SELF-COMPASSION, UNWANTED SEXUAL EXPERIENCES, AND REVICTIMIZATION AMONG COLLEGE STUDENTS

by

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ABSTRACT

Sexual assault is a common problem on college campuses and women between the ages of 18 and 24 are at greatest risk, with 20-25% of female college students experiencing a sexual assault in any given year, compared to 5-6% of male college students. When conducting sexual assault research among college students, it is important to consider risk factors that contribute to revictimization and protective factors that buffer against negative outcomes. Although research has shown the effect of self-compassion on many of the negative outcomes associated with sexual victimization, little work has been conducted with a population of sexual assault survivors. In Study 1, participants with a history of unwanted sexual experiences (N = 16) completed a packet of surveys and a semi-structured interview about coping with and healing from their experience. The interview transcripts reflected many of the key domains of self-compassion, suggesting the need for additional research to understand the association between self-compassion and healing from unwanted sexual experiences. In Study 2, introduction to psychology students (N = 231) completed a battery of measurements to assess their sexual victimization history and associated negative outcomes, as well as protective factors including self-compassion. Analyses tested the hypothesis that greater self-compassion would predict less sexual revictimization among those who reported an unwanted sexual experience earlier in life. Although previous unwanted sexual experiences were positively associated with recent unwanted sexual experiences, there was neither a direct nor indirect effect through self-compassion. Findings from Study 1 suggest that different facets of self-compassion represent factors that both help and hinder coping and healing following an unwanted sexual experience. Although Study 2 failed to find a significant relationship between self-compassion and revictimization, self-compassion was associated with other variables previously shown to predict sexual assault and revictimization. More research is needed to understand the role of self-compassion in healing from sexual trauma and preventing revictimization.

INTRODUCTION

Self-compassion research is a relatively new and rapidly developing area of study in positive psychology. Although this area is new to psychological research, it has been a key component of Buddhist teachings and other religions/philosophies. Variations of self-compassion practice have also been used successfully in clinical settings. The most prominent conceptualization of self-compassion, set forth by Neff (2003a), describes self-compassion as an orientation towards self-care in which individuals regard themselves with kindness, patience, and non-judgmental understanding. Self-compassion is related to positive, adaptive coping with academic failure (Neff, Hsieh, & Dejitthirst, 2003), greater life satisfaction (Hollis-Walker & Colosimo, 2011), and overall psychological health (Neff et al., 2005). Self-compassion is shown to buffer against psychological stress in everyday life (Leary, Tate, Adams, Allen, & Hancock, 2007), however more research is needed to understand how self-compassion can help those faced with an adverse or traumatic event.

One area of trauma research that may benefit from considering self-compassion is healing from college sexual assault. Sexual assault in college is associated with numerous negative outcomes such as depression, anxiety, posttraumatic stress disorder (PTSD; Hill et al., 2011), substance abuse (Ullman, Filipas, Townsend, & Starznski, 2005), and increased risk of future victimization (Ullman & Vasquez, 2015; Ullman, Najdowski, & Filipas, 2009). Research with self-compassion has addressed many of these factors, but not within the context of sexual assault.

Although research has demonstrated the beneficial effect of self-compassion on many of the negative outcomes associated with sexual victimization (e.g., depression), little work has been conducted with a population of sexual assault survivors. One exception is a study examining the role of self-compassion and posttraumatic adjustment among sexual assault survivors. Close (2013) found that self-compassion was negatively associated with psychological distress, negative posttraumatic cognitions, shame, and self-criticism. This study is an important step in understanding the role of self-compassion in healing from sexual assault, but further research is still needed. Specifically, the relationship between self-compassion and revictimization among those with a history of sexual assault is a new area of research. Because having a history of sexual assault is one of the greatest predictors of future victimization (e.g., Messman-Moore & Long, 2003), it is important to identify ways to prevent future trauma among people who have been victimized. Self-compassion may act as a protective factor, which buffering against negative outcomes associated with revictimization. The present research examined the association between self-compassion and revictimization among survivors to determine whether this will be a fruitful avenue of research for improving college assault prevention programs.

College Sexual Assault

Sexual assault is a common problem on college campuses. Women between the ages of 18 and 24 are at greatest risk, with 20-25% of female college students experiencing a sexual assault in any given year (US Department of Justice, 2014).

Furthermore, women with a pre-college history of sexual assault were significantly more likely to experience sexual assault in college compared to those without such a history (Hill et al., 2011). Although college men also are victims of sexual assault, epidemiological data show lower rates of reported sexual assault among male college students compared to females (5-6% of college men reported an assault; US Department of Justice, 2014). These rates may be underreported due to cultural myths about sexual assault and masculinity (Sable, Danis, Mauzy, & Gallagher, 2006). In addition, there is a great deal of variability in reported rates of sexual assault among men by sexual orientation. Research suggests that gay and bisexual men are over ten times more likely than heterosexual men to report a sexual assault (Sexual Assault Report, 2005). Although statistics show a greater prevalence of sexual assault among college women and sexual minority men, the true estimates of sexual assault on college campuses rely on official reporting and may not be accurately represented.

Even though the reporting data illustrate an alarming rate of sexual assault among college students, they potentially only represent a small percentage of college students who actually experience a sexual assault. Sexual assault is one of the most underreported crimes (National Crime Victimization Survey, 2015), and studies suggest that less than 12% of completed or attempted sexual assaults against college women were reported to law enforcement, with even lower rates for college men (US Department of Justice, 2014). The rate of reporting was lower still for individuals who experienced an incapacitated sexual assault, defined as an "unwanted sexual act involving oral, anal, or vaginal penetration that occurs after the victim voluntarily uses drugs or alcohol. The

victim is passed out or awake but too drunk or high to know what she is doing or control her behavior" (Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007, p. 10). Studies reveal that this is the most common form of sexual assault among college students (e.g., Testa & Livingston, 2009), but less than 7% of people who experienced incapacitated sexual assault reported it to law enforcement (US Department of Justice, 2014). Survivors cite a number of reasons for not reporting a sexual assault, including not wanting others to know, lack of proof, fear of retaliation, being unsure of whether the experience was really an assault, not knowing how to report an assault, and fear of being treated unfairly by law enforcement and peers (Campus Sexual Assault Study, 2007). Further, self-blame and shame may contribute to low rates of reporting, especially with regard to incapacitated assault (Littleton, Grills-Taquechel, & Axsom, 2009).

When addressing sexual assault in college, it is especially important to consider the first six weeks of the fall semester. This time period represents the greatest risk for sexual assault and is called the *red zone* (Flack et al., 2008). The underlying reason for the spike in sexual assault during the red zone is not totally understood, but is theorized to be associated with increased heavy episodic drinking (especially among inexperienced drinkers), a lack of social support, and the testing of boundaries in risky situations (Flack et al., 2008). During the red zone, college women are at greatest risk of incapacitated rape, the most common form of sexual assault on college campuses (Flack et al., 2008). A national college survey found that 72% of all reported rapes among college students occurred because the victim was too intoxicated to consent (Testa & Livingston, 2009). The interplay between sexual assault and heavy episodic drinking on college campuses is

not a new area of research—in fact, numerous studies conducted on health issues concerning college students identified sexual assault and heavy episodic drinking as two of the biggest health issues facing students in the U.S. (Testa & Livingston, 2009; Carey, Durney, Shepardson, & Carey, 2015; Messman-Moore, Ward, & Denardi, 2013). Testa and Livingston (2009) state that interventions focused on preventing college sexual assault must also address heavy episodic or binge drinking if they are to be successful.

Preliminary Studies from Montana State University

The national statistics for college sexual assault and the connection with alcohol use discussed above create a compelling narrative, but it is important to understand how those findings are reflected at Montana State University (MSU), the site of the current research. Data collected by MSU's domestic violence and sexual assault advocacy center (VOICE Center) showed that out of a sample of 322 students, 25.5% had personally experienced sexual violence or sexual assault. This finding demonstrates that MSU meets, but does not exceed, the national reported rates of sexual assault on college campuses. When participants were asked about reporting their sexual assault to someone, 24.5% of those who had been assaulted stated that they did not report their experience. These findings reflect similar issues with sexual assault reporting at MSU as documented on the national level. The prevalence of sexual assault at MSU and the reluctance of victims to report it points to the need for further research regarding effective prevention programs and other interventions to support survivors following an assault.

In another study conducted at MSU, college students' sexual experiences and drinking behaviors were assessed using a cross-sectional design (DeCou & Skewes, under review). Participants (N = 201) included 77 men and 124 women who completed self-report questionnaires online using the Qualtrics survey platform. Measures included the Sexual Experiences Survey—Short Form Victimization (SES-SFV; Koss et al., 2006) and the National Institute of Alcohol Abuse and Alcoholism's recommended question set to assess binge alcohol use (NIAAA, 2003). The Sexual Experiences Survey provided data on specific experiences that could be coded as sexual assault or coercion without requiring the respondents to identify the experience as such. Participants were asked to report how many times each specific sexual experience had happened to them (1) within the past year, and (2) after age 14, up until one year ago. These variables are subsequently referred to as "early sexual assault" and "recent sexual assault." It is important to note that having an unwanted or coerced sexual experience was not an inclusion criterion for the study.

Findings showed that 40% (n = 77) of the sample reported experiencing recent sexual assault. Of these, 75% were women (n = 58) and 25% were men (n = 19). Regarding early experiences, half of participants (n = 101, 50%) reported sexual assault since age 14, and the majority of these also were women (n = 76, 75%). The authors examined the association between early victimization, alcohol use, and the odds of a recent sexual assault. Consistent with the literature, the findings revealed that greater reported alcohol consumption was associated with greater odds of a recent sexual assault. More frequent early victimization experiences were also associated with greater odds of

recent victimization. In fact, the strongest predictor of recent sexual assault was a having an early sexual assault experience. Further, there was a significant interaction between early assault and alcohol use in predicting recent assault. Controlling for age and gender, participants who reported drinking more alcohol evidenced substantially increased likelihood of recent sexual assault across increasing levels of adolescent victimization (DeCou & Skewes, under review). These findings suggest that heavy drinking is an important risk factor especially for college students who have experienced early sexual assault, and suggest the need for targeted prevention programs aimed at drinkers with a history of sexual assault to prevent revictimization.

Risk Factors

Risk factors for sexual revictimization are explored in the following sections. Risk factors are defined as factors that are associated with a given outcome yet do not imply a causal relationship between variables (LaMotte, 2016). Although these factors may predict sexual revictimization, at no point do I insinuate that victims are responsible for their assault.

History of Sexual Assault

Of all the risk factors associated with sexual assault victimization in college, having a history of early sexual assault is one of the most important to consider. Several studies reveal an increased risk of sexual victimization for college students who experienced an assault during childhood or adolescence (Ullman & Vasquez, 2015; Ullman, Najdowski, & Filipas, 2009; Classen, Palesh, & Aggarwal, 2005; Messman-

Moore & Long, 2003). Furthermore, recent research conducted at MSU found that a history of sexual assault was the strongest predictor of recent victimization among college students (DeCou & Skewes, under review). This risk factor is noteworthy, as childhood sexual victimization is prevalent in the population. The National Sexual Violence Resource Center (2015) states that 25% of girls and 33% of boys in the U.S. will be sexually abused prior to age 18. Research with college students showed similar rates, with approximately 27% of female college students reporting a history of childhood sexual assault (Hill et al., 2011). Moreover, data from the CDC's National Intimate Partner and Sexual Violence Survey found that over one-third of people who experienced childhood rape also reported being raped as an adult (Black et al., 2011).

There are numerous theories about the underlying reasons for the link between sexual assault in childhood or adolescence and later revictimization, but it is likely that the causal mechanisms reflect a complex interplay of multiple factors. When considering predictors of revictimization, it is important to consider the negative emotional, cognitive, and behavioral outcomes associated with childhood and adolescent sexual assault.

Emotion Regulation

Childhood and adolescent sexual assault are associated with significantly increased substance abuse, depressive symptoms, post-traumatic stress disorder, suicidal ideation and attempts, and engagement in future risky sexual behavior—all of which are independently associated with college sexual assault (Hill et al., 2011). These negative outcomes affecting people with sexual assault histories are linked to impaired emotional awareness and the inability to cope adaptively, also called emotional dysregulation (Gratz

& Roemer, 2004). Emotion dysregulation may play an important role in understanding sexual revictimization (Messman-Moore et al., 2010). It is possible that people with a history of sexual assault who report greater emotional dysregulation are at a greater risk of being revictimized because they lack the ability to effectively cope with and respond to their emotions. This impaired emotional awareness may prevent them from identifying risk factors in their surroundings and in their interactions with others, thus increasing the chance of experiencing a sexual assault (Filipas & Ullman, 2006). People with emotional dysregulation also may be at especially increased risk for revictimization if they drink alcohol to cope with problems or distress (Filipas & Ullman, 2006).

Impaired Risk Perception

Impaired risk perception is a significant predictor of sexual assault. Eshelman, Messman-Moore, and Sheffer (2015) conducted an experiment where women were given a written vignette comprised of 25 chronological statements describing a progression of events leading up to a sexual assault. Participants were instructed to read the vignette and were asked to identify personal risk, or when the situation in the vignette made them uncomfortable. They were also asked to identify when the male in the vignette was sexually aggressive and at what point in the vignette they would leave the situation. The study found that women with a history of sexual assault demonstrated impaired risk perception. That is, they recognized risk and indicated they would leave the situation significantly later than women without a history of sexual assault. Risk perception impairment was linked to both sexual assault history and odds of future sexual victimization.

Alcohol Use and Drinking to Cope

Alcohol impairs risk perception. For example, Eshelman et al. (2015) used self-reported information of participant drinking behaviors and found that greater alcohol consumption was associated with greater impairment in risk recognition and behavioral response. Women who reported more alcohol use perceived more benefits and fewer negative consequences of entering a risky situation and reported greater participation in risky sexual behaviors relative to women who used less alcohol. Women with a history of incapacitated rape were less likely to recognize a risky situation, and when combined with the impairment of alcohol, had high rates of revictimization (Eshelman et al., 2015). Furthermore, this research revealed that the combination of past sexual victimization and heavy episodic drinking increased the risk of revictimization in college and accounted for the high rates of incapacitated rape in first-year college students. It is unknown what causes diminished risk perception among women with a history of incapacitated rape, or whether impaired risk perception may precede the first sexual assault. Future research in the area of risk perception is needed to identify the underlying mechanisms for this phenomenon to reduce impairment and improve recognition of risk.

Research on college sexual assault should consider the interaction between numerous risk factors, including emotion regulation and substance abuse. Alcohol use and drinking motives are potential antecedents of assault that may interact with emotion regulation to influence risk. Coping motives (i.e., drinking to cope with distress) have been shown to predict negative outcomes in numerous domains above and beyond the effects of alcohol consumption alone (e.g., Cooper, 1994). The literature also suggests

that the link between history of sexual assault and risk of future assault may be mediated by drinking to cope (Ullman, Filipas, Townsend, & Starznski, 2005). Regardless of drinking motives, alcohol consumption is a risk factor for college sexual assault. Among women with a history of sexual assault, 41% experienced alcohol-incapacitated rape during their first year of college, compared to 10% of women without a prior history of sexual assault (Carey, Durney, Shepardson, & Carey, 2015). Survivors of incapacitated rape were more likely to report drinking in risky locations such as bars or house parties, where they are typically around strangers in unfamiliar settings (Testa et al., 2003). When drinking, people are less able to process information in their environment, thus decreasing their ability to make self-protective decisions and respond quickly to threats (Davis, Hendershot, George, Norris, & Heiman, 2007). The relationship between a history of early sexual assault, alcohol use, and is well-established, but the direction of the relationship is still unknown. It could be that early drinking preceded both adolescent sexual assault and later alcohol problems, or it could be that adolescent assault resulted in increased drinking to cope with the trauma, which then put women at risk for both future alcohol problems and future sexual assault.

Childhood Sexual Abuse

Risky sexual behavior is another risk factor for revictimization that is associated with sexual assault (Messman-Moore, Walsh, & DiLillo, 2010). Campbell, Sefl, and Ahrens (2004) found that women with a history of sexual assault reported a significant increase in frequency of sexual activity, number of sexual partners, unprotected sex, and frequency of using alcohol or drugs during sex. Women with a history of sexual assault

reported engaging in riskier sexual behaviors following a sexual assault compared to those without a history of sexual assault. Again, victims' behaviors do not cause sexual assault but are indicators of increased risk.

Often, college women with a history of sexual trauma were victimized during childhood, with long-lasting effects. A study by Senn et al. (2007) found evidence linking the severity of child sexual abuse with riskier adult sexual behavior. Findings suggested that coping behaviors mediated this link and predicted risk of revictimization. Individuals who experienced more severe sexual abuse in childhood reported greater use of maladaptive coping strategies, such as drinking and drug use, which in turn increased the risk of experiencing an incapacitated rape. It is also theorized that individuals who experience childhood sexual trauma may believe sex is necessary to obtain love and attention from others, and thus they will seek out a greater number of sexual partners (Cinq-Mars et al., 2003). Finkelhor and Browne (1985) examined the role of powerlessness in adults with a history of childhood sexual assault. As a consequence of the abuse and maltreatment inflicted on them during childhood, it is posited that children with frequent sexual trauma are unable to develop interpersonal skills or the self-efficacy to prevent unwanted sexual advances. Thus, individuals who experienced childhood abuse may have impaired skills to navigate advances from sexually aggressive partners. These findings suggest that skills training may be useful for reducing sexual assault risk factors. However, again it must be emphasized that no victim characteristics or skills deficits cause sexual assault. Perpetrators are solely to blame for sexual assault, and interventions to decrease perpetration are sorely needed.

Self-Blame

Self-blame amongst sexually victimized people is associated with numerous negative outcomes (Hall, French, & Marteau, 2003). Unlike other crimes or traumatic events, sexual assault is associated with many negative assumptions and beliefs about the victim's role in the assault (DuMont, Miller, & Myhr, 2003). These negative assumptions and beliefs are pervasive throughout several areas of society including the legal system (DuMont, Miller, & Myhr, 2003), medical care (Best, Dansky, & Kilpatrick), as well as among communities, family members, and friends (Ullman, 1996). Erroneous beliefs about rape, victims, and perpetrators are known as "rape myths" and have been shown to perpetuate harmful victim-blaming attitudes that extend to self-blame (Burt, 1980). Rape myths also serve as a barrier to reporting and disclosing assault experiences.

As a consequence of widespread rape myths and other societal attributions of blame, many sexual assault survivors internalize victim-blaming attitudes about their assault (Frazier, 1990). Self-blame can manifest as behavioral self-blame (the belief that the victim's own behavior led to the assault), or characterological self-blame (the belief that the victim's personality or character led to the assault) (Janoff-Bulman, 1979). Both attribution styles are linked to prolonged symptoms of psychopathology (Frieze, 2005; Ullman, Townsend, Filipas, & Starzynski, 2007), maladaptive coping (Filipas and Ullman, 2006), and ultimately, as Miller, Markman, and Handley (2007) found, to revictimization. In fact, the degree of self-blame an individual holds following a sexual assault is closely associated with the odds of revictimization in college through negative self-cognitions.

Maladaptive Coping

General coping styles may be important to understand for preventing revictimization among college students. Coping strategies are conceptualized as problem- or emotion-focused and approach- or avoidant-focused (Littleton, Horsley, John, & Nelson, 2007). Problem-focused coping strategies are actions that directly address the distressing situation. This could involve seeking out information about the distressing event and making an action plan (Folkman & Moskowitz, 2004). In comparison, emotion-focused strategies focus on managing emotional distress and may include disengaging from emotions, seeking emotional support, and venting emotions (Folkman & Moskowitz, 2004). Different types of coping are beneficial for different types of stress. Researchers theorize that problem-focused strategies are adaptive in controllable situations, whereas emotion-focused strategies are adaptive in uncontrollable situations (Folkman & Moskowitz, 2004).

Although problem-focused strategies are typically considered more adaptive then emotion-focused, some research suggests that proactive emotion-focused coping can also be adaptive. Specifically, research reveals that emotion-approach coping strategies that involve effortful attempts to be open to and aware of one's emotions may allow people to explore, understand, and regulate their negative emotions (Stanton, Kirk, Cameron & Danoff-Burg, 2000). This conceptualization of emotion-focused coping may prove beneficial in helping victims understand and cope with negative feelings associated with their traumatic experience.

Aside from the situational considerations, the dimension of approach and avoidance is important for determining the adaptive quality of coping strategies. Approach coping involves actions focused directly on the distressing situation, and is typically considered adaptive. This could include seeking out emotional support and making a plan to address the stressor (Snyder & Pulvers, 2001). Avoidant coping involves actions such as withdrawing from others, denying the situation, suppressing emotions related to the distressing event, and using substances to cope with distress (Snyder & Pulvers, 2001). Avoidant strategies may help to reduce stress temporarily, and can be considered adaptive for a short period. However, if individuals rely on avoidant strategies they can become maladaptive and can lead to other problems, further taxing one's coping skills and resources (Snyder & Pulvers, 2001).

Filipas and Ullman (2006) found that college women with a history of sexual assault who used more avoidant coping strategies reported greater PTSD symptoms, depression, substance abuse problems, and rates of revictimization. A history of traumatic life events, including childhood sexual victimization, was related to greater maladaptive and avoidant coping in those victimized in college (Najdowski & Ullman, 2009). Researchers theorize that those with greater childhood trauma evidenced greater use of maladaptive and avoidant coping because experiencing multiple assaults created a need to cope using any means possible. However, using avoidant coping strategies like heavy drinking may lead to additional problems that further impair one's ability to cope. Research also indicates that people who implement avoidant or maladaptive coping strategies following a sexual assault maintained PTSD and general psychological distress

for longer periods of time (Filipas & Ullman, 2006). Helping people cope with trauma in healthy ways is an important goal of psychology research.

The coping literature identifies the failure to disclose a sexual assault as an important antecedent to maladaptive and avoidant coping (Gobin, 2012). The primary idea behind this theory is that people who experience trauma typically report feeling betrayed by the world, and this reduces their ability to trust in others. This inability to trust inhibits the ability to rely on one's social network to cope, thereby increasing the use of maladaptive and avoidant coping strategies (Gobin, 2012). It also may prevent sexual assault survivors from receiving effective support from an advocacy center, professional sources, friends, or family. Research shows that a lack of effective social support may lead to prolonged PTSD symptoms and psychological distress among those who do not disclose sexual victimization or do not have a positive experience with disclosure (Cisler et al., 2012). Phrased another way, a key component of healthy coping and healing from sexual trauma involves telling someone else about the trauma—provided that the person listening is supportive.

Interventions to improve coping skills can be effective. Najdowski and Ullman (2013) conducted a study in which they attempted to change the coping strategies used by sexually victimized college students. Results showed that participants who had completed a coping skills training program reported increased adaptive coping strategies, less severe PTSD and psychological distress, and a subsequent decrease in self-reported revictimization. This study demonstrates that teaching adaptive coping strategies to those

with a history of sexual assault holds great promise for prevention efforts, and suggests important directions for future research.

Self-Compassion

The most prominent theory of self-compassion, proposed by Neff (2003a), conceptualizes self-compassion as a behavioral orientation towards self-care in which an individual is "open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's experience is part of the common human experience" (p. 244). To support research on self-compassion, Neff developed a measure that examines the extent to which individuals engage in the three distinct dimensions of self-compassion: self-kindness vs. self-judgment, common humanity vs. isolation, and mindfulness vs. over-identification (Neff, 2003a).

Neff theorized that individuals who were self-compassionate would exhibit more self-kindness, or warm and understanding behaviors toward themselves, as opposed to those with low self-compassion who may engage in more self-judgment, or self-criticism and blame, when faced with adversity or failure (Neff, 2003b). The second dimension of self-compassion, common humanity vs. isolation, means that individuals who view adversity and failure as part of a broader human experience will associate their struggle with the human condition and not as a personal failing (Neff, 2003a). The final dimension of self-compassion, mindfulness vs. over-identification, describes an individual's ability to openly examine and tolerate their emotions. Those low in self-compassion are prone to

experiencing periods of over-identification, in which people typically become consumed with thoughts concerning their own pain and suffering (Neff, 2003b).

According to Neff (2003b), individuals who over-identify tend to become so immersed with their current emotional distress that they lack the ability or the 'mental space' to take a step back and adopt a more objective view of their experience. Those with an orientation towards mindfulness, or a non-judgmental, open mindset, use mindfulness as an emotion regulation strategy through which painful feelings are not avoided but are held in open awareness. In this state of mindfulness, experiences are treated with kindness and understanding, which enables an individual to actively cope with their experience (Neff, 2003b). Individuals who take a balanced and open view of a distressing event may avoid the problems of over-identifying and avoiding or disassociating themselves from their experience, resulting in better ability to adaptively handle adversity and failure (Neff, 2003b). This balanced and open approach to coping with their experience is closely aligned with the work of Stanton et al. (2000) discussed above, which conceptualized adaptive emotion-focused coping strategies as attempts to mindfully understand and explore negative emotions.

Empirical Work with Self-Compassion

Self-compassion differs from related constructs such as self-esteem and trait mindfulness in important ways. Neff's conceptualization of self-compassion entails a kind, non-judgmental, open approach to self-care in which people find a connection with common human experiences (Neff, 2003a). Although aspects of self-compassion seem similar to self-esteem, Neff and Vonk (2009) measured both and found that self-

compassion was a better predictor of self-worth. Self-compassion, relative to self-esteem, also had a stronger negative association with rumination, anger, and need for cognitive closure. Further, work comparing mindfulness and self-compassion found that self-compassion was a better predictor of mental health symptom severity and life satisfaction when compared to measures of mindfulness alone (Van Dam, Sheppard, Forsyth, & Earleywine, 2011). These findings support the assertion that self-compassion is a distinct construct that warrants examination.

Self-compassion is linked with important aspects of mental health. Neff, Rude, and Kilpatrick (2007) examined the relationship of self-compassion to psychological health and found that self-compassion was positively associated with happiness, optimism, positive affect, wisdom, and personal initiative. Self-compassion was also associated with lower psychological stress, pessimistic thinking, and rumination (Leary, Tate, Adams, Allen, & Hancock, 2007) and an increased sense of connection with others (Corcoran, 2007). The positive mental health outcomes associated with self-compassion are important to consider, and there has been little research examining self-compassion among individuals with a history of trauma. However, there is reason to believe that self-compassion may be associated with healthy coping and healing.

Thompson and Waltz (2007) conducted a study examining self-compassion and coping with trauma and found that self-compassion was negatively associated with avoidant coping strategies, which have been shown to prolong symptoms of trauma. Further, Maheux and Price (2016) examined the association between social support and self-compassion among individuals who had experienced a traumatic event. Specifically,

this study examined the role of self-compassion and social support in the development of PTSD, General Anxiety Disorder (GAD), and depression symptoms. The study found that self-compassion mediated the relationship between social support and the development of psychopathology; lower reported social support was linked to lower self-compassion, which in turn was associated with greater PTSD, GAD, and depression symptom severity.

Further explorations of self-compassion in populations with a history of trauma include a study conducted with children in the Canadian welfare system (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011). People who had experienced higher levels of emotional abuse, emotional neglect, and physical abuse in childhood demonstrated lower self-compassion as adults. Lower self-compassion in turn was associated with more psychological distress, substance abuse problems, and previous suicide attempts. In another study conducted with adolescents in a substance abuse treatment program, self-compassion mediated the relationship between childhood maltreatment and difficulties with emotion regulation (Vettese, Dyer, Ling Li, & Wekerle, 2011).

In the only study to examine self-compassion among sexual assault survivors, Close (2013) used a sample of 141 women who reported experiencing a sexual assault in the past 5 years to examine the relationship between self-compassion and measures of psychological health associated with posttraumatic adjustment. Self-compassion was significantly negatively associated with negative posttraumatic cognitions, shame, and self-criticism related to the assault. Given that self-compassion is associated with known risk factors for sexual assault (e.g., mental health problems, substance abuse, and self-

blame), it is plausible that self-compassion may play a role in preventing revictimization. However, more research is needed to understand this connection.

Current Research

The aim of the current research is to examine the association between self-compassion and sexual revictimization among individuals with a history of unwanted sexual experiences. The term unwanted sexual experiences (USE) was defined as "anything sexual that happened to you that you did not agree to." I did not want to be too specific in defining unwanted sexual experiences, but instead allow participants to report their own perspectives about these types of events. In previous research (e.g., Harned, 2004), USE ranged from minor touching to rape, but still resulted in similar negative mental health consequences. This research aims to explore the role of self-compassion in revictimization among individuals entering college with a history of unwanted sexual experiences. Specifically, I hypothesize that 1) a greater frequency of early unwanted sexual experiences will predict increased recent (i.e., within the past year) unwanted sexual experiences, 2) early unwanted sexual experiences will predict lower self-compassion, and 3) lower self-compassion will predict recent unwanted sexual experiences (see Figure 1).

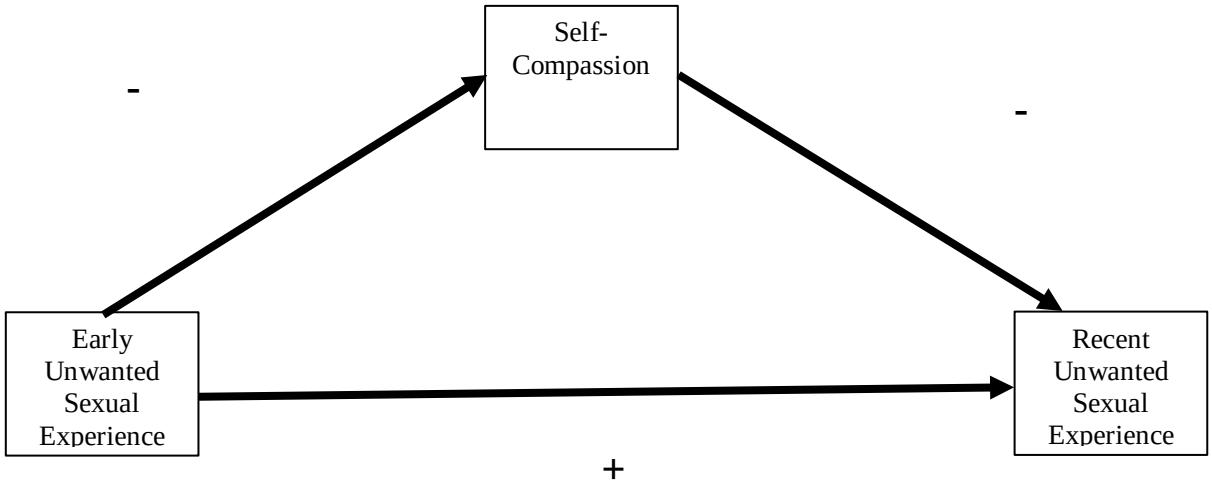

Figure 1. The hypothesized model proposes that self-compassion will have an indirect effect on the association between early unwanted sexual experiences and recent unwanted sexual experiences.

Further exploratory analyses explored associations between self-compassion and other factors known to be important for sexual assault prevention and recovery, including attributions of blame, perceived likelihood of revictimization, sense of control over the recovery process, specific negative outcomes (e.g., substance abuse and psychopathology), and protective factors (e.g., self-esteem and coping style).

In order to gain a deeper understanding of the impact of unwanted sexual experiences on students' lives, this research used both qualitative and quantitative methods and analyses. Study 1 used a mixed-methods research design to understand participants' experiences with coping and healing following a USE and to explore the role of self-compassion in this process. Study 2 used survey data to quantitatively examine associations between self-compassion, negative outcomes of USEs, hypothesized protective factors, and revictimization among students with a history of early USEs. I tested the hypothesis that self-compassion has an indirect effect on the

relationship between early and recent USEs. If supported, findings would suggest that self-compassion training may be a useful intervention for preventing sexual revictimization.

STUDY ONE

The aim of this mixed-methods study was to examine college students' beliefs about sexual assault, sexual consent, and perceived links between unwanted sexual experiences and substance abuse and mental health. I also aimed to explore perceptions of sexual assault risk and protection among individuals with a history of unwanted sexual experiences. In examining these risk and protective factors, I aimed to understand the barriers to healing and identify potential pathways to revictimization among at-risk students. Analyses revealed themes related to the dimensions of self-compassion, which are discussed below.

Methods

Participants

This study included a sample of 16 university students who self-identified as having had an unwanted sexual experience. Only currently enrolled university students were eligible to complete an interview, and students less than 18 years of age were excluded. Of the 16 participants, four had received volunteer training from a campus domestic violence and sexual assault advocacy center. Participants were mostly female (n = 13), but also included two men and one transgender woman. Ages ranged from 18 to 30 years old (M = 22.25; SD = 3.82). All were European American.

Recruitment

Participants were recruited through the use of flyers posted around campus, in-class announcements, referrals by the university sexual assault and domestic violence advocacy center (VOICE Center), and by word of mouth. Flyers provided information about the scope of the study, stating that unwanted sexual experiences would be the focus. Recruitment materials directed potential participants to contact the researcher for more information or to enroll. Upon contacting the researcher, participants were screened for eligibility to complete an interview and were offered the choice of a male or female interviewer. All participants selected a female interviewer.

Interviewers and Research Team

The research team consisted of the author, the faculty mentor, and six undergraduate research assistants. The student members of the research team completed a training workshop on effective and sensitive interview techniques led by the faculty supervisor and members of the VOICE Center. The author, who conducted most of the interviews (n = 14), is a European American female graduate student. The additional interviews were conducted by two European American female undergraduate research assistants (n = 2).

Procedure

This study used individual in-person interviews to qualitatively explore participants' thoughts, opinions, and experiences related to unwanted sex. Students were offered $20 in compensation for their time and effort. After giving informed consent, all

participants completed a packet of measures including background information/demographics and quantitative self-report measures assessing their sexual experiences, alcohol use, drinking motives, and mood/affect (described below). Then the semi-structured interviews took place and were audio recorded with permission from the participant. After the interview, participants again completed the measure of self-reported affect, followed by a brief measure assessing their experience answering the questions posed in the study (see Measures section below). Due to ethical concerns related to researching unwanted sexual experiences and assault, the study included a safety plan and provided a list of crisis counseling resources to all participants. Interviews were transcribed verbatim and data were de-identified prior to analysis. All methods and materials were approved by the university's IRB.

Survey Measures

Demographics and Background. Participants self-reported their gender, age, class standing, and whether they had received any training from the university's sexual assault advocacy center (including training as a peer advocate and/or sexual assault prevention education).

Sexual Victimization History. The Sexual Experiences Survey-Short Form Victimization (SES-SFV; Koss et al., 2006; Koss et al., 2007) is the gold standard measure of sexual victimization among college students, and is the most widely used and widely studied assessment tool available in the literature. The SES-SFV (later referred to as SES) is a 10-item self-report measure that assesses sexual victimization history across

a range of unwanted sexual behaviors. Participants are asked to indicate the frequency ("0, 1, 2, 3 or more times") of each type of unwanted sexual experience described in the past 12 months, and also each occurrence since age 14 (up until the past 12 months). These experiences include unwanted sexual contact (fondling/kissing), attempted and/or completed sexual coercion, and attempted and/or completed rape (vaginal and/or anal sex).

The SES also assesses the frequency of different tactics used to compel unwanted sex. For example, acts of unwanted sexual contact can be assessed by asking participants to indicate whether "Someone had oral sex with me or made 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 pressuring me after I said I didn't want to; (b) Showing displeasure, criticizing my sexuality or my attractiveness, getting angry but not using physical force, after saying 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." In this way, the SES assesses both the frequency of the experience and frequency of the tactic used to compel the experience without requiring the participant to ever identify the experience as sexual assault or rape. The SES-SFV demonstrates adequate internal consistency ($\alpha = .70$), and has been used to assess sexual victimization history among college students in other published studies (Davidson, Lozano, Cole, & Gervais, 2013; Kelley & Gidycz, Donde, 2015).

Mood/Affect. The Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellagan, 1988) was administered before and after the interview to measure any change in affect from taking part in the interview. The PANAS questionnaire consists of 10 terms describing positive affect (PA)—interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, and active—and 10 terms describing negative affect (NA)—distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery, and afraid. Participants were asked to rate items on a scale from 1 to 5 based on the strength of emotion at the time of assessment where 1 = “very slightly or not at all" and 5 = “extremely." The PANAS was scored by summing the responses for the PA and NA separately.

Alcohol Consumption. Participant drinking behavior was assessed using the National Institute on Alcohol Abuse and Alcoholism question set (NIAAA, 2003). Participants were asked to estimate their typical daily drinking (number of standard drinks) during the three months before data collection. A definition of a standard drink was provided along with accompanying graphics to facilitate estimation, and was operationalized as 12 oz. of beer, 5 oz. of wine, or 1.5 oz. of liquor. Daily drinking estimates were summed to yield a total estimate of typical alcohol consumption per week. Participants were also asked to report the number to times they consumed "5 or more drinks in a row (if you are male) or 4 or more drinks in a row (if you are female)," during the two weeks before data collection as an estimate of recent binge drinking (Wechsler & Nelson, 2001).

Drinking Motives. Motives for consuming alcohol were assessed using the 20-item Drinking Motives Questionnaire Revised (DMQ-R; Cooper, 1994). The DMQ-R measures the frequency with which participants consume alcohol in response to four distinct motives: coping (drinking to forget about problems), enhancement (drinking to have a better time), conformity (drinking to fit in), and social (drinking to be sociable). Participants are asked to indicate how frequently they drink in response to each motive, from 1 to 5, with 1 = "almost never/never" and 5 = "almost always/always." The items in each subscale are summed to yield four scores with possible ranges from 5 – 20, with higher scores indicating greater drinking in response to that particular motive.

Experience with Research Participation. At the end of the interview, the Reactions to Research Participation Questionnaire (RRPQ; Newman & Kaloupek, 1996) was administered to assess participants' reactions to participating in the present study. The RRPQ consists of 3 items assessing participants' experience with taking part in the study: "I gained something positive from participating in this study," "Completing this study upset me more than I expected," and "Had I known in advance what completing this study would be like for me, I still would have agreed." Responses are scored from 1 (strongly disagree) to 5 (strongly agree). Item two is reverse scored and then responses are summed to yield a total score, with higher scores indicating more positive experiences with the research study. This measure was included because of ethical concerns about asking sensitive questions about trauma. Although evidence suggests that talking about traumatic events is not harmful for participants, on average, and may even be helpful

(DePrince & Ann Chu, 2007; Griffin, Resick, Waldrop, & Mechanic, 2003; Johnson & Benight; Newman & Kaloupek, 2004; DeCou, Skewes, Lopez, & Skanis, 2012), institutional review boards often have concerns about trauma-focused research. The RRPQ was included in this study to add to the literature on participants' reactions to trauma-focused research.

Interview Protocol

The interviews were conducted using a semi-structured interview guide developed specifically for this study in collaboration with the university's sexual assault and domestic violence advocacy center. The interview consisted of open-ended questions that represented a progression through 10 conceptual domains, including background ("How are things going for you at [University]?"), consent for sex ("How do you define consent for sex?"), experiences with unwanted sex ("How has your experience affected your life?"), coping with unwanted sexual experiences ("How did you cope with what happened to you?"), disclosure, ("Whom did you tell about your experience, if anyone?"), getting help/support ("Why do some people get help whereas others do not?"), experiences with healing ("How has surviving your experience influenced who you are as a person?"), risk factors ("What puts people at risk for experiencing an unwanted sexual experience or assault?"), knowledge of available resources ("What resources are available to help victims at [University]?"), and prevention ("What could be done to prevent sexual assault at [University]?"). The term "unwanted sexual experience" was used instead of "sexual assault" to include individuals with a history of sexual trauma who may not consider their experience to be sexual assault. I worked with the VOICE Center on the

question phrasing for the interview protocol, and the protocol went through several iteration and evaluations before being used in the study. See Appendix A for a copy of the interview protocol.

The interviewers used a nonjudgmental and empathic reflective listening style. Interviews lasted on average 40 minutes, and were audio recorded with participant consent. All participants were asked debriefing questions after the interview to assess any emotional distress or other adverse reactions so that follow-up care could be provided if needed. The debriefing questions included: (a) "What was it like for you to talk about this with me?" and (b) "Compared to when you arrived, do you feel better, the same, or worse?" Other interview studies focused on traumatic experiences have used similar questions to evaluate the impact of participating in research about sensitive topics (e.g., DeCou et al., 2012).

Data Analysis

Composite scores for each survey measure were calculated and descriptive statistics and frequencies were calculated using SPSS (see Table 1). The audio-recorded interviews were transcribed verbatim by undergraduate research assistants and deidentified prior to analysis. Once transcribed, data were entered into a qualitative data management software program (NVivo, 2014). Next, the research team read the transcripts and created codes based on the themes that emerged from the interviews. Following this initial round of open coding, the research team met to discuss and compare themes and identify the codes to be used in subsequent rounds of analysis. This method of analyzing the interviews was consistent with methods based in grounded

theory, which allows qualitative data to be analyzed using content analysis (open coding and constant comparison) for the purpose of identifying common themes and concepts within and across participant transcripts (Charmaz, 2006; Corbin & Strauss, 2008). Because themes related to self-blame and self-compassion strongly emerged from the data, further analysis of these specific themes was a focus of a final round of coding. These findings are described below.

Table 1. Frequencies and Descriptive Statistics of Study Variables

	Percentage (n)	M	SD
Unwanted Sexual Touching			
Early	100% (16)	1.88	1.15
Recent	50% (8)	.93	.69
Attempted Rape			
Early	75%(12)	1.53	1.19
Recent	31%(5)	1.10	.44
Completed Rape			
Early	81%(13)	1.54	1.43
Recent	31%(5)	.91	.50
NIAAA			
Standard Drink Consumption	-	3.53	3.48
Binge Drinking Episodes	-	3.06	3.47
DMQ-R			
Social Drinking Motives	-	2.60	.97
Coping Motives	-	2.11	.85
Enhancement Motives	-	2.12	.89
Conformity Motives	-	1.78	1.29
PANAS			
Time 1	-	71.25	11.90
Time 2	-	72.19	13.37

Findings

Participants discussed several key themes with regard to their USEs. These themes reflect many of the key features of self-compassion, specifically relating to the six specific facets (i.e., self-kindness vs. self-judgment, common humanity vs. isolation, and mindfulness vs. over-identification). These themes provide valuable insight as to how USEs affect students' lives, and shed light on the potential role of self-compassion in healing. Gender differences were explored across transcripts, and the research team was unable to find distinctive differences between narratives by gender. Therefore, the reported findings include quotes from all participants, with participant number and gender indicated after the quote. The transgender woman in the study was denoted as female.

First, before exploring participants' narratives about their USE, I examined their history of sexual victimization (see Table 1). All participants in the study (n = 16; 100%) reported an early USE of sexual touching, and 8 (50%) reported a recent USE of sexual touching. More than half of participants (n = 12, 75%) reported an early attempted rape, and 5 participants (31%) reported a recent attempted rape. The majority of participants reported an early completed rape (n = 13, 81%), and 5 (31%) reported a recent completed rape. Question 10 of the SES asks participants if they think they have been raped, and 9 (45%) indicated yes, they had been raped. This measure demonstrated good internal consistency (Cronbach's alpha =.88).

Regarding drinking behaviors, participants estimated typical alcohol consumption ranging from 0-10 standard drinks for a typical day (M = 3.53, SD = 3.48). Participants

also reported between 0-10 binge drinking episodes in the month prior to data collection (*M* = 3.06, *SD* = 3.47). Participants' drinking motives were assessed with the DMQ-R. Scores on the social drinking motives subscale ranged from 1-4 (*M* = 2.60, *SD* = .97); coping motive scores ranged from 1-3.83 (*M* = 2.11, *SD* = .85); enhancement drinking motives subscales ranged from 1-3.25 (*M* = 2.12, *SD* = .89), and conformity motives ranged from 1-3.80 (*M* = 1.78, *SD* = 1.29). Mean scores on the social, enhancement, and conformity drinking motives scales were similar to scores reported in the literature for college student populations. College students typically drink most often for social reasons and least often for conformity reasons, and this pattern also emerged in the present sample. Average coping motives scores, however, were greater than those typically observed in non-victimized populations (*M* = 2.11 vs. 1.60) (Cooper, 1994). Internal consistency was good for both alcohol measures (NIAAA = .72; DMQ-R = .83).

Self-Kindness vs. Self-Judgment

The self-compassion dimension of self-kindness vs. self-judgment was well represented in the interviews, specifically in the facet of self-judgment related to self-blame. The self-kindness facet of self-compassion was notable in its absence. Self-judgment strongly emerged from the interview data whereas self-kindness was notably absent. Many participants mentioned blaming themselves for their USE, suggesting that self-judgment is a common experience among victims. One person highlighted how many victims believe they could or should have done more to prevent the assault:

> "More times than not, survivors are punishing to themselves. They feel like they deserved it. They blame themselves. What could they have done

> to prevent it when they did nothing to prevent it, and it's their fault." (P04, M)

In furthering this idea that self-blame was a consequence of trying to make sense of what happened and feeling at fault, one participant stated: "You just blame it on yourself, and you make all these excuses of why it was yourself." (P01, F) Another participant emphasized the role of guilt and self-criticism when reflecting upon her USE, saying:

> "I don't really remember a whole lot but I feel like maybe I was…maybe I started it. Like maybe he assumed 'cause I was with them I would do that... I blamed myself. I was like maybe I should've just had sex with him, you know, like, that's what my friends did." (P14, F)

Finally, one participant noted how self-blame was a large barrier in coping with and healing from an unwanted sexual experience:

> "If I didn't blame myself it would be a lot easier to, like, move on from it and just be, like, ok they screwed up, they hurt me. You know, and it's on them, be mad at them… um… it's a lot easier to be mad at somebody else than to be mad at yourself." (P08, F)

In discussing self-blame, one participant suggested that shifting blame to the perpetrator is an important step in overcoming the barrier to healing that self-blame imposes. This idea of shifting the blame away from the individual represents a step towards self-kindness, which was not a common theme throughout the interviews. The lack of reference to self-kindness in the interviews supports the idea that students with USEs tend to have difficulty with self-compassion following a sexual trauma.

Common Humanity vs. Isolation

The second dimension of self-compassion, common humanity vs. isolation, is relevant to the process of coping with and healing from USEs. Finding common

humanity can be achieved through disclosure of traumatic experiences to a supportive person. Research has shown that those who have a positive experience disclosing their USE are better able to use adaptive coping skills and rely on others for help, and this in turn is associated with better outcomes (Ullman, 2007). When people have a positive experience with disclosure, they can start to form connections with others and develop a comforting sense of common humanity. Those who do not disclose their unwanted sexual experience or have a negative disclosure experience may feel alone and isolate themselves from others, and may in turn experience more negative outcomes.

The isolation component of self-compassion presents itself as a barrier to actively seeking out support following a traumatic experience. One participant indicated a perceived societal stigma related to disclosing his unwanted sexual experience based on gender norms and religious affiliation:

> "Um, I don't think that I thought it was sexual assault for a long time. Partially because I was like, I mean there's just like this stigma I feel like, like guys can't really get raped and it's like, oh. So, for a long time I had to come to terms with that and then also there is, like, a big religious role to it too as well, because, like, I was Mormon at the time. I was like, well, if I tell someone about this then I'm going to have to face the facts that God, like, might not be great." (P12, M)

In addition to the perceived lack of support from others, participants also reported that they felt they lost the ability to trust others as a result of their experience. For example, one person said: "It's made me really kind of distrustful of people" (P05, F), making it difficult to obtain needed social support.

Seeking out help/support was important for many participants as they made efforts to heal. There was a shift in some participants' understanding and acceptance of

their USE when they sought out others with similar experiences and shared their stories. The experience of connecting with supportive others is part of the common humanity facet of self-compassion, and one participant mentioned its importance, saying:

> "Knowing that I'm not alone in the effects or the ways that…um, uh, yeah…the ways that it affects me and, uh, not to feel as crazy. I just know it kind of gives me reassurance and kind of, um, makes me feel more connected to that person. It's definitely helped." (P07, F).

Another participant said that researching and reading the stories of others' unwanted sexual experiences helped her to better understand her own, saying:

> "I kept noticing similarities and I was like 'no, no, no that didn't happen to me,' like, 'no, no' and so then I'd read another one and be like, well, that kind of did, but 'no, no, no that didn't happen to me,' and then as I noticed that happened more and more and more I just…yeah. I was like oh, oh yeah. I was talking to someone and I realized that hey, that's assault. It helped me because I realized that other people had been through it and they were feeling the same way that I did." (P11, F)

The common humanity vs. isolation dimension of self-compassion illustrates the importance of connecting with others and obtaining social support in coping with and healing from a USE.

Mindfulness vs. Over-Identification

The final dimension of self-compassion, over-identification vs. mindfulness, represents how individuals cope with negative emotions elicited from adverse or traumatic situations. Those who over-identify, or become consumed with their own negative thoughts and emotions following a traumatic event, are more likely to experience negative mental health outcomes (Neff, Kirkpatrick, & Rude, 2007). Most participants mentioned distressing consequences of their USE, including anxiety,

depression, PTSD symptoms, substance abuse problems, and other physical and mental health problems. One participant stated: “I personally rely on substance abuse and I am working on that. Which I've never had a problem with before, but, um, I smoke and I drink, like, a lot. Um, and just stuff like, emotionally I am a lot different.” (P03, F)

Whereas those who over-identify focus on their negative and helpless feelings following a traumatic event, those who engage in mindfulness, a balanced and open approach to coping with emotions, tend to benefit from it. This open approach means people acknowledge that they have experienced something traumatic, but they don’t view the trauma as defining their identity. Therefore, they are more likely to seek out self-compassionate ways to understand and cope with the situation (e.g., seeking counseling or social support). This approach is in contrast to denying or avoiding thoughts about the trauma. In support of this idea, many participants spoke of their efforts to actively avoid their negative thoughts and feelings about their experience. Congruently, participants identified confronting denial and actively addressing their emotions as an important step toward recovery:

> “I think people have a hard time admitting they have problems. Um, people who aren’t connected with themselves, who think they can handle things. I think people are concerned about it, uh, sounding like they’re weak, uh, not capable of handling bad things that happen to them. Or comparing themselves to other people.” (P09, F).

Few participants described using a mindful approach to coping and healing, suggesting that individuals may not have the skills, self-efficacy, or motivation to adopt an open and mindful approach to dealing with negative emotions resulting from their trauma. This lack of mindfulness is mirrored in the themes related to other aspects of self-

compassion (self-kindness and common humanity), as there was a notable lack of self-compassion (self-judgment, isolation, and over-identification) among the participants. This finding is supported in the self-compassion literature, and suggests that those with a history of unwanted sexual experiences might benefit from self-compassion training to build skills to assist in the coping and healing process.

Experiences with Research Participation

Change in affect during the study was assessed with the PANAS measure. Time one (before the interview) positive affect scores ranged from 18-41 (M = 27.06, SD = 7.23) and negative affect scores ranged from 10-34 (M = 18.63, SD = 6.92). Time two (after the interview) positive affect scores ranged from 12-43 (M = 29.31, SD = 8.90) and negative affect score ranged from 10-31 (M = 17.13, SD = 6.50). Paired sample t-tests were conducted to assess change in positive and negative affect before and after the interview. A significant difference was not found for positive affect $t(15) = -.1.21$, $p > .05$ or negative affect $t(15) = .96$, $p > .05$. The small sample was underpowered to detect statistically significant effects, although changes happened in the predicted direction. Cronbach's alpha for the PANAS at time 1 (.87) and at time 2 (.89) indicated good internal consistency of the measure.

Although significant changes in positive and negative affect were not found, participants did report having a positive experience in the study. During the debriefing portion of the interview, participants were asked how they felt about taking part in the study. Some participants indicated feeling happy to be part of the research. For example, one said:

> "Um, honestly I was kind of excited to talk about it. I, when I saw it, I immediately responded to the message because I was like 'yes, I want to talk about this. I want to share my unwanted experience and help do whatever they're trying to do.'" (P14, F)

Additionally, most participants indicated primarily positive feelings and that they gained a sense of validation from their experience in the study. One participant said:

> "I do feel better. Yeah, I mean it's nice to know that like, what I'm saying is being heard, you know. Even if you don't do anything with this. You know it's nice to know that, like, somebody took the time to like listen to it and is taking what I'm saying, um, and I'm happy that you're doing this in the first place." (P03, F)

While most participants indicated positive experiences, some participants indicated some slight negative feelings following the interview. When asked about the interview experience, one participant said, "About the same, just a little, I don't know the right word for it, melancholic about it but that's it." (P16, F) Although some participants did report slightly negative feelings, none of the participants reported extreme negative feelings or distress from taking part in the study.

Some participants also indicated an altruistic view of participating, indicating that they had reached a point in their healing process that had allowed them to share their experience with others. One participant said:

> "Um, because I am in a position now where I've kind of dealt with it. Um, and I have the ability to talk about it a little bit more and I think that, I think it's important to talk about it. People don't talk about it and some people just can't talk about it and I, like, understand and respect that but I think that I am in a position where I can talk about it and I should because it could help others who can't talk about it, I think." (P12, M)

Finally, participants' reactions to participating in the interview and discussing their USE was assessed using the RRPQ. When participants were asked if they "gained

something positive from taking part in this study," 10 reported they gained something positive from the interview, 3 people reported neutral responses, and 1 participant reported they had not gained something positive. When asked if "completing this study upset me more than I expected," 5 people indicated that the study upset them more than they expected, 1 person reported a neutral response, and 8 people reported they were not upset more than they expected to be during the interview. Finally, in response to the item "had I known in advance what completing this study would be like for me, I still would have agreed," 100% of participants reported that they would still participate in the study.

Discussion

The findings from this study create a rich picture of the study participants' history of USEs and their experiences with coping and healing. Participants reported a wide range of sexual victimization experiences, and although the USEs ranged in severity, participants reported similar negative outcomes following their USE. With regard to drinking motives, DMQ-R scores indicated greater coping motives than typically found in college student samples (e.g., Cooper, 1994). This difference was reflected in the interviews when participants discussed their experiences with coping and healing. Greater drinking to cope makes sense given that victimized people must cope with greater levels of stress. Coping motives may be important to address in prevention and treatment efforts.

Additionally, participants indicated having a generally positive experience from taking part in the study. While a significant change in affect was not found with the

PANAS, participants' responses in the debriefing section of the interview and their responses on the RRPQ indicated a generally positive experience. This finding aligns with past research showing that most participants do not experience undue amounts of stress from taking part in research about traumatic experiences (e.g., DePrince & Ann Chu, 2007; Griffin, Resick, Waldrop, & Mechanic, 2003; Johnson & Benight).

Finally, many of the key domains of self-compassion emerged from the interviews, suggesting the need for additional research to understand the role of self-compassion in healing from USEs. Participants' limited experiences with some of the positive facets of self-compassion (e.g., self-kindness and mindfulness) demonstrate an important need for more research on how self-compassion affects coping, healing, and outcomes of USE, including revictimization. Although a connection between self-compassion and USE emerged in study, more work is needed to understand this relationship. In Study 2, I quantitatively explored associations between self-compassion, early USE, and revictimization (i.e., recent USE) to create a better understanding of how self-compassion affects outcomes associated with sexual trauma.

STUDY TWO

Participants

Study participants were recruited from the introductory psychology subject pool and received two course credits for taking part in the 1-hour study. The study was posted through the SONA portal, and all subject pool students (not just those who have had an unwanted sexual experience) were eligible to participate. Two hundred thirty-one students from the subject pool took the survey, and 41.9% (n = 97) indicated that they had a history of USEs. Sample characteristics are described separately for the overall sample and for the subsample below.

Full Sample Of 231 Students

The total sample was primarily female (63.2%; n = 146), but also included those who identified as male (36.4%; n= 84) and non-binary (4%; n = 1). The majority identified as European American/White (85.7%) but other ethnic identities also were represented (6.1% Latino or Hispanic; 3.5% American Indian/Alaska Native; 2.2% Asian American; .4% African American/Black; and 1.7% reporting other ethnicity). Ages ranged from 18-49 (M = 20.52, SD = 4.59) and class standing included 58.4% freshmen, 22.9% sophomores, 10.0% juniors, and 7.9% seniors.

Subsample Of 97 With USE History

The subsample of students reporting a history of USE was primarily female (82.5%; n = 80) and European American/White (87.6%), but also included 17 males

(17.5%) and other ethnic identities (7.2% Latino American/Chicano/Hispanic American; 6.2% American Indian/Alaska Native; 3.1% Asian American; 1% African American/Black 1%; and 4.1% reporting other ethnicity). Ages ranged from 18-49 (M = 20.88, SD = 5.53) and class standing included 58.8% freshmen, 22.7% sophomores, 10.3% juniors, and 7.2% seniors.

Procedure

The university Institutional Review Board approved all measures and procedures prior to data collection. All participants gave full informed consent and were given ample opportunity to discuss their concerns about this study, with extra attention paid to confidentiality and referrals to services for all students. Data collection took place in person in the faculty advisor's lab on campus in small groups of up to five at a time, closely monitored by trained research assistants. The measures for this study were entered into the Qualtrics survey platform, and participants completed the questions at individual computer workstations with privacy shields installed. The voluntary nature of the study was emphasized, and participants were assured that they could skip any question they did not wish to answer and could stop at any time without consequence. The research assistants monitored participants for signs of distress, and were trained to carry out a safety plan in the event that a participant became inordinately distraught. No participants became overly distressed during the study, and the safety plan was never needed. After completing the study measures, participants were debriefed and provided with a comprehensive list of community and campus resources for counseling, support

groups, substance abuse treatment, and sexual assault/domestic violence advocacy before being thanked for their contribution to the research.

Measures

A brief background questionnaire was administered to collect demographic information including age, gender, ethnicity, and class standing. Standardized assessments included history of sexual assault (both early and recent experiences), childhood trauma (including but not limited to sexual abuse), and common consequences of these negative events (e.g., post-traumatic stress, other mental health symptoms, self-blame, substance abuse) as well as hypothesized resilience/protective factors (e.g., coping, emotion regulation, self-compassion, authenticity). Finally, to assess the effects of asking about difficult topics in research studies like this one, I administered the same measure used in Study 1 to measure participants' experiences with completing the survey.

Primary Measures

The following measures were included to assess the primary constructs of interest: frequency and type of early and recent unwanted sexual experiences, self-compassion, self-blame, and perceived control over the recovery process. These measures allowed us to explore revictimization (i.e., USEs in the past year) among students who experienced early sexual assault or coercion (USEs from age 14 – one year ago).

Sexual Victimization History. The Sexual Experiences Survey-Short Form Victimization (SES-SFV; Koss et al., 2006), previously described in detail, was used to measure sexual victimization. As in Study 1, I calculated two variables from the SES data—frequency of early USE and recent USE. Early USE was found by averaging participants' frequency ratings of assault and coercion experiences from age 14 to one year ago, and recent USE was the mean of frequency ratings of sexual assault and coercion experiences within the past year.

Self-Compassion. The Self-Compassion Scale (Neff, 2003) contains 26 items that assess the degree of self-compassion that one has during times of emotional distress. This measure consists of six subscales: self-kindness (e.g., "When I'm going through a very hard time, I give myself the caring and tenderness I need"), self-judgment (e.g., "I can be a bit cold-hearted towards myself when I'm experiencing suffering"), common humanity (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"), isolation (e.g., "When I'm really struggling I tend to feel like other people must be having an easier time of it"), mindfulness (e.g., "When something upsets me I try to keep my emotions in balance"), and over-identification (e.g., "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). Participants responded to each item on a 5-point scale from 1 (almost never) to 5 (almost always). To calculate variables for inclusion in the analyses, I first calculated the mean of each subscale. For a total self-compassion score, I reverse-scored the negative subscale items (e.g., self-judgment, isolation and over-identification) and then calculated the mean of all items. Higher total scores reflect

greater self-compassion. The SCS has shown good internal and test-retest reliability in previous studies. The internal consistency estimate in previous research with college students was .94 (Neff et al., 2005).

Self-Blame and Perceived Control. The Rape Attribution Questionnaire (RAQ; Frazier, 2003) was used to assess self-blame and other attributions about participants' USEs. This measure is comprised of five subscales that assess blame (self and perpetrator) and perceived control over the recovery process. The blame scales assess behavioral self-blame (e.g., "I used poor judgment") and perpetrator blame (e.g., "The perpetrator thought they could get away with it"). Participants were asked to think how often they had thoughts about self- and perpetrator blame after their USE. Responses were rated on a five point Likert scale ranging from 1 (never) to 5 (very often).

Perceived control scales assess control over the recovery process (e.g., "I feel like the recovery process is in my control"), future likelihood of experiencing a subsequent unwanted sexual experience (e.g., "No matter what steps I take, I could be assaulted again"), and future control (e.g., "I have changed certain behaviors to try to avoid being assaulted again"). Responses for these scales were also on a Likert scale that ranged from 1 (strongly disagree) to 5 (strongly agree). Previous research evaluating validity and reliability of the RAQ found subscale coefficient alphas ranging from .77 to .89, and test-retest reliability coefficients ranging from .68 to .80 (Frazier, 2002).

Secondary Measures

I assessed several risk and protective factors hypothesized to affect outcomes among participants with a history of USEs. These factors included childhood trauma, sexual assault disclosure, mental health, substance use, self-esteem, emotion regulation, and coping styles. I also assessed reactions to participating in the research among all participants. These secondary measures are described briefly below.

Childhood Trauma. The Adverse Childhood Experiences (ACE) questionnaire was developed for the groundbreaking Adverse Childhood Experiences (ACEs) Study funded by the Centers for Disease Control and Prevention (Felitti et al., 1998). The ACEs questionnaire is a 10-item self-report inventory assessing childhood experiences of abuse (physical, emotional, or sexual), neglect (physical or emotional), and exposure to household criminal behavior, violence, mental illness, parental conflict, and substance abuse. Participants are asked to indicate whether they experienced each of the ACEs prior to age 18 (yes or no). The total number of yes responses are summed to yield an overall ACEs score, with higher scores indicating more childhood adversity.

Childhood adversity as measured by the ACEs questionnaire has been shown to be a robust predictor of morbidity and mortality in adulthood from a number of causes (Felitti et al., 1998; Edwards et al., 2005; Felitti, 2009; Gilbert et al., 2015). There is a strong linear relationship between early adversity and a broad range of health risk behaviors and negative outcomes (e.g., smoking, drug abuse, alcohol dependence, risky sexual behavior, mental illness, suicide, obesity, chronic obstructive pulmonary disease, liver disease, stroke, ischemic heart disease). The authors of the ACE study, and the

CDC, propose that childhood trauma dysregulates the stress response system, potentially resulting in a lifetime of maladaptive coping behaviors that cause health problems (Anda & Brown, 2007). In this study, I examined the influence of ACEs on revictimization risk among college students with a history of early USE.

Outcomes of Unwanted Sexual Experiences. Participants who reported an unwanted sexual experience completed the Social Reactions Questionnaire (SRQ; Relyea & Ullman, 2015) to assess the quality of the experience they had in disclosing their USE. Only those who reported a history of USE completed this inventory. The SRQ includes 48 items assessing two overarching factors (negative reactions and positive reactions) and 7 subscales (victim blame, treat differently/stigma, taking control, distraction, egocentric reactions, tangible aid, and emotional support). Participants were asked to indicate how often they experienced each of the responses from other people in response to disclosure, with responses ranging from 0 (never) to 4 (always).

Mental Health Symptoms. The Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (BAI; Beck & Steer, 1990), and the Posttraumatic Checklist (PCL-5; Weathers et al., 2013) were used to assess mental health symptoms. The BDI is a 21-item instrument that assesses symptoms of depression (sadness, loss of pleasure, suicidal thoughts, difficulty concentrating, and changes in eating and sleeping). Participants are instructed to report their experiences with each symptom in the two-week period prior to taking the assessment. Responses on each item range from 0 to 3, with higher scores indicating more severe impairment. Responses are summed to yield a total

score, with higher values representing greater depression. Scores between 0 – 9 indicate minimal depression; 10 – 18 indicates mild depression; 19 – 29 indicates moderate depression; and scores greater than 30 indicate severe depression (Beck, Steer, & Brown, 1996). The BDI is a widely studied and well-known measure of depression that has demonstrated excellent psychometric properties and has been used extensively in research with college students (Gidycz & Koss, 1991; Messman-Moore, Long, & Siegfried, 2000; Wingo et al., 2010).

The BAI is a 21-item checklist of common symptoms of anxiety and panic (heart pounding or racing, fear of losing control, feeling nervous). Instructions direct respondents to indicate how frequently each symptom has bothered them in the previous week. Responses range from 0 (*Not at all*) to 3 (*Severely*). Like the BDI, the BAI involves summing responses to yield a total score, with higher values indicating greater anxiety symptoms in the past week. Scores between 0 – 21 indicate low anxiety; 22 – 35 indicates moderate anxiety; and scores of 36 and above indicate severe anxiety (Beck, Epstein, Brown, & Steer, 1998). The BAI is a valid and reliable measure of anxiety, with high internal consistency (Cronbach's alpha = .92) and adequate test-retest reliability (1-week r = 0.75; Beck et al., 1998). The BAI has been used successfully in other research with college student populations (Gidycz, Coble, Latham, & Layman, 1993; Swanstron et al., 2003).

The Posttraumatic Checklist (PCL-5; Weathers et al., 2013) was used to assess the severity of Posttraumatic Stress Disorder (PTSD) symptoms. The PCL-5 is a 20-item self-report measure that evaluates the degree to which an individual has been bothered in

the past month by PTSD symptoms tied to his or her most currently distressing event. Items are rated from 0 (not at all) to 4 (extremely) and are summed for a total severity score. Subscale severity scores are calculated by summing items in each of the four PTSD symptom clusters specified in the DSM-5: intrusions (e.g., "Repeated, disturbing and unwanted memories of the stressful experience"), avoidance (e.g., "Avoiding memories thoughts, or feelings related to the stressful experience"), negative alterations in cognitions and mood (e.g., "Trouble remembering important parts of the stressful experience"), and alterations in arousal and reactivity (e.g., "Irritable behavior, angry outbursts, or acting aggressively"). Scores greater than 33 indicate clinically significant symptoms meeting DSM–5 criteria for PTSD.

Substance Use. All participants completed the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, De La Fuente, & Grant, 1993), a 10-item self-report measure developed by the World Health Organization as a screening tool for hazardous drinking. Questions include estimates of quantity and frequency of alcohol use and frequency of binge drinking (four or more drinks in one sitting for a woman, five or more for a man). Items are scored from 0 to 4 and responses are summed to yield a total score, with scores greater than 8 indicating hazardous drinking. All participants also completed the Cannabis Use Problems Identification Test (CUPIT; Bashford, Flett, & Copeland, 2010), a 10-item self-report screening instrument for the detection of potentially problematic cannabis use. Questions ask about cannabis use in the last 12 months, with scores of 20 or higher indicating a likely current cannabis use disorder.

Protective Factors. All participants completed measures of potential protective factors, including emotion regulation, self-esteem, and coping styles. Emotion regulation was assessed using the Emotion Regulation Questionnaire (ERQ; Gross and John, 2003), a 10-item measure with two subscales representing reappraisal (e.g., "I control my emotions by changing the way I think about the situation I'm in") and suppression (e.g., "When I am feeling negative emotions, I make sure not to express them"). Reponses are rated on a 7-point scale from 1 (strongly agree) to 7 (strongly agree). Higher scores on the reappraisal scale indicate greater ability to regulate one's emotions, while higher scores on the suppression scale indicate diminished emotion regulation.

Participants also completed the Single Item Self-Esteem Scale (Robins, Hendin, & Trzesniewski, 2001), which consists of one item (e.g., "I have high self-esteem") that assesses perceived self-esteem. Responses range from 1 (not very true of me) to 5 (very true of me). The COPE (Carver, Scheier, & Weintraub, 1989), a 60-item self-report instrument, was used to assess participants' global dispositional coping styles. The COPE includes 15 subscales (positive reinterpretation and growth, mental disengagement, focus on and venting of emotions, use of instrumental social support, active coping, denial, religious coping, humor, behavioral disengagement, restraint, use of emotional social support, substance use, acceptance, suppression of competing activities, and planning) that have been shown to be associated with mental and physical health outcomes in numerous domains. Participants are asked to indicate what they generally do and feel when they experience stressful events on a scale from 1 (I usually don't do this at all) to 4 (I usually do this a lot). Item responses are summed to yield total scores for each

subscale. I categorized the COPE subscales into four separate coping strategies based on the guidelines set forth by Litman (2006). The coping strategies presented in this study are problem-focused coping, avoidant coping, emotion-focused coping, and social support coping. The COPE has demonstrated good psychometric properties in assessing dispositional coping skills (Litman & Lunsford, 2009).

RESULTS

Hypotheses

This study examined the relationship between self-compassion and revictimization for individuals with a history of USEs. I hypothesized that 1) a greater frequency of early USEs would predict greater recent USEs, 2) early USEs would predict lower self-compassion scores, and 3) lower self-compassion scores would predict greater recent USEs.

Data Analysis

Data were analyzed using SPSS version 23. First, I calculated descriptive statistics and correlations for all study variables. I then used multiple regression to test the primary study hypotheses. Before conducting the regression analyses, I evaluated the data to ensure that the assumptions of regression were met. Non-normally distributed variables were log transformed and study variables were centered before they were used in the indirect effects model. An indirect effects analysis with the study variables of early USE, self-compassion, and recent USE was conducted using PROCESS (Hayes, 2012). Finally, to evaluate other exploratory hypotheses, I examined the bivariate correlations between study variables.

Descriptive Statistics

Means, standard deviations, and coefficient alpha estimates are presented in Table 3. They are listed separately by gender and by self-reported USE status.

Participant History of Victimization

Table 3 presents rates of sexual assault and/or coercion as measured by the SES (Koss et al., 2006; Koss et al., 2007) separated by participant gender and type of sexual act. This measure demonstrated good internal validity and had a Cronbach's alpha of .94.

Table 2. Frequency of Unwanted Sexual Experiences History

	Female (n = 146)		Male (n = 84)		Sample (n = 231)	
Sexual Assault and/or Coercion:	Early	Recent College	Early	Recent College	Early	Recent College
Sexual Touching	77 (52%)	42 (29%)	13 (16%)	7 (8%)	90 (21%)	49 (39%)
Oral Sex	37 (25%)	19 (13%)	4 (5%)	5 (6%)	41 (18%)	24 (10%)
Vaginal Sex	53 (36%)	31 (21%)	-	-	53 (23%)	31 (13%)
Anal Sex	53 (36%)	10 (7%)	8 (10%)	3 (4%)	61 (26%)	13 (6%)
Attempted Oral Sex	18 (12%)	10 (7%)	5 (6%)	3 (4%)	23 (10%)	13 (6%)
Attempted Vaginal Sex	39 (26%)	19 (13%)	-	-	39 (17%)	19 (8%)
Attempted Anal Sex	14 (10%)	5 (3%)	7 (8%)	2 (2%)	21 (9%)	7 (3%)
"Have you ever been raped?" (SES Item 10):						
"Yes"	25 (17%)		3 (4%)		28 (12%)	
"No"	121 (83%)		81 (96%)		203 (88%)	

Table 3. Descriptive Data of Study Variables

		Gender (USE) (n = 97)				Gender (No USE) (n = 133)			
		Female (n = 80)		Male (n = 17)		Female (n = 66)		Male (n = 67)	
	α	M	SD	M	SD	M	SD	M	SD
Self-Compassion Scale (SCS)	.94	17.38	3.99	18.88	2.84	17.94	3.04	17.88	3.67
Self-Kindness	.84	2.39	.89	2.16	.50	2.20	.57	2.40	.73
Self-Judgment	.86	3.07	.79	3.32	.78	3.05	.68	3.22	.68
Common Humanity	.77	2.59	.77	2.75	.79	2.51	.71	2.54	.78
Isolation	.81	3.46	.84	3.77	.79	3.34	.81	3.52	.89
Mindfulness	.73	2.62	.73	2.85	.56	2.53	.58	2.72	.76
Over-Identification	.81	3.38	.88	4.09	.80	3.29	.73	3.59	.85
Rape Attribution Questionnaire (RAQ)	.73	4.04	.54	3.95	.50	-	-	-	-
Behavioral Self-Blame	.90	2.63	.98	2.09	.94	-	-	-	-
Perpetrator Blame	.77	2.21	.82	1.51	.82	-	-	-	-
Control Over the Recovery Process	.60	3.37	.53	2.96	.91	-	-	-	-
Future Likelihood	.85	2.62	.94	3.16	.94	-	-	-	-
Future Control	.72	3.30	.64	2.81	.91	-	-	-	-
Social Reactions Questionnaire (SRQ)	.94	2.64	.37	2.55	.39	-	-	-	-
Positive Reactions	.93	1.90	.87	1.39	.93	-	-	-	-
Negative Reactions	.87	1.75	.60	1.32	.33	-	-	-	-

Table 2 Continued

Adverse Childhood Experiences (ACEs)[a]	.70	2	1-4	2	1-4	1	0-3	1	0-2
Beck Depression Inventory (BDI)[a]	.92	13	6-25	11	3-5	13	5-26	8	3-17
Beck Anxiety Inventory (BAI)[a]	.94	14	8-25	6	4-18	10	5-19	6	2-15
Posttraumatic Checklist (PCL-5)[a]	.95	17	8-31	14	3-31	11	5-31	11	2-22
AUDIT[a]	.82	5	3-9	8.5	5-11	5	2-7	7	4-10
CUPIT[a]	.83	10	6-17	8	5-18	9	4-14	11	6-21
ERQ: Cognitive Reappraisal	.86	29.59	5.76	29.65	8.81	28.51	6.62	29.31	6.50
ERQ: Suppression	.76	15.08	4.91	17.00	5.14	15.02	4.31	15.79	5.09
Single Item Self-Esteem	-	4.04	1.64	4.06	1.75	4.20	1.48	4.84	1.64
Problem focused Coping	.94	9.14	2.25	8.96	3.16	9.01	2.43	9.15	2.57
Avoidant Coping	.89	6.89	1.49	6.16	1.83	6.85	1.71	6.57	1.54
Emotion Focused Coping	.87	9.75	2.01	8.94	2.09	9.32	1.98	9.26	2.07
Social Support Coping	.93	10.01	2.66	8.04	2.52	10.31	3.04	8.78	2.81

Note: [a] Median and 25%-75% quartile range reported for non-normally distributed variables

Self-Compassion

Self-compassion scores ranged from 9.20-25.85 (M = 17.64, SD = 3.84), which was consistent with the Neff (2003a) study that found similar results with a sample of 225 female undergraduate students (M = 17.72, SD = 3.74).

Childhood Trauma

ACE scores ranged from 0-8, with 29.9% reporting a score of 0 (n =69), 26.4% reporting a score of 1 (n = 61), 15.2% reporting a score of 2 (n = 35), 11.3% (n = 26) reporting a score of 3, and 17.3% reporting a score of 4 or more (n = 40). Again, higher ACE scores are associated with more negative life and health outcomes. While these scores represent a range of childhood traumas, the reported rates of childhood sexual trauma were of particular interest to the present investigation. Specifically, 8.7% (n =20) of participants indicated they had experienced some type of childhood sexual trauma perpetrated by someone at least 5 years older than them.

Group Differences

I performed independent samples t-tests to examine gender differences in study variables. No gender differences were found in the USE sample. In the entire sample, t-tests showed that females had higher anxiety scores (t [144.54] = 3.66, $p < .01$) and more adverse childhood experiences (t [228] = 3.44, $p < .01$) relative to males. Males in the study reported a greater number of alcohol related problems (t [224] = -2.85, $p < .01$) than females. Finally, independent samples t-tests showed that those in the USE group reported significantly higher anxiety scores (t [198.71] = 3.37, $p <.01$) and greater

adverse childhood experiences (t [204.87] = 4.20, p <.01) but did not differ on any other measure. The finding that individuals who identified as having a USE also have greater ACE scores is consistent with research suggesting that people with higher ACEs have a greater chance of experiencing sexual assault later in life (Gilbert et al., 2015). Additionally, the finding of higher anxiety scores among participants with USEs is also well established in the sexual assault literature (Hill et al., 2011).

Bivariate Correlations

Table 4 shows the bivariate correlations for study variables for the overall sample, and Table 5 shows bivariate correlations only for individuals with a history of USE.

Participant Trauma History

For the overall sample, early USE was positively associated with recent USE (r = .52, p < .01) as well as with adverse childhood experiences (r = .20, p < .01). This finding is consistent with the literature (e.g., Ullman & Vasquez, 2015; Classen et al., 2005; Messman-Moore & Long, 2003). As expected, early USE predicted greater anxiety (r = .15, p < .05), depression (r = .18, p < .05), and PTSD (r = .17, p < .05). Early USE also predicted greater alcohol use problems (r = .21, p < .01), which also is consistent with existing literature (Carey et al., 2015; Testa et al., 2003). Contrary to hypotheses, this study found no significant association between self-compassion and unwanted sexual experiences, which was counter to the findings in the Close (2013) study. Recent USEs, in addition to being correlated with early USEs, were associated with greater alcohol

problems ($r = .21$, $p < .01$) and greater reliance on avoidant coping strategies ($r = .16$, $p < .05$).

Participants who reported a history of USEs completed additional measures to assess attributions of blame, perceived control, and social reactions from others. Greater early USEs predicted less perpetrator blame ($r = -.26$, $p < .05$), less control over the recovery process ($r = -.23$, $p < .05$), and greater negative social reactions from others ($r = .43$, $p < .05$). Recent USEs were not significantly associated with attributions of blame, perceived control, or social reactions.

Self-Compassion

For the overall sample, lower self-compassion scores were associated with greater anxiety ($r = -.58$, $p < .01$), depression ($r = -.46$, $p < .01$), and PTSD ($r = -.45$, $p < .01$). Lower self-compassion scores were also associated with a greater reliance on avoidant coping ($r = -.39$, $p < .01$) and emotion suppression ($r = -.28$, $p < .01$). Higher self-compassion scores were associated with a greater reliance on problem-focused coping strategies ($r = .24$, $p < .01$), emotion-focused strategies ($r = .24$ $p < .01$), and emotional cognitive reappraisal techniques ($r = .43$, $p < .01$). That is, those who reported greater self-compassion showed more adaptive coping. Finally, higher self-compassion scores were associated with higher self-esteem scores ($r = .62$, $p < .01$).

Examining only those participants who reported a history of USE, self-compassion scores were associated with less self-blame ($r = -.27$, $p < .01$), fewer negative social reactions following disclosure ($r = -.25$, $p < .05$), and less perpetrator blame ($r = -.35$, $p < .01$). The negative associations between self-compassion and blame suggest that

people high in self-compassion are less likely to blame anyone, whether themselves or the perpetrators. Higher self-compassion scores also were positively associated with the future likelihood subscale ($r = .23$, $p < .05$). That is, people with higher self-compassion scores felt they had taken important steps to prevent a subsequent USE.

Childhood Trauma

For the overall sample, greater childhood trauma predicted lower self-compassion ($r = -.23$, $p < .01$) and a decreased reliance on emotion-focused coping strategies ($r = -.14$, $p < .05$). Like the other measures of victimization, childhood trauma predicted greater anxiety ($r = .24$, $p < .01$), depression ($r = .28$, $p < .01$), and PTSD ($r = .16$, $p < .05$) symptom severity. For individuals with a reported history of USE, childhood trauma predicted decreased perpetrator blame ($r = -.21$, $p < .05$) and lower scores of self-kindness ($r = -.22$, $p < .05$), but did not predict self-blame.

Table 4. Correlates of All Study Variables for all participants*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.EUSE	1.0																	
2.RUSE	.52**	1.0																
3.ACE	.20**	.06	1.0															
4.SCS	.04	.01	-.23**	1.0														
5.RAQ	.06	-.16	.23*	.13	1.0													
6.SRQ	-.09	-.11	.06	.06	.14	1.0												
7.BDI	.15*	.14	.24**	-.58**	-.12	.06	1.0											
8.BAI	.18*	.09	.28**	-.46**	-.16	-.12	.63**	1.0										
9.PCL	.17*	.12	.16*	-.45**	-.02	-.07	.63**	.50**	1.0									
10.AUDIT	.21**	.21**	-.07	-.01	-.04	-.07	.03	.08	.20**	1.0								
11.CUPIT	.08	-.04	-.06	.01	-.06	.17	.09	.13	.03	.20*	1.0							
12.ERQ-CR	.06	-.08	-.12	.43**	.17	.09	-.37**	-.30**	-.30**	.03	-.07	1.0						
13.ERQ-S	.03	.08	.05	-.28**	-.21*	.00	.34**	.25**	.29**	.00	.01	-.07	1.0					
14.SISE	-.04	.00	-.13	.62**	.05	.02	-.61**	-.40**	-.43**	-.02	-.04	.31**	-.20**	1.0				
15.PFC	-.11	-.06	-.13	.24**	.19	.09	-.12	-.03	-.08	-.16*	.04	.25**	-.13	.26**	1.0			
16.AC	.11	.16*	.07	-.39**	-.14	-.09	.46**	.31**	.37**	.25**	.15	-.14	.20**	-.37**	-.06	1.0		
17.EFC	.11	.03	-.14*	.24**	.06	.13	-.03	-.04	-.02	-.07	-.04	.24**	-.10	.20**	.52**	.06	1.0	
18.SSC	-.06	-.06	-.01	-.06	.09	.11	.14*	.14	.01	-.14*	.00	.07	-.50**	-.03	.40**	.23**	.31**	1.0

Table 4 Continued

Note:* SRQ and RAQ correlations are only for individuals who reported a history of USE. PCUSE = Early Unwanted Sexual Experience, RUSE = Recent Unwanted Sexual Experience, ACE = Adverse Childhood Experiences SCS = Self-Compassion Scale, RAQ = Rape Attribution Questionnaire, SRQ = Social Reactions Questionnaire, BDI = Beck Depression Inventory, BAI = Beck Anxiety Inventory, PCL = Posttraumatic Checklist, AUDIT = Alcohol Use Disorder Identification Test, CUPIT = Cannabis Use Problems Identification Test, ERQ- CR = Emotion Regulation Questionnaire- Cognitive Reappraisal, ERQ-S = Emotion Regulation Questionnaire- Suppression, SISE = Single Item Self-Esteem, PFC = Problem Focused Coping, AC = Avoidant Coping, EFC = Emotion Focused Coping, SSC = Social Support Coping.*p = <.05, **p = <.01

Table 5. Subscale Correlates for Self-Compassion, Rape Attributions, and Social Reactions for participants with a reported USE history

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1.EUSE	1.0																
2.RUSE	.47**	1.0															
3. ACE	.17	-.00	1.0														
4. SCS	.03	.05	-.20	1.0													
5. SK	.12	.07	-.22*	.78**	1.0												
6. SJ	.04	.03	-.17	.87**	.70**	1.0											
7. CH	.08	.00	-.06	.71**	.53**	.46**	1.0										
8. I	-.10	-.01	-.10	.78**	.56**	.70**	.45**	1.0									
9. M	.06	.12	-.17	-.73**	.68**	.54**	.65**	.41**	1.0								
10. OI	-.09	-.02	-.15	.77**	.44**	.70**	.38**	.75**	.53**	1.0							
11.BSB	.15	.14	-.04	-.27**	-.10	-.25*	-.10	-.31**	-.14	-.34**	1.0						
12. PB	-.26*	-.03	-.21*	-.35**	-.23*	-.30**	-.28**	-.32**	-.24*	-.34**	.21*	1.0					
13. CORP	-.23*	-.07	.09	.12	.11	.17	.11	.11	.07	.04	.05	.15	1.0				
14. FL	-.20	-.12	.04	.29**	.14	.23*	.27*	.33**	.23*	.30**	-.36**	-.13	.04	1.0			
15. FC	.07	.03	.10	-.14	-.01	-.19	.00	-.22*	-.06	.28**	.41**	.14	.22*	-.15	1.0		
16. PSR	.11	.01	-.10	-.05	-.13	.05	.03	-.09	-.20	-.10	.12	.31**	.32**	-.06	.14	1.0	
17. NSR	.43**	.15	.15	-.25*	-.23*	-.21	-.21	-.23*	-.25*	-.23*	.28**	.43**	.26*	-.30**	.17	.36**	1.0

Table 5 Continued

Note: EUSE = Early Unwanted Sexual Experience, RUSE = Recent Unwanted Sexual Experience, ACE = Adverse Childhood Experiences, SCS = Self-Compassion, SK= Self-kindness subscale, SJ = Self-judgment subscale, CH = Common Humanity Subscale, I = Isolation Subscale, M = Mindfulness Subscale, OI = Over-identification subscale, BSB = Behavioral Self-blame Subscale, PB = Perpetrator Blame Subscale, CORP = Control Over the Recovery Process Subscale, FL = Future Likelihood Subscale, FC = Future Control Subscale, PSR = Positive Social Reactions Subscale, NSR = Negative Social Reactions.*p = <.05, **p = <.01.

Indirect Effect Analyses

The primary hypothesis for this study was that self-compassion would indirectly affect the relationship between early USE and recent USE. I predicted that early USE would be associated with lower self-compassion, and in turn lower self-compassion would predict recent USE. The PROCESS (Hayes, 2012) macro for SPSS was used to test this indirect effect. Early USE was entered as the independent variable, total self-compassion score was entered as the indirect effect variable, and recent college USE was entered as the dependent variable. Age and gender were included as covariates. As shown in Figure 2, neither a direct nor indirect effect was found for early USE on recent USE through self-compassion. Overall, these findings demonstrate that early USE did not predict differences in self-compassion scores, and differences in self-compassion scores did not predict recent USE.

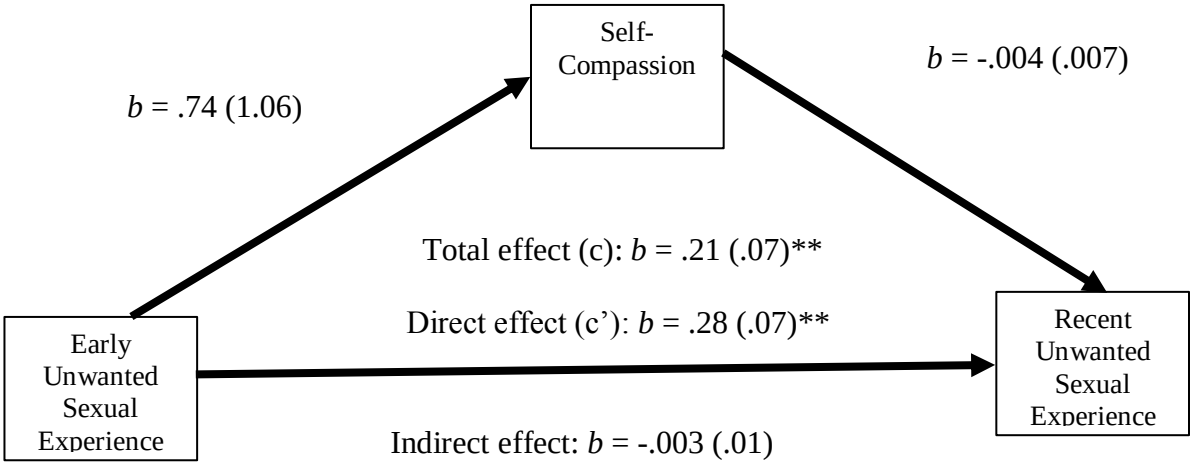

Figure 2. Analysis via PROCESS program (Hayes, 2012) indicates a non-significant indirect effect for early USE and recent USE through self-compassion. A non-significant partial indirect effect was also found for this model (lower/upper confidence interval = -.0411/.0078, p > .05). *p < .05, **p < .01.

In a follow up analysis, the PROCESS (Hayes, 2012) macro for SPSS was utilized again to test a new indirect effects model. In this model, adverse childhood experiences were entered as the independent variable, self-compassion was once again entered as the indirect effect variable, and early USE was entered as the dependent variable (see Figure 3). Age and gender were included as covariates. A significant indirect effect of adverse childhood experiences on early USE through self-compassion was found. The indirect effect through self-compassion only partially accounted for the effect of adverse childhood experiences on USEs. Overall, these findings demonstrate that adverse child childhood experiences predicted early USE both directly and indirectly.

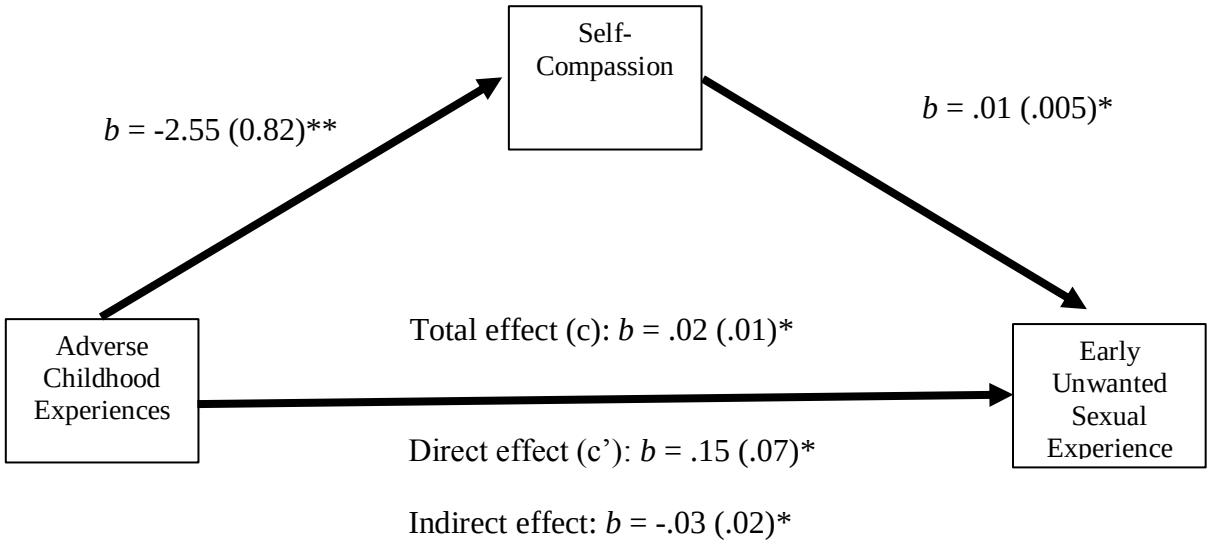

Figure 3. Analysis via PROCESS program (Hayes, 2012) indicates a significant partial indirect effect via self-compassion (lower/upper confidence interval = -.0739/-.0066, $p < .05$). *$p < .05$, **$p < .01$.

DISCUSSION

The goal of the current study was to explore the association between self-compassion and sexual revictimization among individuals with a history of USE. Additional exploratory hypotheses were tested involving self-compassion, attributions of blame, and perceived control to create a better understanding of how people conceptualize their USE and the control they have over the recovery process. While this study found no significant indirect effects between self-compassion and revictimization among individuals with a history of USE, a significant partial indirect effect was found for adverse childhood experiences, self-compassion, and early USE. In the sections below possible explanations for the results discovered from this study are explored.

Self-Compassion and Sexual Trauma

Contrary to my hypotheses, I did not find a significant association between early USE and self-compassion. However, I did find significant associations in the expected direction between adverse childhood experiences and self-compassion (negative) and between adverse childhood experiences and early USE (positive). Self-compassion partially accounted for the association between ACEs and early USEs. Those with greater childhood adversity scored lower in self-compassion and reported more early USEs, but greater self-compassion was associated with more early USEs when ACEs were held constant. More specifically, self-compassion predicted more early USEs when the effects of ACEs were partialed out.

Although a significant association was found for self-compassion and early USEs when ACEs were held constant, this association was found in a direction that was not predicted. With this positive association, it is imperative to consider other variables that could moderate explain this relationship. In a recent study, Testa and Cleveland (2017) longitudinally examined the effects of drinking behaviors and drinking settings on college sexual assault perpetration. The research revealed that situational factors (e.g. party or bar attendance) were a greater predictor of sexual assault perpetration than drinking alone.

Relating this finding back to self-compassion and the findings from the current study, research has shown that greater levels of self-compassion are associated with greater optimism (Neff, Rude, and Kilpatrick, 2007) and an increased scene of connection with others (Corcoran, 2007). Therefore, individuals with higher self-compassion experience increased optimism and connection with others, and thus may be more social and attend more events at bars and parties. When people attend parties or bar events they encounter greater situational risk factors for experiencing a USE. This is one possible explanation for the positive association between self-compassion and early USE, and further research is needed to explore other moderating variables that could explain the positive association between self-compassion and early victimization.

Aside from situational factors, examining differences in the severity of reported sexual trauma may prove beneficial for future research. In the only study to examine self-compassion among women with a history of sexual trauma, Close (2013) found a strong relationship between self-compassion and sexual trauma. In comparing the reported

frequencies of different types of sexual assault, the participants in the Close study reported higher rates of completed rape than the participants in the current study. This finding suggests that I achieved my goal of casting a broader net by using the term USE, defined as "anything sexual that happened to you that you did not agree to," instead of inquiring about "sexual assault." As a consequence, the severity of reported sexual trauma may not be as great in my sample when compared to other studies. Thus, it would be important to determine if USE severity associates with self-compassion as well as negative outcomes of sexual trauma. Research shows that greater assault severity has been associated with increased PTSD symptom severity (Ullman & Filipas, 2001), more negative social reactions from others (Ullman, 2000), and greater psychological distress (Koss, 1993).

Close (2013) did examine differences in self-compassion among people who reported sexual coercion, attempted rape, and completed rape. Those who reported an attempted rape had significantly lower self-compassion then individuals who reported sexual coercion and completed rape, although the effect size was minimal. The author suggests that the severity of sexual trauma and the tactics used by the perpetrator may influence the outcomes of the trauma as well as victim self-compassion. In fact, some research has shown that rape myths, which are prevalent throughout society (Burt, 1980), have established an idea of what constitutes a "true" sexual assault (Lonsway & Fitzgerald, 1994). These findings support the idea that the type/severity of sexual assault can affect outcomes, indicating that different pathways of sexual revictimization may depend on the type and severity of the initial victimization. Findings regarding the

association between the type/severity of sexual trauma and self-compassion are still preliminary and more research is needed.

Self-Compassion and Childhood Trauma

Findings on adverse childhood experiences scores (ACEs) in this study found those who identified as having a USE reported significantly greater ACEs than those who reported no USE. As the number of reported ACEs increases, the odds of developing a substance use disorder, mental health problem, physical health problem, suicide, experiencing domestic violence, and experiencing a sexual assault later in life increase (Felitti et al., 1998; Hills et al, 2000; Dube et al., 2001; Edwards et al., 2003). In examining the link between ACEs and USEs, it is important to look specifically at childhood sexual abuse as a predictor of later sexual trauma in addition to total ACE scores. In the present study, 20 participants who reported USEs indicated they had also experienced sexual abuse during childhood. A more thorough assessment of type, frequency, and severity of childhood sexual abuse is need to better understand this association.

Research suggests conducted with self-compassion among adolescents revealed that greater childhood maltreatment was associated with lower self-compassion (Vettese et al., 2011). This finding is supported by research conducted by Gilbert and colleagues (2006), which suggested there are developmentally sensitive periods in which a child can develop self-compassion. Further, Gilbert and Procter (2006) have suggested that self-compassion is a teachable skill that allows an individual to self-sooth when they are

distressed or when faced with adversity. Gilbert (2005) theorized that individuals raised in a nurturing environment develop self-compassion skills that help with emotion regulation and coping with distress. Children raised in abusive and neglectful households are unlikely to develop self-compassion skills and therefore will experience difficulties self-soothing and regulating their emotions later in life. Additionally, Gilbert and Proctor (2006) suggested that individuals who experience greater and prolonged childhood maltreatment may demonstrate a diminished ability to learn self-compassion skills. This suggests that developmentally appropriate interventions to teach self-compassion are needed.

Further supporting Gilbert's conceptualization of self-compassion, Neff and McGehee (2010) found that attachment and family functioning were influential in the development of self-compassion. These findings indicate that if people lack secure attachment and are raised in dysfunctional households, they may have an inhibited ability to express self-compassion when faced with adverse or traumatic experiences. The findings from the current study are consistent with those from other research on ACEs and the development of self-compassion, suggesting that it is important to consider the role of early childhood trauma in the relationship between self-compassion and sexual revictimization.

Sexual Trauma

This study failed to detect a relationship between behavioral self-blame and early or recent USE. Self-blame is common among victims of sexual trauma and is well-documented in the literature (e.g., Miller et al., 2007). Although a relationship between behavioral self-blame and USE was not found, perpetrator blame and control over the recovery process were negatively associated with early USE. Specifically, as the severity and frequency of early USE increased, participants reported less perpetrator blame and less perceived control over the recovery process. These findings could be related to participants' beliefs about their role as a victim, meaning that those who have experienced sexual victimization may feel incapable of avoiding unwanted sexual advances or feel destined to being revictimized. Because attributions of blame and severity of sexual trauma are related to greater negative outcomes (e.g., Hall, French, &, Marteau; Ullman & Filipas, 2001; Ullman, 2000; Koss 1993), which in turn are associated with revictimization, future research is needed to examine the influence of these attributions on long-term outcomes.

Self-compassion

Behavioral self-blame was negatively associated with self-compassion, which is consistent with findings from the Close (2013) study. In an interesting contrast to the Close study, I found that self-compassion was also negatively associated with perpetrator blame. Specifically, when examining the relationship between perpetrator blame and self-

compassion, self-kindness and common humanity were negatively correlated with perpetrator blame. The negative association between perpetrator blame and the common humanity element of self-compassion may be explained by looking further at how self-compassion is conceptualized. Neff (2003a) states that self-compassion involves a nonjudgmental understating of personal failings (i.e., self-kindness) and the idea that behaviors are viewed as shared human fallibility (i.e., common humanity). Therefore, perpetrator blame attributions may run counter to the main tenants of self-compassion, even though blaming the perpetrator appears to be adaptive. In other words, people with more self-compassion may extend their sense of self-kindness and common humanity to their perpetrators, resulting in less blame overall.

Self-compassion was positively associated with perceived future likelihood, meaning that higher self-compassion was associated with a greater perceived ability to avoid a future USE. Self-compassion has been linked to better posttraumatic adjustment following a sexual assault (Close, 2013). Therefore, it can be theorized that individuals with higher self-compassion would experience better posttraumatic adjustment, and thus believe they are more able to avoid future assaults. While these results are preliminary, they do shed light on how attributions of blame and perceived control correspond with self-compassion. Past studies of self-compassion and sexual trauma have not explored associations between self-compassion, attributions of blame, and perceived control. The present findings bring to light important information on these relationships, and may prove beneficial in understanding the relationship between self-compassion and sexual revictimization.

Limitations and Future Directions

One of the main limitations for this study was the size of the sample. A test of statistical power indicated that a sample of 300 was needed to have sufficient power. Due to time and resource constraints, I needed to stop data collection before a sample of this size could be recruited. An adequately powered study may yield different findings. Moreover, in a sample including more male victims, gender differences may emerge.

Another limitation of this study is the cross-sectional design, which limits the ability to understand directionality between study variables. The cross-sectional design also does not allow for the establishment of cause and effect. Future research is needed to assess the temporality of events. For example, a longitudinal study would allow us to understand how USEs affect the development of self-compassion over time, and whether self-compassion or other variables predict the likelihood of future USEs.

Additionally, the present sample included only introduction to psychology students, limiting the generalizability of the findings. Studying a more high-risk group (e.g., incarcerated women, people in substance abuse treatment), or even a more diverse sample of college students, may yield different findings. Moreover, a more diverse sample would allow for greater exploration of the role of ethnic identity, socioeconomic status, educational attainment, sexual orientation, and other potentially relevant variables.

Finally, in future studies the precision of the time frames assigned to early USE, recent USE, and childhood trauma need to be examined more closely. Overlaps in the assigned time frames may introduce noise-related errors that influenced the statistical analysis.

Future research is needed to understand how early USE and self-compassion influence one another. It may also be beneficial to examine the association between self-compassion and USE longitudinally in order to generate a greater understanding of participants' victimization histories and how they relate to self-compassion.

It also would be important to explore the role of gender in attributions of blame and perceived future control. By exploring gender differences, more information can be gathered on how to prevent revictimization among people from different genders.

Future research also should consider differences between childhood and adolescent sexual trauma. It is likely that early childhood trauma impacts the development of self-compassion and emotion regulation in unique ways, and therefore may contribute to greater rates of revictimization in adolescence and adulthood than adolescent trauma.

Ultimately, the goal of the present line of research is to determine whether self-compassion training may be used to prevent revictimization among people with a history of USE. Because people with a history of sexual trauma are at significantly increased risk of experiencing another sexual trauma, interventions are needed to disrupt the cycle of violence. Self-compassion is a skill that can be learned, and therefore is one candidate for skills training that can be easily implemented to help protect people with a history of sexual victimization. Longitudinal research using experimental design (i.e., randomized controlled trial) is needed to examine the effect of self-compassion and potential for self-compassion training on preventing sexual revictimization.

CONCLUSION

Using both qualitative and quantitative methodology allowed for a greater understanding of the relationship between self-compassion and unwanted sexual experiences. The qualitative findings suggest that different facets of self-compassion represent important aspects of participants' narratives, and both help and hinder coping and healing. For example, blaming the perpetrator emerged in the interviews as a conceptual shift that took place during the healing process. While qualitative methods are not suitable for testing an association between self-compassion and revictimization, they allow for a better understanding of how participants perceive their unwanted sexual experiences. Although the quantitative study did not find a significant relationship between self-compassion and revictimization, self-compassion was associated with other variables previously shown to predict sexual assault and revictimization. Self-compassion still may prove to be a fruitful avenue of research for preventing revictimization. Self-compassion is a relatively new area of study, and only one published study has examined this skill in relation to sexual violence. More research is needed to understand ways to promote healing from sexual trauma and prevent revictimization.

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APPENDICES

APPENDIX A

INTERVIEW PROTOCOL

Before beginning the interview:

- **Informed consent discussion**

- **Have the participant complete the self-report measures:**
  - **Background form**
  - **PNAS**
  - **SES-short form-victimization**
  - **NIAAA question set**
  - **DMQ**

- **Emphasize:**
  - **You do not have to answer any question you don't want to answer**
  - **If you need a break at any time, please let me know**
  - **If you want to stop at any time, please let me know**
  - **Consent for audio recording**
  - **Confidentiality, who will have access to the data**

- **Make sure to explain:**
  - **We are going to be asking questions about your unwanted sexual experience.**
  - **Questions will ask about what let up to what followed your unwanted sexual experience.**
  - **Participants will be asked to think about what role alcohol and drugs play in unwanted sexual experiences and sexual assault.**
  - **We are just gathering information about your experience and at no point will we pass judgment or try to invalidate your experience.**
  - **At no point are we blaming survivors for what happened to them, we just want to better understand your experience with unwanted sexual contact.**
  - **If at any point you feel you cannot talk about this any longer, you can ask to move on to another topic or stop the interview entirely.**
  - **We will not pressure you into answering any questions you do not want to answer.**
  - **You are free give as much information as you are comfortable with and are not obligated to disclose any other information.**
  - **I am not a professional counselor, I am only gathering information. If you feel you need to speak to a counselor, I can refer you to a professional immediately.**
- **Ask if the respondent has concerns or questions**

- **Ask permission to begin**

Introduction

How are things going for you at MSU?

- *What are some of the best things about being here?*[1]
- *What are some of the biggest challenges?*
- *What have your relationships been like since starting at MSU?*

Consent for sex

How do you define consent for sex? What do you think is meant by this term?

- *When is consent for sex necessary?*
- *How do college students typically give consent for sex?*
- *Why is it important to get/give consent for sex?*
- *Whose responsibility is it to get/give consent for sex?*
- *How do you know when consent has been given?*
- *What gets in the way of consent?*

Unwanted Sexual Experiences

What is sexual assault?

- *What is the line that distinguishes sexual assault from other sexual acts?*
- *How do you know if an unwanted experience was an assault?*
- *How do college students talk about sexual assault?*

How has your experience affected your life?

- *What have you experienced personally?*
    - *What happened?*
    - *How old were you?*
    - *What event(s) led up to the experience?*
    - *What situations/contexts contributed to it?*
    - *What were the effects/consequences?*
    - *How did you feel about yourself after the experience?*

- *How have you been affected by other people's experiences?*
    - *What happened?*
    - *How old were you?*
    - *What event(s) led up to the experience?*
    - *What situations/contexts contributed to it?*
    - *What were the effects/consequences?*

[1] *The questions in italics below each main question are prompts. They are not meant to be asked of every participant, but are listed here to propel a conversation in case it stalls.*

- *How did you react to their decision to share their experience with you? What did you say/do?*
- *How did you feel about the person after you learned of the experience?*

Coping with Unwanted Sexual Experience

How did you cope with what happened to you?

- *Did you blame yourself? Why?*
- *Did you make any changes in your life following the experience?*

How did you cope with learning about others' experiences?

How do people generally cope with unwanted sexual experiences?

How should people cope?

Disclosure

Whom did you tell about your experience, if anyone?

- *Did you file a report with law enforcement?*
- *Did you file a report with the title IX office on campus?*
- *Did you report to a medical provider?*
- *The Voice Center?*
- *Other advocacy or crisis centers?*
- *Why did you choose this person?*
- *How did they react?*
- *Did you feel supported? Listened to? Believed?*
- *How did their reaction make you feel?*
- *What positive things resulted from talking about it?*
- *What negative things resulted from talking about it?*

If you did report it, what was your experience?

- *Did you feel supported? Listened to? Believed?*
- *How was reporting the assault helpful?*
- *How was reporting the assault harmful?*

Why do people choose to report or not report sexual assault?

Getting help/support

When should people seek help following a sexual assault?

Where is the best place to get help?

What are some of the good things about getting professional help?

What are some of the not-so-good things about getting professional help?

Why do some people get help whereas others do not?

Experiences with healing

What is your experience of healing from your experience?

How do people typically heal?

What helps?

What gets in the way?

In what ways did healing from your experience help you to grow or change?

How has surviving your experience influenced who you are as a person?

Risk factors

What puts people at risk for experiencing an unwanted sexual experience or assault?

- *Locations*
- *Situations*
- *Behaviors*
- *Contexts*

What things protect people?

- *Locations*
- *Situations*
- *Behaviors*
- *Contexts*

What role does alcohol play?

- *On the part of the victim?*
- *On the part of the perpetrator?*
- *How was alcohol involved in your experience?*

What role do other drugs play?

- *Marijuana?*
- *Prescription pills?*
- *Date rape drugs?*

- *Others?*

Resources

What resources are available to help victims at MSU?
- *Which of these is most helpful? Why?*
- *Which resources are not helpful? Why?*

Have you used any of these resources?
- *What was your experience with them?*

What support services are needed at MSU?

Prevention

What could be done to prevent sexual assault at MSU?

What would be some of the challenges?

How should MSU deal with these challenges?

Who should be the target of prevention efforts?

What advice would you give to people trying to prevent sexual assault?

Wrapping up

What was it like for you to talk about this with me?

Compared to when you arrived, do you feel better, the same, or worse?

Administer the PNAS again and the RRPQ

Referrals:
Give participants packet of referrals, offer assistance in contacting them

APPENDIX B

PRIMARY MEASURES

Sexual Experiences Survey-Short Form Version

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 click 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 boxes a and c. The past 12 months refers to the past year going back from today. Since age 14 refers to your life starting on your 14th birthday and stopping one year ago today. There are no right or wrong answers to these statements, please answer these questions as honestly as you can.

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:	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**
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.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

2.) Someone had oral sex with me or made me have oral sex with them without my consent by:	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**

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.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

If you are a male, check box and skip to item 4 ☐ **3.) A man put his penis into my vagina, or someone inserted fingers or objects without my consent by:**	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**
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.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

4.) A man put his penis into my butt, or someone inserted fingers or objects without my consent by:	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**
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.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

5.) Even though it didn't happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by:	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**
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.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

If you are male, check this box and skip to item 7 ☐ **6.) Even though it didn't happen, a man TRIED to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by:**	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**
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 didn't happen, a man TRIED to put his penis into my butt, or someone tried to stick in fingers or objects without my consent by:	**How many times in the past 12 months?** **0 1 2 3+**	**How many times since age 14?** **0 1 2 3+**
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.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

9. Did any of the experiences described in this survey happen to you 1 or more times?

Yes☐ No☐

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

☐Female only

☐Male only

☐Both females and males

☐I reported no experiences

10. Have you ever been raped? Yes☐ No ☐

Rape Attribution Questionnaire

Below are statements describing thoughts people often have about why an unwanted sexual experience occurred. Please click the box that indicates how often you have had each of the following thoughts in the past week for each of the questions. There are no right or wrong answers to these statements, please answer the questions as honestly as you can.

How often have you thought: I experienced an unwanted sexual experience because . . .

	Never 1	Rarely 2	Sometimes 3	Often 4	Very Often 5
1. I used poor judgment.	☐	☐	☐	☐	☐
2. I should have resisted more.	☐	☐	☐	☐	☐
3. I just put myself in a vulnerable situation.	☐	☐	☐	☐	☐
4. I should have been more cautious.	☐	☐	☐	☐	☐
5. I didn't do enough to protect myself.	☐	☐	☐	☐	☐
6. The perpetrator thought they could get away with it.	☐	☐	☐	☐	☐
7. The perpetrator wanted to feel power over someone.	☐	☐	☐	☐	☐
8. The perpetrator was sick.	☐	☐	☐	☐	☐
9. The perpetrator was angry at women.	☐	☐	☐	☐	☐
10. The perpetrator wanted to hurt someone.	☐	☐	☐	☐	☐

Below are questions about thoughts you may have had following an unwanted sexual experience. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement. People react to unwanted sexual experiences and sexual in many different ways.

	Strongly Disagree 1	Disagree Somewhat 2	Neither agree Nor disagree 3	Agree Somewhat 4	Strongly Agree 5
1. The unwanted sexual experience is going to affect me for a long time but there are things I can do to lessen its effects.	☐	☐	☐	☐	☐
2. I don't feel there is much I can do to help myself feel better.	☐	☐	☐	☐	☐
3. I know what I must do to help myself recover from the unwanted sexual experiences..	☐	☐	☐	☐	☐
4. I am confident that I can get over this if I work at it.	☐	☐	☐	☐	☐
5. I feel like the recovery process is in my control.	☐	☐	☐	☐	☐
6. I am afraid that I will be unwanted sexual experiences again.	☐	☐	☐	☐	☐
7. It is not very likely that I will	☐	☐	☐	☐	☐

have another unwanted sexual experience again.					
8. Now that I have experienced an unwanted sexual experience, the odds are it won't happen again.	☐	☐	☐	☐	☐
9. I feel pretty sure that I won't experience an unwanted sexual experience again.	☐	☐	☐	☐	☐
10. No matter what steps I take, I could experience another unwanted sexual experience again.	☐	☐	☐	☐	☐
11. I have changed certain behaviors to try to avoid having another unwanted sexual experience again.	☐	☐	☐	☐	☐
12. Since the unwanted sexual experience, I try not to put myself in potentially dangerous situations.	☐	☐	☐	☐	☐
13. I do not take any special precautions since the unwanted sexual experience occurred.	☐	☐	☐	☐	☐
14. I have taken steps to protect myself since the	☐	☐	☐	☐	☐

unwanted sexual experience.					
15. I have made a change in my living situation since the unwanted sexual experience.	☐	☐	☐	☐	☐

Self-Compassion Scale

	Almost Never 1	2	3	4	Almost Always 5
1. I'm disapproving and judgmental about my own flaws and inadequacies.	☐	☐	☐	☐	☐
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.	☐	☐	☐	☐	☐
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.	☐	☐	☐	☐	☐
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	☐	☐	☐	☐	☐
5. I try to be loving towards	☐	☐	☐	☐	☐

myself when I'm feeling emotional pain.					
6. When I fail at something important to me I become consumed by feelings of inadequacy.	☐	☐	☐	☐	☐
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.	☐	☐	☐	☐	☐
8. When times are really difficult, I tend to be tough on myself.	☐	☐	☐	☐	☐
9. When something upsets me I try to keep my emotions in balance.	☐	☐	☐	☐	☐
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	☐	☐	☐	☐	☐
11. I'm intolerant and impatient towards those aspects of my personality I don't like.	☐	☐	☐	☐	☐
12. When I'm going through a very hard time, I give myself the caring and	☐	☐	☐	☐	☐

tenderness I need.					
13. When I'm feeling down, I tend to feel like most other people are probably happier than am.	☐	☐	☐	☐	☐
14. When something painful happens I try to take a balanced view of the situation.	☐	☐	☐	☐	☐
15. I try to see my failings as part of the human condition.	☐	☐	☐	☐	☐
16. When I see aspects of myself that I don't like, I get down on myself.	☐	☐	☐	☐	☐
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. I'm kind to myself when I'm experiencing suffering.	☐	☐	☐	☐	☐
20. When something upsets me I get carried away with my feelings.	☐	☐	☐	☐	☐
21. I can be a bit cold-hearted	☐	☐	☐	☐	☐

towards myself when I'm experiencing suffering.					
22. When I'm feeling down I try to approach my feelings with curiosity and openness.	☐	☐	☐	☐	☐
23. I'm tolerant of my own flaws and inadequacies.	☐	☐	☐	☐	☐
24. When something painful happens I tend to blow the incident out of proportion.	☐	☐	☐	☐	☐
25. When I fail at something that's important to me, I tend to feel alone in my failure.	☐	☐	☐	☐	☐
26. I try to be understanding and patient towards those aspects of my personality I don't like.	☐	☐	☐	☐	☐