because homogeneity of variances assumption was violated

Table 4.2 ANOVA Comparing Means of Self-Criticism, Self-Warmth and Mental Health Outcomes for Majority Group (*n* = 348) and Minority Group (*n* = 20) for Sexual Orientation

	Majority Identity		*Minority Identity*				
	M	*SD*	*M*	*SD*	*F*	*df*	*p*
Self-Criticism	2.78	.94	3.33	.98	6.00	1	.02
Self-Warmth	2.86	.82	2.51	.86	3.26	1	.07
Anxiety	1.88	.75	2.58	.90	13.57	1	.00
Depression	1.61	.64	2.17	.77	11.83	1	.001
Suicidal Ideation	1.08	.34	1.29	.59	2.14[w]	1	.16
PTSD Symptoms	1.72	.86	2.35	1.25	4.26[w]	1	.06

[w] = Welch's statistic used because homogeneity of variances assumption was violated

Table 4.3 ANOVA Comparing Means of Self-Criticism, Self-Warmth and Mental Health Outcomes for Sexual Violence (*N* = 368)

	No Sexual Violence		*Sexual Violence*				
	M	*SD*	*M*	*SD*	*F*	*df*	*p*
Self-Criticism	2.70	.94	3.05	.94	9.86	1	.002
Self-Warmth	2.88	.84	2.76	.80	1.32	1	.25
Anxiety	1.77	.71	2.21	.82	18.65[w]	1	.00
Depression	1.53	.57	1.88	.76	14.93[w]	1	.00
Suicidal Ideation	1.07	.32	1.14	.43	1.75[w]	1	.19
PTSD Symptoms	1.58	.77	2.10	1.02	18.36[w]	1	.00

[w] = Welch's statistic used because homogeneity of variances assumption was violated

Path Model

Direct effects. Model fit was acceptable ($\chi^2[4] = 8.15$, $p = .09$; CFI = .99; RMSEA = .06; SRMR = .03). Experiencing sexual violence was positively associated with self-criticism ($b = .34$, $\beta = .17$, $p = .002$), but was not significantly associated with self-warmth ($b = -.12$, $\beta = -.07$, $p = .23$; see Figure 4.1). Experiencing sexual violence was also directly positively associated with anxiety ($b = .23$, $\beta = .14$, $p = .01$), PTSD symptoms ($b = .34$, $\beta = .18$, $p = .003$), and depression ($b = .18$, $\beta = .13$, $p = .03$), but was not associated with suicidal ideation ($b = .04$, $\beta = .06$, $p = .41$). Self-criticism was positively associated with suicidal ideation ($b = .06$, $\beta = .15$, $p =$

.02), anxiety (b = .40, β = .50, p = .00), depression (b = .31, β = .45, p = .00), and PTSD symptoms (b = .36, β = .38, p = .00). Self-warmth was only negatively associated with depression (b = -.10, β = -.13, p = .01). Associations between self-warmth and suicidal ideation (b = .001, β = .003, p = .96), anxiety (b = -.08, β = -.08, p = .13), and PTSD symptoms (b = -.09, β = -.08, p = .17) were not significant.

As for the contextual variables, being heterosexual/straight was negatively associated with self-criticism (b = -.53, β = -.14, p = .02). The associations between sexual orientation and anxiety (b = -.20, β = -.06, p = .14) and depression (b = -.12, β = -.06, p = .45) were not significant.

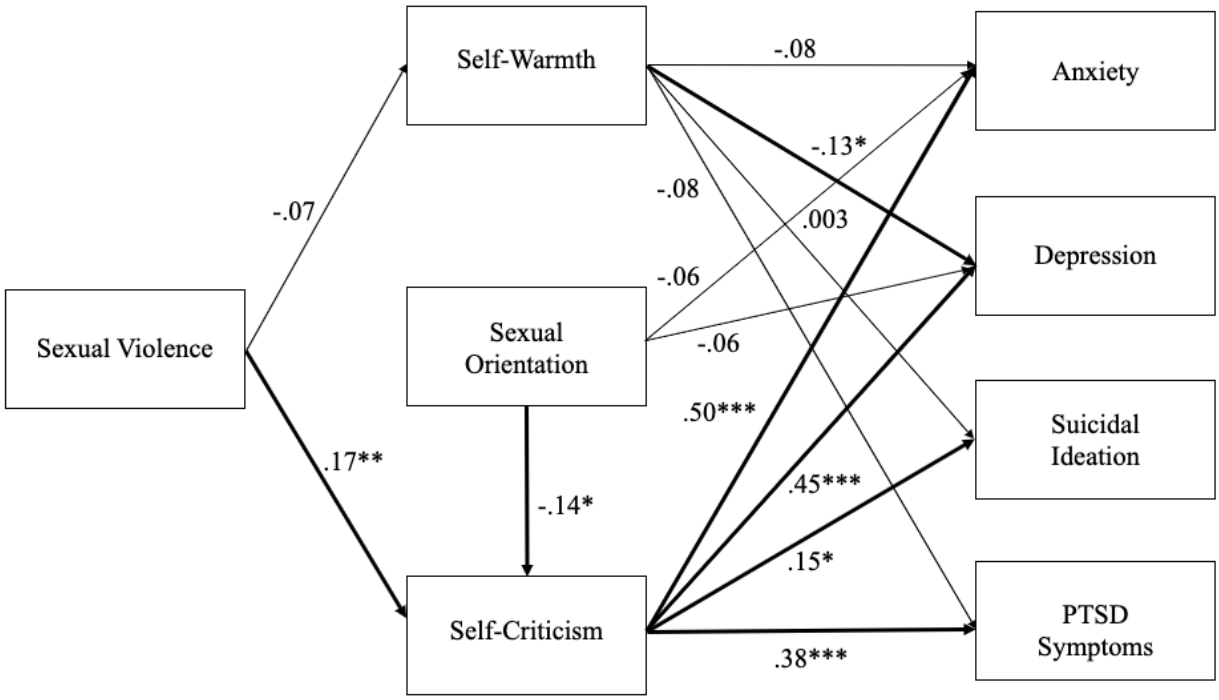

Figure 4.1 Model for effect of sexual violence on mental health outcomes and testing for mediation through self-warmth and self-criticism.

Sexual orientation included as a covariate. Standardized solution. Model fit indices: $\chi^2(4) = 8.15$, p = .09; CFI = .99; RMSEA = .06; SRMR = .03. Direct effects from sexual violence and sexual orientation not pictured for clarity. Significant paths indicated.

*p < .05; **p < .01; ***p < .001 (one-tailed).

Indirect effects. Table 5 shows the bootstrapped indirect effects with 95% confidence intervals. Sexual violence directly and indirectly impacted mental health outcomes through self-criticism. Specifically, experiencing sexual violence increased anxious, depressive, and PTSD symptoms through increased self-criticism. Because there were significant direct paths from sexual violence to anxiety, depression, and PTSD symptoms, self-criticism is only partially mediating these effects. No indirect effects were found through self-warmth.

Table 4.4 Indirect Effects from Sexual Violence to Self-Warmth and Self-Criticism to Mental Health Outcomes (Standardized Solution; *N* = 368)

Predictor	Indirect	Outcome	*β*	CI
Sexual Violence →	Self-Warmth →	Anxiety	.01	-.002, .03
		Depression	.01	-.003, .03
		Suicidal Ideation	.00	-.02, .10
		PTSD Symptoms	.01	-.003, .03
	Self-Criticism →	Anxiety	.08*	.03, .13
		Depression	.08*	.03, .13
		Suicidal Ideation	.03	.004, .06
		PTSD Symptoms	.06*	.02, .11

Note: Indirect paths tested with 2,000 bootstraps. CI = 95% confidence interval. *$p < .05$.

Chapter 5 - Discussion

I found mixed evidence for self-compassion as a mediator of the relationship between sexual violence and mental health outcomes (suicidal ideation, anxiety, depression, and PTSD symptoms). As hypothesized, women who reported experiencing sexual violence also reported greater self-criticism than women who had not experienced sexual violence, and self-criticism partially mediated the relationship between sexual violence and all mental health outcomes except suicidal ideation. However, experiencing sexual violence was not associated with less self-warmth, and self-warmth was only significantly associated with one mental health outcome (depression). Accordingly, self-warmth did not mediate any associations between sexual violence and mental health outcomes. These findings provide mixed evidence to the usefulness of self-compassion (self-criticism and self-warmth) as a construct that would be helpful to survivors of sexual violence in treatment, specifically, that self-criticism may be more salient for survivors than self-warmth.

Conceptualizing Self-Compassion after Sexual Violence

My findings, particularly regarding self-criticism (self-judgment, over-identification, and isolation), support the assertions by feminist critiques of cognitive trauma theory that the experience of trauma for women after sexual violence includes elements of self-criticism such as isolation from others and judgment and shame for emotional reactions. Further, this construct helps explain one of the mechanisms by which sexual violence results in poor mental health outcomes, specifically that sexual violence increases self-judgment and feelings of isolation while decreasing the ability to sit with difficult emotions. Contrary to my hypotheses, self-warmth (loving-kindness, mindfulness, and common humanity) did not provide the buffering

effects I expected.

Although Neff (2016) has argued for the validity of a unidimensional self-compassion construct, in my sample, self-compassion loaded on two factors, similar to the two-factor structure found by other researchers (López, et al., 2015). Further, Muris, van den Broek, Otgaar, Oudenhoven, and Lennartz (2018) found that while the six subscales (self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification) have good face validity with a non-clinical sample, the negative subscales were contributing more variance to the overall score than the positive subscales. This points to potential measurement problems with the self-warmth score in my study, which could be attributed to something unique about self-compassion after sexual violence or limitations with how we are measuring self-compassion in general.

Self-compassion in general, and the self-warmth subscales (mindfulness, self-kindness, and common humanity) specifically, have been associated with aspects of positive psychological functioning such as happiness, optimism, and positive affect (Neff, Rude, & Kirkpatrick, 2007) and mental health outcomes (MacBeth & Gumley, 2012). However, there could be some measurement issues in the context of sexual violence. Although the items were meant to describe compassion towards the self in moments of difficulty, describing sexual violence as simply "difficult" might be a gross understatement of the brutality and inhumanity that survivors experience both physically and psychologically. In order to get two cleanly loading factors for the self-compassion scale (Neff, 2003), I had to drop one item from the common humanity subscale ("*When things are going badly for me, I see the difficulties as part of life that everyone goes through*") and one item from the mindfulness subscale ("*When something upsets me I try to keep my emotions in balance*"). To a survivor of sexual violence, these items might have seemed

dismissive or not possible given the context of violence. A more realistic conceptualization of self-compassion for survivors might be needed in order to address the severity and the context of the violent event.

Clinical Implications

These findings point to the role self-criticism might play in the poorer mental health outcomes experienced by survivors of sexual violence and provide support that implementing self-compassion into treatment for sexual violence might be beneficial for survivors, particularly interventions focused on reducing self-criticism. Sexual violence is inherently dehumanizing; therefore, treatment for this violence must include actions that preserve dignity and client agency. Palmer (1991) explains that "recovery is a reclaiming of oneself" from the experience of and narratives around sexual violence (p. 72). From this lens, an understanding of the factors that make sexual violence against women, particularly women of color and sexual minorities, a common occurrence needs to be emphasized. Self-compassion, in conjunction with postmodern, client-centered treatment modalities, could aid survivors in this reclamation.

Narrative therapy (White, 2007) is a treatment modality that could be a good fit for this kind of work because the client-centered nature of this modality honors the actions survivors have taken to make it through the aftermath of violence rather than pathologizing them. Externalization, a key component of narrative therapy whereby the therapist and client talk about and treat the problem as something separate from the client, "makes it possible for people to experience an identity that is separate from the problem; *the problem becomes the problem*, not the person" (White, 2007, p. 9, emphasis added). Common humanity could fit into these externalizing conversations and be taught as a skill to survivors as a way to externalize self-blame (and victim-blaming narratives) by placing blame where it belongs (e.g. with perpetrators

of violence and the culture that creates and sustains them). Narrative therapy also provides a framework for exploring current narratives about the self and "re-authoring" them (client deciding which parts of their stories are most salient) or "re-membering" them (client deciding which relationships are most important and how they want to be in those relationships; White, 2007). Therapists could introduce cultural narratives about sexuality and sexual violence and help clients work through these in a compassionate way where the focus would be purposefully rejecting harmful narratives and re-authoring and re-membering them in ways that are empowering to survivors of sexual violence.

Self-compassion can also be used with three-phased treatment modalities focused on processing traumatic memories such as Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2005). Self-compassionate mindfulness techniques that focus on grounding in the present moment and bringing non-judgmental and/or compassionate awareness to emotions associated with traumatic memories would be helpful in all three stages of treatment. Further, NET involves processing trauma across the lifespan. The therapist could provide psychoeducation about insidious trauma to help clients identify direct and indirect instances of this kind of trauma to process as well as other traumatic events in their life. The addition of the active de-escalation of self-criticism by the therapist could be a benefit to modalities that focus on processing traumatic events.

This study did not provide much evidence for the usefulness of self-warmth in therapy with sexual assault survivors the way it is currently being conceptualized. However, helping survivors reduce self-criticism first might feel more accomplishable. It might be that asking survivors to practice kindness is too much of a jump particularly when there are many predominant narratives of self-blame and self-hatred for women, especially after violence has

occurred (Tseris, 2013; Wasco, 2003). If self-criticism is more salient for survivors of sexual violence, softening this criticism could be a crucial step before implementing self-compassionate behaviors and attitudes. Maybe it is an easier transition for those trying to learn self-compassion to first experience neutrality towards themselves, where they are not actively providing care to themselves, but they also are not actively tearing themselves down.

Limitations and Future Directions

The biggest limitation with this study is that it did not include the experiences of gender identity minority (e.g., transgender, nonbinary, etc.) individuals. Prevalence rates for these individuals are difficult to find, but evidence suggests that up to 80.6% of gender minority adolescents report some form of sexual violence before age 18 (Sterzing, Edleson, Fisher, & Gartner, 2017) and lifetime rates for sexual assault are 47% for transgender people (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016) pointing to the importance of considering the experiences of this population in sexual violence work. These individuals were not represented in my sample and therefore were not included. Further, race was not a usable contextual variable for my model with this sample. This is probably due to lack of power because my minority identity group was small (n = 57) and heterogenous (multiple racial and ethnic identities were categorized together which might have erased differences among these identities). Sexual orientation might have had fewer power problems because the minority identity group was more homogenous. Much more needs to be done to collect truly representative samples across multiple identities to understand the full impact of sexual violence on individual lives. We also need more work on women who hold multiple marginalized identities (e.g., class, ability status, citizenship status, etc.) because the effects of insidious trauma and discrimination can be cumulative (Root, 1992).

I also used a very broad definition of sexual violence that encompasses a variety of experiences. There could be value in evaluating different sexually violent experiences (e.g., childhood sexual abuse, sexual coercion, sexual assault, etc.) with self-compassion to see if this construct operates differently based on the severity of the violence or in cases where someone has had multiple violent experiences. I also could only measure sexual violence at T1, so I could not evaluate if experiencing sexual violence at later time points influenced reported levels of self-criticism, self-warmth, and mental health outcomes. The feminist critiques of cognitive trauma theory bring up several potential symptoms outside of those listed in the DSM (e.g. shame, powerlessness, self-blame, apathy, etc.; American Psychiatric Association, 2013; Tseris, 2013; Wasco, 2003). Some of these symptoms have been studied to varying depths independently, but we do not have a theory that ties them together. We need more quantitative evidence of these symptoms and a culturally informed theory of trauma that considers contextual factors, as well as cognitive processes and neurobiology, to guide the research being done on sexual violence as well as treatment for sexual trauma.

Further, the potential measurement issues with the self-warmth factor need to be addressed. Future work could look at how survivors of sexual violence are conceptualizing loving kindness, mindfulness, and common humanity. Self-compassion is often used as a construct in positive psychology research. We need more work with clinical samples, particularly those who have experienced sexual violence. Survivors could be helpful in identifying barriers to self-compassion and ways those who interact with survivors could promote self-compassion. Another resource for how self-compassion can be helpful in healing are mental health professionals themselves. Practitioners who are using self-compassion in their work are most likely tailoring it to the needs of their clients. They could be valuable in providing insight as to

where self-compassion could be used in the therapeutic process.

Conclusion

This study provides some evidence that self-compassion might be an important construct to consider in the aftermath of sexual violence. Although the self-criticism subscales (self-judgment, isolation, and overidentification) helped explain the psychological distress experienced after sexual violence, the self-warmth subscales (self-kindness, mindfulness, and common humanity), as they are currently conceptualized, did not provide buffering effects. However, as we better understand how those with marginalized identities experience sexual violence, it will be important to consider constructs beyond the symptoms listed in the DSM (American Psychiatric Association, 2013). The feminist critiques of cognitive trauma theory will be valuable as we seek to understand how women with one or many marginalized identities experience trauma after sexual violence.

Chapter 6 - References

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