Perspectives on Self-Compassion From Adult Female Survivors of Sexual Abuse and the Counselors Who Work With Them

Lisa McLean, Matthew Bambling, and Stanley R. Steindl

Abstract
While compassion-focused therapy (CFT) holds significant promise as an intervention for survivors of sexual abuse, a history of abuse can uniquely impact an individual's capacity to cultivate compassion and may generate a fear of compassion. Understanding the specific perspectives of sexual abuse survivors may inform the application of CFT-based interventions with this client group. Two separate focus groups were established for this purpose, one with adult female survivors of sexual abuse \((n = 7)\) and another with sexual abuse counselors \((n = 7)\). Transcripts were analyzed according to a consensual qualitative research design. Analysis of the survivor focus group identified two core domains, Barriers to Compassion, including poor relational templates, negative perception of self, low coping self-efficacy, and fears, resistance, and misperceptions regarding self-compassion, and Factors Supporting Compassion, including support from others, compassion for others, high coping self-efficacy, motivation and hope for change, and timing and readiness for change. Analysis of the counselor focus group revealed three domains, Therapeutic Factors to Support Compassion, including...
counselor authenticity and modeling, gradual introduction with consideration to individual needs, acknowledgment of suffering and offering an alternative perspective; Factors Affecting Client Readiness and Capacity, including shame, self-blame, and negative sense of self, response from others, and difficulty in changing self-critical habits; and Anticipated Outcomes, including providing a hope and recovery focus, offering an alternative perspective and coping strategy, and restoring trust. Findings are discussed in relation to clinical implications and relevance to a CFT model of intervention.

Keywords
sexual abuse, child abuse, treatment/intervention, history of child abuse, PTSD, anything related to sexual assault, sexual assault

Recent research has shown promising results for compassion-focused therapy (CFT) as a potential treatment option for a wide range of mental health concerns (Kirby, 2017; Leaviss & Uttley, 2015) and in response to trauma (Au et al., 2017; Beaumont, Galpin, & Jenkins, 2012; Lawrence & Lee, 2014). However, it has not been specifically tested as an intervention for adult survivors of childhood sexual abuse. Nevertheless, there is considerable theoretical synergy between the underlying principles of CFT and many of the common impacts and treatment considerations for this client group (McLean, Steindl, & Bambling, 2017), and is worthy of further exploration.

CFT was originally developed by Gilbert (2009a) for clients with high levels of shame and self-criticism, which he noted often occurred in the context of abuse histories (Gilbert, 2009b). This observation is supported empirically, with shame identified as a contributing factor to increased self-criticism in trauma survivors (Harman & Lee, 2010) and posttrauma symptomatology for survivors of sexual abuse (Badour, Resnick, & Kilpatrick, 2017; Whiffen & Macintosh, 2005). A CFT treatment approach aims to target shame and self-criticism via the cultivation of compassion to promote self-soothing, nonjudgmental acceptance, and positive affiliation (Gilbert & Procter, 2006).

CFT defines compassion as “the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it” (Gilbert, 2014, p. 19). Consistent with this definition, Gilbert (2015) suggests there are two psychologies required to understand and respond with compassion. The first relates to the ability to acknowledge and engage with suffering, and requires skills of sensitivity, sympathy, distress tolerance, empathy, non-judgment, and care/motivation for well-being. The second psychology relates to the specific skills required to know how to alleviate and prevent
identified suffering, which include compassionate thinking and reasoning, compassionate behavior, compassionate feeling, compassionate imagery, mindful attention, and sensory focusing.

An ability to cultivate compassion is associated with reduced symptoms of trauma-related shame (Au et al., 2017), depression, anxiety, psychological distress, and enhanced well-being (see Leaviss & Uttley, 2015; Kirby, Tellegen, & Steindl, 2017; MacBeth & Gumley, 2012 for meta-analyses). However, cultivating compassion can also generate significant fears, blocks, and resistance in some clients (Gilbert, McEwan, Matos, & Rivis, 2011). For example, receiving compassion from others may elicit a fear response if there have been experiences of traumatic shame and a lack of safeness and warmth in affiliative relationships during childhood (Gilbert, 2010; Matos, Duarte, & Pinto-Gouveia, 2017). Fears of compassion for self and from others is associated with elevated self-criticism (Gilbert et al., 2011), and fear of self-compassion is associated with increased posttraumatic stress disorder (PTSD) symptom severity for female survivors of child maltreatment (Boykin et al., 2018) and childhood sexual abuse specifically (Miron, Seligowski, Boykin, & Orcutt, 2016).

Given the potential complexity in achieving beneficial outcomes without activating or exacerbating adverse reactions for survivors of sexual abuse, it may be useful to better understand the specific needs and considerations for this client group prior to developing and implementing a compassion-focused treatment program. Two focus group discussions were, therefore, convened for this purpose—one with survivors of childhood sexual abuse, and another with counselors who work with them. The aim of this study was to elicit the perceptions and experience of adult female survivors of childhood sexual abuse in relation to self-compassion, utilizing a consensual qualitative research (CQR) design to inform the development of a CFT-based intervention for this client group. The study sought to learn from the lived experience and shared wisdom from survivors themselves, and counselors who work with them, to identify and understand how a treatment program based on a CFT framework could be adapted to most appropriately support the cultivation of self-compassion for survivors of childhood sexual abuse.

The decision to conduct a focus group discussion with sexual assault counselors was to offer greater representation, albeit indirectly, of client needs and experience. Experienced counselors working in specialized sexual assault services across a diverse geographic region and with clients from a range of backgrounds can provide exponentially richer information than two separate survivor focus groups alone. The decision to focus only on female survivors in both the focus group discussions and intended treatment program is not to minimize the experience of male survivors of sexual abuse nor
suggest that the cultivation of self-compassion may not be similarly beneficial for them. Instead, the decision is in recognition of the different therapeutic considerations for male and female survivors (Cashmore & Shackel, 2014; Ullman & Filipas, 2005), the intended single-gendered nature of the intervention to be developed, and the practical need for containment in relation to the scope of the study.

Method

Focus Group 1—Sexual Abuse Survivors

Participants and process. Participants were adult female sexual abuse survivors recruited by counselors from a local sexual assault service, in south-east Queensland, Australia, based on purposive (nonrandom) sampling to ensure appropriate group selection. Inclusion criteria required participants to be female, at least 18 years of age, and to have experienced at least one self-reported incident of childhood sexual abuse. Consistent with the aims and design of the study, inclusion criteria were intentionally broad to elicit information from a representative sample of women accessing a sexual assault service without prior assumptions relating to the nature of their experience or presenting concerns. Participants were excluded if they had an acute (within the past 3 months) sexual assault experience, current suicidality, untreated psychosis, or active substance dependence to minimize the likelihood of emotional distress and symptom exacerbation resulting from the group discussion. In addition, participants who already had considerable exposure to CFT were excluded due to the potential for their existing knowledge and experience to dominate discussion, and/or deter other participants from sharing. Participation was entirely voluntary, and no incentives were used in the recruitment process.

A total of eight survivors of sexual abuse consented to participate. One client was later excluded due to an acute mental health issue, which occurred prior to the scheduled discussion. The seven female participants were Caucasian and aged between 32 and 61 years of age, with a mean age of 50 years. All had experienced childhood sexual abuse, and four had experienced abuse in both childhood and as adults. Five participants met in a group context and two participated in an individual context, resulting in a mixed qualitative design. A combined qualitative approach can be beneficial for pragmatic reasons but may also offer a more comprehensive understanding of the phenomenon being investigated (Lambert & Loiselle, 2008).

The group and individual discussions were facilitated by the first author and were audio-recorded. Participants were provided with a brief orientation
to the group approach (a modified version was used for the individual interviews), with an emphasis on privacy and confidentiality, and that there were no “right” or “wrong” answers as all input was valued. Consistent with the qualitative research design, the facilitator was neutral, did not lead or influence the discussion, and allowed discussion of each question to reach its natural conclusion, while managing time and equity of participation.

The questions were initially broad (e.g., “What comes to mind when you hear the phrase self-compassion?”), moving to focused questions as the discussion progressed (e.g., “How do you think experiencing a trauma like sexual assault affects self-compassion?”). Prompts were developed for each question to assist in generating discussion if needed. The enquiry-based nature of the process meant that information was received rather than provided. However, to ensure a shared understanding of the core concept being investigated, a definition and explanation of compassion according to the CFT framework was provided to participants after the first question (which asked for participants’ own understanding and definition). The definition provided was, “the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it” (Gilbert, 2014, p. 19).

**Focus Group 2—Sexual Abuse Counselors**

*Participants and process.* Participants were sexual assault counselors recruited via email correspondence to the Queensland Sexual Assault Network (QSAN). Interested participants were provided with written information about the study and invited to seek any further information or clarification as required, prior to returning the consent form. Ideally, counselors with more than 5 years’ experience working with survivors of sexual abuse were sought. Participation was entirely voluntary, and no incentives were used to facilitate recruitment.

A total of seven counselors from six sexual assault services participated in the focus group discussion facilitated by the first author at a central location. Five participants were from services within South-East Queensland, Australia, and participated in person. Two participants from a remote service participated via Skype. Six out of the seven participants had more than 5 years’ experience, with one participant having more than 5 years’ experience in mental health services (including work with survivors) moving to a specialized sexual assault service within the previous 3 months. Two participants worked primarily with young women (up to 25 years), and one participant worked exclusively with women who had intellectual disabilities. The process for the discussion was consistent with the one used for the survivor focus group, and the questions asked mirrored those asked of the survivors as much as possible.
Ethics approval was obtained for both focus groups by Bellberry Human Research Ethics Committee.

**Data Analysis**

A CQR design (Hill, Thompson, & Williams, 1997) was used to analyze the data, which consisted of de-identified verbatim transcripts of all focus group discussions, prepared by the first author, and checked for accuracy by another member of the data analysis team. The CQR approach is designed for enquiry into “previously unexplored topics” (Hill et al., 1997, p. 518) and, therefore, applicable to the present study. CQR identifies common themes from qualitative data, collected via responses to focused, open-ended questions on a particular topic. CQR requires researchers to remain open to whatever emerges from the data, rather than seek data based on preconceived expectations and theoretical hypotheses.

In an effort to reduce bias and increase validity, CQR recommends the involvement of a primary team of three to five researchers who engage in a systematic process of analyzing the data, and democratically reaching consensus on output. An auditor who is separate to the primary team checks the consensus output as a further validity measure. In the present study, the primary team consisted of three members. Two members (one of whom was the first author) reached consensus in the first instance, and the third team member (third author for the counselor group analysis) provided an initial audit of the analyzed data. Once consensus had been reached at this level, recommended outcomes were forwarded to a fourth person (the second author) who provided a final audit. The consensual nature of this process ensures the highest level of inter-rater reliability. All team members had qualifications and extensive experience in either psychology or social work and familiarized themselves with the CQR process (as outlined by Hill et al., 2005; Hill et al., 1997).

Consistent with the CQR process, the first author noted any potential biases prior to facilitation of the focus group discussions. Hill et al. (1997) define biases as “personal issues that make it difficult for researchers to respond objectively to the data” (p. 539). Awareness of these biases in advance of facilitation and analysis, ongoing reflection on their potential influence throughout the process, and transparency with other team members offer another form of accountability and rigor.

Output from the CQR analysis emerges from the identification of broad domains (themes), a summary of core ideas for each participant, outlining how their comments reflect the broad domains, which are then cross-analyzed to determine categories within each domain across participants. All comments made during the discussion are represented by a domain and category.
Results

Domains, categories, frequencies, and indicative quotes for both survivor and counselor focus groups are summarized in Tables 1 and 2, respectively. Each category (with a minimum of three out of seven participant responses) will be briefly explained, followed by a discussion on the clinical implications of these findings.

Survivor Focus Group

Domain 1: Barriers to compassion. Participants discussed factors that may inhibit understanding, openness, and capacity for self-compassion, including having poor relational templates for compassion, negative self-perception, low coping self-efficacy, and fears, resistance, and misperceptions regarding compassion.

Poor relational templates

*I never experienced affection, love, so I didn’t know how to love, I didn’t know how to give affection.*

All but one participant commented on the lack of compassion and support they had received from others throughout their life. Participants discussed experiencing abuse from people they trusted and/or relied on for their attachment and safety needs, and the minimizing and/or judgmental response they received upon disclosure. More than half the participants had experienced a pattern of revictimization throughout their life, further reinforcing threat-focused relational templates.

Negative perception of self

*You just shut down again, and . . . think I’m obviously a bad person or they wouldn’t have done it.*

All participants made comments reflecting low self-worth and perceptions of nondeserving. This finding is consistent with a qualitative analysis conducted by Lawrence and Lee (2014), which identified the theme of “I don’t deserve self-compassion” as part of initial reactions for participants completing a CFT for trauma course. In the present study, several participants discussed the internalized negative messages they received from others throughout their lives as a contributing factor to the negative beliefs they now had about themselves.
Table 1. Domain, Category, Frequency, and Indicative Quotes for Survivor Focus Group.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories and Frequencies$^a$</th>
<th>Indicative Quotes</th>
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<tbody>
<tr>
<td>Barriers to Compassion</td>
<td>Poor relational templates—</td>
<td>I don’t know, but for me I never experienced affection, love, so I didn’t know how to love, I didn’t know how to give affection; Every perpetrator has been somebody I’ve trusted, and it’s not just one or two, it’s been quite a few; I’ve just come out of a domestic violence relationship of ten years so I’m still going through stuff and dealing with that.</td>
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<td>General (6)</td>
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<td>Negative perception of self—</td>
<td>I go through some days where I want to starve myself because I don’t feel like I deserve to eat; I don’t ever put myself first . . . I think it’s just that I don’t feel as though I deserve to be put first; You really can’t give yourself love and nurturing if you have no sense of yourself; For me, sexual abuse, yes, it’s hard, but it’s actually all the embedded shame beliefs of not deserving; You (I) think I’m obviously a bad person or they wouldn’t have done it.</td>
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<td>General (7)</td>
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<td>Low coping self-efficacy—</td>
<td>I had extremely bad coping mechanisms, I’ve had a lot of suicide attempts; I was on (a) heavy drugs, drinking spiral; I was just going to… numb it however I could, whatever that meant.</td>
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<td></td>
<td>General (6)</td>
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<td>Fears/resistance/misperceptions regarding self-compassion—</td>
<td>The fear is that I’d be happy. Because in my head, after everything that’s been said to me, happy’s not good; I was scared that the new comfort zone wasn’t going to be comfortable, it was going to be new, which is foreign to me and not comfortable; That was how I was raised, you know, that nothing good can happen to you; It sort of represents self-pity somehow, and I don’t want to be a self-pitying person.</td>
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<td>Typical (4)</td>
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<td>Factors Supporting Compassion</td>
<td>Support from others—</td>
<td>It’s in counseling, it’s in healing that you find yourself to value; My support has always been friends, not family . . . I’ve always had really good friends that have been there for me; The only way you’re going to get through it and to work (it) out and to heal is by people that you care about to know.</td>
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<td>General (7)</td>
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<th>Indicative Quotes</th>
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<td>Compassion for others—</td>
<td>General (6)</td>
<td>Compassion for other people, I mean . . . I’ll do anything . . . whoever I can help, because that is the only thing in a way that keeps me going; You have that compassion, because you don’t want anybody going through what you did; Comforting him (son) and talking him through things . . . and it came around to a bit like taking my own advice, that’s how I kind of tapped into self-compassion.</td>
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<td>High coping self-efficacy—</td>
<td>General (6)</td>
<td>It’s not that I never feel uncomfortable, it’s that I’m okay with feeling uncomfortable, and I don’t feel alone, because I’m there; You get the opportunity to be proud of what you’ve done; It’s not just letting that go, but when I really start to get more in touch with who I am, there’s actually like an excitement for life, and it’s sort of starting to be a joy, and a hope, and wanting to fully live my life; When an adult self and a child self can meet, then you know you can get a sense of yourself, and that’s where the nurturing can happen, and you can give yourself nurturing, compassion, love.</td>
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<td>Motivation/hope for change</td>
<td>General (6)</td>
<td>I’m trying to handle things for my son because I want to be the best person I can be for me so I can be for him; that’s the biggest thing I think, is breaking those cycles, and not just for ourselves, but for the children. The motivation for me has just been almost like this incredible determination that I was going to overcome this now, I was going to really end up thriving; I didn’t want to be crouched in that tiny little box, I was too big for the box, and I didn’t fit anymore; There’s hope for something new and better.</td>
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<td>Timing/readiness for change</td>
<td>Variant (3)</td>
<td>Baby steps I think is going to be the best help, it’s hard to learn something starting half way up the ladder; It’s only when you’re ready. Because your mind is like that, it will protect you; Eventually you’ll get there, and it will get quicker and quicker.</td>
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<sup>a</sup>General = all or all but one case; Typical = at least half; Variant = at least two or three; the number of participants who endorsed each category is provided in brackets.
Table 2. Domain, Category, Frequency, and Indicative Quotes for Counselor Focus Group.

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<tr>
<td>Therapeutic Factors to Support Compassion</td>
<td>Counselor authenticity and modeling—General (7)</td>
<td>I like that idea that the modeling stuff we're showing in the room, and the examples we're giving of self-compassion . . . it's simple kind of stuff, but it's so powerful; I don't think I can actually practice or help others in this respect until I get it down pat myself, and I'm becoming quite aware that it's a huge learning curve; My core inner belief creates the basis of the sessions I have with my clients.</td>
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<td>Gradual introduction; individually tailored—General (6)</td>
<td>Some clients you have to do it very, very slowly because you know they might have learnt to live that way for years and years and it's almost like taking their very way of living out from under them; Plant the seed of . . . looking after yourself . . . but doing that gently, and I guess what I'd refer to as realistically; really getting to know that person so you're not just saying &quot;do this,&quot; really taking the time; How can we best support you (client) in what's the most concern that you have, what can we address, and also acknowledging the things that we can't address sometimes.</td>
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<td>Acknowledge suffering and offer alternative perspective—Variant (2)</td>
<td>Naming shame is so important . . . and then we might explore some ways of being more compassionate and seeing it a different way; If you don't recognize it, you can't acknowledge it, and if you can't do that, you can't . . . unlearn it, reframe it, or address it.</td>
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<td>Factors Affecting Client Readiness and Capacity</td>
<td>Shame, self-blame, and negative sense of self—Typical (5)</td>
<td>To process the trauma, they (client) find a reason for it that's plausible, and the easiest way to find a reason for it is to look at yourself and blame yourself; One recurring theme that I've often found over the years is that shame, is that guilt, that self-loathing, or the critical voice going on, seems to be inherent in trauma inflicted from sexual violence; Often we're not just talking about sexual assault, there's a lot of other abuse within that, that silence, that secrecy sense of it . . . that blame and shame and how they see themselves . . . or that making sense of why it happened to me.</td>
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<td>Response from others—Typical (5)</td>
<td>It's compassion at every level, so it's the first person they told, how the police respond, it's how the doctor responds . . . that then informs I think a little bit about how they're going to feel I think, about their own self-compassion or shame; Very much the first response is usually very, very strong, so if they're not believed or threatened . . . it's going to set a whole new thing in place you have to work with before you can do anything else; In every level of our society there's messages that sexual assault isn't a real pain . . . and then (its) so easy for self-compassion to be the thing that you let go of or don't hold onto because you get messages from so many different areas.</td>
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<th>Domains</th>
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<td>Difficult to acknowledge and let go of self-criticism—Typical (4)</td>
<td>It’s the unknown and letting go of a whole way of living; There seems to be in the families I’ve worked with, a fair bit of, look it happened to me, you’ve just got to deal with it, it’s just an accepted culture . . . it’s a big thing for them to step away from that; Instead of something over here that happens . . . it’s us (clients) that’s owning that label a little too much, so letting go of that to be up here with the self-compassion is scary.</td>
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<td>Anticipated Outcomes Provides hope and a focus on recovery—Typical (5)</td>
<td>It (self-compassion) creates the basis of everything they can rebuild for themselves; I think it moves us into recovery, this model or approach, as opposed to staying with the trauma; It’s hopeful, it’s empowering . . . with self-compassion it changes to a hopeful, more positive, more empowered kind of place to be.</td>
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<td>Offers alternative perspective and coping strategy—General (6)</td>
<td>When we talk about shame and self-blame, (self-compassion) is an antidote to that; If they (clients) have had strategies which would be deemed unhelpful . . . they can see they have choices . . . and they have the ability to control and make informed choices; I love the idea of the motivational bit being built into the definition because it’s you know, I can make a choice, I can lead this in the direction that I want it to go.</td>
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<td>Restores trust—Variant (2)</td>
<td>It (self-compassion) would build trust; Clients we see have a guarded sense of self, . . . and trusting anybody . . . and seeing the world as a dangerous place (so) if you have that inner self-compassion it will allow them to open up and have those positive relationships.</td>
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Low coping self-efficacy

I wasn’t even always aware when I was triggered or when I was hurt, or when a trauma experience or related feelings were coming up for me. I was just going to . . . numb it however I could, whatever that meant.

In the context of a trauma experience, self-efficacy relates to a belief in one’s ability to manage the challenges and impacts resulting from the experience (Benight & Bandura, 2004). The motivation to acknowledge and engage with distress, even for the purpose of developing helpful strategies to alleviate it, may, therefore, be limited if clients believe they do not have the required competencies to tolerate and manage trauma symptoms. The majority of participants in the present study discussed their reliance on avoidant coping.
strategies to manage their trauma symptoms, including substance abuse, suicide attempts, and numbing.

**Fears/resistance/misperceptions regarding self-compassion**

*When you say self-compassion, I get uncomfortable because of that feeling that it's too much . . . that it represents self-pity somehow, and I don't want to be a self-pitying person.*

For survivors of sexual abuse, positive emotions can be frightening, as it can signal a relaxation of the threat system, increasing perceptions of vulnerability and danger (Gilbert et al., 2011). Two participants specifically referred to a mistrust of happiness, and another participant discussed a fear of the unknown. In addition, there are a number of common misperceptions, or myths, in relation to self-compassion, specifically, that it is associated with self-pity, narcissism, selfishness, weakness, and complacency (Neff, 2015). One participant believed self-compassion meant self-pity or self-indulgence and, therefore, held a negative view about self-compassion. This participant also suggested that self-compassion might detract from her focus on her children’s well-being.

**Domain 2: Factors supporting compassion.** Comments made by participants in relation to this domain indicated the importance of an openness and capacity for the cultivation of compassion and/or a foundation on which to build. It includes positive experiences of receiving support and compassion from others; an ability to offer compassion to others; an ability to tolerate personal distress, motivation and hope for positive change; and readiness for this change to occur.

**Support from others**

*I noticed as a child that the only people I ever felt any love from was strangers. So, I’ve always had really good friends that have been there for me.*

All participants discussed the value of receiving support from others. While the majority of comments related to support received from counselors and other professionals, this is expected given participants were recruited from a sexual assault counseling service. Support from others may offer a valuable foundation on which to understand the benefits of this response, provide a new relational template that associates compassion with safety and contentment as opposed to threat, and facilitate greater openness to further develop this capacity with self and others.
Compassion for others

With (my son) struggling so much in his life . . . compassion’s just what he needs, and so . . . comforting him and talking him through things . . . and it came around to a bit like taking my own advice, that’s how I kind of tapped into self-compassion.

In a CFT approach, compassion is considered to flow in three directions—compassion offered from self to others, compassion received from others to self, and self-compassion (Gilbert & Choden, 2014). Each flow can offer an experience of soothing and connection, which are key factors in threat regulation and providing a sense of emotional safety and well-being (Gilbert, 2014). Regardless of their level of comfort (or discomfort) with self-compassion, all but one participant referred to their motivation and priority for offering compassion to others. Activating support-giving schemas toward others has been shown to increase self-compassion (Breines & Chen, 2013) and may, therefore, provide a foundation on which to enhance self-to-self relating.

High coping self-efficacy

It’s not that I never feel uncomfortable, it’s that I’m okay with feeling uncomfortable, and I don’t feel alone, because I’m there.

While low coping self-efficacy was identified as a potential barrier to compassion, all but one participant also made reference to the importance of their perceived progress in learning new and more adaptive ways of responding to their distress. This awareness can support self-efficacy and enhance the motivation to cope with suffering without engaging in maladaptive avoidance strategies.

Motivation/hope for change

And that’s the biggest thing I think, is breaking those cycles, and not just for ourselves, but for the children.

Several participants identified their children as facilitating their compassion motivation. They highlighted the inter-generational impact of their abuse and wanting to experience and model a new way of responding to themselves and the challenges they were experiencing. The ineffectiveness of current maladaptive coping strategies was identified as another facilitator for compassion motivation. Three participants specifically discussed feeling a sense of hope in relation to positive change, including one participant who said that
self-compassion would be positive for healing. Snyder (2002) suggests that people with high levels of hope demonstrate greater decisiveness, agency, determination, and motivation to achieve their goals, compared with people with reduced hope.

**Timing/readiness for change**

*It’s not something you’re going to accept straight up, it’s something you’ve got to work to do. And just the baby steps I think is going to be the best help. It’s hard to learn something starting half way up the ladder.*

Given the significant fears, blocks, and resistances that can be associated with cultivating compassion, particularly for this client group (Miron et al., 2016), adequate time and opportunity are needed to address these concerns (Lawrence & Lee, 2014). Three participants in the present study specifically identified the need for a gradual and appropriately paced process. One participant reflected on advice received from a previous counselor that change would only occur when she was ready. Another participant recognized that with practice, the benefits will be experienced “quicker and quicker,” and another understood that there may be some initial resistance, but with “baby steps,” learning could occur.

**Counselor Focus Group**

**Domain 1: Therapeutic factors to support compassion.** Participants in the counselor focus group considered that the therapist or therapeutic process had an important role in supporting compassion cultivation. This included authentically offering compassion to both clients and themselves, and the need to be considerate of client readiness and individual needs and concerns. Acknowledging suffering and offering an alternative perspective also emerged as a factor (see Table 2); however, it will not be discussed in further detail as it was a variant category (only identified by two participants).

**Counselor authenticity and modeling**

*I don’t think I can actually practice or help others in this respect until I get it down pat myself, and I’m becoming quite aware that it’s a huge learning curve.*

Counselors reflected on the importance of offering compassion both explicitly and implicitly. They recognized how they can offer a message of care and interest in alleviating distress from the moment of first contact. They
acknowledged incidental actions such as making a cup of tea or providing choice in terms of where to sit in the counseling space, as processes that may help clients feel valued. A counselor’s capacity to respond to the distress being experienced by clients with compassion and understanding may provide the foundation for clients to relate similarly with themselves (Gilbert & Procter, 2006; Lawrence & Lee, 2014).

**Gradual introduction; individually tailored**

Some clients you have to do it very, very slowly because you know they might have learned to live that way for years and years, and it’s almost like taking their very way of living out from under them.

Consistent with the “timing/readiness” category, which emerged from the survivor group, counselors understood the need to introduce compassion as an alternative coping strategy gradually, and with consideration to individual client’s specific needs and concerns. Some counselors commented on the need to clarify how compassion was uniquely defined and expressed for each client. The need for specific considerations in relation to male clients, indigenous clients, and people with intellectual disabilities was also noted.

**Domain 2: Factors Affecting Client Readiness and Capacity.** Counselors suggested that various client-related factors may affect their capacity for cultivating compassion, including the client’s assessment and perception of themselves, the response they have received from others in relation to their abuse experience, and the challenge of letting go of familiar, albeit maladaptive, coping behaviors.

**Shame, self-blame, and negative sense of self**

One recurring theme that I’ve often found over the years is that shame, is that guilt, that self-loathing, or the critical voice going on, seems to be inherent in trauma inflicted from sexual violence.

Counselors’ comments reinforced the “negative perception of self” category, which emerged from the survivor discussions. Counselors discussed the development of shame, self-blame, and low self-worth as partially resulting from client’s efforts to make sense of their sexual abuse experience. For example, one counselor reflected on a young woman she had been working with who stated that it was too hard for her to believe someone could be “that cruel,” and it made more sense for her to believe that there was something wrong with her instead.
Response from others

It’s compassion at every level, so it’s the first person they told, how the police respond, it’s how the doctor responds. It’s that level of compassion at every level that then informs I think a little bit about how they’re going to feel I think, about their own self-compassion or shame or whatever it is.

Counselors identified the influence of other people’s responses in terms of how survivors perceived themselves and their experience of abuse. They discussed this impact on both an inter-personal and societal level, whereby experiences of sexual abuse are invalidated and minimized, especially in comparison with other forms of trauma, and/or the victim is held responsible in some way. One counselor suggested that even outside of the context of sexual abuse, there is a negative societal connotation with the idea of “loving yourself,” implying that it is ego-based, which may reinforce misperceptions of self-compassion.

Difficult to acknowledge distress and let go of self-criticism

It’s the unknown and letting go of a whole way of living.

This category reinforces the need for appropriate timing and pacing for cultivating compassion, and an understanding of the fears, blocks, and resistances that may be present for many clients. It also mirrors the coping self-efficacy categories, which emerged as either a barrier or supporting factor from the survivor focus group. That is, counselors recognized that clients may be limited in their willingness and capacity to acknowledge distress as the first step toward cultivating compassion, and let go of familiar, albeit maladaptive coping strategies, as it may be perceived as too overwhelming for them.

Domain 3: Anticipated outcomes. Counselors reported potential benefits for clients of increased self-compassion, including that compassion offers hope- and recovery-oriented language and approach, and a positive and adaptive alternative coping strategy. Restoring trust also emerged as a variant category (see Table 2), so it will not be discussed in further detail.

Provides hope and a focus on recovery

Just coming from that lens of self-compassion is just the hopefulness of it, you know . . . it’s hopeful, it’s empowering . . . it just feels like with self-compassion it changes to a hopeful, more positive, more empowered kind of place to be.
Hope has been identified as an important facilitating factor in the therapeutic process (Snyder, Michael, & Cheavens, 1999), and counselors suggested that compassion could make a valuable contribution to this process. One counselor commented that compassion could “create the basis of everything they can rebuild for themselves,” another stated it would provide hope, and another that it would “reduce distress generally.” Two counselors made reference to the capacity of self-compassion to facilitate a focus on recovery rather than “staying with the trauma.”

_**An alternative perspective and coping strategy**_

*If they have had strategies which would be deemed unhelpful . . . it opens up, they can see they have choices, they’re in control and they have the ability to control and make informed choices.*

Compassion was identified as a potential antidote to shame and self-blame, and a way to help clients develop an alternative perspective in relation to their experience of abuse. For example, reference was made to the difficulty survivors can have in separating their sense of self from their abuse experience. According to the counselors, self-compassion may allow clients to recognize that their abuse experience need not define them, and that they have choice and control in relation to their life outcomes. One counselor also commented that it may help clients to remain engaged in the therapeutic process by taking a compassionate response to relapse rather than feeling shamed by their perceived failure. This is consistent with the abstinence violation effect (Larimer, Palmer, & Marlatt, 1999), which suggests that the emotional response and attributions made following a lapse in intended behavior change influences whether it progresses to a relapse or a re-commitment to change efforts.

**Discussion**

This study used focus groups and individual interviews to understand the perceptions of self-compassion from sexual abuse survivors and the counselors who work with them to inform the development of a CFT-based treatment program for this client group. While survivor and counselor discussions were analyzed separately, common themes emerged relating to survivor, counselor, or the therapeutic processes that can either facilitate or inhibit the cultivation of compassion.

Barriers to compassion identified across groups included negative response from others and limited/negative experiences of receiving compassion, low self-worth, and internalized feelings of shame and self-blame; fears
and resistances to compassion; and a perceived inability to acknowledge and cope with personal distress. Supporting factors across groups included positive support from others (including counselors), a capacity to offer compassion to others, openness to alternative coping strategies, motivation and readiness for change, and a belief in their capacity to do so.

There are a number of clinical implications relating to these outcomes. First, the nature of the relationship and response received from others can influence capacity for self-compassion. Participants in the survivor focus group discussed the negative and invalidating messages they had received from others throughout their life and its impact on their self-worth. However, they also identified the valuable role of others, including counselors, who had provided a positive relational experience. Counselors also acknowledged that the response received from others following sexual abuse can set the tone for how survivors respond to themselves. This observation is supported by research that shows that invalidation of trauma and negative social reactions in response to sexual abuse can contribute to self-blame and increased psychopathology (Hong & Lishner, 2016; Ullman, Townsend, Filipas, & Starzynski, 2007) whereas positive social support can serve as a protective factor (Maheux & Price, 2016; Schumm, Briggs-Phillips, & Hobfoll, 2006). Counselors, therefore, have a valuable opportunity to offer positive support and create new relational templates, which increase clients’ openness to receiving compassion from others, as well as themselves (Gilbert & Procter, 2006).

Second, it is important for counselors to understand the impact of previous relational experiences and prepare for potential resistance and reactivity against their care-giving efforts. It may take some time for clients to trust this response and feel safe enough to allow themselves to receive it. Consistent with this consideration, timing, readiness, gradual introduction, and awareness of individual needs were identified as important considerations by both counselors and survivors in the present study.

Third, consistent with the initial rationale for CFT (Gilbert, 2009a), feelings of shame and negative self-perceptions emerged as significant barriers to self-compassion across both focus group discussions and is, therefore, an important target of intervention. Shame-based appraisals of trauma can maintain an ongoing sense of threat, which contributes to post-traumatic stress symptoms (Ehlers & Clark, 2000; Fairbrother & Rachman, 2006), and shame memories, which become central to a person’s identity and life story, are particularly problematic (Pinto-Gouveia & Matos, 2011). In CFT, shame is viewed as an evolved function to alert us to the violation of social norms and values (Gilbert, 1997). Survivors can, therefore, be supported to understand that while childhood sexual abuse is indeed a violation of these norms and values, the shame is not theirs to own.
Furthermore, self-compassion is unlikely if survivors believe they are not worthy of receiving it (Goetz, Keltner, & Simon-Thomas, 2010). Koss and Figueredo (2004) suggest that following a trauma such as sexual assault, survivors seek to find causal attributions for the experience. Internal attributions of either characterological or behavioral self-blame, whereby survivors believe that it was something about their character or behavior that caused the abuse, have been shown to contribute to increased psychological distress for sexual abuse survivors (Feiring, Taska, & Chen, 2002; Frazier, 2003; Koss & Figueredo, 2004). A CFT approach utilizes information from evolutionary psychology, neurobiology, and developmental theory (Gilbert, 2009a) to offer an alternative perspective and help clients make sense of their experience, without the need for shame, self-blame, or self-criticism.

Fourth, it is important to clarify what self-compassion means and how it can be helpful. Misperceptions that equate self-compassion with self-pity, ego, or self-indulgence, can activate unnecessary resistance and should be a relatively straightforward barrier to address. Having a clear understanding of what is meant by compassion can also help build a belief and sense of confidence in its capacity to generate positive change. Counselors recognized that letting go of long-held maladaptive coping strategies can generate significant anxiety, which is understandable if they were initially developed as attempts to enhance a sense of safety or comfort in the short-term (Polusny & Follette, 1995). A CFT approach seeks to develop compassionate competencies that respond to both the ability to acknowledge and remain attuned to suffering, and the skills required to alleviate and prevent it (Gilbert, 2009a). Supporting clients to understand and experience the positive effects of self-compassion through the development of these competencies may enhance coping self-efficacy and minimize the need for unhelpful responses.

Finally, this study suggests it is important for both counselors and clients alike to attend to motivational factors in the cultivation of compassion. Counselors can assist clients to identify their reasons and ability for change and help maintain their compassion motivation and commitment (Steindl, Kirby, & Tellegen, 2018). Counselors should also consider their own motivation for cultivating compassion both within themselves and as part of the therapeutic process, to support authenticity and modeling, and to remain motivated and committed when the process becomes challenging. Counselors are likely to benefit from a personal practice of compassion cultivation as the embodiment of compassion has been shown to promote greater self-compassion and compassion directed to others (Matos, Duarte, Duarte, Gilbert, & Pinto-Gouveia, 2018).
Limitations and Future Directions

While providing important qualitative data, the present study has several limitations. The sample size was modest, and while considerable effort was made to recruit a broad representation of clients, including consultation with an Indigenous community liaison worker and provision of study information to a diverse range of clients, participants of the survivor focus group were all Caucasian and predominantly middle-aged, in addition to all being female and receiving counseling from a service in a large regional area. Broader representation was obtained from counselor focus group participants, which consisted of two counselors who worked specifically with young people, another who worked exclusively with women who had an intellectual disability, two from a service in a remote region, and all had experience working with women from diverse cultural backgrounds. Nevertheless, considerations in relation to the issue of self-compassion are likely to be different across culture, age, gender, socioeconomic, and other circumstances, and as such, outcomes are tentative and cannot be considered representative beyond the context of the study. It does offer an exciting opportunity for exploration in future studies, however.

It is also important to note that participants for the survivor focus group were not assessed to determine whether any issues relating to self-compassion or shame were directly attributable to their experience of childhood sexual abuse. Future studies may seek to identify the factors specifically relating to childhood sexual abuse, which may inhibit or facilitate self-compassion.

Another potential limitation is that transcripts were analyzed based on verbal content only. A greater depth of analysis may have resulted from consideration to nonverbal data both within and between participants, and future studies would benefit from taking this factor into account.

Despite these limitations, the findings of this study suggest that CFT may be a suitable framework for survivors of sexual abuse. CFT specifically targets shame and self-criticism, as well as fears, blocks, and resistances in relation to compassion and self-compassion (Gilbert, 2014), which are factors that emerged from both focus groups. In addition, Gilbert (2009b) highlights the important role therapists have in providing an experience of safeness for clients as the foundation for them to be able to explore difficult issues, and counselors in this study reflected an understanding of this role. Most importantly, this study provided direct feedback from sexual abuse survivors and counselors as to how CFT may be tailored for this target population. In particular, this study highlighted a number of therapeutic and client factors that may act as potential barriers or facilitators of self-compassion. It is recommended that results from this study are incorporated into a CFT protocol for this client group and evaluated in a randomized control trial or effectiveness study.
Authors’ Note
The first author was employed by the sexual assault service in which the survivor focus group discussion took place, however was not involved directly in the recruitment of participants.

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