The Recovery of Sexual Health After Sexual Assault

Holly Richmond

A Dissertation Submitted to the Faculty of The Chicago School of Professional Psychology In Partial Fulfillment of the Requirements For the Degree of Doctor of Philosophy

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2014

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Abstract

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Survivors of sexual assault experience physiologically and psychologically distressing symptoms. Sexual health, in particular, can be impaired as a result of sexual assault. Although substantive research exists concerning treatment modalities and outcomes of survivors’ aggregate recovery, little is available in regard to sexual assault survivors’ experiences of healing, particularly the embodied process of regaining sexual health. Toward the goal of better understanding this process, a grounded theory design and analysis was used to determine emergent themes and theories concerning the interplay of sexual assault, sexual health, and embodiment. The embodied experience of sexual health recovery was observed with 12 female participants over the age of 18 who are survivors of sexual assault. The research was unique in that it did not focus on specific therapeutic treatment outcomes, but rather the experience of each participant as they moved through their respective processes of recovery from survival to embodiment and finally to empowerment. The collective data revealed themes and concepts that contextualize sexual health recovery and its corresponding psychosomatic presentations in survivors of sexual assault. Providing insight into survivors’ embodied processes of recovery of sexual health will contribute to professional literature and inform future directions for research in the fields of somatic psychology, trauma therapy, and human sexuality.
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Dedication

For my boys, Danny and Archer.

“There is no wisdom without love.”

—N. Sri Ram
Chapter 1: Nature of the Study

According to a 2010 report from the National Institute of Justice (NIJ), 18% of women in the United States are sexually assaulted over the course of a lifetime. In 2008 alone, these data revealed that individuals age 12 or older experienced an estimated 222,000 sexual assaults (National Institute of Justice, 2010). Crimes involving sexual assault are among the most frequently committed offenses in the United States, and yet recent national estimates indicate 84% remain unreported to authorities (Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007). The Federal Bureau of Investigation reported fewer than 2% of sexually assaulted women age 12 or over report the assaults, and even fewer (.3%) male survivors of the same age range report assaults (National Sexual Violence Resource Center, 2010). The most recent and methodologically rigorous studies (Centers for Disease Control and Prevention, 2011; National Institute of Justice, 2010) showed sexual assault still occurs at rates that approximate those first identified more than 20 years ago by Koss, Gidycz, and Wisiewski (1987).

Data from the Centers for Disease Control (CDC) National Intimate Partner and Sexual Violence Survey (Black et al., 2011) presented a set of national prevalence data on “sexual violence victimization” (p. 1) using respondents’ sexual orientation identification at the time of the survey. Sexual violence victimization includes acts of intimate partner violence, sexual violence, and stalking victimization (Black et al., 2011). The CDC’s data revealed nearly 1 in 2 women (44.6%) and 1 in 5 men (22.2%) experienced sexual violence victimization at some point in their lives. When the CDC’s respondents were asked specifically about rape, defined as involving forced penetration or being forced to
penetrate, nearly 1 in 5 women (18.3%) and 1 in 71 men (1.4%) reported having been raped in their lifetime. The study also found lesbians and gay men reported intimate partner violence and sexual violence over their lifetimes at levels equal to or higher than those of heterosexuals. Additionally, bisexual women reported a higher incidence of rape (61.1%) and physical violence or stalking by an intimate partner than did either lesbian (43.8%) or heterosexual women (35%). These reports demonstrate sexual assault is not restricted to a particular sexual orientation, and more importantly, that the rates are not declining (Black et al., 2011; National Institute of Justice, 2010).

**Statement of Problem**

It was not until the 1970s that sexual assault garnered increased national attention both socially and clinically (Bachar et al., 2010; Bass & Davis, 2008). Forty years ago, rape was commonly thought to be perpetrated by men at the fringe of society. Now, however, rape is acknowledged to occur at all levels along the social spectrum and, in the majority of cases, is committed or attempted by a person known to the victim (Bachar et al., 2010). Nearly 1 in 10 women (9.4%) have been raped by someone known to them and an estimated 16.9% of women and 8.0% of men have experienced sexual violence other than rape by someone known to them (Black et al., 2011).

Researchers have suggested that critical societal structures may be at risk when sexual assault occurs (Bachar, Campbell, Fisher, & Rumburg, 2010). The U.S. Merit Systems Protection Board reported sexual harassment alone cost the federal government an estimated $327 million in losses associated with job turnover, sick leave, and lost productivity among federal employees (National Institute of Justice, 2010). Fifty percent of sexual assault survivors lost their jobs due to the severity of their reactions (Ellis,
Atkeson, & Calhoun, 1981). Men and women who experience rape or stalking by any perpetrator or physical violence by an intimate partner are more likely to report frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical health and poor mental health as compared to men and women who have not experienced these forms of violence (Black et al., 2011). The authors further stated women who report these forms of violence were more likely to have asthma, irritable bowel syndrome, and diabetes than women who did not experience these forms of violence.

The findings of the CDC’s report (2011) on sexual violence victimization underscore the toll sexual violence, stalking, and intimate partner violence takes on women and men in the United States. These forms of violence often begin at an early age (Bass & Davis, 2008; Black et al., 2011; Giami, 2002) and lead to negative health consequences across the lifespan. Collective action is required to implement preventative approaches and ensure appropriate responses by medical health professionals and mental health clinicians. This action must be based on reliable data and continued research, which the present study may contribute to.

Recent findings indicate sexual violence continues to be an important health issue affecting women and men in the United States. Although no demographic group is immune from sexual violence, consistent patterns emerge with respect to the subpopulations in the United States that are the most heavily affected. Consistent with previous national studies (Tjaden & Thoennes, 2000), the findings in the recent CDC survey indicate women are most heavily subjected to sexual violence (Black et al., 2011). Sexual assault and other forms of sexual violence are often first experienced during childhood and remain prevalent among young adults aged 18–24. Survivors who
reported sexual assault prior to 18 years of age had a higher prevalence of subsequent victimization as an adult. These data provide further evidence that when sexual assault occurs, particularly when it occurs early in a survivor’s life, it is often repeated in adulthood (Black et al., 2011; Tjaden & Thoennes, 2000; Smith, White, & Holland, 2003; West, Williams, & Siegel, 2000).

Statement of Purpose

Significant research exists concerning the treatment of sexual assault (Braddock, 1997; Haines, 2007; Kimerling & Calhoun, 1994; Ogden, 2006; Maltz, 2001; Rothschild, 2000; Russell & Davis, 2007). Similarly, there is a rapidly growing body of literature in the field of sexual health (Faravelli et al., 2004; Giami, 2002; Schwartz, 1996; Traeen & Schaller, 2010; World Health Organization, 2002; Wylie, 2001). However, little research exists that combines the recovery from sexual assault with co-occurring recovery of sexual health. This construct is worthy of consideration. Studies demonstrate the effects of sexual assault are debilitating both psychologically and physiologically, particularly in regard to survivors’ sexual health (Black et al., 2011; Faravelli et al., 2004; Giami, 2000).

The body plays a significant role in the recovery from sexual assault, particularly in regard to survivors’ feelings of empowerment and sexual self-efficacy (i.e., the ability to self-generate the desired outcome) (Bryant & Schofield, 2007; Young, 1992). The experience of trauma creates a dilemma of “having a body” versus “living in a body” and makes troubling the centrality of the body in human existence (Young, 1992, p. 91). In an effort to deepen the understanding of the somatic component involved in recovery from sexual assault, the researcher will explore the nature of survivors’ relationships to their bodies through principles of embodiment as well as its impact on subsequent
movement toward healthy sexuality. The researcher explores how survivors move from being in their body to being embodied, and the ways in which that process corresponds to empowerment and sexual health.

This study will generate definitions and theories surrounding sexual health and embodiment, and how they are integrated into the process of recovery from sexual assault. These concepts will be investigated via one central query within the qualitative analysis: What is the embodied process of recovery of sexual health after sexual assault? The grounded theory emergent in this study may present therapeutic and psychoeducational tools for trauma specialists working with sexual assault survivors, including rape crisis counselors, sex therapists, and human sexuality educators. Additionally, the data will offer psychotherapists, psychologists, and somatic psychotherapy practitioners new ways in which to realize and enhance survivors’ mind-body connections on their paths to recovery. Exploring the embodied experiences of survivors, with an understanding of their journeys toward sexual health, will not only improve the conceptualization of recovery, but also, in a more propitious sense, inform strategies for prevention.

**Definition of Terms**

The present study includes four concepts in its central query, consisting of sexual assault, sexual health, recovery, and embodiment. The first three concepts—sexual assault, sexual health, and recovery—will be briefly defined within this chapter and expanded upon in the following review of the literature. The fourth concept of the query, embodiment, will serve as an umbrella under which to investigate how, and to what extent, sexual assault, sexual health, and recovery are experienced by survivors.
**Sexual assault.** Sexual assault is an attack on the body (a violation of a person’s physical being) and an attack on the mind (a violation of a person’s right to choose), both of which elicit a sense of inherent lack of safety and feelings of disempowerment. According to the United States Department of Justice (DOJ)/National Institute of Justice (2010):

Sexual assault covers a wide range of unwanted behaviors—up to but not including penetration—that are attempted or completed against a victim’s will or when a victim cannot consent because of age, disability, or the influence of alcohol or drugs. Sexual assault may involve actual or threatened physical force, use of weapons, coercion or intimidation. (Terms & Definitions, para. 1)

Rape is nonconsensual oral, anal, or vaginal penetration of the victim by body parts or objects using force, threats of bodily harm, or taking advantage of a victim who is incapable of giving consent. (Terms & Definitions, para. 2)

For the purposes of this study, the term *sexual assault* will be used broadly to include rape. Additionally, when considering the therapeutic milieu, using the word *survivor* rather than *victim* serves to facilitate a language of empowerment and will be used here as well.

**Sexual health.** As critical as it is to comprehend what is meant by the term “sexual assault,” it is equally important to understand what is meant by “sexual health.” In most cases, they can be considered to have antithetical properties (Braddock, 1992; Faravelli et al., 2004; Resnick, 2001; Schwartz, 1996; Traeen & Schaller, 2010; Young, 1992). Because sexual assault includes an act of sexual violence, a survivor’s sexual health is most often affected (Faravelli et al., 2004). Additionally, just as sexual assault
includes psychosomatic components, so too does sexual health. The World Health Organization (WHO; 2002) stated sexual health requires that an individual have a “positive and respectful” view of sexuality (p. 1). The WHO defines sexual health as:

The integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love…Fundamental to this concept are the right to sexual information and sexual pleasure. (WHO, 2002, p. 1)

Recovery. No governmental organization or national health institution offered a comprehensive definition of recovery that suited the present study’s requirements. To be specific, the researcher could not find a concrete definition of recovery in relation to a sexual assault survivor’s sexual health. Therefore, the researcher chose to investigate definitions and theories regarding recovery from experts that consider the body, and principles of embodiment, as essential components to recovery, thus reinforcing the somatic nature of the study. Specifically, the concept of recovery after sexual assault is described to provide insight into its physical, emotional, and spiritual elements of sexual health.

The recovery process is multidetermined (Resnick, 2001) and researchers have suggested that many factors impact the outcome, including details of the sexual assault, self-esteem, interpersonal relationships, past relationship history, and a survivor’s culture and environment (Resnick, 2001; Schwartz, 1996; Traeen & Schaller, 2010; Young, 1992). Braddock (1997) concurred with the multidimensional facets of recovery and focused research and treatment objectives on survivors’ relationships to their sexual selves. “Sexuality is what it is like to be a woman or a man” (p. 191). Yet because of
sexual trauma, the survivor’s view of the sexual self often shatters, which disrupts normal developmental patterns. Thus, confusion may ensue. “The meaning of sexuality may be genitally focused; the survivor may perceive little more of sexuality than the abuse she or he experiences. In other words, the trauma shapes the view of sexuality” (Braddock, 1997, p. 191).

Rather than focusing on sexual recovery as a matter of the genitals, Braddock (1997) included numerous aspects of the self. Braddock considered the body and its capacity for rigidity and flexibility, the breath and its ability to regulate affect, and the voice in its force and restriction. Recovery, for Braddock, is defined as a sacred journey of embodiment and spirituality.

Spirituality is breathing, using our breath, sound, and movements, listening to the movements of our spirit inside. It’s embodying the sacred. It doesn’t have to be a struggle. It’s standing and holding open a space for the spirit to come in.

(Braddock, 1997, p. 201)

Braddock suggested recovery occurs when spiritual depths become the depths of feelings, unfolding the experiences of one’s life, and learning to trust in oneself.

Maltz (2001) also viewed recovery as an embodied process, and considered the voice, physiology, and boundaries to be vital components. Survivors often feel objectified, and as Braddock also suggested, sexuality too often boils down to functions of the genitalia. Maltz believed leaving a sense of objectification behind is fundamental to the process of recovery. She suggested survivors learn to use their voices and assert themselves to validate their experiences. In so doing, Maltz suggested survivors affirm
themselves intrapersonally and interpersonally, which facilitates respect. “To express the self is to find the voice” (Maltz, 2001, p. 126).

Lowen (1967) suggested a body is forsaken when it becomes a source of pain and humiliation instead of pleasure and pride. In this sense, a survivor may refuse to accept or identify with his or her body, turning against it, ignoring it, or attempting to transform it into something more desirable. “However, as long as the body remains an object of the ego, it may fulfill the ego’s pride but it will never provide the joy and satisfaction that the alive body offers” (Lowen, 1967, p. 209). In considering the perception of the body as an object versus an inherent part of self, Whitehouse (1995) wrote:

The less the body is experienced, the more it becomes an appearance; the less reality it has the more it must be undressed or dressed up; the less it is one’s own known body, the further away it moves from anything to do with one’s self. (p. 245)

The body’s impact and meaning on a survivor’s path to recovery is vital (Braddock, 1997; Bryant & Schofield, 2007; Haines, 2007; Maltz, 2001; Ogden, 2006; Rothschild, 2000; Young, 1992). Due to an experience or multiple experiences of sexual assault, survivors often fail to understand the message that their bodies belong to them (Maltz, 2001). Internalizing this concept may be essential to sexual recovery because it is a way of unfolding the false, learned self-concept that a survivor is a sexual object and nothing more. In this study, recovery is considered to include the presence of embodiment and the ability to recognize and harness physical, emotional, and spiritual aspects of one’s self. This development may be crucial for survivors, allowing them to thwart any lingering associations between their sexual selves and their objectified selves.
Recovery, in regard to the present study, is as much somatic as it is psychological, and assumes that the body, mind, and spirit are one interconnected biological system. As research suggests, the body is crucial to recovery (Braddock, 1997; Bryant & Schofield, 2007; Haines, 2007; Lowen, 1967; Maltz, 2001; Rothschild, 2000; Young, 1992). Rather than being something to get away from, it is a source of wholeness to be returned to (Maltz, 2001). Looking at recovery after sexual assault from a somatic perspective allows the body to become an inherent and essential part of healthy change and the healing process (Haines, 2007). As survivors recover, sexuality may emerge from a new and embodied place. It becomes less about how sex is supposed to look and more about one’s own experience of sex, desire, and pleasure (Haines, 2007).

The present study’s researcher chose to look specifically at the recovery of sexual health after sexual assault because of her clinical work with survivors. In her experience, the recovery of sexual health is often ignored or entirely overlooked in the formulation and observation of treatment goals. This may be due to social and cultural pretenses regarding the open discussion of sex, the clinician’s own personal reticence or bashfulness, or inadequate training in the areas of sexual health and sex therapy (Braddock, 1997; Coleman, 2002; Haines, 2007; Maltz, 2001).

Discovering how these three concepts function independently and interdependently throughout a survivor’s experience is central to answering the research question. Examining the concepts through a somatic lens gives the body and mind equal import and fills a gap in the research on the topic of sexual assault and survivors’ subsequent recovery of sexual health.
Emergence of Somatic Psychology and Embodiment Principles

Due to the present study’s desired contribution to the field of somatic psychology, it is important to understand what has shaped its ideology, as well as the principles that inform the researcher’s somatic perspective. It is equally vital to understand what is meant by the concept of embodiment. The principles of embodiment are the primary link to the present study’s somatic nature. The process of the recovery of sexual health after sexual assault will be investigated from an embodied viewpoint, thus linking together the field of somatic psychology and research into and treatment of sexual assault.

The dual, split nature of the body and mind, where the body is in the domain of physicians and the mind is in the domain of psychoanalysts, was pronounced in Western thought for centuries (Barratt, 2010; Caldwell, 1997). It was not until the early 20th century that the mind-body paradigm was even considered by psychoanalysts and not until the last four decades has the association between the physiological and psychological been popularized, with numerous forms of somatically based psychotherapies emerging (Caldwell, 1997). Somatic psychotherapies “…seek to resensitize us to our birthright of healthy and optimal functioning by using the direct physical experience of the body as a healing tool” (Caldwell, 1997, p. 2). Somatic psychotherapy principles advocate humanity’s continued evolution toward reclaiming its integrative being (Caldwell, 1997).

Barratt (2010) stated, “somatic psychology is the psychology of the body, the discipline that focuses on our living experience of embodiment as human beings and that recognizes this experience as the foundation and origination of all our experiential
potential” (p. 21). Barratt further suggests, like Caldwell, that somatic psychology is an epistemic shift that will result in a new appreciation of the human condition. Utilizing these theories, the present study’s researcher conceptualizes somatic psychology as a set of principles and methodologies that look at the whole person, not merely psychological aspects in contrast to physical. Somatic psychology includes an individual’s experience of being, where the body is not talked about and prodded in a medical sense, but felt and discovered in a holistic sense.

Most of the approaches used today in somatic therapies grew out of traditions that had their beginnings in early psychoanalytic theory and practice (Cornell, 2009). The field of psychoanalytically oriented psychotherapy became based in what came to be known as the talking cures, though there was, arguably, always some degree of attention to the body’s “considerable difficulties and opportunities,” which formed a key aspect of the beginning stages of psychoanalytic conceptions of human functioning (Cornell, 2009, p. 79). Reich (1986) was among the earliest and most influential psychoanalysts to think differently about how to approach the field’s theory and practice. Reich wrote extensively about the harm of sexual repression and the damage done by blocking libidinal energy. Moreover, Reich developed the notion of character armoring and described how it expresses and contains a person’s fear of orgasmic energy (Barratt, 2010; Reich, 1986). Crucial to Reich’s evolution, and prominent in the development of body psychotherapies, was what he described as the breakthrough into a vegetative realm (Cornell, 2009; Reich, 1986). Vegetative referred to the autonomic nervous system, a realm of psychic organization that he would frame in the language of implicit or subsymbolic experience (Cornell, 2009; Reich, 1986). Reich developed a psychotherapy
that was grounded in precognitive neural and somatic processes. He opened a new theoretical understanding and therapeutic process based on shifts in the body.

We learn much about this phenomenon [of inner emptiness and deadening] if we make the patient relive the transition from the alive to the dead condition as vividly as possible, and if we pay the closest attention to the swings from one condition to the other during treatment…The transition from full living experiencing to inner deadness is usually caused by severe disappointments in love. (Reich, 1949, p. 325–326)

Reich theorized his patients were afraid of their own impulses, aggression, and vitality. Of importance to the present study is Reich’s belief that neurosis is rooted in physical and sexual conditions as well as a lack of “orgastic potency” (Reich, 1949, p. 230). He coined the term orgone, which was derived from orgasm and organism, defining it as a cosmic energy or life force. Reich believed if one could prevent the neurosis by embracing the orgone, the betterment of humanity would ensue. He viewed orgasm as integral to psychological health because it discharges excess energy and leads to a collapse of neurotic charter structures. Reich proposed that orgasm is absent in neurosis and that only a “free body can experience and express a total body orgasm, not a genital one” (Caldwell, 1997, p. 21).

Reich’s contribution to somatic psychology and its relationship to sexuality cannot be overstated, yet his theories do not wholly inform the present study’s researcher’s sexual worldview. Limitations are observed in Reich’s almost singular focus on his patients’ fears of their own impulses, most notably sex and orgasm (Reich, 1949). He did not give voice to the idea that it may not be fear as much as something that is
never learned, or perhaps unlearned, because of life circumstances. Particularly, what is the role of relationship, or lack thereof, in problems of orgastic potency? “He did not seem to grasp the intense fear of the absence of the other during periods of extreme emotional disorganization and vulnerability” (Cornell, 2009, p. 80). Qualities including emotional availability, yearning, empathy, and tenderness are often found in the presence of others, and are a necessary component of an individual’s ability to find reorganization in the midst of disorganization. These qualities “were rarely a part of Reich’s own character or his therapeutic repertoire” (Cornell, 2009, p. 80), but have become central features of contemporary models of somatic psychotherapy. Furthermore, it seems to the present study’s researcher that orgasm, and its presumed discharge of excess energy, is not the primary marker of psychological health, at least in regard to survivors of sexual assault. Rather, it is the recognition and realization of body-mind integration. This integration “demands an awareness of one’s sexuality, and encompasses sexual behavior that has physical, psychological and spiritual aspects” (Wylie, 2001, p. 317).

The present study researcher’s sexual and somatic worldview is informed by the lived-body (embodiment) paradigm. This emphasizes the belief that it is one’s perception of the world that is crucial to not only cognitively understanding the world, but also emotionally understanding the world relationally, sexually, dependently, physically, emotionally, and so forth. “The argument here is that we can only understand our lived world with the apparatus with which we are provided to sense it, namely our bodies” (Shaw, 2004, p. 274). People are born with eyes expecting to see, ears expecting to hear, and bodies expecting to be held and touched. Humans’ knowledge of the world is body oriented (Liedloff, 1986).
An examination of experience reveals that it is the body, which first understands the world, grasping its surroundings and moving to fulfill its goals. In phenomenological terms, the body is not just a caused mechanism, but an intentional entity always directed toward an object, a world. (Leder, 1984, p. 31)

Lowen (1967) suggested the body is characterized by a life of its own. It has spontaneity of gestures and vivacity of expression. “It hums, it vibrates, it glows” (Lowen, 1967, p. 209). Lowen went on to propose people are accustomed to thinking of their bodies as instruments or as a “tool of the mind” (p. 209), and they are unaware of its capacity to feel. The notion of embodiment, for the purposes of this study, allows for an interaction with one’s surroundings, including relationally to others, lending a perspective of dynamism to the body. The body is not simply a filter of external stimuli but a barometer for life. Bodily reactions are at the very center of our being and are related to past and present experiences (Shaw, 2004). Embodiment, for the purposes of this study, is defined as the way in which an individual lives in and experiences the world through his or her body, especially through perception, emotion, language, and movement in space, time, and sexuality (Merleau-Ponty, 1962; Wilde, 1999).

Bodies are the means by which people engage and understand the world (Merleau-Ponty, 1962). “The world is not an object such that I have in my possession the law of its making; it is the natural setting of, and field for, all of my thoughts and all of my explicit perceptions” (Merleau-Ponty, 1962, p. xi). It is worth considering how sexual trauma affects one’s worldview when its “laws” (Merleau-Ponty, p. xi) are broken and inflict suffering upon survivors. Stromsted (1998) believed one’s history is encoded in the body just as the “rings of a tree encode the life story of that tree” (p. 146). The act
of sex and one’s inherent sexuality are integral parts of self. Merleau-Ponty (1962) elucidated this position, suggesting sex is a critical life force and inseparable from one’s being. His nondual philosophy proposes that, when considering sexuality and being, one cannot exist without the other. “There must be an Eros or a Libido which breathes life into an original world, gives sexual value or meaning to external stimuli and outlines for each subject the use he shall make of his objective body” (Merleau-Ponty, 1962, p. 180).

Given this theoretical stance—the inherent oneness of sex and self—the present study will illuminate how survivors define and perceive recovery after sexual assault. Principles of embodiment serve as the bridge to these discoveries, where all aspects of a survivor’s recovery process are considered data in the grounded theory design.

**Contribution to the Field of Somatic Psychology**

The focus of the present qualitative research study is on participants’ perceptions and experiences as well as how they make sense of their lives. Specifically, it concerns how they understand the embodied process of recovery following sexual assault. The researcher is interested in the process as well the outcome. Although this approach provides a direction of study, it does so without leading or pointing to a conclusion (Creswell, 2009; Willig, 2008). A qualitative research method was the best choice for the present somatic psychology study insofar as the qualitative research tradition “relies on the utilization of tacit knowledge (intuitive and felt knowledge) because often the nuances of the multiple realities can be appreciated most in this way” (Creswell, 2009, p. 195). Specifically, the logic of grounded theory guides the methods of data gathering as well as of theoretical development (Charmaz, 2006). “All is data” (Glasser, 2002, p. 34)
is a position that allows the researcher to interpret the quality, relevance, and usefulness of the data for emerging theories in her area of interest. This approach does not force preconceived notions on the data. Rather, it follows leads that are defined in the data.

Using a grounded theory qualitative approach allowed evaluation of the fit between the study’s research question and the emerging data. The present study’s research and conclusions were grounded in solid emergent data and include participants’ verbal responses as well as somatic cues. These cues include shifts in stance/position, hand gestures, changes in breathing, level of eye contact, twitching or trembling, and rigidity or flexibility in posture. Additionally, participants’ prosody and how they utilize nonverbal (silent) and verbal pauses (throat clearing, ehs, ums, etc.) were considered data.

**Summary**

Based on the following review of the literature, the researcher’s curiosity was piqued by substantive research into sexual assault, and how the overlap of sexual assault and sexual health has been largely ignored, particularly from an embodiment perspective. Insight into the nature of this phenomenon has explicit value in treatment, education, and the prevention of sexual assault. The researcher’s dedication to recognizing and evaluating both verbal and somatic language from participants lends itself to the study of somatic psychology. Moreover, because the researcher looked specifically at principles of embodiment and psychosomatic unity in the process of the recovery of sexual health after sexual assault, the emergent data and subsequent conclusions may make a significant contribution to somatic psychology theory.
Outline of Remaining Chapters

The following chapters of the present study include a literature review, research methods and design, results, and discussion. The literature review focuses on topics including sexual assault, sexual health, recovery, and embodiment, and ways in which these topics do and do not overlap in recent literature. The research methods and design section covers the data analysis procedures the researcher employed in order to carry out the study. The results section reports the descriptive statistics, as well as inferential findings. All findings are discussed in terms of relevance and significance to the phenomenon of study. Lastly, the researcher draws conclusions about the study results and makes recommendations for further research in regard to the embodied process of the recovery of sexual health in survivors of sexual assault.
Chapter 2: Review of the Literature

High prevalence rates and an abundance of research on sexual assault point to a need for a deeper understanding of survivors’ experiences. In order to glean insight into this often devastating and life-changing occurrence, it is vital to comprehend the manifestation of survivors’ psychosomatic symptomology. Both the mind and the body hold equal weight when first discovering and assessing symptoms, as well as subsequently when devising a treatment plan toward the goal of recovery. The first section of the review of the literature, herein, will define psychosomatic as it relates to its clinical presentation in survivors, and moreover will explore common psychosomatic manifestations that survivors experience. Second, the term sexual health will be defined and characterized, with subsequent consideration of how it is affected by sexual assault. Third, the concept of embodiment will be investigated and its impact will be considered as it relates to the recovery of sexual health after sexual assault. In aggregate, these definitions serve as the backbone of the grounded theory analysis.

Psychosomatic Manifestations of Sexual Assault

Understanding sexual assault survivors from a psychosomatic orientation creates an opportunity to examine the relationship between emotional life and bodily process, both normal and pathological, rather than either the body or the mind in isolation from one another (WHO, 1964). For the purposes of this study, the author will focus on the manifestation and presentation of psychosomatic symptomology, rather than the clinical definition of various psychosomatic disorders. In an attempt to understand the whole survivor, it is necessary to consider the most common psychological and physiological
components related to the consequences of sexual assault supported by recent literature. Given the nature of grounded theory methodology, data gathered from the study’s participants will guide the focus of the research. In classic grounded theory style (Glaser & Strauss, 1967), the data are grounded in the analysis, and the review of the literature is modified upon completion of the data collection.

Sexual assault survivors present with a wide range of psychological and physiological sequelae, the most prevalent of which include rape related-post traumatic stress disorder (RR-PTSD), sexual dysfunction, depression, and relational problems (Kimerling & Calhoun, 1994; Najdowski & Ullman, 2009; Ullman, Filipas, Townsend, & Starzynski, 2007). These diagnoses, particularly within the RR-PTSD category, which is the most widely researched (Frazier, 2003; Koss, Figueredo, & Prince, 2002; Koss, Gidycz, & Wisiewski, 1992; Najdowski & Ullman, 2009; Ullman, Filipas, et al., 2007), fall into three categories: problems with reliving, avoidance, and arousal (Bisson & Andrew, 2007). Each category involves fear and anxiety as primary emotional components, which may help answer the present study’s research question encompassing the embodied process of survivors’ recovery.

Young (1990) was among the first to recognize disorders related to psychosomatic manifestation of symptoms within the population of sexual trauma survivors. She identified dissociation, multiple personality disorder, eating disorders, somatization disorders, self-mutilation, and suicide attempts as health consequences associated with sexual assault. Nearly two decades later, a meta-analysis was conducted, building on Young’s study, as well as other systematic reviews that empirically evaluated sexual trauma outcomes from behavioral, psychiatric, psychological, and maladjustment
perspectives (Chen et al., 2009). The meta-analysis expanded the research to include somatic sequelae. Significant associations were observed between rape and the lifetime diagnosis of fibromyalgia, chronic pelvic pain, and functional gastrointestinal disorders (Chen et al., 2009). When considering the potential mechanisms and implications of their research, the authors did not attempt to validate a theory to explain these associations. Rather, they speculated sexual trauma might be an inciting factor in a multistep process that culminates in somatic dysfunctions. When considering the present grounded theory analysis, bearing in mind these past studies, it is crucial to have a clear understanding of the common diagnoses and psychosomatic symptoms found in survivors. Comprehending both the psychological and physiological qualities—paying attention to what both the mind and body are communicating—may provide a broader picture of survivors’ holistic experiences.

Sexual Trauma Versus Nonsexual Trauma

The majority of survivors do not seek treatment for psychosomatic symptoms from mental health providers (psychotherapists, rape crisis centers, or victim assistance programs), but rather from primary care physicians (Kimerling & Calhoun, 1994; Koss, Gidycz, & Wisiewski, 1992). The authors postulate this noted discrepancy in treatment-seeking behavior is relevant to medical professionals and mental health providers in order for survivors to receive comprehensive treatment. There is a dichotomy and strong dualistic nature, perhaps, as to how survivors comprehend their injuries, both physical and mental, as well as in how they seek treatment for them. According to Kimerling and Calhoun (1994), facilitating an understanding of the relationship between psychological
and physical symptoms may have the potential to inform how the process of recovery occurs.

Faravelli et al. (2004) conducted the first study on the psychosomatic effects of rape verses the psychosomatic effects of other traumatic, nonsexual events such as car accidents and robbery. The authors found the psychopathological consequences of rape could be specific and may warrant particular attention. “In particular, most of the raped women show a significant impairment in the areas of painful re-experience of the traumatic event, sexual disorders, and eating disorders” (p. 1485). Faravelli et al. postulated the different events have different meanings based on whether there was physical contact with an aggressor, such as rape, or impersonal trauma, such as a car accident, and so the nature of the event produces distinctive reactions in survivors.

When trauma includes a sexual component as opposed to nonsexual, studies showed physiological responses include an increase in glucocorticoid steroid receptors, which leaves survivors hyper-responsive to a variety of stimuli (Najdowski & Ullman, 2009; Schwartz, 1996; Yehuda, Southwick, Krystal, Bremner, Charney, & Mason, 1993). “These changes, as well as alterations in serotonin uptake and dopamine metabolites, suggest that the psychological numbing, intrusion, avoidance, and affect dysregulation also have a physiological base that upholds and perpetuates them” (Schwartz, 1996, p. 197). The research suggests sexual trauma may interfere with the capacity of the survivor to develop an integrated sense of self, power, esteem, safety, and trust. Schwartz also explored the consequences regarding survivors’ capacity for intimacy and related sexual disorders. This exploration will be considered in the following review of the literature section on sexual health.
Sociocultural Consequences

In addition to common psychosomatic symptomology found in the literature, sexual assault survivors also elicit sociocultural consequences. Mukamana and Brysiewicz (2008) discovered survivors suffer from a loss of identity, particularly if the rape included a loss of virginity, as well as social isolation and a loss of hope for the future. The propensity for loss of hope significantly increased if the survivors were unable to talk about the rape and share their experiences with others (Mukamana & Brysiewicz, 2008). Ullman et al. (2007) also studied the psychosocial correlates of PTSD symptom severity in sexual assault survivors on an ethnically diverse population. As the authors expected, very few demographic or assault characteristics predicted symptoms. Rather, trauma histories, postassault self-blame, perceived threat to self, coping, avoidance, and negative social reactions had higher correlations to RR-PTSD severity. “The only protective factor was survivors’ perception that they had greater control over their recovery process in the present, which predicted fewer symptoms” (Ullman et al., 2007, p. 821).

When considering the relationship between social correlates and psychosomatic implications after rape, Najdowski and Ullman (2009) demonstrated self-blame is predictive of more RR-PTSD symptoms and poorer recovery. Congruently, perceived control over one’s own recovery and adaptive coping skills are associated with fewer stress symptoms. The study’s results highlight the need for longitudinal research in the field of sexual assault to identify feedback loops, effective coping strategies, and maladaptive cognitions and distress. Identifying these parameters may facilitate better mental health outcomes (Najdowski & Ullman, 2009). The authors further suggested
blaming oneself for the experience of adult sexual assault is a common response among survivors. Moreover, future researchers should explore ways in which self-blame can be reduced. In the study’s discussion section, the authors pointed to a need for taking into account survivors’ other possible lifetime traumatic events. Their results suggest the effect of cumulative trauma on the development and implementation of various coping strategies will be an important focus for future research.

Whether through a single episode of rape or cumulative trauma, physical complaints offer researchers significant information regarding the consequences of sexual assault. Stein, Land, Laffaye, Staz, Lennox, and Dresselhaus (2004) found sexual assault was associated with a significant increase in somatization scores, physical complaints across multiple symptom domains, and health anxiety. Sexual assault was also a significant statistical predictor of having multiple sick days and being a frequent user of primary healthcare services. The study’s authors stated causal mechanisms cannot be inferred from the data, though they did note a strong association between sexual trauma exposure and somatic symptoms, illness attitudes, and healthcare utilization. “It is unclear how sexual trauma leads to increased somatization and health anxiety, though one posit is that sexual assault, particularly early in life, may lead to disturbances in somatic perception and body identity” (Stein et al., 2004, p. 180).

The present study’s researcher seeks to add clarity to the process by which survivors’ bodies, through perception and identity, change after sexual assault. This may help to uncover the embodied nature of survivors’ recovery. In order to understand the array of consequences survivors experience, it is necessary to look at both the immediate and long-term effects of sexual assault from a psychosomatic orientation. Jordon (2007)
examined exactly that in a study of the acute and chronic health implications regarding violence against women. The study assessed acute injury associated with rape and intimate partner violence as well as chronic, stress-related syndromes. The first part of the study investigated acute injuries and the crisis phase of recovery, looking at patterns of genital injuries from rape. A case was built for the notion that the prevalence and location of genital injury may provide only a partial description of the nature of trauma associated with rape and necessitate a “multidimensional definition of genital injury patterns” (Jordan, 2007, p. 244). The author also offered areas for new research advancement, which may lead to improvements in healthcare, forensic, and criminal justice.

Part two of the study (Jordan, 2007), and of greater significance to the present study, focused on the complex, chronic, and historically overlooked associations of sexual violence and women’s health. The author proposed a need for a deeper understanding of the relationship between violence, stress, and somatic syndromes toward the goal of clarifying the consequences of rapes in regard to long-term health and the overall quality of life. This portion of the study highlighted the additional vulnerability of women exposed to violence for psychosomatic illness ranging from stress-related disorders such as fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome. When considering the study in total, Jordan reinforced the damaging effects of rape in the short and long term. She went beyond causal links to explore other complex, cumulative, and chronic effects that manifest over the lifetime of survivors. She identified the use of culturally sensitive universal screening tools, in both sexual and reproductive health contexts for current or historic victimization, as being critical for
furthering future comprehensive and effective treatment of the psychological and physical consequences survivors endure. Jordan (2007) suggested that beyond initial screening, it is necessary to incorporate enhanced physician training, public policy support, and better data collection to ensure a better delivery of comprehensive health care to survivors. The study’s discussion section contains a proposal for an advance to the research in three ways: improve methodologies associated with the empirical study of violence on women’s health; extend the research to incorporate more subtle and complex associations to identify specific mechanisms by which the consequences of rape are manifested in women’s health; and incorporate interdisciplinary research teams that bring together scientists and advocates for women’s health (Jordan, 2007).

Crofford (2007) looked at the specific somatic syndromes of sexual violence and stress. “Exposure to the stressor of violence is likely to create a state of vulnerability to stress-related somatic syndromes, and also contribute to symptom expression and severity” (Crofford, 2007, p. 299). In accordance with other relevant literature in the field of sexual assault and its psychosomatic consequences, the author conceived that understanding the relationship between sexual violence as well as stress and somatic syndromes will help to clarify survivors’ long-term consequences to health and quality of life. “There is no question that women exposed to emotional, physical, and sexual abuse suffer negative consequences with respect to health-related quality of life” (Crofford, 2007, p. 308).

Koss and Heslet (2011) also considered the acute effects and late consequences of rape. This study supports the finding of other recent studies (Frazier, 2003; Koss, Figueredo, & Prince, 2002; Najdowski & Ullman, 2009; Ullman et al., 2007) that the
medical treatment of sexually victimized women can be improved by understanding underlying psychosomatic symptomology. Koss and Heslet propose that by identifying victimization history, physicians and primary care givers will be better able to appropriate support services. The final section of the study examined the role of physicians in fostering disclosure of victimization, which will not only allow them to treat the acute physical symptoms, but assess for long-term psychosomatic consequences. “Ignoring this aspect may produce a patient who will return repeatedly for multiple problems and may enhance the potential of other members of the patient’s family to become future victims and/or patients” (Koss & Heslet, 2011, p. 57). The authors suggested the need for primary health care providers to refer to mental health professionals and specific trauma and rape crisis resources in the community. “Identification of patients with a history of victimization reduces the potential of negative health sequelae, promotes more efficient use of resources, and improves patient well-being” (Koss & Heslet, 2011, p. 58).

A comprehensive review of the literature on sexual assault has shown fear and anxiety responses in survivors are the most widely researched (Kimerling & Calhoun, 1994; Koss, Gidycz, & Wisiewski, 1992; Najdowski & Ullman, 2009; Ullman, Filipas, Townsend, & Starzynski, 2007). In addition to the research on fear and anxiety, in 2002 Foa observed and reported on depression in both the immediate and long-term reactions of rape survivors. Depression was shown to decline within a three-month period for the majority of the study’s participants, whereas fear reactions were shown to be more persistent. Rape victims appear to be more anxious as well as more depressed than those who successfully ward off a rape attempt (Foa, 2002). This confirms what Kilpatrick,
Veronen, and Resick found in a pioneering study in 1979 which noted that “the conclusion that fear and anxiety represent relatively long-term problems for rape victims seems inescapable” (p. 668). Resick followed that study with numerous others, including her research into the specific psychosomatic symptomology and its treatment in adult victims of sexual assault. She was one of the first to identify PTSD rather than solely measuring fear and anxiety responses. The study also correctly identifies the prevalent and long-lasting depressive reactions in rape survivors, finding that almost half of all survivors suffer from significant depressive symptoms within the first month after the assault. Now, over two decades later, Resick’s words still resonate and are realized: “With the increased interest in trauma generally and in information-processing models as an explanation for PTSD and other symptoms resulting from traumatic events, there should be a great deal of research on both theory and treatment in the 1990s” (Resick, 1990, p. 501).

**Social Support in Recovery**

To that end, in 1994 Kimerling and Calhoun presented a comprehensive study that looked at somatic symptoms, social support, and treatment seeking among sexual assault victims. The focus of their research, which aligns with the aim of the current grounded theory study, is the suggestion of identifying mechanisms by which psychosomatic symptoms develop and defining in what specific ways these symptoms have patterns. This yields important information for recognizing survivors and implementing effective interventions (Kimerling & Calhoun, 1994). The authors suggest psychological distress is often interpreted as somatic distress and that it may be labeled as
physical illness. They argued that psychological distress causes individuals to interpret common bodily sensations as evidence of disease.

Studies by Mukamana and Brysiewicz (2008) and Ullman et al. (2007) supported Kimerling and Calhoun’s (1994) findings in their investigation of social support as a moderating variable in their theoretical explanations of somatic symptoms. They discovered social support and the use of psychological services has an assuaging effect on psychological distress, severity of physical symptoms, subjective health scores, and the utilization of primary care health services (Kimerling & Calhoun, 1994).

Examining another component of social support, similarly to the more recent study by Koss and Heslet (2011), Kimerling and Calhoun noted a need for collaboration between physicians and psychologists in treatment facilities. First, the research shows survivors do not appear to be receiving the psychological treatment they deserve or require in the first year post-assault. And second, the authors believe collaboration between physicians and psychologists could also decrease the rising health care costs that have become the focus of government attention. The authors suggest an attempt at preventative medicine should be made to assess medical patients with the physical symptoms common to victimization experiences in order to facilitate treatment of both physical and psychological symptoms. “Therefore, a better understanding of the relationship between psychological distress and physical symptoms in sexual assault victims has the potential to greatly enhance the efficiency and efficacy of current treatments in both the psychological and medical community” (Kimerling & Calhoun, 1994, p. 12).
Consequences to sexual health and well-being are central to the present grounded theory study’s research question. Foa (2002) found that a fear of sex and lowered arousal were the most common dysfunctions reported. Sexual functioning was shown to be substantially disrupted immediately following rape, but did return to pre-rape levels after a few months. Sexual satisfaction, however, stayed low for an average of 18 months post-rape. This study is of particular interest because it explores theoretical questions about critical parts of sexual health recovery and moreover informs practitioners on treatment planning. Although the present study is not treatment outcome focused, data revealing fundamental aspects of psychosomatic recovery will be valuable in formulating future directions for sexual assault and sexual health research.

Studies that investigate the psychosomatic manifestations of symptoms following sexual assault are extensive. However, there is a lack of evidence demonstrating how and why some survivors transition from living with these negative consequences to living symptom free. One might ask, “How do these survivors successfully integrate their experience?” This gap presents an opportunity to conceptualize recovery after sexual assault from an embodied perspective. The present study seeks to help fill this gap by discovering qualities related to sexual health within the survivor’s embodied recovery.

**Sexual Health**

Sexual assault is a sexual act, and thus a survivors’ sexual health is often affected (Faravelli et al., 2004). Coming to an agreed upon definition of the term *sexual health* has been a collaborative process for entities committed to improving it. Global policy recognition for sexual health was defined by the Programme of Action of the International Conference on Population and Development (ICPD, 1994). Statements
regarding sexual health were drawn from a 1975 technical report by the World Health Organization (WHO), which defined sexual health as

the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love…Fundamental to this concept are the right to sexual information and the right to pleasure. (p. 1)

Just as the literature on sexual assault suggests a psychosomatic component, so too does the literature surrounding sexual health. The WHO (2002) suggests sexual health requires that one have a “positive and respectful” view of sexuality. Researchers (Coleman, 2002; Faravelli et al., 2004; Schwartz, 1996; Traen & Schaller, 2010) suggest sexual health not only contributes to an individual’s sense of themselves and their own sexuality, but also to the interpersonal nature of sexual intimacy. Wylie (2001) proposed healthy sexuality demands an awareness of one’s sexuality, and moreover “encompasses sexual behavior that has physical, psychological and spiritual aspects” (p. 317).

During the Consultation on Sexual Health, a conference convened by the WHO Department of Reproductive Health and Research in 2002, the definition of sexual health was amended to reflect its multidimensional nature. The revised definition now reads:

Sexual Health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual
health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2002, p. 4)

Utilizing research from the WHO convention and the 2002 amendment, Coleman (2002) described sexual health as containing three basic elements. The first element was the capacity to enjoy and control sexual and reproductive behavior within one’s own social and personal ethic beliefs. Second was the ability to be free from fear, shame, guilt, false beliefs, and other psychological factors that impair or inhibit sexual arousal and response. And the last element was the ability to be free from physical disorders or disease that interferes with sexual functioning. The integration of these critical facets has been used since 2002 and distinguishes the biological aspects of sex from concepts of healthy sexuality.

**Subjective Sexual Well-Being**

The literature suggests sexual health encompasses numerous qualities including those that are physical, somatic, spiritual, and emotional (Coleman, 2002; Faravelli et al., 2004; Schwartz, 1996; Traeen & Schaller, 2010; Wylie, 2001; WHO, 2002). The research also implies that an individual’s subjective sense of sexual health and well-being must also be considered (Coleman, 2002; Faravelli et al., 2004; Laumann, Paik, Glasser, Kang, Wang, Levinson, & Gingell, 2006; Schwartz, 1996; Traeen & Schaller, 2010; Wylie, 2001). Researchers consider how healthy sexuality is defined by an individual. How does healthy sexuality function and serve the psychosomatic self interpersonally and interpersonally? Traeen and Schaller (2010) analyzed subjective sexual well-being in terms of emotional and cognitive evaluation of each person’s sexual functioning. The
authors built on a 2006 study (Laumann, Paik, Glasser, Kang, Wang, Levinson, & Gingell, 2006) and formulated a definition for subjective sexual well-being as the cognitive and emotional evaluation of a person’s sexuality with the perceived emotional and physical satisfaction with one’s sex life, over several domains of importance to sexual health and sexual well-being. Sexual well-being is a broader term than sexual satisfaction. (Traeen & Schaller, 2010, p. 180)

Not only did Traeen and Schaller (2010) find that the presence of sexual problems significantly impacted sexual well-being, the study also revealed that subjective sexual well-being was related to the individual’s sense of self. If an individual had a habitualized poor or negative sense of self, their sexual well-being would be poorly or negatively impacted. If they had an affirmative or highly regarded sense of self, their subjective sexual well-being would be positively impacted (Traeen & Schaller, 2010).

The authors suggest that the concept of subjective sexual well-being taps into the extent to which sexual expectations are met. They also suggest subjective sexual well-being examines the balance between the rewarding and problematic sexual issues in a person’s life. “As subjective sexual well-being is related to the person’s self-perception, therapy to improve the way he or she perceives himself/herself may also prove useful” (Traeen & Schaller, 2010, p. 192).

The present grounded theory study does not empirically evaluate sexual dysfunction—the counterpoint to sexual health and well-being—although it does include a screening tool (Derogatis, 1987) to rule out a sexual dysfunction diagnosis in participants. Much literature is devoted to the study of female sexual dysfunction (Armato, 2006; Basson, 2008; Berman, Berman, & Kanaly, 2003; Laumann et al., 2006;
WHO, 2002) and the evidence within those studies will be used to strengthen the argument for the comprehensive and psychosomatic nature of sexual health.

**Sexual Functioning**

Based on empirical evidence, the characteristics of sexual health, like the characteristics of the consequences of sexual assault, cannot be discovered merely in the body (Coleman, 2002; Faravelli et al., 2004; Laumann et al., 2006; Schwartz, 1996; Traeen & Schaller, 2010; Wylie, 2001). A psychosomatic schema encompasses a survivor’s entire holistic being rather than her mind at one moment and her body in another. In a study on female sexual dysfunction and its definitions and classifications, Mimoun and Wylie (2009) suggested that not only is sexuality an important part of a woman’s life and well-being, but it also encompasses aspects of her sexual identity, her sexual functioning, and her sexual relationships. These aspects are modulated throughout a woman’s life by several factors, including her relationship with her partners, her capacity for intimacy, and her performance, as well as socio-cultural variables like her education and taboos (Mimoun & Wylie, 2009). Indeed, “A woman’s expression of her sexuality is unique to her and likely to change over time” (p. 116). In their conclusion, the study’s authors make a case for the critical nature of sexual health in relation to overall health and well-being. They point to sexual dysfunctions’ high negative impact on relationships, stress the value for physicians to be able to successfully evaluate sexual functioning in their patients, and thereby make appropriate referrals for treatment and recovery (Mimoun & Wylie, 2009).

Evidence established a link between sexual trauma and sexual dysfunction, and thereby, the lack of sexual health (Basson, 2008; Berman, Berman, & Kanaly, 2003;
Laumann et al., 2006; Sprei & Courtois, 1988). The majority of female survivors of childhood sexual trauma are reported to have experienced long-term sexual consequences (Brown, 1995). Within the past two and a half decades, researchers and mental health providers have begun to seriously consider the possible repercussions to adult survivors’ sexual health (Basson, 2008; Berman, Berman, & Kanaly, 2003; Brown, 1995; Laumann et al., 2006; Sprei & Courtois, 1988; Wylie, 2001). Mental health care providers previously believed sexual health would self-correct if the client successfully worked through their sexual trauma history (Brown, 1995). Brown’s research suggested this is not the case, but rather, as research into the consequences of sexual trauma continues, the treatment of sexual dysfunction is emerging as a key issue. From a clinical perspective, Brown argued for the further development of awareness and knowledge surrounding the link between sexual trauma and sexual dysfunction. This will support survivors in the process of identifying effective strategies for recovery and “renew hope for healing and the possibility of enjoyable adult sexual expression” (Brown, 1995, p. 40).

Sprei and Courtois (1988) suggested earlier studies on the impact of sexual assault on sexual functioning had not been investigated adequately for lack of empirical evidence. Their research focused on the treatment of women’s sexual dysfunction arising from sexual assault, and offered a comprehensive overview of different types of sexual assault as well as a consideration of the sequelae of assault, as they relate to different kinds of sexual dysfunction (Sprei & Courtois, 1988). The authors believe predominant feelings resulting from sexual assault, such as anxiety, fear, anger, guilt, shame, mistrust, and helplessness, mimic those frequently related to sexual dysfunctions in general. “That the locus of the assault is sexual, it follows that sexual dysfunction may be a consequence
of sexual victimization” (p. 277). Because their research was focused on a treatment approach, the authors offer several suggestions for clinicians. One such suggestion that aligns with the present grounded theory study is an appreciation of the functional value that the sexual dysfunctions serve in helping the survivor move past the assault, i.e. inhibiting flashbacks, intrusive memories, and the feelings associated with the original assault (Sprei & Courtois, 1988). This suggests a link between the body and mind in the recovery from sexual assault.

Nearly a decade later, Schwartz et al. (1996) examined the link between sexual trauma, bonding, and hypersexuality. The authors considered myriad physical and psychological consequences. The evidence suggests the capacity for survivors to be intimate becomes structurally blocked and associated with ambivalence. “Often intimacy becomes the lowest common pathway in which physiologic dysregulation and disorders of sexual desire, arousal, and response become manifestations of such issues” (Schwartz et al., 1996, p. 198). The author posits sexual desire, arousal, and orgasmic response are natural functions of a psychical and psychological nature. When this natural process becomes supplanted by sexual trauma, it often results in a lack of ability for the survivor to master their environment, their self-efficacy, and self-esteem, as well as the ability to establish and maintain intimate relationships. Research suggests anything that situationally enhances or inhibits relational intimacy may influence the individual’s ability to give and receive sexual pleasure. “Sex is innately pleasurable—unless something mitigates that pleasure” (p. 200). Schwartz’s research proposed that if healthy sexuality is exploited by sexual trauma including hate, violence, or shame, then the individual is often left feeling defective or injured because of his or her gender, body, or
sexuality. In the study’s conclusion, the authors made a case for sex therapy and the clinician’s orientation to psychosomatic components of recovery (Schwartz et al., 1996).

**Emotional Regulation**

In addition to the negative impacts on survivors’ sexual health, self-esteem, self-efficacy, and intimate relationships, research shows there can also be ill effects on survivors’ emotion regulation. Rellini, Vujanovic, Gilbert, and Zvolensky (2012) examined sexual and relationship satisfaction among young adult women survivors in the context of difficulties in the regulation of emotions. The authors built on empirical evidence, which suggests a high prevalence of relational and sexual problems among adult women exposed to sexual trauma in childhood and adolescence (Basson, 2008; Berman, Berman, & Kanaly, 2003; Laumann et al., 2006; Rellini & Meston, 2007; Scholerdt & Heiman, 2003). Research also points to common symptoms of inhibited sexual desire, lower levels of sexual satisfaction, arousal problems, and difficulties developing emotional intimacy with a partner (Rellini & Meston, 2007; Rellini et al., 2012; Scholerdt & Heiman, 2003). The authors hypothesized greater emotional regulation difficulties would interact with the effects of childhood sexual trauma on variables such as sexual satisfaction, relationship intimacy, and expression of affection. Their prediction was driven by the prospect that childhood and adolescent trauma may have the most deleterious interpersonal effects when co-occurring with problems regulating emotional states (Rellini et al., 2012). The authors summarize their research—and mostly consistent hypotheses—by stating that in conjunction with recent evidence (Rellini & Meston, 2007; Scholerdt & Heiman, 2003), individual differences in emotion
regulation may be relevant to better understanding the characteristics of survivors’ sexual and relationship satisfaction.

Kierr (2011) also examined emotional regulation and emotional resonance as body-based ways of knowing oneself and fostering healthy sexuality. The author suggests that sexual health is individually defined and can be diminished secondary to sexual trauma, including childhood sexual abuse and sexual assault in adulthood. As a dance/movement therapist, Kierr works with the body in order to offer a path that leads to the subject of sexuality without the need to express sexual dysfunction, such as arousal and orgasm disorders or sexual fears at the outset. “Dance/movement therapists can support therapeutic explorations that increase understanding of individual sexual development and sexual behavior” (p. 44).

Kierr’s research (2011) serves as another link that reinforces the bond between body and mind when it comes to issues of sexual well-being. Her research introduced the importance of embodiment and an embodied process of recovery toward the goal of healthy sexuality for survivors of sexual assault. Kierr speaks to somatic psychology modalities that facilitate healthy sexuality including breath awareness, guided imagery, and sensory integration. Her research suggests these experiential activities may help lead to a reduction in sexual fears, an increase in emotional resonance, and ultimately, healthy sexuality.

Rothschild (2000) also advocates for the use of experiential exercises when helping survivors move toward a goal of healthy sexuality. In working with a survivor’s somatic memory, Rothschild creates a script that links body sensations, such as speed of breathing, temperature, and posture, with verbal terms for body and emotional awareness.
“In a few instances it will be possible to eliminate some trauma symptoms just by using body awareness. Such an intervention will not necessarily resolve the trauma, but could go a long way to restoring normal functioning” (Rothschild, 2000, p. 105). Rothschild suggests at that point a survivor will be in a more powerful position to make decisions about their own individual path toward healing.

Research shows therapeutic journaling and self-questionnaires for relearning healthy sexual touch, including the ability to receive pleasure, are also useful in encouraging a survivor’s healing process (Haines, 2007; Maltz, 2001). Maltz suggests the decision to reclaim healthy sexuality is life affirming and reflects a natural urge to liberate oneself from past constriction. Her protocol addresses the ability for survivors to identify and tame fears, create realistic goals, and reclaim sexuality for oneself. Her extensive work with survivors utilizing this protocol, and other similar protocols, suggests written and verbal activities help survivors feel more comfortable when deciding to make changes in regard to their current level of sexual functioning. Maltz (2001) states, “Seeing our fears illuminated, we can better focus on the healing changes we wish to make” (p. 73).

Haines (2007) worked with survivors using self-guided sexuality exercises that are also both written and verbal in nature. She suggests creating emotional sourcing with these exercises, which helps survivors center themselves and gain perspective on the recovery process. “This eases the process of working through difficult emotions and traumas…I have seen many survivors develop confidence and compassion for themselves by learning to fully recognize and express their feelings” (p. 179).
“Awareness itself is the first step in healing” (Braddock, 1997, p. 191). Braddock suggested survivors need to develop awareness of what is being spoken and thought, as well as awareness of body responses, sensations, and feeling, in order to begin or deepen the process of recovery. “The sexual journey is a rich one, demanding we wholly explore, experience and look at old messages, patterns and barriers to fullness” (p. 191). Braddock worked with survivors through observational charts, visual affirmations, illustrations, and questionnaires that expose old patterns versus new in order to encourage survivors toward more self-awareness and healing. Braddock, utilizing the Braddock Body Process, has created safe yet effective ways to ask survivors how they learned about sex and their sexuality, what messages they received, what messages are still prevalent, and which messages are positive or negative. She also inquires specifically about sexual function, including orgasm and other avenues for receiving pleasure. Her goals are to examine any barriers to healthy sexuality and sexual activity and to clear negative messages in order to enable survivors to feel more alive, free, and in control of their sexual healing (Braddock, 1997).

Research suggests utilizing questionnaires, journaling, and other means for self-expression may facilitate survivors’ recovery processes (Braddock, 1997; Haines, 2007; Kierr, 2011; Maltz, 2001; Rothschild, 2000). Posing questions or suggesting exercises may encourage survivors to think about their sexuality and their goals for healing in unexplored ways. Research also suggests utilizing these forms of inquiry can help survivors realize they have a choice in all aspects of their sexuality, which they may have never experienced before (Braddock, 1997; Kierr, 2011; Maltz, 2001; Rothschild, 2000). The choice can be as simple as whether or not to complete an exercise, or the larger goal
of choosing whether or not to have sex, and with whom. It is the present study’s researcher’s hope that the intensive interview protocol used for data collection will similarly encourage new ways for participants to think about and experience their sexual healing. The present grounded theory study seeks to discover additional correlations between and within survivors’ body and minds as they move from the consequences of rape to an awareness, appreciation, and celebration of their sexual health.

**Embodiment**

Sexual assault and trauma may lead survivors to experience their own bodies as foreign (Stromsted, 2000). This sense of alienation serves to keep survivors locked into feelings of disempowerment, cordoning them off from physical and emotional pleasure, as well as from their potential for comprehensive psychosomatic health (Braddock, 1997; Rothschild, 2000; Stromsted, 2000). Gilligan (1998) put forth the idea that the aftermath of sexual assault often brings both a sense of chaos and rigidity to the survivor’s inner (somatic/spiritual) and outer (emotional/relational) worlds. When an old identity dies and a new one is not yet born, physical and psychological symptoms often appear as unpleasant somatic sensations, such as tiredness, tightness in the chest and stomach, and an inability to restrain tearful outbursts (Gilligan, 1998; Braddock, 1997; Stromsted, 2000). Gilligan hypothesizes that clients in this state often feel like their body is a rebel and they have lost the war. He stated, “Emotional pain hurts, quite physically and quite literally, in our entrails” (Gilligan, 1998, p. 42).

Embodiment bridges the disconnection between emotional pain experienced in the psyche and physical pain felt in the body, either or both of which can be misunderstood or undetected by the survivor (Stromsted, 2000). Facilitating a quality of
embodiment—the ability to recognize and elicit control over physiological and psychological symptoms—may be central to helping survivors experience the process of recovery (Braddock, 1997; Rothschild, 2000; Stromsted, 2000). Understanding embodiment may also help mental health practitioners recognize the emotional content of the body’s language of intentionality. Boadella (1996) suggested every survivor carries with them not only their problems but also their body. The body can never be left behind, even if they forget it as in depersonalization, or they treat it as a mechanical object within the context of the schizoid process, or they experience it as a source of threat through hypochondriacal behavior (Boadella, 1996). In order to explore this phenomenon—what role the body and embodiment play in the recovery of sexual health after sexual assault—a review of the literature, beginning with early conceptualizations of embodiment and its origins, will commence.

**Merleau-Ponty**

Merleau-Ponty (1962) was among the first and most influential philosophers to delve into the ontology of being and embodiment. In his seminal work, he examines the concepts of being and embodiment from multifaceted, phenomenological perspectives including projection, attention, and judgment through the environment of the body (sexuality), the world as it is perceived, and being in the world. Merleau-Ponty (1982) helped clarify the meaning of embodiment. The definition of embodiment for the purposes of the present grounded theory study follows: The way in which an individual lives in and experiences the world through their body, especially through perception, emotion, language, movement in space, time, and sexuality (Merleau-Ponty, 1962/1982; Wilde, 1999).
Of particular relevance to the present grounded theory study is Merleau-Ponty’s exploration of embodiment through the body in its sexual being. He suggests embodiment and sexual life are forms of “original intentionality” and endow experience with degrees of vitality and fruitfulness. “Thus sexuality is not an autonomous cycle. It has internal links with the whole active and cognitive being, these three sectors of behavior displaying but a single typical structure, and standing in relationship to each other of reciprocal expression” (Merleau-Ponty, 1962, p. 182). He suggests the preeminent value of integrating sexuality into the human being rather than defining it as a purely bodily process, specifically in regard to psychoanalysis. He writes about the duality of psychoanalysis at that time in history, where embodiment and sexuality are concerned. On one side of the argument is the premise that sexuality is a substructure of life; on the other, the notion of sexuality to the extent it is absorbed into the whole of existence.

We do not reduce sexuality to something other than itself by relating it to the ambiguity of the body. For, to thought, the body as an object is not ambiguous; it becomes so only in the experience of which we have it, and pre-eminently in sexual experience, and through the fact of sexuality. To treat sexuality as dialectic is not to make a process of knowledge out of it, nor to identify a man’s history with the history of his consciousness. (Merleau-Ponty, 1962, p. 194)

The nondual foundation Merleau-Ponty suggested in regard to sexuality and being—that one cannot exist without the other—set the stage for more recent works, which will be explored herein (Bryant & Schofield, 2007; Jolly, 2011; Kovacs, 1982; Meissner, 1998; Price, 2007; Price & Thompson, 2007; Reimann et al., 2012; Wilde, 43
1999; Young, 1992). Although the present grounded theory study focuses on and uses the term *embodiment* rather than *being*, Merleau-Ponty’s words resonate deeply nearly seven decades later when considering how the concepts of embodiment unite with sexuality. He spoke to sexuality’s dramatic nature, suggesting that people commit their whole personal lives to it. He wondered why bodies become the mirror of people’s beings:

> Unless it is because it is a natural self, a current of given existence, with the result that we never know whether the forces which bear us on are its or ours—or with the result rather that they are never entirely either its or ours. There is no outstripping of sexuality any more than there is any sexuality enclosed within itself. No one is saved and no one is totally lost. (Merleau-Ponty, 1962, p. 198)

Of particular relevance to the present study is Merleau-Ponty’s assertion that the body is the primary place through which an individual knows the world, rather than placing consciousness as the principal source of knowledge. Merleau-Ponty’s contribution to the philosophic and phenomenological realm is his insight that the body, and that which is perceived (consciousness), cannot be disentangled from one another. This quality of unity is, as Merleau-Ponty states, “the lived body” (Merleau-Ponty, 1962, p. 95). This lived body is in contrast to *le corps proper*, e.g. the body as merely thing and/or object. He perceives sexuality and the body as nondual, and this nonduality as a perceivable phenomenon and the vehicle of one’s presence within himself, as well as the outward presence to others. This notion has significant relevance to the present study because it suggests individuals cannot separate their consciousness from their sexuality. Moreover, individuals’ meet and receive the world, including others, through their body. This intimation leads the present study’s researcher to consider what that means for
survivors, and how the quality of embodiment exists and shifts after sexual assault as they move through the process of recovery.

The idea that individuals perceive each other through their body—from an embodied perception—was first broached in Merleau-Ponty’s investigations of the topics of sexuality and communication (Madison, 1981; Merleau-Ponty, 1962). He put forth the idea that individuals are more than isolated perceiving body-subjects, which exist in a cultural void. A vague notion of humanity beyond the self is implicit in all actions, and the idea of a unified mass of humanity lies somewhere beyond the scope of each person’s own body and perception, but is, at the same time, somehow like them (Madison, 1981; Merleau-Ponty, 1962). It is this notion of intersubjectivity that ties together sexuality and communication.

The same reason that prevents us from reducing existence to the body or sexuality, prevents us also from reducing sexuality to existence; the fact is that existence is not a set of facts capable of being reduced to others or to which they can reduce themselves, but the ambiguous setting of their inter-communication, the point at which their boundaries run into each other, or again their woven. (Merleau-Ponty, 1962, p. 193)

**Sexuality**

Sexuality and its interdependence with embodiment are ways in which individuals make meaning of the world, and it is through sexuality that a meaningful world is opened up (Craft, 2009; Merleau-Ponty, 1962). Therefore, in the philosophical underpinning of Merleau-Ponty’s work regarding embodiment, there are no explicit points regarding sexual health that do not have a consciousness etiology. The differing expressions of
sexuality are all encompassing with existence. Merleau-Ponty’s conceptualizations of embodiment and nonduality of being are significant contributions to the field of somatic psychology as well as to the foundation of the present study. Yet, the present study’s author also recognizes some inherent limitations to Merleau-Ponty’s philosophical insights. The omission of reference to gender identity or sexual preference brings into question how Merleau-Ponty’s views may change when considering individuals who recognize themselves as gay, lesbian, queer or bisexual, for example. Did only considering heterosexuality limit his perceptions of embodiment and sexuality? Or, because of his nondual philosophy, do gender identity and sexual preference become a mute point? Furthermore, while Merleau-Ponty’s contribution to philosophy and embodiment cannot be overlooked, the language he uses to describe these concepts is often prohibitory.

Given Merleau-Ponty’s contributions to the fields of philosophy and psychology, and withstanding the complexities of his writing and their translation, innumerable philosophers and researchers have built on his concepts of embodiment in the past seventy years. Recent research in the fields of sociology, ecology, psychology, biology, nursing and somatic psychology have contributed empirical evidence to the nature and understanding of embodiment. Weiss (1999), like Merleau-Ponty, suggests embodiment is not an autonomous cycle, but exists as intersubjective and intercorporeal states. The presence of internal links exists within the entire cognitive being and moreover stands in relationship to each other of reciprocal expression. “To describe embodiment as intercorporeality is to emphasize that the experience of being embodied is never a private affair, but is always mediated by our continual interactions with other human and non-
human bodies” (Weiss, 1999, p. 5). Weiss states the necessity for recognizing the numerous “corporeal exchanges,” which take place in individuals’ everyday lives (p. 5). These correspondences of information, thought, and feeling through the body demand a reciprocal recognition of “the ongoing construction and reconstruction of our bodies and body images” (Weiss, p. 5). This idea of intercorporeal correspondence is one of the distinct parallels between Weiss and Merleau-Ponty that resonates with the present study’s author. Examining the body and the inherent language of the body as part of a collective consciousness may offer valuable insight toward answering the present study’s research question, thereby clarifying the link between embodiment and sexual health.

Objectification

Merleau-Ponty (1962) and Weiss (1999) similarly treated objectification as a significant theme in regard to embodiment. Merleau-Ponty asserted when an individual shows his body, he does so “nervously or with the intention to fascinate” (Merleau-Ponty, 1962, p. 193). On one hand, an individual may feel another’s gaze on his body as stealing something from him. On the other hand, he may believe revealing his naked body will in some way indebt or endear that person to him (Merleau-Ponty, 1962). Shame and fear, or immodesty and predatory behavior, become two sides of the self, e.g. master and slave.

In so far as I have a body, I may be reduced to the status of an object beneath the gaze of another person, and no longer count as a person for him, or else I may become his master, and, in my turn, look at him. (Merleau-Ponty, 1962, p. 193)

Again, Merleau-Ponty is reaffirming his position on the lived body versus the copor body, or body as simply object. Likewise, Weiss (1999) suggests the idea of body
image posits the body as a given entity and as the core of certain desires and forms of communication. She believes this is not to deny the materiality of the body or to suggest that the body is solely an illusion of cultural conceptions, but to accept the imagination, or consciousness, itself as a “fictive realm” (Weiss, 1999, p. 37). “The body image, then, enables us to identify not only with the bodies and body images of others, but also can express a desire to achieve a stable identity by projecting that very stability into our own bodies” (Weiss, 1999, p. 36).

Kovacs (1982) offered additional insights and conclusions regarding the philosophical, nondual, and ethical dimensions of human sexuality and the interdisciplinary field of embodiment. First, he states the dignity and value of each person should not be separated from the sacredness of the body. Each moment of objectification of the body and inherent sexuality leads to a lack of respect for the humanness of a person. Second, he suggests the value and uniqueness of a human intersects within the dialectical nature of human sexuality, “converging on the affirmation of the symbolic and expressive function of body and sexuality in the dynamics of human living” (Kovacs, 1982, p. 216).

Intersubjectivity

In 1998, Meissner explored the embodied self, looking at the self and the body self, and how psychoanalysis includes, or does not include, these selves. His concepts enjoy meaningful distinctions united in the belief that the human mind exists in a human body and that they are intertwined and derived in complex and multitudinous ways (Meissner, 1998). Given these considerations, Meissner sought further articulation of the notion of self as inherently enmeshed in the body such that it is a bodily component—the
body self—and functions as an organizing element of the self system which embraces both a person’s “real” self and personality. “From this perspective, there is nothing that falls within the purview of psychoanalysis as a science of the human phenomenon that does not involve a bodily reference—explicitly or implicitly” (Meissner, 1998, p. 87). The self is inherently embodied, and Meissner believes sexuality is a quality of embodiment that the body self-expresses, i.e., self-as-agent and the self-as-object insofar as the self involves bodily connection. He posits the linkage between any construct of bodily functioning and the integrity of the self-as-agent would constitute an essential and elemental piece of the self (Meissner, 1998).

A year later, Wilde (1999) contributed a paper titled “Why Embodiment Now?” which offered insight into the historical evolution of embodiment, its relevance at the current moment in history, and embodied meanings of illnesses explored in terms of their relevance for nursing (Wilde, 1999). Wilde believes using embodied perspectives may help researchers learn how people manage illness. This line of thinking has particular relevance for the present grounded theory study. Examining how survivors of sexual assault manage sexual trauma and recover from it, particularly in regard to healthy sexuality, may be important for discovering more effective—and proficient—paths toward recovery.

In concurrence with Merleau-Ponty (1962) and his afore reviewed viewpoints on intersubjectivity, Wilde (1999) suggests embodied existence takes place within the specified world that each individual is born into and lives, and that this world is shaped not only by culture and history, but also by personal relationships.
As embodied beings, we know the world through shared understandings, making the world a social and intersubjective experience. What one person experiences in the world may be similar to that which others experience because all of us open into the same world and, thus, our experiences may be similar. (Wilde, 1999, p. 29)

Embodiment, for the present study and for Wilde (1999), is a central belief that is part of the researchers’ theoretical framework. In that sense, the body is a pivotal construct by which to understand people. Wilde explains her approach to nursing as one that is essentially and fundamentally about people’s experience of embodied being, “particularly at those times when the body fails to function normally” (Wilde, 1999, p. 31). This construct seems an invaluable contribution for the present study when exploring the consequences of sexual assault and eventual recovery of sexual health. So too is Wilde’s suggestion that there is a key piece—a central quality—to embodiment which encourages and enables a body’s transformation from illness to health.

Reimann et al. (2012) further explored the question of psychological mechanisms underlying bodily effects. The authors examine whether emotions function as the bridge between bodily perceptions and downstream cognitive processing and assume a mediating role, or if emotions can be considered purely bodily perceptions. In the paper’s conclusion, the authors suggest both views—emotions as cognitive appraisals and emotions as bodily perceptions (Reimann et al., 2012). Rather than relying on an outdated conception of a disembodied view of cognition, the authors suggest recent advances in neuroscience have helped to restore the notion that the human mind and body
function together as an integrated system, and offer new possibilities for incorporating and unifying studies of cognition and affect (Reimann et al., 2012).

Further considering dimensions of mindbody connection, Price and Thomson (2007) correlate embodiment with psychophysical awareness. “Psychophysical awareness is linked to the conscious internal processes of self-knowledge and regulation that facilitate human growth and well-being” (p. 946). The authors believe that in order to successfully engage in psychophysical awareness, one must have access to inner bodily stimuli and an awareness of bodily experiences. This state is in contrast to that of dissociation and avoidance of noticing bodily experiences (Price & Thompson, 2007). “Sexual symptoms and dysfunction, common sequels of sexual abuse, are also thought to be related to bodily dissociation” (p. 946). Fogel (2011) also explored embodiment in contrast to dissociation. He suggests that embodiment is an essential component of all forms of human development and well-being. Its absence, at any age, is a type of dissociation from the embodied experience. The whole body—with both physiological and psychological awareness—is central to the understanding of human development during times of health, as well as times of illness.

Research into the subject of dissociation contributes to a significant portion of the literature on embodiment (Fogel, 2011; Jolly, 2011; Price, 2007; Price & Thompson, 2007; Reimann et al., 2012). Dissociation is relevant to the present grounded theory study because it is important to understand what embodiment isn’t in order to discern what it is. Price and Thompson (2007) study measures of body awareness and body dissociation in order to explicate the underlying mechanisms involved in psychosomatic health. In somatic theory, psychosomatic awareness is an integral part of the conscious
internal process of self-awareness and emotional regulation that facilitates health. The authors suggest that in order to successfully engage in psychophysical awareness, it is necessary to gain access to inner bodily stimuli and achieve body awareness. “This involves presence in and acceptance of bodily experience (i.e., bodily association) versus the avoidance or dissociation from bodily experience” (Thompson & Price, 2007). Based on this evidence the authors conclude that body awareness and dissociation are involved in the construct of psychosomatic knowledge.

Dissociation is also researched in regard to its consequence to survivors during recovery from sexual trauma (Price, 2007; Price & Thompson, 2007). As the literature has established, common sequelae of sexual assault include negative sexual symptoms and dysfunction. These are believed to be related to bodily dissociation (Price, 2007; Price & Thompson, 2007). Specifically, survivors constitute one population for which dissociation is linked with poor health and illness, and may form a barrier to recovery. “Re-association with the bodily self may be a key to healing problematic dissociation and improving mental and physical health in this population” (Price, 2007, p. 127). Results from these associated studies suggest emotional awareness is integral to body awareness and bodily dissociation, which in turn suggests that emotional awareness may be a vital component of psychosomatic realization.

Further evidence from these studies provides evidence of the link between sexual trauma and bodily dissociation. The authors discovered that a lack of sensory awareness and the underlying processes of inner connection to the self are common among survivors of sexual assault. They called this phenomenon “body connection” (Price, 2007; Price & Thompson, 2007). Price (2007) suggests survivors typically seek body therapy in sexual
abuse recovery to increase their sense of body connection, e.g. to increase the sense of continuity and integration between self and bodily experience. A common self-description includes being “cut off from the neck down” or “a walking head,” indicating that sense-of-self does not incorporate bodily experience (Price, 2007, p. 119). The study notes bodywork and body-psychotherapy techniques that include the capacity to be present, developing body literacy (i.e., the ability to identify and articulate bodily experience), facilitating access to somatic and emotional awareness, and verbal processing session experiences to facilitate cognitive understanding, acceptance, and insight. “Thus, these techniques are thought to facilitate increased body awareness as a primary strategy for dissociation reduction, involving the connection between sensory, emotional and cognitive awareness” (Price, 2007, p. 119). The authors noted a methodological gap in the literature with an emphasis on psychophysical awareness and relevance to mind-body intervention research (Price, 2007; Price & Thompson, 2007).

Stern (1985) investigated this gap in the literature, including the use of verbal processing and cognitive awareness, through the lens of human development and developmental psychiatry. He looked specifically at language and its insufficiency in communicating an idea or message’s entire, or embodied, meaning. He stated that language is a double-edged sword, making some parts of our experiences less sharable with ourselves and with others. He believes language drives a wedge between two simultaneous forms of interpersonal experience—the lived experience and the verbally expressed experience—and causes a split in the experience of the self.

Jolly (2011) contributed to this notion of the “wedge” and insufficient nature of solely the spoken word in her research on embodiment through the lens of trauma and
narrative. She suggests the progression from the violated self to the recovered self through narrative healing alone is akin to a progression within the medical model of diagnosis and treatment moderated by language rather than evidence from the body (Jolly, 2011). She concluded by arguing the narrative (cognitive and verbal) as well as the body must create continuity between the survivor’s stories, so that it is felt rather than simply spoken about. When a survivor looks in the mirror, the mind and body are one and the same, rather than “the split looking at itself…it is the power, presence and intensity of the moment in which the body transcends itself for survival” (Jolly, 2011, p. 311).

**Psychotherapeutic Interventions**

Much of the literature pertaining to embodiment and sexuality focuses on psychotherapy interventions and somatic psychotherapy modalities. While the present grounded theory study is not concerned with therapeutic outcomes, the evidence from the studies is useful toward the goal of understanding what embodiment means in relation to sexuality. Minge (2007) explored ways in which embodied art (painting, autoethnographic narrative, and poetry) expresses how the body stores the memory of rape and love. Minge suggested embodied art is an educational and empowering process to reach and release stored bodily memories. “I paint to grip the different textures of my experience with rape. I paint to create energy of emotion and body memory into text” (p. 259). Embodied art, she offers, may bring the inside out without the necessity of language. The study’s hypothesis, which states embodied art may reconstitute the way in which a survivor understands her rape, is supported by Minge’s own personal experience. “This process has allowed me the space to reconfigure my sexual body, my body memory” (p. 276). However, current, empirically reviewed research does not exist to
support her supposition. In light of the present grounded theory study, this gap in the
research is well noted and may ultimately offer some clues toward the embodied process
of sexual health recovery and, moreover, could possibly contribute to future studies.

Similarly to Minge’s use of her body through art, studies suggest instead of
serving as an inactive or lifeless form upon which sexual well-being is etched, the body
and its inherent sexuality is itself a dynamic force in engendering sexual health and self-
efficacy (Bryant & Schofield, 2007; Young, 1992). Young studied the problem of
embodiment and its relationship to the formation of personal sexual identity and
psychological integrity. Her research question explores the ways sexual trauma affects a
survivor’s sense of living in his or her body, and by extension, living within one’s own
culture and society. She conceptualizes the problem of embodiment after traumatization
in this way: How does a survivor live with, but not in, a dangerous, damaged, or dead
body? In addition, she wonders how a survivor lives in a world that presented such
danger and damage (Young, 1992). Young hypothesized that a survivor of sexual trauma
faced with “physical and psychological annihilation” (p. 90) may abandon the body and
make it outside of herself. She suggests the experience of sexual trauma calls into
question the survivor’s relation to having a body versus living in a body. This is similar
to Merleau-Ponty’s conception of the “lived body” versus the “corpor body” (Merleau-
Ponty, 1962, p. 94), i.e., embodiment versus objectification. Young’s research shows
embodiment is overlooked in literature regarding sexual assault and sexual abuse. Young
suggested this is a mistake because sexual trauma “is inscribed on the bodies of
survivors, leaving a mark that can perhaps be explained but never effaced” (Young,
1992). The study’s conclusion offered evidence supporting embodiment’s relevance to
research concerning the assessment and treatment of sexual trauma (Young, 1992; Stern, 1985; van der Kolk, 1987).

Bryant and Schofield (2007) found the sexual life histories of the women in their study provided an insight into the embodied qualities involved in sexual health and the making of feminine sexual identities. Trauma may undermine progress toward sexual well-being, given that it is outside the bounds of embodiment and embodied sexual self-expression. The authors believe the body and the concept of embodiment are shaped by one’s social and cultural discourse. How survivors bridge the gap between “symbolic and material domains” (p. 338) and encourage the development of embodied sexual expression may impact the dynamic relationship between psyche and soma as sexual identities emerge (Bryant & Schofield, 2007).

Despite the existence of considerable empirical studies on embodiment, research that explores embodiment specifically in regard to the experiences of sexual assault survivors’ is lacking. According to Stromsted (2000), viewing “the body as a transformative vessel” (p. 11) offers an inroad to this research process by identifying the primary somatic response in survivors of sexual assault. This response is “control.” The author suggested it might be key to understanding the process of recovery. This response evolves from feelings of disempowerment and lack of control over one’s body, relationships, and environment.

Research into the three central areas of concern for this study—recovery from sexual assault, sexual health, and embodiment—offer possibilities for how these constructs may co-occur. While the literature to date successfully elucidates how integration promotes attention to the mind and the body, as opposed to the mind or the
body, a gap exists in understanding how a survivor of sexual assault moves into a position of sexual health. It is the researcher’s belief that embodiment plays a critical role and may ultimately facilitate a survivor’s feelings of psychosomatic well-being. This study seeks to address this void by asking: What is the embodied process of recovery of sexual health for survivors of sexual assault?
Chapter 3: Methodology

To explore the embodied experience of sexual assault survivors’ recovery of sexual health, a qualitative research modality was employed. Creswell (2009) identified qualitative research as a method for exploring and understanding the meanings individuals or groups assign to a specific problem. Qualitative research is an emergent design, where meanings and interpretations are negotiated with human data sources; it is the participants’ realities that the researcher attempts to reconstruct (Creswell, 2009; Lincoln & Guba, 1994). The data that emerge from qualitative studies are descriptive and interpretive, meaning it is reported in words rather than in numbers (Creswell, 2009). The focus of the present qualitative research study was on participants’ perceptions and experiences, and how they make sense of their lives, specifically, how they make sense of their embodied process of recovery following sexual assault. The goal was to study the process as well the outcome. Although this approach provides a direction of study, it does so without leading or pointing to a conclusion (Creswell, 2009; Willig, 2008). A qualitative research method was the best choice for the present somatic psychology study insofar as the qualitative research tradition “relies on the utilization of tacit knowledge (intuitive and felt knowledge) because often the nuances of the multiple realities can be appreciated most in this way” (Creswell, 2009, p. 195).

The present study used a grounded theory approach to become familiar with themes and concepts that contextualize recovery from sexual assault and its corresponding psychosomatic presentations of sexual health. First developed by sociologists Glaser and Strauss (1967), grounded theory’s history lies in symbolic interactionism, a process that assumes people inherently construct their own realities
through shared symbols and experiences (Fassinger, 2005). Stated in another way, the interactionism paradigm holds that individuals engage in a world that requires reflexive interaction as averse to environmental response (Goulding, 2005). Behavior is goal driven, arising from social interaction that is highly symbolic in and of itself. “This behavior involves various forms of communication, both verbal and non-verbal, and the notion of symbols is intrinsic to the perspective” (Goulding, 2005, p. 296). Therefore, when researchers gather participants with similar experiences or characteristics, grounded theory’s methodological design attempts to capture the process by which they understand their lives and their social context (Fassinger, 2005). Research based on grounded theory “is done to produce abstract concepts and propositions about the relationships between them” (Fassinger, 2005, p. 160). Because of its symbolic origins, which promote attention to nonverbal communication, a grounded theory methodology was the ideal choice for this particular somatic psychology study.

The data analysis process for grounded theory has, for the most part, remained the same over the past 45 years. However, there is one critical point where the present grounded theory study differs from the original qualitative methodology. Unlike Glaser and Strauss’s classic grounded theory (1967), which suggests discovering theory as emerging from data separate from the researcher, the present study adopted the more contemporary and more widely utilized grounded theory principles of Charmaz (1995b/2000/2006). In so doing, it was assumed that neither data nor theories are discovered in isolation from the researcher. The researcher is part of the world she is studying and a part of the data she collects. Given the verity that qualitative research is interpretive, the interpretation was based on the researcher analyzing the data, i.e., the researcher is
involved in a sustained and extensive encounter with the participants (Charmaz, 1995b; Creswell, 2009). Researchers’ interpretations cannot be realized as detached from their own histories, experiences, and backgrounds. Charmaz (2006) stated, “We are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices” (p. 10).

Grounded theory involves the progressive identification and integration of categories of meaning, or similarities, from data (Willig, 2008). “Grounded theory is both the process of category identification and integration (as method) and its product (as theory)” (Willig, 2008, p. 35). Grounded theory is also inductive and deductive, where researchers may try to verify the hypotheses generated by constantly comparing conceptualized data on different levels of abstraction, which contain deductive steps. This qualitative method provides the researcher with guidelines for identifying similarities, making links between these similarities, and establishing relationships within them. Grounded theory provides an exploratory framework with which to understand the phenomenon being studied. As Charmaz (2006) suggested, the researcher discovered how exciting empirical research can be through gathering rich data and letting her world appear anew through that data. Gathering such data provided solid material for building a significant analysis. “Rich data are detailed, focused and full. They reveal participants’ views, feelings, intentions and actions as well as the context and structures of their lives” (Charmaz, 2006, p. 14).
Sampling

Within grounded theory methodology, the research question sets no expectation for results. The present study’s research question (What is the embodied process of recovery of sexual health after sexual assault?) serves only to identify the phenomenon being studied at the outset. The answer(s) to the research question may change, becoming progressively focused throughout the research process (Willig, 2008).

Grounded theory, and the process by which it answers the research question, is unlike most other qualitative research methods in that it merges the processes of data collection and analysis. The researcher moved back and forth between the two in an attempt to ground the analysis in the data being collected (Willig, 2008). Grounded theory does not offer a specified protocol to take the researcher from the formulation of the research question to data analysis to the discussion of the analysis. In contrast, grounded theory encourages the researcher to continuously review earlier stages of the research and, if necessary, to change direction. Truth is not the goal of grounded theory methodology, but rather a conceptualization of participants’ experiences by using empirical data (Willig, 2008).

Although the research question excludes certainty of answer, it is necessary to narrow the participant pool given the phenomenon of study. Qualitative research uses purposeful sampling to select the site where the research will be conducted, and also to find individuals to participate in the study. Purposeful sampling is defined as the “non-random sampling of individuals likely to be able to make a significant contribution to the data collection for a qualitative report” (Coolican, 2009, p. 246). Miles and Huberman (1994) identified four aspects of purposeful sampling: the setting (where the research will
take place), the actors (who will be observed or interviewed), the events (what the actors will be observed or interviewed doing), and the process (the evolving nature of events undertaken by the actors within the setting).

Utilizing purposeful sampling as the umbrella under which to conduct the present qualitative study, the researcher employed theoretical sampling, which is specific to grounded theory methodology. Theoretical sampling is central to grounded theory qualitative sampling because it allows the researcher to generate properties of developing categories or theory. It does not allow the researcher to sample randomly or sample representative distributions of a particular population. Theoretical sampling focuses on category development, a key part of the analytic process. This focus promotes robust and salient categories, and its strategies advance analytic thinking at a crucial stage of the research.

Theoretical sampling means seeking pertinent data to develop your emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories constituting your theory. You conduct theoretical sampling by sampling to develop the properties of your categories until no new properties emerge. (Charmaz, 2006, p. 96)

Charmaz suggested theoretical sampling keeps researchers from becoming stuck in a process of unfocused analysis. Theoretical sampling not only offers a place for researchers to start, but also directs researchers where to go (Charmaz, 2006). The strategies and logic of theoretical sampling are ideal for grounded theory, where data is emergent and grounded in the analysis. It encourages researchers to start with the data, construct tentative ideas about the data, and then examine those ideas through further
empirical inquiry. In the present study’s case, it allows the participants to illuminate and define the boundaries and relevance of the categories significant to the embodied process of the recovery of sexual health after sexual assault. Once again, if the researcher is strictly adhering to the conceptual underpinnings of grounded theory analysis, there is no preconception about what the data will reveal. The data speak for themselves and set the discovery process in motion. Once relevance is established, the researcher can pursue a new direction.

Participants

One of the appeals of grounded theory methodology is it allows for a wide range of data collection, including observations, interviews, and memos, which describe situations, record events, illustrate feelings, and keep track of ideas (Goulding, 2005). Glaser (1978) suggested that although grounded theory is uniquely suited to fieldwork and qualitative data, it could easily be used as a general method of analysis with any form of data collection, such as surveys, experiments, or case studies. Glaser asserted grounded theory can combine and integrate differing approaches, and that it transcends specific data collection methods (Glaser, 1978). It is because of these characteristics that grounded theory methodology was chosen, as it will provide the richest data by allowing the participants to drive the analysis. It is the best method to honor participants’ experiences and capture them in their purest form.

Interpretive qualitative methods dictate entering participants’ worlds and asking them to reveal personal experiences and how they process or relate to those experiences. Respect for participants, as well as rapport between participants and researcher, is vital to the research process. Dey (1999) reflected on Glasser and Strauss’s original strategy that
chose to forego rapport, and instead met the participants as blank slates, offering no personal interaction. More contemporary qualitative data discovery almost always insists on establishing rapport in order to gain solid data. “If researchers do not establish rapport, they risk losing access to conduct subsequent interviews or observations” (Charmaz, 2006, p. 19).

The present study’s researcher established rapport with her participants. It is her belief that the respect she showed for the study’s participants shaped the content of the data she collected. Charmaz (2006) suggested researchers demonstrate respect by making concerted efforts to learn about participants’ views and actions, and try to understand their lives from their perspectives. This means the researcher must challenge her biases of the world she is studying, not unintentionally repeat those biases.

It means discovering what our research participants take for granted or do not state, as well as what they do say and do. As we try to look at their world through their eyes, we offer our participants respect and, to our best ability, understanding, although we may not agree with them. We try to understand but do not necessarily adopt or reproduce their views as our own; rather we interpret them. (Charmaz, 2006, p. 19)

With these qualities in place, the present study’s researcher recruited participants from the Santa Barbara Rape Crisis Center (SBRCC) in Santa Barbara, California, where they were receiving counseling services. Specifically, they were long-term therapy clients, meaning their sexual assault happened at least one year prior to beginning therapeutic services at SBRCC. This is in contrast to crisis clients who experienced their sexual assault less than one year prior to utilizing SBRCC’s services, which may have
included healthcare, law enforcement and legal advocacy, or crisis counseling. Access to participants was gained through referrals from the clinical director and counselors at SBRCC who believed they had clients who met the inclusion characteristics for the study. Further evaluation of their suitability for the study was garnered through a screening process, which is discussed in a later portion of this methodology chapter.

There was no inducement for research participation. Participants were asked to freely give their time toward the primary goal of helping the researcher to understand the process of recovery of sexual health after sexual assault. It is the researcher’s hope that the participants will also gain more clarity, appreciation and self-confidence surrounding their own recovery, which may in turn encourage them to help others. Furthermore, there was no deception in the research process. “Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study’s significant prospective scientific, educational, or applied value, and that effective nondeceptive alternative procedures are not feasible” (Cone & Foster, 2006, p. 340).

All interviews took place within the SBRCC offices. The researcher believed conducting the interviews in a familiar place eased participants’ anxiety and promoted a sense of safety, even though the researcher was a relative stranger. The surroundings were also familiar to the researcher because she worked as a marriage and family therapy intern at SBRCC from April 2009 through June 2012. Over that period, the researcher completed over 2,000 hours of individual psychotherapy hours with survivors of sexual assault and their significant others. As the researcher learned more about the overall process of recovery for survivors, she became aware of one aspect of their recovery that
was often overlooked both by the survivor and previous counselors, if in fact survivors had received prior therapy for their assault. That overlooked aspect was sexual health. Questions that were not asked include, “How has your sexual health changed?” and “Do you feel claiming or reclaiming your sexual health is vital to your recovery after the sexual assault?” Although most survivors feel it is a highly personal issue to discuss, the researcher believes from her professional experience, and as the literature suggests, sexual health is crucial to the process of recovery.

**Sample Size and Data Saturation**

A sample size (N) of 12 participants was selected for study participation in order to meet data saturation requirements. Data saturation is a critical objective of grounded theory analysis and “its aim” (Glaser, 1998, p. 190). It lets the researcher know when she can stop collecting data, which is only when additional data ceases to provide more information. “Categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of the core theoretical categories” (Charmaz, 2006, p. 113). Data saturation is not, however, observing or hearing the same stories from participants. It applies only to finding the same patterns, or categories, in the data. Glaser’s (1998) perspective on data saturation forms the foundation for observing theoretical concepts within grounded theory analysis.

Saturation is not seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidents, which yield different properties of the pattern, until no new properties of the pattern emerge. This yields the conceptual density that when integrated into hypotheses make up the body of the generated grounded theory with theoretical completeness. (p. 191)
This conceptualization of data saturation allows the researcher to treat categories theoretically and raise them to an abstract level, while at the same time maintaining their connections to the data from which the categories were constructed. Research suggests that a researcher using grounded theory keeps sampling until the categories are saturated, and that this logic supersedes sample size, which may, in fact, be quite small (Charmaz, 1995b/2000/2006; Dey, 1999; Glaser, 1978; Glaser, 1998; Glaser & Strauss, 1967; Goulding, 2005; Stern, 2001). The present study’s researcher will adhere to this premise and begin with the previously noted relatively small sample size, increasing \((N)\) only if necessary.

**Ethical Considerations**

The participants recruited through SBRCC were fully informed of ethical issues. The researcher strictly adhered to the principles and standards of the Institutional Review Board (IRB) for the state of California and the American Psychological Associations’ (APA) *Ethical Principles of Psychologists and Code of Conduct* (1992). The central principle of the APA’s code is to avoid bringing harm to participants, and to carefully weigh the cost-benefit ratio in conducting research. Readers of the present study will have all assurance possible that individuals participated willingly and without coercion of any kind, after being informed about their role in the study and any risks that may be involved. The study’s researcher understands that she has the obligation to describe the methods being used to comply with the ethical principles, with particular emphasis on the specific safeguards that are being applied (Meltzoff, 1998).

Researchers have identified a series of ethical issues that require attention before, during, and after a qualitative study, and suggest the analysis-related implications
(Coolican, 2009; Creswell, 2009; Goodwin, 2010; Goulding, 2005; Mathison, Ross, & Cornett, 1993; Meltzoff, 1998; Miles & Huberman, 1994; Willig, 2008). The present study’s researcher critically considered the following issues and their implications: worthiness of the project; competence and boundaries; informed consent, benefits, cost, and reciprocity; harm and risk; honesty and trust; privacy, confidentiality, and anonymity; intervention and advocacy; research integrity and quality; ownership of data and conclusions; use and misuse of results (Miles & Huberman, 1994, p. 290–295). Specific appendices for privacy and confidentiality (Appendix A), multiple relationships, coercion, and informed consent (Appendix B) are included. Informed consent is a central feature in the APA’s ethical principles and code, specifying the notion that in deciding whether to participate in psychology research, human participants are given enough information about the study’s purpose and procedures to decide if they wish to volunteer (Goodwin, 2010).

In regard to risk versus benefit, the researcher did not anticipate a high level of risk for participants, due primarily to the nature of the grounded theory methodology. The researcher followed where the data led her, driven by the participants. The study involved no intervention or outcome expectation, which helped promote adherence to a minimal risk experience for participants. Participants were only asked about their embodied experience of recovery of sexual health after sexual assault to discover how the process occurs. The present study’s researcher was aware of the possibility of re-traumatization in having the participants discuss aspects of their sexual assault. However, the interview questions being asked of the participants were implicitly focused on the recovery process from the assault, not the details of the assault itself. Goodwin
(2010) suggests that the distinction between “risk” and “minimal risk” is not razor sharp. It is based on the degree to which the people being studied find themselves in situations similar to “those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests” (Department of Health and Human Services, 1983, p. 297). The researcher took every step to make certain the interview questions did not place the participants in extraordinarily uncomfortable situations; each participant was briefed, through the informed consent process, prior to the study’s commencement to ensure they knew what to expect. Furthermore, the researcher was attuned to the symptoms of re-traumatization and trained in its immediate treatment. If necessary, she would act accordingly to protect the health and well-being of the study’s participants. Steps to address possible re-traumatization of participants included: consultation with their primary therapist; increased contact and/or sessions between the primary therapist and participant during the duration of the study; referral to additional sexual assault recovery resources including bibliotherapy, movement therapy (e.g. yoga, tai chi), and group therapy meetings in the local area; and possible discontinuation of participant status in the study. Additionally, in the unlikely case of severe distress on the part of a participant, SBRCC always provides at least one California-state licensed therapist onsite, as well as three full-time advocates to enable contact between survivors and community resources.

In an effort to further augment the low risk quality of the study and adhere to the ethical guidelines, participants were required to meet the following criteria: they must be over age 18 and report a history of sexual assault in adulthood (after age 18); have the
ability to provide informed consent and understand the confidentiality agreement; and have the ability to speak and understand English.

**Screening**

Due to the nature of the research question, all participants had to elicit healthy psychosomatic presentations of sexual health, and thus were screened using the Derogatis Interview for Sexual Function-Self Report (DISF-SR), a multidimensional assessment of sexual functioning (Derogatis, 1987). The DISF-SR is a brief, semi-structured interview designed to provide an estimate of the quality of an individual’s current level of sexual functioning in quantitative terms using 4-point Likert scales. The DISF-SR represents the quality of current sexual functioning in a multi-domain format, which to some degree parallels the phases of the sexual response cycle (Masters & Johnson, 1966). The semi-structured interview is arranged in five (V) domains that include a total of 25 questions addressing an individual’s sexual activities in the areas of: I. Sexual Cognition/Fantasy, II. Sexual Arousal, III. Sexual Behavior/Experience, IV. Orgasm, V. Sexual Drive/Relationship (Derogatis, 1987).

The DISF-SR was designed to address the need for a set of brief, multidimensional outcome measures that represent the status of an individual’s current sexual functioning through multiple levels of interpretation. Those levels include: the discrete item level (e.g., “A full erection upon awakening,” “Your ability to have an orgasm”), the functional domain level (e.g., sexual arousal score), and the global summary level (e.g., DISF-SR total score). There are separate semi-structured interview protocols for females and males, and thus norms and standardized scores are gender keyed. Clinician assessments of the participant’s quality of sexual functioning are
determined on an item-for-item basis, and may be obtained in both raw and standardized score formats. “The instrument may be used repeatedly throughout efficacy or effectiveness trials, or may be implemented solely at pre- and post-intervention without significant practice effects or loss of validity” (Derogatis, 1987, p. 1).

The psychometrics suggest the DISF-SR is highly reliable and a valid measure of sexual functioning (Derogatis, 1987). The interrater coefficient for the DISF-SR total score was a highly satisfactory .91. Similarly, test-retest reliability coefficients were good, ranging from .80 to .90, with the stability coefficient for the DISF-SR total score being .86. The pattern of these correlations represents a central psychometric characteristic of the instrument, which relates to most discernable aspects of construct validity (Derogatis, 1987). The DISF-SR was only used as a screening tool for the present study, and its results were factored into the final qualitative grounded theory analysis.

Each potential participant identified by counselors or the clinical director at SBRCC was given the DISF-SR, which required 15 to 20 minutes to complete. This interview was conducted during the first meeting with the researcher, when she described the nature of the study and reviewed all ethical considerations including consent and confidentiality. Given the fact the researcher explicitly described the purpose of the study and sexual health qualifications necessary for each participant to the clinical director and SBRCC counselors who referred participants, she believed it was unlikely the individuals recommended would score below the norm. However, if a preliminary participant did score below the norm, he or she was excluded from the study.

In addition to the DISF-SR, the Global Assessment of Functioning (GAF) Scale was used as a screening tool. The GAF score appears on Axis V of a multi-axial
assessment and allows for the reporting of the clinician or researcher’s judgment of an individual’s overall level of functioning (American Psychiatric Association, 2000). The GAF Scale is useful for tracking an individual’s clinical progress, but also for ascertaining an accurate level of functioning at the current moment. The later scenario is the manner in which the GAF Scale was used for the present study.

The GAF Scale is divided into 10 ranges of functioning and involves the researcher picking a single value between 0–100 that best reflects the individual’s overall level of functioning at a certain point in time. The present study’s researcher believed this would be useful as an additional standardized screening measure to help ensure the present level of function or dysfunction, rather than relying on the opinion of the participant’s counselor or the participant’s own estimation. The GAF Scale operationalized the “psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness” (APA, 2000). If the present study’s researcher encountered a potential participant with a GAF score of 60 or below, which demonstrate moderate symptoms, e.g., flat affect and circumstantial speech, occasional panic attacks, or moderate difficulty in social, occupational or school functioning (APA, 2000), they were excluded from the study.

In addition to identifying sexual dysfunction and a GAF score of 60 or below, exclusion criteria included participants reporting being actively suicidal, having an active psychotic disorder, or currently receiving treatment for sexual dysfunction.

**Data Collection**

Data for this study were collected using a self-developed interview protocol (Appendix E) designed to elicit responses about participants’ interpersonal and
intrapersonal relationships, as well as body image, pleasure, fantasy, orgasm, and social support. The interviews took approximately 60 minutes per participant and followed the qualitative method of intensive interviewing. Intensive interviewing is a directed conversation (Lofland & Lofland, 1995). This type of interviewing prompts a deeper exploration of a particular experience or process, and thus is an advantageous method for interpretive inquiry (Charmaz, 2006). By using this process, the researcher sought to understand the topic and whether or not the participant had the relevant experience to shed light on that topic (Fontana & Frey, 1994). The carefully developed interview questions encouraged the participant to describe and reflect upon his or her experiences in ways that seldom occur in everyday life (Charmaz, 2006). The researcher’s job was to listen, observe, and encourage the participant to add more or go deeper. “Hence, in this conversation, the participant does most of the talking” (Charmaz, 2006, p. 26).

The present study’s researcher designed seven broad, nonjudgmental, open-ended questions, each with subsections to elicit further thought and more detailed expression, both verbally and somatically on the part of the participant. Charmaz (2006) suggested that by creating such questions, the researcher encourages unanticipated statements and stories to emerge. The combination of how the researcher constructs the questions and conducts the interview shapes how well she achieves balance between making the interview open-ended and focusing on significant statements. Because of the somatic nature of the present study, the researcher also focused on significant visual cues including eye contact, postural adjustments, pauses, and prosody variations. The tenets of intensive interviewing the researcher followed are delineated by Charmaz (2006):
As a grounded theorist, the intent was to learn what was happening from the beginning of the analysis. This attempt to learn aids in correcting tendencies to follow preconceived notions. In addition to pursuing themes from the interviews, the researcher looked for repetitive concepts in the data and then returns to the participant to gather focused data to answer analytic questions and to fill conceptual gaps (Glaser, 1998). Grounded theory interviewing techniques narrow the range of interview topics in order to gather particular data for developing theoretical frameworks. “Thus, the combination of flexibility and control inherent in intensive interviewing techniques fit grounded theory strategies for increasing the analytic incisiveness of the resultant analysis” (Charmaz, 2006, p. 29).
The researcher transcribed the most evident and what she believes to be the most pertinent data during each interview using a pen and paper. She noted key words and phrases as well as somatic cues, such as shifts in stance/position, hand gestures, changes in breathing, level of eye contact, twitching or trembling, and rigidity or flexibility in posture, in the margins of her notes next to each question. The researcher also followed participants’ prosody and how they utilize nonverbal (silent) and verbal pauses (throat clearing, ehs, ums, etc.). The interviews were audio recorded for comprehensive analysis purposes post-interview, including transcription by a professional transcriber/transcription service deemed appropriate by the researcher and her committee chair.

At the beginning of each interview, the researcher reminded participants of the ethical guidelines being followed as well as their rights as stipulated by the signed informed consent and confidentiality agreements. It was restated that all data gathered from each participant during the course of the study is strictly confidential. The researcher approximated conducting interviews at SBRCC over a period of 10 days (longer if data saturation is not reached). During those 10 days, the written and recorded transcripts were stored in a locked file cabinet within the SBRCC offices. When the researcher determined data saturation had been achieved and no further interviews were necessary, she transported the transcripts in a locked briefcase from the SBRCC offices in Santa Barbara, California, to her home in Benicia, California. Once there, they were stored in the locked briefcase within a locked file cabinet in the researcher’s office.

The participants were never identified by name, nor were they mentioned in any published or unpublished material resulting from the research. Each participant was
given a number, e.g., 101–112, and that number followed the participant through each subsequent interview until data saturation was reached. To further augment confidentiality, if the researcher believed there may be identifying characteristics garnered through data collection, upon transcription she sanitized that information by changing the participant’s age, gender, race, occupation, etc. The researcher’s laptop computer is also password protected and did not leave her office during the data analysis and result or the discussion-writing stage of the study.

Participants were informed that the written transcripts and audio recordings collected during the interviews would be destroyed seven years after the date the dissertation was successfully defended. Until that time, the DISF-SR screening tool results, written transcripts, and digital recordings will continue to be stored in the same manner in which they were stored during data analysis. Lastly, participants were informed that the research results are reported as a summary, and no individual identifying information is presented in the dissertation, during oral defense, or in any other published or unpublished works. During the signing of the informed consent, participants were given the option to obtain a copy of the summary of results upon study completion either by U.S. Postal Service or email.

**Data Analysis**

Despite the open, flexible nature of grounded theory data collection, there exists a set of specific principles, called coding, used for analyzing and abstracting information. Coding is a heuristic technique, and the initial step in a rigorous and evocative analytical interpretation for a study (Saldana, 2009). “Coding is not just labeling, it is linking. It
leads the researcher from the data to the idea and from the idea to all the data pertaining to that idea” (Richards & Morse, 2007, p. 137).

Grounded theory coding goes through numerous cycles in order for the researcher to recode and further manage, filter, highlight, and focus the salient features of the data for generating categories, themes, and concepts, grasping meaning, and building theory (Saldana, 2009). Dey (1999) suggested when researchers discover categories, they impute meaning, and when they use coding, they compute meaning. Saldana (2009) concurred and posits that qualitative codes are in essence capturing essential elements of the research story that, when clustered together according to similarity and regularity, actively facilitate the development of categories and thus the analysis of their connections.

The data in the present study was coded per the grounded theory procedure using open, axial, and theoretical processes first developed by Glaser and Strauss (1967) and elucidated by Charmaz (1995b/2000/2006). Charmaz (2006) suggested that coding involves categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data. The researcher’s codes show how she selects, separates, and sorts data to begin an analytic accounting of them. “Coding is the first step in moving beyond concrete statements in the data to making analytic interpretations. Researchers aim to make an interpretive rendering that begins with coding and illuminates studied life” (Charmaz, 2006, p. 43). Coding is the primary link between collecting data and developing an emergent theory to explain these data. In the present study, the process of grounded theory coding allows the researcher to define what is happening in the data collected from survivors’ interviews, and begin to grapple with
what it means in progressive terms. The researcher asked herself the following: “What are the most general concepts or themes present in the data?” “How do these concepts link to define categories?” And, “How do the categories fit together to produce a theory for describing the embodied process of recovery of sexual health after sexual assault?”

The four stages of grounded theory analysis—coding, concepts/themes, categories, and theory—were used as a framework in preparation for answering the research question. Open coding is the first level of coding abstraction. Written data from the transcripts are conceptualized word-by-word and line-by-line to explore the experience or problem and begin to understand how it is being resolved. Open coding was done in the left-hand margin of the researcher’s transcription. With open coding, the researcher is conceptualizing all incidents in the data, which yield numerous concepts or themes. Open codes are provisional in the sense that the researcher may reword them to improve the fit with the data. Part of the fit is the degree to which they capture and condense meaning and actions (Charmaz, 2006). Charmaz encourages researchers to stay close to the data in the open coding phase, which can prompt the realization of areas in which more data is necessary. Per standard grounded theory strategy, “Make codes fit the data rather than forcing the data to fit the codes” (Charmaz, 2006, p. 49).

The second level of grounded theory coding is axial, during which time the researcher searches for links through the identification of concepts that may go some way toward offering an explanation of the phenomenon under study (Goulding, 2005). The purposes of axial coding are to sort, synthesize, and organize large amounts of data and reassemble them in new ways after open coding (Creswell, 1998). Axial coding is achieved by specifying relationships and delineating core categories or constructs around
which the other concepts revolve. Goulding (2005) suggested axial coding is the appreciation of concepts in terms of their vigorous interrelationships, forming the basis for theory construction. Strauss and Corbin (1990) defined axial coding as “a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories” (Strauss & Corbin, 1990, p. 96). For her part, Charmaz (2006) suggested axial coding relates categories to subcategories, specifies the properties and dimensions of a category, andreassembles the data the researcher has unraveled during open coding to give coherence to the emerging analysis.

Theoretical coding is the third and final level of coding in grounded theory analysis, and the process follows the codes the researcher has selected in axial coding (Charmaz, 2006). Theoretical codes integrate the theory by weaving the differing concepts into hypotheses that work together to help answer the research question. Theoretical coding showcases the data that has emerged during the comparative process of analysis. A theoretical code pulls together all concepts in order to offer an explanation of the phenomenon under study (Glaser & Strauss, 1967). It will have theoretical significance and is traceable back through the data. Charmaz (2006) suggested theoretic codes add precision and clarity to the data as well as aid the researcher in making the analysis coherent and comprehensible. “Theoretical codes not only conceptualize how the researcher’s substantive codes are related, but also move the analytic story in a theoretical direction” (Charmaz, 2006, p. 63).

An additional and vital aspect of grounded theory coding is in vivo coding. Grounded theorists generally refer to codes of participants’ specific terms and phrases as in vivo codes. These terms provide an essential analytic point of departure to help
preserve participants’ meanings of their views and actions in the coding itself (Charmaz, 2006). It is critical for the researcher to pay attention to language while coding. *In vivo* codes serve as symbolic markers of participants’ speech and meaning. As with any other code, *in vivo* codes need to be subjected to comparative and analytic treatment.

“Although the terms may be catchy, *in vivo* codes do not stand on their own in a robust grounded theory analysis; these codes need to be integrated into theory” (Charmaz, 2006, p. 55). Three kinds of *in vivo* codes researchers have proven to be useful include: general terms that have a cultural shared meaning that flag condensed but significant meanings; a participants’ innovative term that captures meanings or experience; insider shorthand terms specific to a particular group that reflect their perspective (Charmaz, 1995b/2000/2006; Glaser, 1978/1998; Goodwin, 2010; Saldana, 2009; Willig, 2008).

Given the somatic nature of the study, the researcher was able to identify nonverbal *in vivo* codes as well. The researcher looked for common somatic signs such as postural adjustments, pauses, and twitches, which may be repetitive from one participant to the next at specific times during the interview process. As with the verbal *in vivo* codes, the researcher exposed the nonverbal codes to grounded theory’s comparative analytic treatment.

Memoing is yet another central part of grounded theory analysis, which begins in the open coding phase (Glaser, 1998). Memos are the theoretical write-up of notions regarding substantive codes and their relationships as they emerge while collecting and analyzing data. Memoing helps the researcher to conceptualize incidents and is an important tool to both refine and keep track of ideas that develop as the researcher compares line-to-line, and then concept-to-concept, in the evolving theory (Glaser, 1998).
Charmaz (2006) described memos as informal analytic notes. She suggested memoing start in the open coding phase and move upward through theoretical categories. Memo writing is the pivotal intermediate step between data collection and writing the first draft of the study’s results. Memo writing constitutes a crucial method in grounded theory because it prompts the researcher to analyze her data and codes early in the research process (Charmaz, 2006). Memos catch the researcher’s thoughts, capture the comparisons and connections, and crystallize questions and directions of analytical pursuit; new ideas and insights arise during the act of writing. Through memo writing, the researcher constructs analytic notes to explicate and fill out categories. “Memos give space and place for making comparisons between data and data, data and codes, codes of data and other codes, codes and category, and category and concept, and for articulating conjectures about these comparisons” (Charmaz, 2006, p. 73).

Lastly, in regard to coding data gathered from the present grounded theory analysis, utilizing qualitative data analytic software is an option. In this domain, the software can assist the researcher in putting the data into “chunks” or concepts (e.g., into separate words, phrases, lines, sentences, paragraphs, and free-form segments) and then attach codes or key words to those concepts (Miles & Huberman, 1994). NVivo is a computer software package specifically designed for rich, text-based, and multimedia information, where deep levels of analysis on large or small volumes of data are required (Qualitative Software Research International, 2013). The program is designed to do exactly what the researcher does manually, but with more ease, less time, and perhaps more detail. NVivo uncovers subtle trends and the automated analysis allows the researcher to dig more deeply into areas of interest. For example, the software package
permits the researcher to search for an exact word or words that are similar in meaning to quickly test theories. As with manual coding, NVivo helps track concepts by providing space for annotations to capture ideas or create memos. It also features automated links that “glue” items with similar themes together (Qualitative Software Research International, 2013). NVivo displays connections, ideas, and findings using a range of visualization tools such as charts, maps, and models, and easily allows the researcher to view the live data behind them.

**Reflexivity**

A central delineation of most types of qualitative methodologies is the degree to which they emphasize reflexivity. Namely, it is the importance the qualitative methodology places on the role of the researcher in constructing meaning throughout the study (Willig, 2008). “Reflexivity requires an awareness of the researcher’s contribution to the research process, and an acknowledgement of the impossibility of remaining outside of one’s subject matter while conducting research” (Willig, 2008, p. 10). Reflexivity encourages the researcher to explore the ways in which his or her involvement with a particular study influences, acts upon, and informs the research.

Researchers have identified two types of reflexivity: personal reflexivity and epistemological reflexivity (Charmaz, 1995b/2000/2006; Coolican, 2009; Creswell, 2009; Meltzoff, 1998; Miles & Huberman, 1994; Strauss & Corbin, 1990; Willig, 2008). Personal reflexivity involves the researcher reflecting on her values, experiences, beliefs, interests, and social identities, and how they have shaped the research. It also involves considering how the research may have changed the researcher as a person and as a research professional. Epistemological reflexivity has more to do with the actual
methodology involved in the study, and requires the researcher to ask questions such as, “How has the research question defined and limited what can be found?” And, “How has the design of the study and method of analysis (e.g. manual coding versus NVivo coding) constructed the data and findings?” Lastly, the researcher can ask him or herself how the research question may have been investigated differently (Miles & Huberman, 1994; Strauss & Corbin, 1990; Willig, 2008).

Pursuant to Charmaz’s (1995b/2000/2006) principles of grounded theory data analysis, the researcher recognized her personal perspective constructed the interpretation of the data. The researcher scrutinized her research experience, decisions, and interpretations in ways that brought her into the process and allow the reader to assess to what extent the researcher’s interests, positions, and assumptions influenced the inquiry (Charmaz, 2006; Coolican, 2009). To that end, the researcher kept a personal reflexivity journal of her experience participating in the study. The researcher commenced journaling at the beginning of data collection. Reflections she considered include:

* What her relationships with the participants feel like
* Reconsidering what a participant said during an important exchange
* A new hypothesis that might explain some perplexing observations
* A mental note to pursue an issue further in the next interview
* Cross-allusions to material in another part of the data set
* Personal reactions, including somatic, to a participant’s remarks
* Elaboration or clarification of a prior incident that now seems significant. (Miles & Huberman, 1994, p. 66)
Per the ethical principles set forth in the APA’s guidelines and code of conduct, the researcher followed protocol and refrained from writing any identifying information regarding participants in the journal. As stated in the research design, each participant was given a number. That number corresponded to notes made in the journal. Additionally, as with the collected data, the journal was stored in a locked file cabinet when not in use by the researcher during and between interviews throughout the data collection process. Upon completion of the study and successful defense of the dissertation, the journal containing all of the researcher’s reflexive remarks will be stored for a period of seven years in the same locked file cabinet as the data. At the seven-year mark, all data, including the journal, will be shredded and properly disposed of.

The researcher welcomes the opportunity to be a part of the world she is studying and the data she is collecting. Due to the somatic nature of the study, the researcher paid particular attention to her own possible physiological changes, which may be prompted by the process (e.g., increased heart rate, queasiness, fidgeting). The researcher also reflected on salient feelings such as avoidance of difficult emotions, or on the other hand, over identifying with certain words or actions that could signal preconceptions or biases. “A sound reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them coherently in written reports” (Charmaz, 2006, p. 188).

**Strengths, Limitations, and Contributions to the Field**

A commitment to awareness, a dedication to accuracy, and the assurance that research will be grounded in data is required if the results are to make a valid contribution
to the literature and field of somatic psychology. Given this awareness regarding the utilization of grounded theory methodology, the researcher was open to the possibility that her theoretical position may be influenced or changed. It may change due to what the specific data reveal, or in a more general sense, the research question itself may skew or limit “what can be found” (Willig, 2008, p. 201). The researcher acknowledges her bias toward embodiment, and thus the reflexivity portion of the data analysis is an essential part of the investigative process. It illuminates emerging bias, opinion, or resistance on the part of the researcher, and offers another layer of scrutiny. This contribution is critical when producing an accurate reflection of the participants’ lived experience (Willig, 2008, p. 208).

There were some inherent limitations to this study that must be considered when interpreting the data. Because participants were recruited only from Santa Barbara, California, results cannot be generalized to all sexual assault survivors. Additionally, the researcher was present while the qualitative measures were applied; questions were asked directly to participants from the interview protocol. Results may have been different if the participants transcribed the answers themselves. It is also worth acknowledging the risk of aiming for theoretical saturation but not reaching it (e.g., invoking the term uncritically) (Charmaz, 2006). Again, the researcher stringently followed grounded theory methodology protocol to ensure the data speaks for itself, rather than the researcher’s biases speaking for the data.

The study’s methodological tradeoffs did not override the relevance of the data collected, or the noteworthiness of the categories, themes, and theories that were discovered. The researcher adhered to the criteria for rigor in qualitative research (Guba
& Lincoln, 1994), which includes an examination of all relevant aspects of credibility, transferability, dependability, and confirmability.

Summary

The complexity of both the psychological and physiological symptoms of survivors of sexual assault demands attention and careful thought in order to understand the process of recovery, especially as it relates to sexual health. By narrowing the lens of existing research and looking mainly at the embodied process of recovery of survivors’ sexual health, the present study offers a perspective not currently available in the literature. It is the researcher’s conviction that the study made a significant contribution to the field in terms of research and clinical interventions.
Chapter 4: Results

Consistent with Charmaz’s (1995/2000/2006) grounded theory framework, the results depicted in this chapter utilize a constructivist approach. Priority was placed on the phenomena of the study and both data and analysis were created from shared experiences and relationships with participants (Charmaz, 2006). The results reflect how participants construct meanings and actions in relation to the specific questions asked during the interview process. “A constructivist approach means more than how individuals view their situations. It not only theorizes the interpretive work that research participants do, but also acknowledges that the resulting theory is an interpretation” (Charmaz, 2006, p. 130).

The results, as shown in the chapter’s figures and excerpts, represent grounded theory constructive analysis because they combine and interpret implicit meanings that constitute a category. In this way, a seemingly banal statement alludes to a range of meanings and helps define a category. “An interpretive analysis invites the reader’s imaginative participation in related experiences through theoretical rendering of the category” (Charmaz, 2006, p. 147). This interpretation provides the categories with significance. Without it, participants’ “unexplicated statements” (p. 147) about the recovery of sexual health after sexual assault would remain unexplored thoughts and lack theoretical influence.

Before presenting the results, the researcher will reiterate the importance of stating her intent through grounded theory design as defined by Charmaz (1995/2000/2006). This approach tempers subjectivity and ambiguity through shared assumptions about the topic of study, yet also through the well-established format for
conducting research. Charmaz stated a grounded theory study’s purpose succinctly: “In the end, inquiry takes us outward yet reflecting about it draws us inward. Subsequently, grounded theory leads us back to the world for a further look and deeper reflection—again and again” (Charmaz, 2006, p. 149). The researcher’s analytic renderings of what she hears and observes are interpretations through dialogue that is verbal, prosodic, and somatic. It is worth reflecting on the importance and influence of the researcher’s inherent biases garnered through her own life experience. The reflexivity component of the study is presented in Chapter 5 and serves as a reminder that the researcher is a part of the constructed theory rather than a mere observer reporting verbatim discourse.

Screening Tool Results and Demographics

Thirteen potential participants, all female, contacted the researcher in response to the recruitment flyer distributed at the Santa Barbara Rape Crisis Center (SBRCC). As per the data collection strategy presented in Chapter 3, the researcher set up appointments with the potential participants by phone and met with them at the SBRCC for 75–90 minutes at the designated time. During this initial interview, the researcher conducted the Global Assessment of Functioning (GAF) and gave each participant a score based on the participant’s judgment of her own functioning within the ranges designated in the assessment tool, i.e., 60–70, 70–80, 80–90, 90–100. Upon request from the researcher, the participant’s counselor at the SBRCC then confirmed this score for validity and relative accuracy. All GAF scores were agreed upon within a 9-point differential by the researcher, participant, and therapist. This degree of accuracy through the collectively agreed upon GAF score provided reassurance to the researcher that each candidate was qualified to participate in the study given the results of this first screening tool.
Furthermore, no participant scored 60 or below, which would have disqualified them from participating.

The second assessment/screening tool conducted was the Derogatis Interview for Sexual Functioning-Self Report (DISF-SR). In addition to the five primary domain scores, the DISF-SR has an aggregate total score. Norms are based on normalized area $t$ scores, which means $t$ scores have true percentile-based equivalents. A $t$ score of 50 represents the 50th percentile of the normative distribution; a $t$ score of 40 is one standard deviation below the mean and reflects the 16th percentile. A $t$ score below 40 represents the margins of the clinical range, and $t$ scores on any of the domains or the total score of $< 37$ are considered in the clinical range (Derogatis, 1987).

Only one participant, number 113, scored below 40 and was therefore deemed to be in the clinical range for sexual dysfunction and was disqualified from participating in the study. Due to the ethical protocol put in place for the study, the researcher conducted the rest of the initial interview as usual by delivering the seven-question, semi-structured interview. The GAF and DISF-SR results for participant 113 are showed in Figures 1 and Figure 2, though a grounded theory analysis was not performed on her answers to the semi-structured interview questions (Appendix E).

The demographic information for study participants is shown in Figure 1. Characteristics include: participant number (101–113), age, ethnicity, years since assault, GAF score, and DISF-SR $T$ score. In summary, all participants were female between the ages of 26 and 65. Nine participants were Caucasian, one was Japanese/Mexican, two were Hispanic and one was Slavic. Years since assault range from 3 to 47, with a mean of
18.6 years. DISF-SR T-scores range from 32 (participant 113, not useable) to useable scores of 51 to 68, with a mean of 61.8.

Figure 1. Graphical representation of demographic information of study participants.

Figure 2 is a histogram showing a graphical representation of the distribution of data for the DISF-SR. It depicts the estimate of the probability distribution of the continuous variables on the DISF-SR and is normalized by displaying relative frequencies. It shows the frequency of each participant’s responses (raw score and T-
score) for the five domains, e.g. cognition/fantasy, arousal, behavior/experience, orgasm, and sexual drive.

Figure 2. Graphic representation of distribution of data for DISF-SR.

Data

The 12 transcripts from the seven-question, semistructured interview were professionally transcribed utilizing the confidentiality measures put in place and described in Chapter 3. Upon completion, the transcripts were reviewed by the researcher for accuracy by comparing them to the audiotape session material. The researcher found
the transcripts to be complete and accurate. All transcripts are saved as Microsoft Word (.docx) files.

Although the data analysis results will be thoroughly presented later in this chapter, it is important to note the tenor and affect of participants during data collection. The data collection process went smoothly with no participants appearing triggered or distressed by the questions asked. In the best-case scenarios, several participants said, “That’s a great question,” and elucidated at length, while worst-case scenarios included answers such as “I don’t know” and no further content was given. The researcher most often gave an additional probe question—something phrased slightly differently than the original interview question—after an “I don’t know” response. Sometimes the probes did elicit new information and sometimes they did not. The researcher used her own experience working with survivors, as well as her gut therapeutic instincts to determine whether to push a participant into a deeper level of exploration of her answer or leave “I don’t know” as the answer in and of itself.

Of utmost importance, and in keeping with her own personal ethics and those stipulated by the APA and IRB, the researcher does not believe any participants were emotionally harmed or left in a worse state than prior to beginning the study. If anything, several participants reported being nervous at the start of the interview but feeling comfortable and calm by the end. In brief, they described the interview as a difficult, yet revealing and enlightening process. When asked the fourth predetermined probe of question number seven, “How are you feeling after this interview? Do you need me to help arrange additional support for you at this time?” all participants answered, generally and in their own personal way, that they felt “fine” or “good” and did not need the
researcher to arrange for additional support. A final question to each participant was inquiring when her next session with her SBRCC counselor was scheduled. Answers ranged from later that day to less than two weeks from that day. This reassured the researcher that adequate support was in place.

The researcher was keenly aware of the significance of the face-to-face interviews, particularly in regard to the somatic nature of the study. She followed Charmaz’s tenets of intensive interviewing (2006) in order to get as much data as possible out of the first round of interviews and limit the number of times she needed to contact the participants. In particular, she stopped frequently to explore statements, request more information, come back to earlier points, restate the participants’ points to check for accuracy, slow the pace, and use observational skills based on her somatic psychology training (Charmaz, 2006). Even with this diligence, at the end of the interview the researcher reiterated the possible need to contact the participant again if she deemed more information was needed in regard to a particular question or questions. All participants were amenable to being contacted by phone within two weeks of their initial interview date.

**First Stage Analysis**

As the grounded theory method of analysis requires, the researcher undertook first stage open coding within one week of collecting the initial data in order to follow up with participants, if necessary, within the two-week timeframe agreed upon. Line-by-line coding of hand-written notes and the official transcripts were then completed. Line-by-line coding entails naming each line of the written data (Glaser, 1978) and allows the researcher to remain open to the data and see its nuances. While Glaser (1978) and
Charmaz (2006) posited this might seem like an arbitrary exercise because not every line contains a complete sentence, the researcher believes it was critical in helping recognize early emergent themes and, most notably, see where data was lacking on some answers from certain participants. “Engaging in line-by-line coding as the first step helps the researcher to refocus later interviews. The following flexible strategies should be utilized” (Charmaz, 2006, p. 50):

* Breaking the data up into their component parts or properties
* Defining the actions on which they rest
* Looking for tacit assumptions
* Explicating implicit actions and meanings
* Crystallizing the significance of points
* Comparing data with data
* Identifying gaps in the data.

The first open coding analysis using line-by-line coding revealed 64 emergent codes from the seven questions and offered clear insight into where gaps in the data existed. The researcher called 5 of the 12 participants to clarify or expound upon their answers to specific question(s) within the semi-structured interview. It is notable that questions four and five were the ones in which clarification was needed from each of the five participants contacted. Question four deals with sexual fantasies and question five explores beliefs about orgasm. The significance of the brevity of data from these two questions led the researcher to wonder whether the questions were not phrased as succinctly as they could have been or if, due to the personal nature of the questions,
participants were hesitant to reveal more. Another possibility is these participants had not given fantasy or orgasm a great deal of thought since their sexual assault.

Rather than delving into the reason behind the brevity in these answers, the researcher took 20–30 minutes per participant, over the phone, to ask the questions again. Unless participants requested it, the researcher did not tell them what their initial responses to the questions were. The researcher asked them to speak slowly and allow pauses after the questions were answered in order to accurately transcribe, using pen and paper, their responses.

The researcher transcribed notes into Microsoft documents, which also included audible somatic cues such as deep breaths, ehs, ums, or long pauses, and added those notes to the original official transcripts for the appropriate participant. The researcher then utilized second cycle line-by-line open coding to ascertain how the new data fit with the original data. “Second cycle coding methods, if needed, are advanced ways of reorganizing and reanalyzing data coded through first cycle methods. They each require fitting categories with one another to develop a coherent synthesis of the data corpus” (Saldana, 2009, p. 149). The researcher recognized that before the categories were assembled, the data might need to be recoded because she had discovered more accurate words or phrases than those that were discovered for the original codes. Some codes merge together because they are conceptually similar, infrequent codes will be noted for relevance, and some codes that seemed like important codes during the first cycle are dropped because they become marginal or redundant (Lewins & Silver, 2007).

Knowing that an expert in NVivo qualitative software would assist in the analysis of the data, the researcher’s goal was to ensure participants answered all questions as
thoroughly as possible. The researcher needed to be confident no new theoretical insights or properties were emerging and that data saturation requirements had been achieved. The reflexivity portion of this Chapter 5 more fully explains the researcher’s assurances and struggles with the analytic reality of meeting data saturation requirements per grounded theory analysis. In brief, while the researcher realized there was always more a participant could say and always more insight to be revealed, she had to rely on Charmaz (2006) and Glaser (1998) for their expert definitions of data saturation. To reiterate the concept of data saturation discussed in Chapter 3, “saturation is not merely seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidents which yield different properties of the pattern until no new properties of the pattern emerge” (Glaser, 1998, p. 191). Charmaz believed this notion of data saturation forms the foundation for treating theoretical concepts in grounded theory. “When you treat categories theoretically, you raise them to an abstract and general level while preserving their specific connections to the data from which you constructed these categories” (Charmaz, 2006, p. 113).

After the second round of interviews with the five participants and the second cycle coding was complete, the researcher believed data saturation requirements had been met based on the above definitions. It was at this point she released the transcripts to an NVivo software specialist (getting all appropriate confidentiality forms signed) for statistical analysis.
NVivo Data Analysis and Interview Titling for Coding

Twelve interviews were provided to the NVivo specialist as Word document files. Files were renamed to include gender, years since assault, age, and interview ID number. This was done to take advantage of the sorting feature in NVivo 10, which sorts coding reports alphabetically according to the titles of the interviews, assuming text has been coded from those documents.

- Gender - all female (F)
- Years since assault (03yr to 47yr)
- Age (age26 to age65)
- Interview ID (01–12)

Interview titles sort alphabetically within the coding reports by gender, then by years since assault, then by age, and finally by ID as shown below.

1. F_03yr_age30_08
2. F_05yr_age45_11
3. F_08yr_age27_01
4. F_10yr_age34_02
5. F_12yr_age26_06
6. F_12yr_age34_10
7. F_14yr_age39_03
8. F_15yr_age35_04
9. F_16yr_age36_09
10. F_40yr_age53_05
11. F_42yr_age63_07
12. F_47yr_age65_12

Node Titles Created From Interview Guides

Seven categories (nodes) were created in NVivo 10 to mirror the interview guide.

Q1-How felt after sexual assault
Q2-Changes in relationships with others
Q3-Present in body during sexual encounter
Q4-Changes in sexual fantasies
Q5-Beliefs about orgasm
Q6-How is relationship to your body different
Q7: Sexual health

Coding Process: Interviews

The 12 interviews were prepared and imported using NVivo 10 qualitative software and coded to seven “Interview Questions” node titles as shown above. Each interview was read manually and categories (nodes) were created during the process to mirror the interview questions. During the initial coding process, many nodes were created, retitled, and/or merged with others as content was manipulated and organized, resulting in a total of eight nodes with 303 subcategories for the 12 interviews as shown below.

Interview Questions (Node Listing of Coding Reports)

Q1-How felt after sexual assault (5 subcategories)
  • Feelings after assault (31 subcategories)
    – Alienated
    – Angry
    – Betrayed
    – Confused
    – Depressed
    – Disenfranchised
    – Disgusted
    – Distrustful
    – Feeling bad
    – Frightened
    – Guilty - Culpable - Blameworthy
    – Hatred
    – Identity
    – In denial
    – Isolated
    – Lonely
    – Marked as dirty
    – Need to escape
    – Numb
    – Powerless
    – Robbed
    – Self-reflection
    – Shame
- Shunned
- Stupid
- Taken advantage of
- Unsafe - Vulnerable
- Untrustworthy
- Victimized
- Worthless
- Yucky

• Feelings prior to assault (2 subcategories)
  - Negative prior (7 subcategories)
    o Angry
    o Bad
    o Fear
    o Guilt with sex
    o Insecure
    o Not confident
    o Uncomfortable
  - Positive prior (14 subcategories)
    o Adventurous
    o Confident - Capable
    o Full of life
    o Generous
    o Happy-go-lucky
    o Optimistic
    o Outgoing
    o Passionate
    o Reasoned anger
    o Relationships
    o Sex as positive thing
    o Somewhat shy
    o Top of the world
    o Trusting

• Number of assaults and approximate age
• Perpetrators and situations (8 subcategories)
  - BF or ex-BF or casual acquaintance
  - Boss
  - Cannot remember
  - Doctor
  - Family member
  - Not stated
  - Serial rapist - unclear if known
  - Stranger

• Prominent feelings (15 subcategories)
  - Alienation - Lonely
  - Angry
– Betrayed
– Emotionally beat-up
– Empty
– Fear
– Guilty
– Insecure
– Loss of self-confidence
– Loss of self-esteem
– Sad
– Shock
– Shut down - doomed
– Stupid
– Undeserving

Q2-Changes in relationships with others (4 subcategories)

• Changes in relationships (7 subcategories)
  – Boyfriend or sexual partner
  – Business partner and friend
  – Casual friends
  – Family
  – Husband
  – Men, in general
  – Women, in general

• Changes in self (18 subcategories)
  – Abstinence
  – Bitter
  – Broken - Disintegrated - A wreck
  – Cautious
  – Devastated
  – Discretionary
  – Distrustful
  – Fearful - Panic attacks
  – Frozen
  – Hesitant - Unsure
  – Isolation - Closed off
  – Manipulative
  – Numb
  – Practical
  – Questioned myself
  – Tainted all experiences
  – Unconfident
  – Weak

• Intimate relationship stronger or weaker (2 subcategories)
  – Not in intimate sexual relationship
  – Weaker

• Main feeling belief or quality impacted relationships (11 subcategories)
– Abstinence
– Asexual
– Depression
– Fear of perpetrator
– Fear of vagina
– Game playing
– Guilt
– Isolation
– Over-extended
– Promiscuity
– Substance abuse

Q3-Present in body during sexual encounter (4 subcategories)
• Assault changed body functions (14 subcategories)
  – Anxiety
  – Body hatred
  – Flashbacks
  – Hypersensitivity
  – Insomnia
  – No changes
  – Numbness
  – Pain
  – Panic attacks - hyperventilate
  – Physical damage & infection
  – Recoil
  – Self-concept
  – Sexuality
  – Violent or traumatic triggers
• How give or receive pleasure (2 subcategories)
  – Give (8 subcategories)
    o Anxiety
    o Cautious
    o Disgusting
    o Fun
    o Out of body
    o Powerful - In control
    o Specifies oral sex (7 subcategories)
      ▪ Can't give - okay receive
      ▪ Comfortable
      ▪ Disgusting
      ▪ Submissive
      ▪ Trigger
      ▪ Unrespected
      ▪ Used and dirty
    o Unrespected
Receive (10 subcategories)
  - Cautious
  - Difficult
  - Do not want pleasure
  - Hard to accept - Suppress
  - Love it - Like it
  - Shame
  - Specifies oral sex (6 subcategories)
    - Boring
    - Comfortable
    - Distracted
    - Fear
    - Receive okay - can't give
    - Uncomfortable
  - Taking control
  - Uncomfortable
  - Vulnerable

• Pleasure during sex – any difference (4 subcategories)
  - No or not as much
  - Recognition of rape as crime
  - Yes - always
  - Yes but some anxiety

• Present in body (2 subcategories)
  - Not present
  - Present

Q4-Changes in sexual fantasies (4 subcategories)
• Changes in sexual fantasies (13 subcategories)
  - Does not have sexual fantasies
  - Dominance - pain
  - Dwindled
  - Guilt-ridden
  - More complicated after therapy
  - No face
  - Non-erotic
  - Oral sex
  - Sadistic - Pain pleasure
  - Same sex
  - Unconventional - more intense
  - Violent to regular
  - Young guys - loving relationships

• Fantasies kept secret (3 subcategories)
  - Depends
  - No
  - Yes
• Fantasies most exciting (8 subcategories)
  – Bisexual - Multiple partners
  – Dominated - controlled
  – None recognized
  – Non-participatory observer
  – Sadistic
  – Safe - loving
  – Teasing participation
  – Unobserved sex in public
• Fantasies scare disturb feel ashamed (7 subcategories)
  – Arousal - orgasm
  – Focus on partner
  – None
  – Rape - BDSM - Sadistic
  – Recumbent or uninvolved partner
  – Same sex
  – Underage partner

Q5-Beliefs about orgasm (4 subcategories)
• After assault
• Before assault
• Orgasm - Pleasure – do you deserve (3 subcategories)
  – Maybe
  – No
  – Yes
• Orgasm experiences now (8 subcategories)
  – Addictive
  – Before assault
  – Feeling of release
  – Hyperstimulates
  – Out of control
  – Pleasurable
  – Pressure to achieve
  – Scary - overwhelming - holding back

Q6-How is relationship to your body different (4 subcategories)
• Body (2 subcategories)
  – Immediately after assault
  – Today
• Relationship with food and exercise (2 subcategories)
  – Exercise (2 subcategories)
    o Negative
    o Positive
  – Food (2 subcategories)
    o Negative
• **Positive**
  - See when look in mirror (3 subcategories)
    - Negative
    - Other
    - Positive

• **Self-harm experiences** (2 subcategories)
  - In the past (6 subcategories)
    o Addiction - Exercise
    o Cutting - Self-inflicted pain
    o Eating disorder
    o None
    o Sexual behavior
    o Substance abuse
  - Today or occasional (6 subcategories)
    o Addiction - Exercise
    o Addiction - Video games
    o Cutting
    o Eating disorder
    o No
    o Substance abuse

**Q7-Sexual health** (4 subcategories)

• **About you or encompass relationships** (3 subcategories)
  - Encompasses - Others
  - Encompasses - Sexual partners
  - Exceptions

• **How will you know** (9 subcategories)
  - Acceptance
  - Balanced
  - Comfortable
  - Connected and present
  - Healthy expectations
  - Not afraid
  - Open communication
  - Sexually active
  - Trusting

• **Support in maintaining** (10 subcategories)
  - Children
  - Counselor - Rape Crisis Center
  - Do not talk to them for support
  - Friends
  - Husband - Fiancé
  - Media
  - Naturopath
  - Self - Self-reflection - Journaling
- Sexual partner
- Therapist
- What does term mean to you (10 subcategories)
  - Boundaries
  - Comfortable
  - Connected and present
  - Faithful to one partner
  - Healthy expectations
  - Open communication
  - Proud
  - Self-acceptance
  - Sexually active
  - Shared space

Q8-Anything else (5 subcategories)
- How did you get from there to here
- How feel now - need additional support
- See results of study
- What has been most helpful
- Why not ask for help at that time

**Coding Strategy and Reports**

The coding strategy used in the NVivo analysis provides reminders within various nodes rather than attempting to code every line of text to every node possible. It is also coded for context, which is important to provide meaning for qualitative analysis. The content is analyzed as it relates to the node title. Because coding is a subjective process, the researcher wants to note the NVivo analysis is not exhaustive. In this study, categories have multiple meanings and content was coded to multiple questions when relevant.

In reading the coding reports, 303 individual coding reports have been compiled into eight coding reports (following the titles Q₁–Q₈ noted above). A table of contents with page numbers appears at the end of each interview title. Thus, Appendix F contains eight coding reports with page numbers. Excerpts from the reports are found later in this
chapter with the researcher’s own interpretation and analysis for axial and theoretical coding purposes.

**Frequency Counts**

A frequency counts spreadsheet (Appendix F) presents the frequency of references for each individual node. NVivo 10 automatically inserts the number of references and percentages at the end of each interview title. The percentages give an idea of proportionality of references that were coded from the interview to the category. The references relate to the number of times text was selected within the interview, and the percentage is the percent of the document each selection represents.

There are up to six layers in the node listings. The first layer of coding contains the main category “Interview Questions,” which is empty in NVivo 10 because everything is coded to subcategories. The second layer of coding contains nine core subcategories; the third layer of coding contains subcategories emerging from the second layer; and so on through the sixth layer.

Responses are mutually exclusive (either/or) when comments can only be coded to one or another category within the same set. Furthermore, each interview is only counted once in frequency counts regardless of how many selections of text have occurred within each interview. In regard to the frequency counts spreadsheet, coding an interview to multiple categories is called “multiple coding” and is due to the nature of responses from a single interview having meaning in more than one category. The interview is only counted once within the subcategory but many participants do provide a variety of responses to a single question and the same content can be coded to multiple nodes.
Observations and Limitations

Utilizing Charmaz (2006) and Glaser (1998) constructs for grounded theory analysis, it is essential that reports are read and evaluated qualitatively rather than relying on frequency counts. Frequency counts point the researcher in various directions, but these directions must be viewed with discretion. The answers relayed from the seven open-ended questions presented in the semi-structured interview are reliant upon the researcher’s interpretation as data is selected from within the reports. This forms the basis for axial and theoretical coding, and the final determination of a theoretical construct for the study.

Axial Codes

The coding in this NVivo analysis is a mixture of inductive and deductive reasoning involving first-stage, open “in vivo” coding (Charmaz, 2006; Glaser, 1998), as well as second-stage axial coding. It is the researcher’s responsibility to continue to use inductive and deductive reasoning to further perform axial coding and theoretical coding.

Numerous codes (8 with 303 subcategories) were created to reflect emotions expressed by participants, and in vivo coding was often used as the best way to capture the stated emotion. Reading through the nodes list gives a visual snapshot of the emotional turmoil, reconciliation, and hope expressed by participants. The researcher has merged and collapsed these smaller units into broader axial codes by relying on her subjective experience of collecting and analyzing the data, where, per grounded theory analysis, everything is considered data.

Utilizing the frequency reports and her own review of the transcripts, the researcher narrowed the open codes down to two to three codes per the original semi-
structured interview question (Q₁–Q₇). The “Anything else?” node (Q₈), initially discovered from the NVivo analysis, is not a considered a question in and of itself within the original semi-structured interview, but is explored as an appendage and supplementary data to Q₇. Excerpts that influenced the axial codes are presented in the following section, though this is not an exhaustive presentation of each time a participant used a common word or phrase. These excerpts felt most relevant to the researcher as she progressed through the grounded theory coding process. There is a number at the end of each excerpt representing the number of the participant who stated it, e.g. 101–112.

**Q₁:**

The first axial code identified for Q₁ (“How did you feel after your sexual assault?”) was “guilt” or “guilty.”

Okay. So, I have actually been raped twice: once when I was 14 and once when I was, I think, 24 or 23. Wait, let me think about this. Yeah, it was a month before I turned 24, so I was 23. I will probably focus on the more recent one, but I felt extremely guilty and stupid, and I felt like it was all my fault. And, to be quite honest, I mean obviously you can't get raped without a rapist, but the situation leading up to it, I still feel was my fault, and I recognize that. (101)

I told myself I wouldn’t drink again. I blamed myself. (106)

I have a lot of shame and guilt. (103)

The second axial code identified for Q₁ was “isolated.”

But at the time, when it happened, I felt that there was no one to reach out to. I felt completely and utterly alone. I felt like I didn't want to tell my girlfriends
because that would make them feel like it was their fault because they left me, even though I told them to. And I just felt completely isolated once again. (104)

The third axial code identified for Q1 was “powerless.”

Feeling robbed, it's like you were stripped. You didn't feel power anymore almost like a veil was opened up, like a reality and protection something that you just couldn't fathom before. (106)

So my whole family is from California. And so I had no one. Somehow that I don't remember. And that's another reason why I felt so stupid and guilty because I felt had it been here, I would've told someone immediately. And I felt like I would've - I would've felt more empowered to like, let's find this guy or something. Or I would have told someone that was my friend, and they would have said, you have to go to the hospital and get a rape kit done. And because I was all alone, I just balled up into a hermit crab and did nothing. And that's the part I feel guilty about. (110)

In summary, the axial codes identified for Q1 were: guilt, isolated and powerless.

Q2:

The first axial code identified for Q2 (“How did your relationship with others change after your sexual assault?”) was “distrustful.”
Because there are so many years when I couldn't talk about stuff like that because I thought it was inappropriate, or I thought the person would go say something to someone else. I didn't understand trust, and where it should be given and where it should not be given. Because I grew up in a situation where I could not even trust my parents. Because they broke my trust so many times. So it was like, if I can't trust them, then I can't trust anybody. Trust has been a huge issue with not only the rape but just my adult life. Because in the process of me trying to trust, trying to learn how to trust, I also made the mistake giving it away to soon to some people. Because that was my attempt to try. Because before I didn't give it to anyone. So then you go through that whole balance of the pendulum swinging from this far left extreme of having zero trust in anyone to, oh, I'm going to trust people that don't even deserve it, to balancing out and figuring out where your level of trust and comfort with people should be. (107)

And after the sexual assault, I did not trust people's motives for even having any interaction, even a non-sexual interaction. Whether you are male or female, and especially if you are male. (111)

The second axial code identified for Q2 was “weaker.”

Very much weaker. And I don't know if that was because of my own reaction to it, or if it was because my boyfriend thought I had cheated on him. (104)
In summary, the axial codes identified for Q2 were “distrustful” and “weaker.” Additionally, 58 percent of participants reported becoming more promiscuous after the rape than they were before, which they identified as making their intimate relationships weaker.

Q3:

The first axial code identified for Q3 (“What have you noticed about being present in your body during a sexual encounter since your assault?”) was that it became “more difficult.”

It's difficult. But then it just depends on the way my boyfriend approaches it. If he eases his way into it - if he starts out with like a back rub, you know, and kind of like work your way in there and stuff. But my big thing is that I have to make sure that I communicate with him and tell him ahead of time, before he gets frustrated, that I'm not interested. And it feels like I have to constantly explain myself ahead of time before he gets frustrated. But then when it's like in the moment, and when it's too late past that point, and I say no, he gets pissed off. But then I get mad at him. It's hard for me to understand it from his point of view. And, honestly, at certain times, I really don't give a shit about how you feel. So it's hard, it's really hard at that end. (106)

The second axial code identified for Q3 was experiencing “panic attacks” and “hyperventilating.”

And for a long time I couldn't drink. It was like if I took a sip of alcohol, I would start to have a panic attack. And shortly after the rape, I actually had my first real
panic attack. And I felt like I was dying. And I didn't know what to think. It was a really, really bad episode. And it was because I had drank for the first time after that. And it wasn't like I was drunk all; I just had a drink. It was just like the feeling of being even close to vulnerable made me freak out. (109)

Not recently. Before, like if I would see him - because I would see him around town and stuff, just at random times - I would like have a panic attack and hyperventilate. I couldn't breathe. (103)

The third axial code for Q3 was “not present.”
I think prior to me getting serious help in the last three years, I was - I always had the right corner of the room is where I would be doing any sort of sexual experience, with any partner. I would always go out of - I was never present. (102)

Foreplay is really difficult for me to do, because it requires me being present in a way where I feel I have to be open to giving and receiving. And that might sound weird, because I have a very easy time reaching orgasm. But I don't know how to explain how that is other than I usually skip the foreplay, and if I do any it's very little, and then I go right to sex. And even when I'm having intercourse, I'm not fully in my body. The only time I'm fully in my body is at the moment of orgasm, and then the moment I'm not in that moment, I'm back into stepping back from
my partner. So I'll go through the motions with him, the cuddling or the talking, but there's always a piece of me that's outside of the situation. (103)

Usually, I trust in God. Like having a conversation outside of the room. Or myself, just like, why am I once again allowing this to happen? And sometimes it was in a relationship so you try to be present, and other times it was with just a one-off person. It was almost sickening. Your brain switches. You don't really know how you got where you were at. You kind of wake up midstride and you're like almost just want to puke. You're disgusted like, who is this person? It's almost like a light switch. (104)

But initially I was like - I could give you a horrible quote. Should I say it? My first boyfriend told me when I was like 18 that I was like fucking a door. Which was indicative of the kind of guy I picked as well. Because I suppose if you're not in your body, it would not be much fun for them either. (105)

The axial codes identified for Q3 were “more difficult,” “panic attacks and/or hyperventilate,” and “not present.” The researcher feels it is also significant that 33% of participants reported not experiencing as much pleasure during sex after their sexual assault.

**Q4:**

There were two axial codes identified for Q4: “How have your sexual fantasies changed from pre-sexual assault to the present time?” The two most frequent codes identified were “does not have sexual fantasies” at the present time (25%), or sexual
fantasies now involve “rape,” “bondage, dominance, sadism, masochism (BDSM)” or images that are “sadistic” (50%).

The excerpts that were relevant to the first axial code, “Does not have sexual fantasies,” are:

No. I mean, after the sexual assault, I went asexual. I didn't have any interest - didn't want to talk about it, didn't want to think about it, didn't want to see it, didn't want to do it. (110)

I don't have any sexual fantasies. In fact, that word used to make me so angry when Marty would say it: "I have a fantasy." Oh, God, don't say that. Because my dad would say it all the time. (105)

In regard to the second axial code, “BDSM,” the researcher was appreciative and somewhat surprised that the 50 percent of participants who reported these fantasies were so open and willing to discuss them.

Yes. Sometimes I think those are the only fantasies I feel guilty about getting pleasure off of. Because I feel like on some level I'm trying to work it out with myself. But then, it makes me feel guilty because it's like, what if I - like, you know, like guys you see in movies, like when they are sexually assaulting someone, they are like, "You like it, you dirty slut," and stuff like that. I'll have fantasies like that, and it will make me feel even more guilty, like maybe I did like it. Stuff like that. When obviously I didn't like it. (101)
I have explored documentaries about different types of sexuality and in particular about sadism or dominatrix type things, identifying in a way that I didn't before that take control aspect of being in control and bringing that to the table. And somehow it makes me feel not so bad about having those fantasies, but at the same time there's still a piece of me that's not completely okay with it. (103)

The fantasies that I have had are more pain. Very dominating, like even though it's almost reverse psychology in my brain. You would think you wouldn't like somebody to shoving you up against a wall and being forceful with you, but that is kind of like the only way I feel that I get aroused at all is forcefulness. (104)

Yes. I feel more aroused when in the fantasy I allow that person to dominate me. But yet I'm not getting anything. In the fantasy is always more about them dominating me get aroused, and then I'm not allowing them to have anything from me. (107)

Qs:

Two axial codes were identified for Q5: “What are your beliefs about orgasm?” They were “I deserve them” and that orgasms are “purely pleasurable.” The following are excerpts that describe participants’ feelings that they “deserve them”:

Because I went through so many years of not, and it feels really good, and it makes me happy, and why shouldn't I get that? I've endured enough sexual pain over the years, not that anyone should have to endure sexual pain in order to get an orgasm. (112)
Because I want to feel - I don't know how to describe this. I want to be able to feel like I'm in control over a situation of not being in control, if that makes any sense. (106)

Because every woman has the right to have that experience. And every man has the right to be able to orgasm. It's a natural thing. It's a wonderful, natural thing. I just wish I could do it without the freaking Catholic guilt attached to it. (111)

In regard to orgasms being “purely pleasurable,” participants expressed these sentiments:

It really depends on the situation. Pleasurable in the moment of it when the orgasm finally overtakes me and I can finally let go. It's absolutely pleasurable, but there is guilt associated with it, and that guilt has some scariness associated with it. And because it's so easy for me to orgasm, sometimes I feel guilty about orgasming so quickly. (103)

It's like my entire body - there's like this wave - you know how when you detonate a bomb you get a shock wave. So it's like a wave that goes through my entire body, except it's not like a shock wave but it's a wave of pleasure and relaxation. Like it seems like it just goes through and I'm totally - like my entire body is completely relaxed. (109)
Q6:

There were also two axial codes identified for Q6: “How is your relationship to your body different today than it was immediately after your sexual assault?” One hundred percent of participants reported they feel differently and better about their bodies today than they did immediately after the sexual assault. Regarding the time period from immediately after their sexual assault until they began their recovery process, 83 percent reported a negative relationship with food and exercise, with 42 percent describing themselves as having an eating disorder or issues with over exercising. Substance abuse issues were reported in 33 percent.

Very different. I think that one way that I coped with what happened is that my body image became focused on the way I looked. I felt so fat and so unhappy with myself that I stopped eating, and when I did eat, I would make myself throw up. And I got a really bad eating disorder, especially in Chile. That is what happened in Chile because I had no control there. I was living there. I was living with the family. I was raped about two days after my birthday down there. I had only been there a few days. I had no control over anything. I didn't really speak the language, but I did have control over my body, and that was one way that I dealt with it. I just kind of destroyed it through alcohol and drugs. So the image of myself - it's hard to remember the questions. (102)

So I don't think of myself as garbage, which is what I used to think about myself. I was told that's what I was. It's hard not to feel that way when somebody tells you that, when it's the position you're in. (107)
I didn't realize that I had a body after my sexual assault. Or I gave up on having a body. I think one thing or the other. And I didn't even know that until I went to yoga class. An intro yoga class - that was in 06. That was shortly after I started therapy. Probably about half a year or a year after the beginning of therapy. And it was like, "Feel your feet on the floor." What? I just thought it was kind of a turning point for me to realize that I have a body. (109)

In regard to negative relationships with food and experiencing eating disorders and/or over-exercising, these excerpts felt most relevant:

I have a little trouble with food. I'm constantly battling hunger for more food. And I eat to - I like the feeling of fullness. I have a craving for chocolate a lot. So it's a real struggle. Basically I love food. I love the taste of food. And my tendency would be to eat more than is good for me because I don't like to be overweight. So it's an ongoing problem. (112)

And I'm just now to the point where I'm healthy and stable enough and have enough knowledge behind information on nutrition and what's good to eat and what's good and what's not. Because we're constantly fed lies about what's good. And ever since I found out I had high blood pressure at 19, it has been this huge journey - almost 10-year-long journey towards totally redoing my eating habits and the way that I eat, as far as going to food for comfort. And trying to completely turn that on its head, eating super healthy. (101)
But this time when I had stopped, my boyfriend - because like he is going to school to become a drug and alcohol counselor. And so he really helped me out through it. And he said, "You really have to be careful about what you eat and when you eat it, because when you don't eat your body is in starvation mode. And then when you stuff your face, your body is like, well I finally have food, and it is going to store it as fat." (103)

It's a love-hate relationship. I love food. I love to cook food. I love the social aspects of food. But it's also been an abuse that I have used to get through any bad feeling or any shame that I've gone through, and unfortunately I have used it in such a way that that's the reason I am so big, and it's just a love-hate relationship. I cook really well, and I love how people enjoy my food, but I use food as a drug unfortunately. (104)

I have had all kinds of aches and pains for so long, and I used to exercise just pushing through them. And I got to a point where I was tired of being in pain from misalignment and holding tension for years in parts of my back, or little injuries here and there, shoulders, knees - various times each one of these has been injured. So now I exercise only up until I hit the point of discomfort. Which, I have to push a little bit through that to actually give my muscles enough exercise. So now I feel totally out of shape, and I feel very physically weak. (109)
In regard to participants who reported “substance abuse” issues, these excerpts felt relevant:

And if I wasn't in rehab, most likely after that had happened, I would have gone back into drug abuse. You can trust and believe that. (111)

No. I gave it (wine) up. Almost a year ago now. It was becoming - I just didn't like it, even though I was having only one or two glasses of wine at night. It didn't feel like it was really healthy for me. And so I just made a commitment to stop. And it was difficult for the first couple of months especially around dinnertime. Habitually having that glass of wine with dinner. (112)

Q7:

There were two axial codes identified for Q7: “How will you know when you are sexually healthy and what does the term ‘sexual health’ mean to you?” Participants were also asked, as the first follow-up probe to the Q7, if sexual health was solely about them or included their sexual partner. One hundred percent of participants said sexual health included their sexual partners. Thirty-three percent said the ability to have “open communication” would/does inform them that they are sexually healthy, and 42 percent reported “self-acceptance” as part of how they define sexual health.

When addressing the issue of sexual health encompassing their sexual partners, these are some of participants’ responses:

It's not just about me. I definitely believe it encompasses the couple as a whole, and even when there are children involved. I think that - even more so when there are children - I think that couples really need to stay connected. Somebody was
wording it to me as gourmet sex versus bread-and-butter sex, and it just really
rings in my head. Like when life is crazy and there are kids involved, you're not
always going to get back gourmet sex. You shouldn't hold out for the gourmet
sex, because it could be months down the road. So sometimes you just need to
have that bread-and-butter. (101)

Definitely relationship with my partner. If it were just about me, I think I would, I
don’t know. First of all it has never been just about me. I think it's always been
about the other person for me. (102)

Well, if sexual health is all about me, then I have that one down. Because I think
sex by default is not just about satisfying a sexual need. It's more than, okay, I
gave myself an orgasm, and I’m good. I think by definition it involves a yearning.
It involves an impulse to share that with another person. Otherwise we would all
just be masturbating. And it would be good enough. And the fact that it isn't, for
me at least, means that it automatically includes relationships. (109)

Yes. I think it does (involve a partner). Because if you've got somebody that's not
on the same page as you in terms of what you like and how you see sexuality, and
how much you want, and that kind of stuff, then it's a very unhappy situation.
You're not being met, and you can't really be gratified if the other person doesn't
feel about this the same way you do. And I'm thinking about my ex-husband, who
was mostly impotent, and pretty immature sexually even when he was able to
perform at all. And that was very unsatisfying. It made him feel like I was stale and old. Not able to express that part of myself. And I was very frustrated, and ultimately that was the main reason that I left the marriage. There wasn't an outlet for me to express my healthy sexuality. And I wasn't willing to give that up forever. (112)

When considering participants’ emphasis on “open communication,” they made it clear that for each partner to be able to express his or her needs was crucial to sexual health.

Wow. That's a good question. That is a question I don't think I have ever asked myself. Sexually healthy - that's a good question to sit with for a while. I think it would be not withholding from a spouse. Which I don't feel I'm intentionally doing to get back to him, so I don't think I'm doing that right now, but in the future I need to be not using sex against your spouse or partner, or whomever. But being able to trust him to be a part of me in his own way as well. So I know I have needs that I am trying to experience with him, but yet he needs to learn to experience his own needs at the same time. So I need to learn to express what I hope that it would look like for me to accept him. But at the same time I need to encourage him to communicate with me maybe what he is feeling along the way. So we can hopefully build a bit of a foundation to start building off of. (104)

Yes, I think I will be a lot more open than I have ever been. It just doesn't feel good to want something and then not express it. (107)
Sexual health means somebody who is proud of who they are sexually and is willing to be open about it and can communicate about it and feels that they have clear boundaries that are worth defending. Boundaries is the thing that I think most people forget. (108)

“Self-acceptance” was the other most frequently identified code for defining sexual health for Q7.

Being connected with oneself, being in a state of acceptance. As opposed to having negative feelings towards one's desires, or parts. (111)

I think enjoying one's sexuality, however you want it to be. Being able to give and receive pleasure. Without any kind of hang-ups. Just experiencing it as a pleasurable, natural, fun part of life. That's what it is to me anyway. (106)

I will know that I am sexually healthy when I no longer feel afraid of being judged for what I'm doing, when I know that what I'm doing is a normal, safe, and healthy thing that I have a right to do and that does not hurt anyone. (108)

The last two prompts for Q7 did not address specific issues of healthy sexuality and recovery as the previous seven questions had, but rather served as a check-in with each participant to ensure the researcher “didn’t miss anything” and that they were feeling comfortable and well supported at the interview’s conclusion (e.g. “How are you

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feeling right now?”). Participant 102 gave a particularly direct response in the excerpt below, which shows the interaction between researcher and participant:

Researcher: Are there any other questions you wish I had asked? Or anything that I've missed?

Respondent: Yes, I think it would be something like, “how do you feel you've got to this point? How is it that you are able at this point in your life to be able to talk this way? To be sexually healthy?” Something like that.

Researcher: Great. I love that question. So how do you feel you got to this point?

Respondent: I think that for me, it's finding that rock bottom, shifting that place, making horrible mistakes that you can't believe you did. And I think I see this in a lot of my friends who have problems with addiction of some sort, or are needing to recover from something. I needed to get to that place where my whole life was a fucking train wreck. Then I realize like, oh yes, I have to deal with this, and I have to do it now before I lose everything that's important to me, including myself, especially myself. And I think that that is really truly what helped me. I started seeking help and realized that I really didn't have a good sexual - that I didn't have healthy sexual relationships and that I was doing things that that were really bad for me, that I was trying to sabotage anything that was happy for me. And I think that that is what ultimately got me to the rape crisis center. And luckily I have a husband who is fantastic and who himself needed to get help. And I think him getting help, realizing that we are not perfect, and that we do need somebody to just say, "Hey, let's look at this a different way," has been really good. (102)
Other participants echoed similar responses, making references to reaching places where they knew they needed help. They mentioned finding inner resources and strength to seek help from loved ones, SBRCC, and their therapist, and feeling comfortable at that time in their lives to work on themselves, their sexuality, and their relationships without harsh self-judgment.

I think the last question was the hardest. It's hard to talk about your mistakes. And it's nice to be able to talk about it in a positive way and realize how important things are. Like, I wouldn't go back and change really anything. I wouldn't go back and change the fact that my grandfather was an abusive pedophile. I wouldn't change any of that. I would experience what I experienced to get me where I am. Because where I am is healthy. It's good. (103)

**Subcategory: Mid-Level/Axial Themes**

From the frequency counts and transcripts reviewed by the researcher, seven themes (one per semi-structured interview question) were discovered utilizing axial, mid-level coding strategies.

**Theme 1:** Survivors felt guilty, isolated, and powerless after their sexual assault.

**Theme 2:** Survivors’ relationships became weaker after their sexual assault. They were distrustful of others, yet became promiscuous to lessen the impact of the sexual assault.

**Theme 3:** It became more difficult for survivors to be present in their bodies after their sexual assault. They experienced less physical pleasure along with panic attacks, hyperventilation, and elements of dissociation.
Theme 4: Survivors’ fantasies run the gamut from non-existent to those encompassing BDSM practices. Elements of control are at play.

Theme 5: Survivors believe they deserve to experience orgasms, and when they do, they are purely pleasurable.

Theme 6: Survivors’ relationships to their bodies are different (more positive) than immediately after their sexual assault. Survivors use(d) food, exercise, and substances as coping strategies post assault.

Theme 7: Survivors define sexual health as inclusive of their intimate partners and incorporating open communication and self-acceptance. Survivors feel empowered by their ability to recover in the face of adversity.

**Major Axial Themes**

Strauss and Corbin (1990) view axial coding as building a “dense texture of relationships around the axis of the category” (p. 64). The researcher followed the development of the major category toward the goal of sorting, synthesizing, and organizing the large amount of data (Creswell, 2009). After identifying seven codes at the mid-level, the researcher sought to piece this new data back together to discover the final level and major axial themes. According to Strauss and Corbin, this level of axial coding answers questions such as when, where, why, how, and with what consequences (Strauss & Corbin, 1990). Considering these questions, the researcher was able to link relationships between categories on a conceptual rather than descriptive level. Specifically, the researcher asked herself these questions: “How did the process of the recovery of sexual health after sexual assault occur?” “What were the psychosomatic consequences?” and “What role did the body play in recovery of sexual health?”
The researcher became hyperaware at this point in the coding process of the potential for her own predispositions and biases to present themselves. Therefore, following Charmaz’s (2006) constructs for grounded theory, she followed no explicit frame to guide the analytic construction of themes. “At best, axial coding helps to clarify and to extend the analytic power of emerging ideas. At worst, it casts a technological overlay on the data and perhaps the final analysis” (Charmaz, 2006, p. 63). The researcher’s only intent was to obtain a more thorough grasp of the studied phenomena—the embodied process of the recovery of sexual health after sexual assault. Three major axial themes were identified:

Major axial theme 1: Sexual assault elicits feelings of isolation and powerlessness.

Major axial theme 2: The body becomes a means of control both in sexual and non-sexual expression.

Major axial theme 3: Survivors’ sexual health encompasses relationships, self-acceptance, and the physical and emotional ability to receive pleasure.

Theoretical Codes

To begin the theoretical coding process, the researcher utilized Glaser’s classic series of 18 theoretical coding families (1978) which include the “Six C’s: Causes, Contexts, Contingencies, Consequences, Covariances and Conditions” (p. 74), “degree, dimension, interactive, theoretical and type coding families” (p. 74), as well as those that derive from major concepts such as “self-identity, means-goals, cultural and consensus” families (p. 75). In considering this next and final level of coding, the researcher considered the axial mid-level and major themes to look for representations and structural function to create a bigger picture (Charmaz, 2006).
The researcher sought to identify two theoretical codes from the grounded theory analysis thus far. Her considerations included, first and foremost, a constant reflection back to the research question: What is the embodied process of recovery of sexual health after sexual assault? She also contemplated the survivors’ individual data in the study of this phenomenon, as well as the collective conscience or cultural overlay of being a survivor.

Theoretical code\textsubscript{1}: Connection with others and acceptance of self are essential components of survivors’ recovery of sexual health.

Theoretical code\textsubscript{2}: External means of control inhibit the ability to be present in the body and receive pleasure.

\textbf{Theoretical Construct and Chapter Summary}

The researcher returned to grounded theory’s foundation of symbolic interactionism to inform the final stage of the analysis process. Deducing the theoretical construct or cohesive theory emergent in the data demonstrates how the researcher thought about the analysis and locates, as if through a textual diagram, the argument that she makes (Charmaz, 2006). Charmaz (2006) also suggests trying to “balance the logic of exposition with the logic of the theorized experience” (p. 173). A linear logic was used to organize and present this analysis and make it understandable. However, the researcher recognizes the experience of survivors is not necessarily linear, nor must it fit into clear codes, themes, and theory.

The theoretical construct discovered for the present grounded theory study was: The recovery of survivors’ sexual health is conditional to connection with others and relinquishing strict means of control in order to receive pleasure physically and
emotionally. This theory seeks to provide insight into the embodied process of the recovery of sexual health after sexual assault as it is derived from survivors’ narratives and somatic presentations. It is the researcher’s best attempt to fit their experiences neatly into one paradigm, which she realizes is fraught with concerns of simplistic thinking. The researcher believes she has stayed true to grounded theory’s construct of following where the data leads, where all is considered data. Again, a thorough description of this process will be illustrated in the following chapter’s reflexivity section.
Chapter 5: Discussion

Summary of Major Findings

The major findings discovered in the present study point to four constructs relating to survivors’ recovery of sexual health. Those constructs include connection, control, physical pleasure, and emotional gratification. A grounded theory qualitative protocol was used to analyze 12 transcripts derived from a seven-question, semistructured interview completed by study participants. The semistructured interview explored psychological and somatic aspects of recovery of sexual health for survivors of sexual assault. The results provided a comprehensive and unbiased answer to the study’s original research question: What is the embodied process of recovery of sexual health after sexual assault?

The grounded theory analysis began with open coding, which resulted in a total of eight nodes with 303 subcategories. The nodes reflect semistructured interview questions 1 through 7 (Q1–Q7) with an “Anything else?” node created as Q8, though this node served in the subsequent analysis process as collaborative data to Q7. Utilizing the frequency counts spreadsheet (Appendix F) and a review of the transcripts, the researcher coded to multiple categories due to the nature of responses from a single interview having meaning in more than one category. This interpretation formed the basis for the emerging axial codes.

Two to three axial codes per node (Q1–Q7) were combined and merged into seven axial themes. The seven minor axial themes (one per node, Q1–Q7) were coded and condensed into three major axial themes, which focused on survivors’ feelings of isolation and powerlessness, the body as a means of control, and discerning their meaning
of sexual health. The next stage of the grounded theory analysis, theoretical coding, revealed two theoretical codes. Those codes exposed survivors’ desire for connection with others, self-acceptance, and replacing or abstaining from negatively impactful external means of control.

One theoretical construct/theory was discovered from the two theoretical themes in the researcher’s attempt to answer the research question. The grounded theory discovered for the present study was: The recovery of survivors’ sexual health is conditional to connection with others and relinquishing strict means of control in order to receive pleasure physically and emotionally.

**Discussion of Findings**

The first stage open coding process was more diagnostic and analytic than the second and third phases of the grounded theory discovery process. The open coding phase was completed both by an NVivo qualitative analysis expert and the researcher. The nodes and subcategories discovered in the open coding phase were based on frequency counts through a review of the transcripts. The researcher’s analytic discernment and subjective observation came more prominently into play in the second axial phase and third stage theoretical coding. Thus, the researcher will present the “Discussion of Findings” section herein beginning with the axial coding phase.

After the initial open coding phase was complete (303 subcategories in 8 nodes), two to three axial codes were discovered per node, Q1–Q7. Codes that were identified during the second-level coding process from the seven interview questions included “guilty,” “isolated,” “powerless,” “distrustful,” “weaker,” “more difficult,” “panic attacks,” “hyperventilating,” “does not have sexual fantasies,” “rape,” “bondage,
dominance, sadism, masochism (BDSM),” “purely pleasurable,” “different,” “substance abuse,” “not present,” “open communication” and “self-acceptance.” From these 17 codes, the researcher implemented an additional level of axial coding to discover seven themes, one per question (Q1–Q7).

Discussion of Axial Themes

Survivors felt guilty, isolated, and powerless after their sexual assault, and their relationships became weaker. They were distrustful of others. Some avoided intimate relationships for months or years, while others coped by becoming more promiscuous than they had been prior to their assault. Those who reported promiscuity believe this reaction was a way of minimizing the importance or seriousness of the assault. Haines (2007) notes many therapeutic models still pathologize sexual aversion and compulsion as types of dysfunction, making survivors feel something is wrong with them rather than viewing the strategies as a survivor’s best attempt to move forward. “The choices were intelligent at the time. They were survival-smart” (Haines, 2007, p. 52).

From the researcher’s experience as a rape crisis counselor, she sees this scenario frequently. Promiscuity can be a survivor’s attempt to make sex meaningless, which lessens the trauma and impact of the initial assault. Promiscuity post assault can also be used as a means of trying to rewrite the script of the assault and the meaning a survivor ascribes to sex. For example, if a survivor has enough indiscriminate sex she may believe she will eventually have a different outcome than what she felt during and immediately after her assault. That outcome is usually a way to negate many of the categories previously identified in this study including guilt, isolation, powerlessness, disgust, and shame.
It should be noted that “shame” was identified as one of the original 303 subcategories but its frequency count was not high enough to be included in the subsequent coding process. The researcher has wondered about this because it is a word and concept most rape crisis counselors explore diligently with survivors during their recovery; it seemed survivors should be familiar with this term and its meaning. Based on the data, it is not a word the majority of participants used. This was the first unexpected outcome the researcher encountered in the grounded theory analysis process. The lack of frequency of this subcategory and consequently the lack of relevance to survivors’ discourse was the first chance the researcher had to put her biases and preconceived notions in check regarding what would be discovered.

Other themes revealed at this stage of coding included difficulty for survivors to be present in their bodies during sex following their sexual assault. They experienced less physical pleasure and many experienced panic attacks, which included hyperventilating. The participants who described these events alluded to aspects of dissociation from their emotions and their physical body. They did not report any lapse of consciousness, but rather a sense of being separate from themselves and/or observing themselves from another area in the room. They were not present for either the emotional or physical experience happening in that moment. This is one of the major perceptions that changed as participants moved through the recovery process. They went from not being present to being fully present and able to experience the moment. The shift toward psychosomatic presence and its relationship to embodiment will be explored later in this chapter as third level themes and the theoretical construct is discussed.
The axial theme stage of coding also uncovered concepts related to survivors’ fantasies. Fantasies ranged from nonexistent (25%) to those including rape and BDSM practices (50%). Participants who talked about not having fantasies were also not engaged in intimate sexual relationships at this time, as a matter of choice. This theme gave the researcher pause as she wondered whether having an active sexual fantasy life and sexual imagination was a vital component of healthy sexuality. Based on the data and analysis, it is not. The study’s participants met the conditions for healthy sexuality as it has been defined. To reiterate the definition established in Chapter 1, the World Health Organization (WHO, 2002) states sexual health requires that an individual have a “positive and respectful” view of sexuality (p. 1). The WHO defines sexual health as:

The integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love…Fundamental to this concept are the right to sexual information and sexual pleasure. (WHO, 2002, p. 1)

Given this definition, an active fantasy life is not a requirement. However, this was an interesting theme to explore because half of the 12 participants discussed having fantasies that included rape scenes and elements of BDSM practices. In the researcher’s own frame of reference, it seems “no fantasies” would be on one end of the fantasy spectrum and “rape fantasies” and “BDSM fantasies” would be on the other. In regard to survivors’ fantasies, there is not a significant presence in the middle of the scale, which could be interpreted as more heteronormative, “vanilla” sexual activities such as watching couples engage in kissing, fondling, or intercourse, viewing male or female masturbation scenes, or reading erotic literature. The participants who did report having
fantasies were exceptionally forthcoming about their rape and BDSM fantasies. Current research indicates between 31% and 57% of women have fantasies in which they are forced into sex against their will (Bivona, 2009). Another study showed rape fantasies play a major role in the fantasy lives of 1 to 2 people in 10 (Critelli & Bivona, 2008). Survivors can feel that it is a betrayal of their minds and bodies to be turned on by imagining rape, though researchers have stated rape fantasies are a natural and common part of both male and female sexuality (Haines, 2007; Maltz, 2001).

In her work with survivors, the researcher uses these statistics to help normalize adverse reactions to rape fantasies. Although a survivor has experienced rape, this does not mean she should be held to a different sexual fantasy standard than others. It should be noted the researcher was unable to locate statistics about rape fantasies specific to sexual assault survivors, which could indicate a future area of research. In her therapeutic work with survivors, the researcher finds rape fantasies are often used similarly to how survivors engage in sexual promiscuity. It is a way to rewrite the script of their assault and ascribe a new meaning for or significance of sex. Having a rape fantasy allows survivors to alter the details of their sexual assault or view it as happening to someone else. Because it is a fantasy, they are in control of exactly what happens and to whom.

In regard to fantasies involving BDSM practices, all participants discussed liking the aspect of control of whether they identified with the dominant or subservient partner. The participants who identified with the dominant role saw it expressly as a way of controlling the scene and the acts performed during sex, including their partner. Participants who identified with the subservient role talked about their desire to give up control in a safe and controlled environment with a trusted partner. Giving up control and
being treated respectfully in sex play became critical steps toward recovery. Thus, control was the overriding factor in all scenarios of the rape and BDSM fantasies.

Another axial theme discovered was a survivor’s belief that she deserves to experience orgasm, which was true for all 12 participants. This belief was also explored in the context of survivors’ physical feeling and sense of their orgasms. The researcher inquired whether orgasm was purely pleasurable or if it felt scary or out of control, or if there was another word(s) that fit how it felt to them. All respondents reported orgasm was purely pleasurable. In the researcher’s experience working with survivors, she has encountered many who did not believe they deserved to experience sexual pleasure, and others for whom orgasm felt scary, exposing them to too much vulnerability in an intimate situation. The unconditional nature and significance of this theme in regard to the study’s 12 participants was another chance for the researcher to monitor her preconceived notions and follow only where the data led her. However, when consulting the current literature, there were few examples that examined sexual assault in connection with pleasure and orgasm in a positive sense or in terms of recovery (Kleinplatz, 2007; Mitchell, Hirschman, & Hall, 1999; Sarkar & Sarkar, 2005). The majority of literature concerning sexual assault and orgasm looked at it in terms of sexual dysfunction—lack of orgasm and sexual pleasure—in survivors of sexual assault. This may point to a need for future research into how and at what point in the recovery process survivors are able to experience the pleasure of orgasm, both physically and emotionally.

In regard to body image and issues with food, exercise, and substances, the sixth axial theme offered the insight that survivors’ relationships to their bodies are different, in a positive way, than immediately after their sexual assault. However, 83% of the
study’s participants reported a negative relationship with food and exercise, with 42% describing themselves as having an eating disorder during the time period immediately after their assault until they began their recovery process. These statistics support current literature on the high correlation between sexual assault and eating disorders, inclusive of disordered compensatory behavior such as excessive exercise and laxative/diuretic abuse (Bryant & Schofield, 2007; Dubosc, Capitaine, Franko, Bui, Brunet, Chabrol, & Rodgers, 2012; Fischer, Stojek, & Hartzell, 2010; Harned, 2000). Of the participants, 33% reported having substance abuse issues. These statistics support current literature on the high correlation between sexual assault and substance abuse (Hunter, Robison, & Jason, 2012; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013; Walsh, Messman-Moore, Zerubavel, Chandley, DeNardi, & Walker, 2013).

How survivors define sexual health versus how it is defined in the literature was a point of great interest to the researcher. The final axial theme revealed survivors characterize sexual health as inclusive of their intimate partners and how they incorporate open communication. Nearly half (42%) stated self-acceptance was a crucial part of sexual health. When considering each of the seven axial themes identified and the WHO’s (2002) definition of sexual health, concepts that correlate include: sex being a positive experience, integrating the mind and body, enhancing personality, including communication, and being pleasurable. Though the researcher sees the value in a broad definition of sexual health for clinical purposes, she also realizes the potential worth in discovering a definition specific to sexual assault survivors. For example, it may be beneficial to determine how open communication is facilitated and why it is fundamental to survivors’ sexual health. Or how self-acceptance, which may be correlated to
“enhancing personality” in the WHO (2002) definition, influences the dynamic between a survivor and his or her partner.

The final level of axial coding revealed three major axial themes, which merge the seven minor themes discussed above. The first found sexual assault elicits feelings of isolation and powerlessness. The factor of isolation is supported in recent literature regarding survivors of sexual assault (Averill, Padilla, & Clements, 2007; Farr, 2011; Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010), though the concept of powerlessness is explored in relation to childhood sexual abuse more so than sexual assault (Bryant, 2001; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Westphal & Bonanno, 2007).

It was also discovered the body becomes a means of control both in sexual and non-sexual expression, which as previously stated in regard to fantasies (Bivona, 2009; Critelli & Bivona, 2008; Haines, 2007; Maltz, 2001), eating disorders (Bryant & Schofield, 2007; Dubosc et al., 2012; Fischer, Stojek, & Hartzell, 2010; Harned, 2000), and substance abuse (Hunter, Robinson, & Jason, 2012; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013; Walsh et al., 2013) is strongly supported by current literature.

The final major axial theme defines sexual health for survivors. Survivors believe sexual health encompasses relationships, self-acceptance, and the physical and emotional ability to receive pleasure. This definition is highly correlated with recent literature regarding sexual health (Coleman, 2002; Faravelli et al., 2004; Schwartz, 1996; Traeen & Schaller, 2010; WHO, 2002; Wylie, 2001). Although, as stated, there are some differences between survivors’ definition of sexual health and a general or clinical definition that may warrant further study.
Discussion of theoretical codes. In Chapter 4, the researcher noted she relied heavily on Glaser (1978) and Charmaz’s (2006) classic and venerated protocol for grounded theory analysis throughout the final stage of theoretical coding. Grounded theory does allow for the researcher’s subjective discernment of the data, though at this stage the present study’s researcher was intensely aware of and committed to following the data unequivocally. Discernment and her own subjective experience and beliefs were reserved for interpreting the final theoretical construct and how it did, or did not, answer the study’s research question. Her journaling increased at this stage as a means of controlling for inferences of what she thought, even subconsciously, she might be looking for in an attempt to answer the research question. This process of journaling will be explored in this chapter’s reflexivity section.

The first consideration at this theoretical coding stage was pulling apart each individual participant’s uniqueness and contribution to the data, yet also looking for associations in codes that would establish a culture or collectivity of being a survivor of sexual assault. By linking the themes present in the axial coding phase, the researcher discovered theoretical codes were emerging, which pointed to a representation of generalizability for the study’s participants and, potentially, survivors as a collective whole.

The first theoretical code that emerged reinforced survivors’ needs for connection with others including their intimate partners as well as friends, family, and community, e.g. the Santa Barbara Rape Crisis Center (SBRCC). Connection was determined to be a necessary aspect of survivors’ recovery of sexual health. Unbeknownst to the researcher, as it is a theme she has not previously investigated, the literature strongly supports the
necessity for connection in recovery from sexual assault (Fahs, 2011; Gerbarg & Brown, 2011; Leech & Littlefield, 2011; Saakvitne, Gamble, Pearlman, & Lev, 2000). Gerbarg and Brown (2011) suggest social support and connection with partners and peers play a central role in breaking the pattern of trauma symptoms in survivors. Additionally, research shows physical and psychological stress from sexual assault can be buffered if the survivor has social support, develops active coping mechanisms, and seeks connection with others, including community resources (Leech & Littlefield, 2011).

The first theoretical code also included survivors’ necessity for self-acceptance in their process of recovery. When researching the term “self-acceptance” in relation to sexual assault recovery in recent literature, the researcher found very little to support this third-stage code. The literature regarding self-acceptance and survivors’ recovery was directed toward children recovering from sexual abuse, as well as lesbian, gay, transgendered, and bisexual individuals recovering from victimization, not specially sexual assault (Estensen, 2005; Hershberger & D’Augelli, 1995; Vernon & Hay, 1988). This finding was unexpected and gave the researcher pause. She considered her analytic process again, ensuring codes and themes were linked accurately and without bias.

Grounded theory methodology had been followed per Charmaz (2006) and Glaser’s (1998) guidelines. The researcher further considered whether other researchers and study participants had used a different word or term for “self-acceptance,” such as “respect,” “confidence,” or “self-efficacy.” Although it seems reasonable that self-acceptance would be a major facet of survivors’ recovery, the literature does not support the present study’s findings. Thus, the two scenarios the researcher contemplated in this instance were (a) the present study’s findings lack generalizability and transferability, or (b) as per grounded
theory’s fundamental objectives of discovering emergent properties, the study had produced a new theory for future research.

The second theoretical code that emerged pointed to external means of control, such as eating disorders and substance abuse as inhibiting a survivor’s ability to be present in her body and receive pleasure. As previously stated in this chapter, eating disorders are highly correlated with sexual assault survivors’ symptomology (Bryant & Schofield, 2007; Dubosc et al., 2012; Fischer, Stojek, & Hartzell, 2010; Harned, 2000). Research also suggests substance abuse is used as a coping mechanism for survivors before their process of recovery begins (Hunter, Robinson, & Jason, 2012; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013; Walsh et al., 2013).

Further significance of this theoretic code lies in the discovery that external means of control limit a survivor’s ability to be present in her body and thus receive pleasure. At the first minor axial coding phase, Q3 analyzed a survivor’s ability to be present in her body during sex and intimate encounters. Participants talked about not being present in their bodies immediately following their sexual assault through means of dissociation and/or using substances or other methods of external control. Their dissociation had both a physical and psychological component. They alluded to having a conscious awareness their body was engaged with their intimate partner, but felt a sense of separateness from their physicality and the experience in total. They were neither emotionally nor fully physically present enough to be able to receive pleasure.

In reflecting back on the axial coding process for Q5, which looked at survivors’ ability to receive pleasure, it was revealed they felt deserving of pleasure inclusive of orgasm. This was true after their recovery process had begun and their ability to be
present in their body during sex and moments of intimacy was established or reestablished. This was a significant point for consideration by the researcher. Due to the somatic nature of the study and the researcher’s objective to explore the process of embodiment, she wondered if indeed this second theoretical code was pointing toward principles of embodiment. If so, how relevant were they in relation to survivors’ overall experience of recovering sexual health?

**Discussion of theoretical construct.** Based purely on the emergent data, progressive identification and integration of categories of meaning and similarities (Willig, 2008), the final theoretical construct discovered for the present study was: The recovery of survivors’ sexual health is conditional to connection with others and relinquishing strict means of control in order to receive pleasure physically and emotionally. At this juncture, it was necessary for the researcher to explore how the theoretical construct answered, or did not answer, the research question.

As the review of the literature suggests in Chapter 2, the body plays a significant role in survivors’ recovery from sexual assault (Bryant & Schofield, 2007; Young, 1992). The experience of sexual assault creates the dilemma of “having a body” versus “living in a body” and makes troubling the centrality of the body in human existence (Young, 1992, p. 91). To discuss the meaning of the discovered theoretical construct, it is necessary to contemplate whether and how the construct meets the criteria for embodiment. In short, did survivors move from having a body (or being in a body without a conscious presence) to being embodied? If so, how? Lastly, how does that process correspond to their recovery of sexual health?
The present study’s emergent data suggests sexual assault does lead survivors to experience their own body as foreign and as something they were alienated from in the months or years following their assault preceding their recovery process (Stromsted, 2000). This cordoned them off from physical and emotional responsiveness, including the ability to receive pleasure, as well as their potential to realize the psychosomatic benefits of sexual health as defined in the present study (Braddock, 1997; Gilligan, 1998; Rothschild, 2000; Stromsted, 2000). Participants reflected on facets of psychological dissociation, as well as the use of external means of control, e.g. eating disorder and substances, as ways of dissociating and not being present. They discussed transitioning to feelings of being present when their process of recovery progressed. It is the researcher’s goal in this discussion of findings to determine if being present is analogous to being embodied.

**Interpreting Principles of Embodiment**

Merleau-Ponty’s (1962) definition of embodiment serves as the researcher’s guide in seeking to determine the meaning of the theoretical construct in regard to the research question. The definition of embodiment set forth in Chapter 2 states: Embodiment is the way in which an individual lives in and experiences the world through their body, especially through perception, emotion, language, movement in space, time, and sexuality (Merleau-Ponty, 1962/1982; Wilde, 1999). The body and sexuality are viewed as non-dual, as both are absorbed into the whole of existence (Merleau-Ponty, 1962). This non-dual conviction informed the foundation for other philosophers, researchers, and clinicians interested in sexuality and embodiment, many of whom were explored previously in the present study (Bryant & Schofield, 2007; Jolly, 2011; Kovacs, 1982;
Meissner, 1998; Price, 2007; Price & Thompson, 2007; Reimann et al., 2012; Wilde, 1999; Young, 1992). It was through the researcher’s comprehensive review of this relevant literature that the criteria for embodiment were devised.

Literature on embodiment suggests individuals live, experience, and perceive others and the world through their body, i.e., from an embodied perspective. Sexuality and its interdependence with embodiment are ways in which individuals make meaning of the world, and it is through sexuality that a meaningful world is opened up (Craft, 2009; Merleau-Ponty, 1962). Therefore, relying on this philosophical perspective, all facets of sexual health have a consciousness etiology and differing expressions of sexuality are contained in existence. The researcher can identify several codes and themes of the final grounded theory discovered that include elements established in this perspective of embodiment. The factors that most strongly correlate with this point of view, and thus provide information on survivors’ process of embodiment, include the ideas of: being present, deserving pleasure, sexual health as inclusive of intimate partner, connection with others, and open communication. It is the researcher’s belief, as supported by the data, that each of these five essential criteria to the recovery of sexual health after sexual assault does have an etiology based in consciousness. Specifically, these experiences are not possible without conscious awareness, which points to an embodied process occurring.

The researcher believes elements of embodiment are present in the final theoretical construct and valuable steps have been taken toward answering the study’s research question. However, she cannot unequivocally state the precise criteria for embodiment have been met in the participants’ experiences or shown in the data analysis.
process via the emergent codes, themes, and theories. The present study suggests five facets of embodiment are present, though they are not explicitly stated. The strongest link may be found in examining survivors’ implication that connection to others is necessary for the recovery of sexual health. Survivors’ beliefs about, and somatic experiences of, relationship and connection may be an antecedent to the broad presence of embodiment as it is described herein. The researcher proposes additional studies should be undertaken to more fully establish how, and the extent to which, embodiment plays a role in the recovery of sexual health after sexual assault. In light of this proposition, implications for future research are investigated at length later in this chapter.

**Somatic Interpretations**

Principles of embodiment are the primary link to the present study’s somatic nature. However, several other somatic psychology precepts also factor into the grounded theory analysis and make a significant contribution to the findings. The researcher concentrated on contributions to the literature in somatic psychology from prominent philosophers, clinicians, and researchers including, but not limited to, Barratt (2010), Caldwell (1997), Reich (1986), and Shaw (2004). The study of the psychology of the body focuses on individuals’ experience of living and is foundational to their experiential potential (Barratt, 2010). It was essential to the researcher that the present study look at the whole survivor, not merely her physical attributes or concerns in contrast to her psychological well being. Discovering the embodied process of a survivor’s recovery meant examining not only how she thought about her body and her experience of recovery, but how she felt about it in a somatic sense. The body often reveals the first clue in a survivor’s experience both in regard to the original trauma and recovery from
that trauma. It is a barometer for stages of recovery and ultimately a survivor’s sexual health (Shaw, 2004).

The researcher considered somatic data from participants as foundational to the discovery of theory. Not only did she note each participant’s “ehs,” “uhhs,” deep breaths, fidgeting, clasping of hands and foot tapping, but the prosodic nature of what was being communicated was also noted. There was little somatic data that was entirely unexpected or surprising. Rather, it confirmed the exceptional ability of the body to powerfully communicate a story and sense of being in a particular moment. All 12 participants displayed somatic cues of tightening, withdrawing, and holding back more at the beginning of the interview than at the end. During the beginning phase of the interview (Q1–Q3), pauses in survivors’ responses were exhibited by looking away from the researcher/avoiding eye contact, squeezing their knees together, tightening their fists, and crossing their arms. Their tone of voice was low and staid. During the middle phase of the interview process (following Q3), the researcher noted shorter “ums” and “ehs,” but increased fidgeting and foot tapping, which could be construed as signs of continued nervousness. However, there were less long pauses and signs of withdrawing or protecting. By the middle to end of the interview process (following Q5), participants’ dialogue had a salient and more rhythmic lilt and elicited fewer pauses or words serving as space fillers. Dialogue came more easily and was reflected in an openness, a lack of rigidity in posture, and a lightened tenor of speech. The researcher felt she was somatically witnessing each survivor’s story of recovery through her body language and patterns of speech.
Although the present study may not have elicited new discoveries about the body’s ability to communicate experience, the researcher believes collecting somatic data and exploring it reinforced the importance of the body in the survivors’ recovery. At the beginning of the interview the body served as armor as it most often does immediately following a survivors’ sexual assault (Braddock, 1997; Wilde, 1999; Young, 1992). The body reflected a survivor’s loss of trust and an uncertainty that it could be trusted to protect her from both physical and emotional trauma (Rothschild, 2000). Although the researcher was confident the study’s participants felt respected and safe during the interview, it became obvious that the mind and body, while nondual in nature, can have different time frames for knowing and somatically sensing this reality. In the latter stage of the interview, it was fascinating to watch the integration of participants’ mind and body awareness. The researcher felt as if she were witnessing a visual representation of the study’s outlined principles of embodiment and tenets of somatic psychology (Barratt, 2010; Caldwell, 1997; Merleau-Ponty, 1962; Reich, 1986; Shaw, 2004; Wilde, 1999).

Participants knew they were safe and had the benefit of being seen and heard embracing the totality of their experience and being. The opportunity to witness survivors’ psychosomatic integration reaffirmed the researcher’s hypothesis and supported existing literature that suggests the embodied process of recovery from sexual assault has a physical component and is both personal and relational. (This was evidenced in these moments by participants’ feeling of safety and trust in the researcher.) Survivors reach a point in their recovery process where they are certain the body will keep the mind safe and the mind will keep the body safe (Braddock, 1997; Rothschild, 2000). The
“who” of their being is matched by the sensations of their body. Experiences are integrated and lay the foundation for the survivor’s whole, embodied self.

**Examination of Reflexivity**

Qualitative methodologies are generally distinguished by the degree to which they emphasize principles of reflexivity (Willig, 2008). Grounded theory, as it is utilized in the present study, requires a high degree of reflexivity (Charmaz, 1995b/2000/2006; Coolican, 2009; Strauss & Corbin, 1990). Reflexivity requires an awareness of the researcher’s contribution to the research process and an acknowledgment of the impossibility of remaining outside of one’s subject matter while conducting research (Willig, 2008). It necessitates the researcher’s exploration of how her involvement in the study influences, acts upon, or informs the data discovered.

The original purpose of grounded theory was to allow new theories to emerge through an inductive process, which facilitates the discovery of new categories, themes, and theory. “This was meant to liberate the researcher from the straightjacket of hypothetical-deductive research” (Willig, 2008, p. 46). While in many ways this process assumes the data speaks for itself and the researcher follows it precisely, by adhering to the social constructivist version of grounded theory, the method concedes that what is observed depends on the observer. Dey (1999) stated,

> Even if we accept the proposition that categories are discovered, what we discover will depend to some degree on what we are looking for, just as Columbus could hardly have discovered America if he had not been looking for the Indies in the first place. (p. 104)
The present study’s social constructivist grounded theory methodology (Charmaz, 2006) addresses these concerns by encouraging the researcher to fully develop all angles of reflexivity. The researcher acknowledges that the process of categorization occurs during data collection and analysis, for which she is an unambiguous participant.

To answer the question, “What grounds grounded theory?” (Willig, 2008, p. 46), it is recommended the researcher document, carefully and in detail, each phase of data collection and the discovery process (Pidgeon & Henwood, 1997). This demonstrates the ways in which the researcher’s assumptions, values, sampling decisions, analytic technique, interpretations, and biases have shaped what is discovered. Some qualitative analysts still see the fairly modern version of social constructivist grounded theory as an epistemological limitation of the original methodology (Dey, 1999; Pidgeon & Harwood, 1997; Stanley & Wise, 1983) and assert it is not yet clear whether this version requires more than a recognition of the active role of the researcher in the analytic process (Willig, 2008).

In an attempt to curtail this potential inherent limitation, the researcher kept a journal from four weeks preceding the data collection process until the end of the data analysis phase, at which time she arrived at the study’s final theoretical construct. Not only did she journal about her personal reactions to particular participants and their narratives, she also noted her somatic reactions. She wrote about her thoughts and feelings immediately after an interview’s conclusion as well as throughout the six-week long data collection and analysis process as more thoughts and feelings surfaced. She included reflections such as the level to which she empathized with a participant or harbored judgments, what findings surprised her, and the ways in which she was mindful
about and took precautions toward not allowing her biases to influence the data. The researcher also kept a list of three epistemological questions specific to grounded theory adapted from Willig (2008) on the front page of her journal and referred to them before each journaling session. Question number three is particularly relevant to principles of reflexivity. The questions include:

1. What kind of knowledge does the grounded theory method aim to produce in this study?
2. What kinds of assumptions does grounded theory make about the phenomenon being discovered in this study?
3. How does grounded theory influence what the researcher discovers in this study?

In regard to question one, the study was designed to identify and illuminate the contextualized social progression of the embodied process of recovery of sexual health after sexual assault. The researcher was fully aware of the limitations that could occur if she approached data analysis with preconceived notions or “pet theories” (Willig, 2008, p. 45). She categorized the data and discovered emergent themes and theories based, to the highest degree possible, on only what the data displayed. The present grounded theory study aimed to produce knowledge that deciphered how the recovery of sexual health is specific to sexual assault survivors. The researcher’s intent was to (a) complete a reliable and valid study, (b) have the study be a valuable resource to fellow researchers, and (c) make contributions to the field of somatic psychology and clinical management of sexual assault survivors relevant to treatment selections and outcomes.
The second epistemological question encouraged the researcher to look at ways in which the study’s participants negotiated and managed their recovery process. Additionally, she wondered how participants’ actions were the same or different in comparison to each other, and how their experience contributed to the social phenomenon of recovery of sexual health after sexual assault. Participants’ interpretations of the events of their assault and subsequent recovery shaped not only their answers but also the consequences of those answers on the discovery of theory.

The third epistemological question facilitated the researcher’s expression of the principles of reflexivity throughout her journaling process. Acting as a witness, she took detailed notes of her reactions to better understand what role she played in the data collection and analysis process. The researcher first considered how her relationship with each participant felt. She reflected on the qualities of the back and forth dialogues, as well as the somatic connection, or lack thereof, between researcher and participant. This was the first time she had acted in the role of researcher rather than therapist, and she quickly recognized the challenges that presented. She found herself wanting to offer feedback or reassurance as she does in the therapy room, but in nearly all instances was able to maintain her objective role as researcher. The researcher only offered feedback and reassurance when it seemed appropriate and necessary to help the participant move forward in the interview process. The researcher believes these few exchanges did not impact the data collection process significantly.

The researcher was surprised, as she often is with her clients, that there were participants who immediately felt more likeable to her than others. This seemed like a substantial breech of grounded theory methodology and she journaled about her
judgments and reactions to what a participant said immediately following the interview. For example, if the researcher thought, “Why would you continue to do that?” following a participant’s response, she wrote about her biases, unbecoming as they may be, in order to maintain her role as objective truth-teller. Biases and judgments she noted included wondering why, and how, it could take her older participants so long to “get their life together” (Richmond, 2013, p. 3) and attain recovery. The researcher also had to check her biases about participants’ blaming God for their rape, but then crediting “him” for their recovery. The same was true of participants who relied or still rely on 12-step programs to attain or maintain recovery. The researcher concedes to biases about the role of religion in trauma recovery as well as the highly structured, position of powerlessness stance most 12-step programs advocate. The researcher supports clients who utilize these programs, but has to carefully guard her opinions. She acted in the same manner during the interview process with the study’s participants.

The researcher often reconsidered what a participant said when she was transcribing her notes. Typically, upon further reflection more could be interpreted than the meaning the researcher first assigned to the response. What seemed like a simplistic answer during the interview carried significant meaning upon additional examination. A participant’s comment of “I don’t know” became enormously telling in and of itself. As the researcher got deeper into the data collection process, she took more time to honor participants’ succinct responses rather than immediately probing for more detail. She realized a short answer did not mean a participant was necessarily avoiding difficult emotions any more than the researcher’s lack of tears meant she was avoiding a somatically empathic response. Many feelings related to rape and recovery had been
processed at an earlier time by the participants, which is why they were ideal for the study. As for the researcher, she certainly has not become immune or hardened to stories of sexual assault. However, her work as a rape crisis counselor has to some extent normalized survivors’ narratives and provided a solid foundation for her to work therapeutically rather from an emotionally reactive place. The researcher has developed measures of self-care in order to process any potential vicarious trauma or issues of countertransference.

Looking explicitly at the researcher’s somatic reactions to the data collection process, she first noted her increased heart rate, fidgeting, and quickly paced manner of speaking when meeting with the first few participants. As previously stated, this was the first time the researcher acted in the role of researcher rather than therapist, and that role came with trepidation about “doing it right” (Richmond, 2013, p. 2). Writing about her nervousness and expectations of herself was helpful in acknowledging somatic responses, validating them as part of the learning curve, and finding constructive ways to move on. By participant number four, all somatic signs of nervousness had been quelled. Other somatic responses were more similar to what the researcher had experienced in her therapeutic work with survivors. Just as there were a few participants whom she felt less empathy toward than others, there were several participants who did elicit deeply felt somatic responses in the researcher. Rather than exploring why one participant brought tears to her eyes and a heaviness to her heart more so than another, the researcher focused first on curtailing the influence of her somatic responses in the interview room. She did this through noticing and practicing mindfulness, which typically meant slowing things down. Second, she journaled about measures she could take outside of the data collection
process such as exercising or reading for pleasure or, if necessary, calling her former clinical supervisor or her dissertation chairperson to address self-care issues. The researcher was six months pregnant during data collection and was thus aware of pregnancy related hormonal responses and the possibility of increased emotions. Keeping these emotions in check was more difficult than usual because the researcher did not have her typical channel for stress relief of strenuous aerobic exercise. Walking became a substitute for running and prenatal yoga replaced vinyasa flow classes. The researcher feels strongly that she was able to find an outlet for residual somatic reactions and emotional energy, as well a safe space to settle herself in her revised exercise regime. As a somatic therapist, the researcher understands her body is as much a barometer for participants’ experiences as it is for her own, and is skilled at finding activities that provide quietness and clarity.

The data analysis process felt more emotionally contained for the researcher than did data collection. However, data analysis was fraught with potential for looking, and finding, connections in codes and themes that perhaps did not exist. The potential for inaccuracy when deciding if the criteria for theoretical saturation had been met will be discussed further in this chapter’s “Limitation” section. In regard to the reflexivity component of the discovery process, the researcher carefully monitored potential biases toward qualities inherent to the study such as embodiment, shame, or addictions. She did this to some extent through her journal, but more so by way of creating visual memos and maps that noted frequency counts, how codes and themes linked, and the direction in which these links moved the analysis toward the next emergent theme or theory. As the researcher noted in this chapter’s “Discussion of Findings” section, some emergent
themes were familiar to the researcher due to her work with survivors, though most were unexpected and unfamiliar. The researcher also had surprises regarding what she did not find. One such surprise was the lack of a strong correlation to shame. This example and others like it proved to be extraordinarily useful in staying focused and keeping the analytic process of discovery grounded in the data.

In summary of the process of reflexivity, the researcher believes she has adequately represented, in a systematic and accessible manner, a clear picture of the social construct of the recovery of sexual health after sexual assault. Her commitment to acknowledging potential biases and assumptions has been present throughout the formulation and execution of the study (Willig, 2008). Grounded theory and the social constructivist approach is daunting in that it unconditionally relies on the researcher’s skills and objectivity in her ability to collect and analyze data in order to determine an accurate outcome. The present study’s researcher utilized several means of self-exploration and support in order to assure her inherent predisposition and potential partiality remained secondary. However, given the present study’s version of grounded theory methodology (Charmaz, 1990/1995b/2000/2006), she also acknowledges her role in the research process. The researcher takes responsibility for the meaning ascribed to the social construct being studied, i.e., survivors’ recovery of sexual health. From a social constructivist perspective, grounded theory does not capture social reality; instead, it is itself a social construction of reality (Charmaz, 1990, p. 1165).

Limitations of Study

Even with the researcher’s commitment to accuracy in data analysis and thorough exploration of principles of reflexivity, there are several limitations to the present study
that warrant discussion. To begin, grounded theory methodology generates the potential for the researcher to aim for theoretical saturation and possibly invoke the term uncritically (Charmaz, 2006; Dey, 1999; Glaser & Strauss, 1967). As previously described, the researcher took every means possible to follow only where the data led. Not only did she guard against potential biases, she remained open to the possibility that her theoretical position may change (Willig, 2008). She allowed for the prospect that embodiment may not be a factor in recovery of sexual health from sexual assault, e.g. what she was looking for in her research question may not exist. Although the study’s data suggests principles of embodiment are present in survivors’ process of recovery, this finding is worthy of discussion due to the researcher’s theoretic and therapeutic bias as a somatic therapist, and the fact that embodiment was a foundational aspect of the present study.

In terms specific to limitations in the data analysis procedure, grounded theory promotes the use of language from discovered in vivo codes, but also contends those codes parallel what existing literature reports on the topic of study. Thus, as the researcher maintains an objective perspective, she is in fact being steered toward principles inherent to the research question, which she investigated in the review of the literature. For example, the present study examined principles of sexual assault, sexual health, recovery, and embodiment. Because not all of the principles within these subjects linked to codes and themes discovered, the researcher believes her methodology is grounded in the data. Furthermore, the emergent data that did not correlate to the existing research opens the door to future research on the topic of survivors’ embodied process of recovery of sexual health.
Also in regard to the use of language, the researcher wonders how delivering the interview protocol in person versus via written report may have changed the narrative survivors offered. Did delivering the interview protocol in person, as she did, create more spontaneity, comfort, and openness on the part of the participants due to the connection with the researcher? Or, if participants were allowed to take the interview protocol home and complete it on their own time, would they have felt compelled or perhaps freer to share more, particularly after being assigned a number to assure their anonymity? These are questions worthy of consideration and potentially only answerable through revised future studies.

Demographic, etiological, and cultural limitations must also be discussed. It was a disappointment to the researcher that only females responded to the study’s recruitment flyer. SBRCC’s clinical director informed the researcher the center presently had few male clients, so the female-only $n$ of 12 was not unexpected. The researcher believes there are two questions that must be addressed in regard to this particular limitation. First, would the results have been different if the study had included male participants? This would be an easy alteration to the study if it were to be replicated. The researcher would need to spend more time and/or seek out additional sources of participants in order to locate male survivors. Second, how would the results be different if all participants were male rather than female? It is the researcher’s belief, based on her experience working with male survivors, that an all-male study results would be highly correlated with the present study’s all-female results. Literature suggests survivors go through universal stages of symptoms and recovery, e.g. the criteria for Rape Trauma Syndrome, which includes acute adjustment and reorganization phases (Rothschild, 2000; Sprei & Courtois,
1988; Van der Kolk, 1987). However, there is less current literature available regarding male survivors, and thus a mixed-gender study or all-male study warrants further investigation.

In addition to limitations due to gender, the present study also contended with a limited range of participant ethnicity. Figure 1 delineates participant demographics, including ethnicity. The majority of participants (eight) were exclusively Caucasian with one being of Caucasian/Hispanic descent. Of the remaining three participants, one was Hispanic, one Japanese/Mexican, and one Slavic. For the limited $n$ and the study’s Santa Barbara, California, locale, the researcher was encouraged to have some measure of diversity but realizes a more even balance between Caucasian and other ethnicities would have been preferable. It is worthwhile to consider whether results of a replicated study would vary depending on the ethnic skew of participants given the same Santa Barbara, California, study site. Further studies could contribute significant findings to current literature by investigating if and how differences are manifested in the recovery process for various ethnicities of survivors.

Participants were only recruited from Santa Barbara, California, which creates an inherent limitation to the present study in terms of generalizability. Results cannot be generalized to all sexual assault survivors. The researcher believes the results may not be generalizable to survivors across the United States or even to different areas of California. Santa Barbara has numerous geographic, demographic, and socioeconomic characteristics that make it unique and thus limit the study’s generalizability, necessitating replication in order to confirm validity.
Although the study’s 12 participants presented diversity in age (26 to 65 years of age) and socioeconomic status (students to high-level executives), all possessed a considerable degree of financial stability. None were homeless and none lived in poverty, meaning they did not worry about meeting their day-to-day needs for food, shelter, and clothing. The researcher would go as far as to say all participants experienced some degree of affluence and privilege for the mere fact of living in Santa Barbara, California. The city of Santa Barbara imparts access to abundant community resources including nonprofit mental health clinics, such as SBRCC, and low-fee or no-fee medical health clinics. The city also offers a multitude of free cultural and educational opportunities. In short, it is a beautiful, generally favorable place to live. Even the temperate weather makes it an easy-living city year-round. In order to comprehensively examine elements of generalizability, it is necessary to take all of these factors into consideration. For example, how would the outcome of the study be different with participants from an impoverished area like South Central Los Angeles? How might the outcome be different with participants from a rural area of Northern California, a large city in the Midwest, or an even more costly and opportunity-rich city such as New York? To purport an accurately generalizable study, the outcome would have to be replicated to all survivors worldwide, from affluent European cities to remote towns in India. Although the researcher considers the study’s outlined principles of embodiment to be applicable to all individuals (Merleau-Ponty, 1967) and the literature suggests uniform stages of symptomatology and recovery from sexual assault (Rothschild, 2000; Sprei & Courtois, 1988; Van der Kolk, 1987), she does believe socioeconomic status, cultural and
educational opportunities, as well as community resources, may affect the study’s outcome.

A final point to consider in regard to the study’s generalizability is the familiarity and safety SBRCC offered participants. This is also the case for the researcher. She addressed this issue in her journal, wondering what it would have been like to conduct interviews in a place unbeknownst to her and the participants. However, she also wrote about being grateful for one less obstacle to overcome in assuring participants’ comfort and safety, including a built-in support network of therapists and advocates. The researcher suggests results could have been different if the interviews had been conducted outside of SBRCC.

**Discussion of Strengths**

Although the researcher identified several evident and potential limitations to the present study, she does not believe they outweigh the relevance of the data collected or the verity of the final theoretical construct. Meticulous adherence to grounded theory methodology lends credibility to what was discovered specific to all characteristics and qualities of the study. The relevance of the data in answering the research question, the noteworthiness of the codes and themes, and the specificity of the final emergent theory meet the criteria for rigor in qualitative research (Guba & Lincoln, 1994).

The four criteria for rigor in qualitative research include the following components and conditions for establishing verity:

1. **Credibility**—What is the truth-value from participants’ perspective, i.e., are the results believable?
2. **Transferability**—Can results be generalized or transferred to another context or setting?

3. **Dependability**—Can the study be replicated or repeated, and are the findings consistent?

4. **Confirmability**—Was the study sound, and was there sufficient neutrality on the part of the researcher, i.e., were the findings shaped by participants and not researcher bias, motivation, or interest? (Guba & Lincoln, 1994)

Credibility was first established through prolonged engagement, which required the researcher to spend sufficient time in the field to learn or understand the culture or phenomenon of interests (Lincoln & Guba, 1985). The researcher has worked for over four years as a sexual assault counselor and spent two years designing and carrying out the grounded theory qualitative study, with eight weeks of data collection and analysis. The second component of credibility adhered to was persistent observation. “If prolonged engagement provides scope, persistent observation provides depth” (Lincoln & Guba, 1985, p. 304). Prolonged engagement renders the researcher open to multiple influences and contextual factors that impinged upon the phenomenon being studied. Its purpose is to identify characteristics and elements in the situation that are most relevant to answering the research question. The researcher focused on three central elements within the research question, e.g., sexual assault, recovery of sexual health, and embodiment. By keeping the lens narrow, namely by focusing on recovery of sexual health rather than recovery in general, the researcher feels she has met this specific criteria for credibility.

In regard to corroborating transferability, the researcher relied on thick description. Thick description is described by Lincoln and Guba (1985) as a way of
achieving a type of external validity. By describing a phenomenon in sufficient detail, one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people. Grounded theory methodology lends itself to thick description through several means including the semi-structured, intensive interview protocol, probe questions, follow-up interviews with participants if necessary, and the extensive coding process. The researcher believes she described the phenomenon being studied in sufficient detail to meet the criteria for transferability. She also concedes there were several limitations to the study in regard to transferability and generalizability, which were discussed in this chapter’s previous section.

Lincoln and Guba (1985) created the concept of an inquiry audit to establish dependability. The use of an inquiry audit is “the process in which the researcher or reviewer examines the process and the product of the research for consistency” (Lincoln & Guba, 1985, p. 317). Lincoln and Guba’s concept of an inquiry audit is formulated on the notion that “credibility cannot exist without dependability and a demonstration of the former is sufficient to establish the latter” (p. 316). When considering the present study, the researcher believes it exhibits a high level of credibility; she has confidence in the truth of her findings. Looking specifically at issues of dependability, this criterion was established both through the accurate reporting of participants’ experience and meticulous attention paid to the data analysis process. Transcripts were precise and the emergent data discovered within was grounded in the data. These factors suggest the findings are consistent and could be repeated.

Reflexivity is the technique the researcher relied on to establish confirmability. She attended systematically to the context of knowledge construction, especially to the
effect that her own potential biases or preconceived notions could have at every step of the research process (Lincoln & Guba, 1985). Thus, a degree of neutrality was sought. There was also a broad investigation of the extent to which the study’s findings could have been shaped by the researcher’s biases rather than solely the participants’ experience. The researcher was amply aware of the grounded theory perspective (Charmaz, 2006) that affirms the researcher shapes all research, yet feels her extensive exploration of the principles of reflexivity establish the study’s confirmability.

The present study met the criteria for rigor in qualitative research (Lincoln & Guba, 1985; Guba & Lincoln, 1994) by establishing credibility, transferability, dependability, and confirmability. The soundness of the data collection procedure and quality of data analysis, per grounded theory specifications, is evident herein. The researcher believes she adhered to the accurate protocol for her chosen method of qualitative research, which produced constructive, precise, and valuable data relevant to the phenomenon of study.

**Implications for Future Research**

Although the present study’s findings may not definitively point toward the full expression of embodiment on the part of survivors, the researcher believes what was not discovered lends credibility and validity to her methodology. Specifically, data may not have included strong indicators of embodiment because the researcher did not point participants in that direction, per grounded theory protocol. The study was a first step in exploring how the embodied process of recovery occurs, and it may have laid the framework for additional studies by asking questions that addressed both the psyche and soma in relation to healthy sexuality. However, because the interview questions did not
explicitly use the word “embodiment,” participants did not use it either. The study’s participants were a naïve population in so far as they did not have knowledge of somatic psychology and the concept of embodiment. When the researcher stated in her recruitment flyer, and during the initial interview, that she was exploring the embodied process of the recovery of sexual health, it could have been the first time these survivors had heard the word “embodiment.” The only qualifier offered in light of embodiment was that the study focused on examining the bodily process of recovery, as well the psychological process. The researcher did not guide participants toward expressing ideas about embodiment, and they did not go in that direction except through the associations the researcher previously identified such as connection, communication, ability to receive pleasure, etc. The data emerged naturally and was consistent with what was being asked. The data analysis process revealed the codes, themes, and theory that emerged, all of which point toward the stipulated and accurate use of grounded theory methodology.

Given the present study’s outcome, the researcher realizes the nature of the research question implies she believes there is an embodied process of recovery of sexual health for survivors of sexual assault. Knowing what she knows now, the researcher must consider whether stating the research question as “What is the psychosomatic process of recovery of sexual health after sexual assault?” rather than “What is the embodied process of the recovery of sexual health after sexual assault?” may have been more applicable to this first-stage study. The mere fact that the researcher was looking for an embodied process points to a bias for what would be discovered. Because the researcher was diligent about protecting the study’s integrity and following grounded theory procedure, she was able to guard against this bias. It is possible, even probable, the
present study’s questions were not specific enough to the determined definition of embodiment and thus another study or studies should be conducted which look directly at that concept.

Given the researcher’s theoretic and clinical background in somatic psychology, as well as the nature of the doctoral degree for which this study fulfills, she realizes measures of somatic findings and interpretations were somewhat preordained. Considering her interest in embodiment and the results of the present study, as well as the supporting literature, there is considerable opportunity for future research. One such opportunity would be to find participants who met the same criteria for inclusion, but conduct an eight-week experiential group therapy intervention. During the eight weeks, participants would learn about principles of embodiment and practice them within the group setting and at home. Following this therapeutic training, a semi-structured interview protocol would be delivered that addressed concepts more specific to the established principles of embodiment. The researcher would have to once again be diligent about following only where the data led, but in this instance participants would have knowledge of and be familiar with the terminology and practices of embodiment. Within this scenario, it would be the researcher’s goal to increase survivors’ awareness of embodiment and thus their potential for healing.

In addition to the larger scope of what could be discovered in regard to the connection between survivors, embodiment, and sexual health, the researcher has identified specific areas that may contribute to understanding the phenomenon of recovery. The first concept for consideration is how connection leads to embodiment. Is the idea of connection survivors describe truly an element of embodiment? The present
study suggests survivors’ connection occurs with others and with self. It may be valuable to discern if a survivor’s connection with others is a requisite for connection with self, and, if so, what is the order of that connection? Does a survivor connect to self before being able to connect to others? Or, is it necessary to repair the rupture in intimate relationships caused by the sexual assault(s) before establishing an embodied connection to self? It is also possible the connection occurs simultaneously. The ways in which connection is linked to embodiment and the process by which that connection occurs may provide valuable insight into survivors’ recovery of sexual health.

The researcher feels it is also necessary to thoroughly investigate the concepts of pleasure and orgasm. The present study suggests survivors believe they deserve to receive pleasure inclusive of orgasm, but it may be constructive to more fully understand how that belief is connected to principles of embodiment. For example, is the feeling of orgasm based only in the genitals or is it, as Reich (1949) suggests, something that occurs within the entire body? The present study’s data intimates survivors who have achieved the ascribed degree of recovery of sexual health do not possess neuroses rooted in physical and sexual conditions making them afraid of their own sexual vitality (Reich, 1949). Orgasms do not feel scary or out of control, and rather than being afraid of them they believe “every woman has the right to that experience [orgasm]” (Q5, participant 111).

To fully explore how orgasm and embodiment are linked, delving more deeply into Reich’s “orgone” hypothesis may be beneficial. Is a survivor’s orgasm inclusive of “orgastic potency” (p. 230)? To fulfill principles of embodiment, does orgasm have to be full body and contain “cosmic energy” and “life force” (Reich, 1949, p. 231)?
Reich states his belief that only a free body can express a total body orgasm in contrast to a genital one, the researcher wonders whether a free body is only achievable by an individual who perceives orgasm as an embodied process? In short, similar to the necessity to explore how survivors identify connection as a piece of embodiment, it may also be necessary to understand how they experience pleasure and orgasm.

Lastly, and as previously noted, the researcher would be curious about how sexual health is specific to survivors compared to non-survivors. As participant 102 offered in response to Q7, she believed her rapes and subsequent negative symptoms were imperative to achieving her present level of healthy sexuality. Participant 103 stated she would not change anything about her history, and it was the experience of rape that got her to where she is today, a place where she is “healthy” and “good.” The researcher wonders whether these beliefs are embodied beliefs. Is this type of enlightenment crucial to an embodied process of recovery of sexual health for survivors? And, what is the level of implicit and explicit awareness of this enlightenment in regard to themselves (psychologically and somatically), their relationship to others, and the healthy expression of their sexuality?

Because the researcher views the present study as a first step to further understanding principles of embodiment in relation to survivors’ recovery of sexual health, the implications for future research are vast. By narrowing even further the lens of existing research and looking specifically at the embodied process of recovery of survivors’ sexual health, it is the researcher’s hope that future studies will provide answers to the questions presented above. Those answers may impart crucial insight into
how sexual health is embodied by survivors of sexual abuse and offer more efficacious paths to recovery.

Contribution to Theory

The theoretical consequences of the study’s results offer an original perspective and noteworthy contribution to the field of somatic psychology. This is predominantly applicable to research investigating and reporting outcomes pertinent to survivors of sexual assault, though the researcher believes the results may translate to other areas of research within the scope and practice of somatic psychology. The results offer a perspective not currently available in the literature due, in part, to a lack of research into the integration of the study’s three main areas of focus, e.g., sexual assault, recovery of sexual health, and embodiment. The study has set a precedent for possible implications for these three areas of research, which the researcher hopes is expanded upon. By looking more fully at the psychological and bodily processes of recovery, a significant contribution to the field of somatic psychology may be made.

The present study offers an inroad for a unique contribution to the field of somatic psychology in terms of unexplored directions for research in sexuality and psychosomatic well-being. As Caldwell (1997) suggests, new insights seek to resensitize humanity to the direct physical experience of the body as a tool toward healing. By furthering the principles of somatic psychology, the present study may contribute to the continued evolution of viewing the body, and its capacity for health, as nondual. Research into the criteria and conditions of embodiment, which are central to the study of somatic psychology (Barratt, 2010; Boadella, 1996; Caldwell, 1997; Merleau-Ponty, 1962; Reich, 1986; Wilde, 1999), have the potential to advance theory in multitudinous ways. It is the
researcher’s hope that further studies into the relationship between sexuality and embodiment may result in a new appreciation for the human condition (Barratt, 2010). Promoting theory and methodologies that address an individual’s two strata of nonduality—psyche and soma, and self and sexuality—may inform the experience of being. Further examining the experience of being from a somatic psychology perspective may influence the present understanding of how embodied recovery occurs and ways in which it can be advanced.

**Contribution to Practice**

The practical consequences of the study’s results may contribute to several psychoeducational and clinical arenas including crisis counselors, trauma specialists, couple’s therapists, somatic psychologists, sex therapists, and sexuality educators. First-line medical responders as well as physicians who treat survivors at later stages of recovery may also benefit from the present outcome and implications for future research. Although it would be necessary to utilize larger and more diverse sample sizes, and repeat iterations of the study in the methods previously discussed, the theories derived may hold promising outcomes for survivors’ recovery.

The field of crisis counseling is the first aspect of sexual assault management and recovery immediately relevant to the present study’s findings. Providing information to assist crisis counselors in addressing a survivor’s somatic as well as psychological responses may help them de-escalate the trauma response and lessen the effects of the acute stage of Rape Trauma Syndrome. In the same vein, providing first-line medical responders with similar information may help them to more effectively treat the immediate psychosomatic effects of rape once any physical injuries are attended to.
Rather than encouraging a fractured healthcare system that promotes singular focus either to a survivor’s physical condition or emotional state, the present study’s result may advance the practice of holistic treatment strategies. In so doing, survivors could benefit from comprehensive and modernized procedures that address psychosomatic wellness.

Implications for the advancement of couple’s therapy were discovered throughout the study and are succinctly stated within the final theoretical construct. Survivors predicate recovery of sexual health on their connection to others, inclusive of their intimate partners. The embodied, nondual process of recovery is not solely based on the survivor but on the survivor’s relationship to others. In the researcher’s clinical experience, she often witnessed a survivor’s significant other attributing all problems within the relationship to the occurrence of the sexual assault and the survivor’s inability to address the consequences. Although the bulk of the therapeutic work may lie with the survivor, results of the present study suggest psychosomatic recovery requires active participation for those individuals closest to the survivor as well. This was particularly evident in data that emerged in regard to the expression of healthy sexuality. Survivors spoke about the ability to be present, relinquish external means of control, and receive pleasure in correlation with their intimate relationships. Couple’s therapists who have this awareness may be able to more effectively and efficiently treat couple’s with a history of sexual assault and help them move toward a more stable and communicative future.

Results from the present study may be useful to somatic psychologists in furthering their knowledge of the nonduality of sexuality and self (Merleau-Ponty, 1962) just as they promote awareness to the nonduality of psyche and soma (Barratt, 2010; Boadella, 1996; Caldwell, 1997; Wilde, 1999). By recognizing the psychosomatic
symptomology and consequences of sexual assault, somatic therapists could help clients deconstruct their symptoms, make meaning of the symptoms’ presentation, and utilize somatic psychotherapy modalities in treatment. Modalities such as the Braddock Body Process, Somatic Experiencing, Autogenic Relaxation and Hakomi are modalities particularly suited to the holistic treatment of sexual assault, though the researcher believes the present study’s preliminary results, as well as future studies, could be adaptable to most somatic modalities. By acknowledging the consequences of sexual assault to the mind and body, and developing and/or integrating a treatment protocol based on the present study’s theoretical construct, it may be possible to directly address and accelerate, in an appropriate therapeutic manner, survivors’ recovery.

The collective goal for clinicians and educators who work in the field of sexual assault is to have tools that ultimately lead to prevention. The results of this study may contribute to preventative measures by offering theories about how perceptions of the psyche and the soma are different before the assault and after. For example, the goal for many survivors is to return to the broad psychological, physical, and sexual level of functioning that preceded the assault. Based on the present study’s preliminary results and the possible contribution of further research, it may be possible to identify what factors were present and contributed to these aspects of the individual’s health. Once discovered, a psychoeducational protocol could be devised that promoted attention to the identified factors for both survivors and the general population (non-survivors). Advancing knowledge about sexual health inclusive of the somatic factors discovered herein may, at the very least, inform young women and men about what is possible where choice, connection, and pleasure are concerned. The researcher believes additional
knowledge holds the promise of encouraging a holistically based, embodied appreciation of sexuality to which all individuals are entitled.

The final aspect of practical consequences to be addressed is the contribution to and development of the discipline of somatic sex therapy. Building from the foundations of somatic psychotherapy (Barratt, 2010; Boadella, 1996; Caldwell, 1997; Merleau-Ponty, 1962; Reich, 1986; Wilde, 1999) and sex therapy (Basson, 2008; Berman, Berman, & Kanaly, 2003; Brown, 1995; Laumann et al., 2006; Sprei & Courtois, 1988; Wylie, 2001), the researcher is hopeful the present study’s results will add to the burgeoning discourse integrating these two therapeutic orientations. Braddock (1997), Ogden (2006/2013), and Resnick (1997/2012) are practitioners the researcher has studied with and feels have the most relevance to the development of her unique vision of a somatic sex therapy modality. Each of these three experts has a specific area of interest in regard to a mind/body approach to sexuality. Braddock’s work (1997) focuses on helping clients recover from sexual trauma by utilizing breath and movement practices based on interactive principles including Tai Chi and Qi Gong. Ogden (2006/2013) focuses her work on recovery as well as the integration of spirituality and sexuality, and Resnick (1997/2012) combines traditional sex therapy with guided imagery and body-based exercises to assist individuals and couples with enhancing performance, desire, and connection.

The present study’s researcher believes the results of this study and future studies may be the first step toward developing a new, integrative somatic sex therapy modality. She perceives this current work as a chapter or specific protocol to address recovery of sexual health for survivors, which will eventually be contained within a larger scope of
practice. Utilizing her training in sex therapy and theoretical orientation in somatic psychotherapy, she sees potential not only for treating survivors of sexual assault, but also for addressing broad areas of sexual health for all individuals. Somatic sex therapy may advance the way the extensive therapeutic community thinks about the body’s response to sexual trauma, the psychosomatic presentation of negative consequences, and the repair process both for individuals and their relationships. The development of a somatic sex therapy practice may also contribute to an original perspective on how embodiment affects all individuals’ experience of desire, pleasure, and love.

Conclusion

The present study’s research question (What is the embodied process of recovery of sexual health after sexual assault?) has been answered to the greatest extent possible through a grounded theory process of analysis and interpretation. Results were comprehensive and provided insight into the particular phenomenon of study, and also offered implications for future research. In summary, the theoretical construct discovered states the recovery of survivors’ sexual health is conditional to connection with others and relinquishing strict means of control in order to receive pleasure physically and emotionally.

Psychosomatic implications for survivors’ recovery are well established in the literature (Basson, 2008; Berman, Berman, & Kanaly, 2003; Laumann et al., 2006; Rellini & Meston, 2007; Scholerdt & Heiman, 2003). The present study identified many of the known characteristics, as well as suggested additional areas for consideration. Aspects of control, pleasure, and connection dominated the theoretical construct, and were explored in their relationship to principles of embodiment. The results suggest there
is a conscious etiology to embodiment within the recovery process. In short, survivors communicate with their bodies as well as through words. The degree to which a survivor is aware of qualities of embodiment may have to do with her implicit and explicit awareness of self and self-acceptance. A crucial area for future studies is investigating how survivors’ description of connection—to self and others—is linked to embodiment. Understanding how a survivor senses connection, as well as pleasure and control, may advance treatment protocols and possibly methods taken toward prevention.

Thoroughly investigating survivors’ embodied process of recovery may also provide a unique definition and perspective on sexual health. Sexual health is about the survivor’s health as well as the health of her intimate relationships. Results suggest the nondual nature of sexuality and self is present and vital for survivors, and points to a necessary attunement to and awareness of the mindbody connection. “Pleasure is the visceral, body-felt experience of well being—it’s the embodiment of happiness” (Resnick, 1997, p. 23).

The present study’s results suggest survivors’ pleasure, connection, and willingness to relinquish external means of control are experienced on a multitude of levels. It is necessary to explore further how pleasure and connection is experienced emotionally, as well as in the genitals, entire body, and perhaps even through spiritual awareness, in order to fully understand the role of embodiment. “These areas are our body-based, positively no-no-denying-it truth detectors. When we feel something here, no matter that are heads are telling us something different, we know our body holds the truth. The body never lies” (Resnick, 1997, p. 23).
Encouraging an embodied sense of connection through open communication and psychosomatic presence may help survivors move beyond any limiting and lingering labels they ascribed to themselves post-assault. It is the researcher’s hope that the present study will be expanded upon to more precisely identify elements of embodied connection for survivors. From there, it will be necessary to apply them to a protocol addressing recovery of sexual health. As survivors aide researchers in defining sexual health, discoveries will likely point to psychosomatic elements not yet identified in the present study. Further research investigating the specific characteristics of embodied recovery has the potential to deepen survivors’ sense of self, create a climate of mutual respect with partners, and encourage the full embrace of pleasure the present study’s participants identified and considered their unequivocal right.

The results of the present study suggest a first step has been made in the field of somatic psychotherapy and treatment of sexual assault survivors. A new understanding of the embodied process of recovery of sexual health may offer survivors increased opportunities for healing. This understanding may also help bring forth their resilient and ever-evolving self that lies within. A survivor is neither singularly her mind nor her body; she is its inclusive whole. In the words of Whitehouse and Johnson (1995):

[J]ust as the body changes in the course of working with the psyche, so the psyche changes in the course of working with the body. We would do well to remember that the two are not separate entities but mysteriously a totality. (p. 242)
References


Appendix A

Confidentiality Statement

Your privacy in regard to the information you disclose during this research study is protected within the limits of the law in the state of California. There are circumstances in which the researcher, a mandated reporter, is required by law to reveal information, typically as protection for the client, i.e. research study participant.

A report to the police department or the appropriate child or adult protective services agency is required in the following cases:

1. If the researcher believes the participant is dangerous to himself/herself or others
2. If there is a reason to suspect child abuse
3. If there is a reason to suspect elder abuse
Appendix B

Informed Consent

Title: The Recovery of Sexual Health after Sexual Assault

Investigators: Holly Richmond, M.A.

We are asking you to participate in a research study. Please take your time to read the information below and feel free to ask any questions before signing this document.

Purpose: This study is being conducted in order to better understand the process of the recovery of sexual health after sexual assault. Understanding this process may facilitate the development of new therapeutic protocols when working with survivors of sexual assault.

Procedures: You will be asked to complete a seven-question intensive interview questionnaire, which will take approximately 60 minutes. The questions will be directed toward the goal of understanding the process of the recovery of sexual health after sexual assault. There will be no questions directly relating to the experience of sexual assault, only questions regarding survivors’ recovery. If necessary, based on data analysis procedures, a secondary 60-minute interview will be conducted. During the second interview, you will be asked to go into more detail about one or more of the primary interview questions. No new interview questions will be added to the questionnaire. No compensation/remuneration will be provided.

Risks to Participation: The researcher does not anticipate a high level of risk to you by participating in this study. You will only be asked about your process of recovery after sexual assault, in order to help the researcher better ascertain how that process occurs. You will not be asked questions specifically related to your assault. However, certainly there is an emotional risk associated with discussing past events of this nature. The researcher has put numerous safeguards in place to efficiently protect and attend to your emotional health.

Benefits to Participants: You may not directly benefit from this study. However, the researcher hopes the information learned from this study may benefit mental health clinicians and society in our understanding of how the recovery of sexual health happens...
after sexual assault. In so doing, the data collected may lead to more effective treatment strategies for survivors.

**Alternatives to Participation:** Participation in this study is voluntary. You may withdraw from study participation at anytime without any penalty.

**Confidentiality:** Your identity as a participant in this study will be kept in strict confidence. No information that identifies you in any way will be released without your separate written approval. Please be aware that all information will be protected to the limits allowed by law. Additionally, the researcher will destroy all data collected within five years of the signing of this document, per APA guidelines.

**Questions/Concerns:** Please contact the researcher, Holly Richmond, M.A., regarding study related questions. Ms. Richmond can be reached at phone: (310) 650-0335, or by email at hollyrichmond@att.net. At the end of the study you may request a summary of results. These results will follow the confidentiality guidelines and contain no identifying information. If you have questions concerning your rights in this research study you may contact the Institutional Review Board (IRB), which is concerned with the protection of subjects in research project. You may reach the IRB office Monday–Friday by calling (312) 467-2343 or writing: Institutional Review Board, The Chicago School of Professional Psychology, 325 N. Wells, Chicago, Illinois, 60654.

**Consent**

**Subject**
The research project and the procedures have been explained to me. I agree to participate in this study. My participation is voluntary and I do not have to sign this form if I do not want to be part of this research project. I will receive a copy of this consent form for my records.

**Signature of Subject:** __________________________
**Date:** ______

**Signature of the Person Obtaining Consent:** __________________________
**Date:** ______
Appendix C

Recruitment

Are you curious about how sexual assault has affected your sexuality?
What does being sexually healthy mean to you?
What role does your body play in the path to recovery?

If these questions interest you, you may be eligible for research study.

Qualifications for the study include:
* Being a woman or man over the age of 18 who has experienced sexual assault or abuse
* Being a long-term client of SBRCC (not a crisis client). Specifically, your assault or abuse must have happened at least one year ago

During your participation in this study, you will have the unique opportunity to explore your process of recovery from an embodied perspective. You will be asked a series of questions during a 60-minute interview to discover how the mind-body connection facilitates your sense of sexuality through recovery.

All aspects of your participation will be held in the strictest confidence, and your anonymity will be protected per the American Psychological Association (APA) and Institutional Review Board (IRB) ethics guidelines.

If interested, please contact:
Holly Richmond, M.A.
Phone: (310) 650-0335. Email: hollyrichmond@att.net
Doctoral Candidate, Somatic Psychology
The Chicago School of Professional Psychology, Los Angeles
Appendix D

Letter of Support/Site Approval

May 16, 2013

Dear Ms. Holly Richmond,

This letter is to inform you that Santa Barbara Rape Crisis Center (SBRCC) has reviewed your research titled, The Recovery of Sexual Health After Sexual Assault. We support your research and approve the recruitment and participation of subjects from SBRCC. SBRCC is authorizing you to conduct your from September 24th, 2013 through October 8th, 2013. This letter of support is contingent on IRB approval and is revocable and non-binding. SBRCC appreciates your consideration and support.

If you have any questions or need further assistance, please contact Yesenia Curiel at yesenia@sbrcc.net or 805-963-6832 xt 16.

Sincerely,

Yesenia Curiel
Program Director
Appendix E

Intensive-Structured Interview Protocol

Dates of study: October–November 2013
Place: Santa Barbara Rape Crisis Center
Researcher: Holly Richmond
Participants: 101, 102, 103–112
Today’s date:

Instructions: The following questions will be asked, in order, with ample opportunity for follow-up probes. The questions explore the embodied process of the recovery of sexual health in survivors of sexual assault.

1. How did you feel after your sexual assault?
   * How was this different than how you felt prior to the assault?
   * Was one particular feeling more prominent than the others, i.e. were you more angry than you were scared?

2. How did your relationships with others change after your sexual assault?
   * If you were in an intimate sexual relationship, did that relationship get stronger or weaker after the sexual assault?
   * What was the main feeling, belief, or quality you experienced that had an impact on your relationships with others? For example, did you experience promiscuity? Isolation? How did you experience either of those?

3. What have you noticed about being in your body during a sexual encounter since your assault? For example, are you present or not, and how do you know so? Is this different than before your assault?
   * Do you experience pleasure during sex? If so, how? Did you experience this same type of pleasure before the assault?
   * How is it for you to receive pleasure? To give pleasure?
   * Are there ways the assault has changed how your body functions?

4. How have your sexual fantasies changed from pre-sexual assault to the present time?
   * What fantasies are most exciting?
*What fantasies scare, disturb, or make you feel shameful?

*Do you ever feel you have to keep your fantasies a secret? If so, from whom? Was this the case before your assault as well?

5. What are your beliefs about orgasm? Were you able to orgasm before you were sexually assaulted?

*How does orgasm feel? Scary? Out of control? Purely pleasurable?

*Do you believe you deserve to experience orgasm? If so, why?

6. How is your relationship to your body different today than it was immediately after your sexual assault?

*What do you see when you look in the mirror?

*What is your relationship like with food and exercise?

*Do you engage in self-harm (i.e. cutting)? Did you before the assault?

7. How will you know when you are sexually healthy, i.e., what does the term “sexual health” mean to you?

*Is sexual health solely about you, or does sexual health encompass relationships with your sexual partners? How so?

*To who do you, or will you, look for support in maintaining your sexual health?

*Is there any other question you wish I had asked, or anything I have missed?

*How are you feeling after this interview? Do you need me to help arrange additional support for you at this time?

Thank you for your time and participation in this study. If you wish to view the results, please list your name, address, and email address.

Cordially,

Holly Richmond, MFT
Student, Somatic Psychology Department
The Chicago School of Professional Psychology, Los Angeles
### Appendix F

**Coding Reports**

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<th>% of Docs (12 total)</th>
<th>Q1-How felt after sexual assault</th>
<th>No. of Docs</th>
<th>% of Docs (12 total)</th>
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<th>No. of Docs</th>
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<td>□ Assault changed body functions</td>
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<td>□ How give or receive pleasure, continued</td>
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<td>□ Fear</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>- Sexuality</td>
<td>1</td>
<td>8%</td>
<td>□ Receive okay-can't</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>- Violent or traumatic triggers</td>
<td>2</td>
<td>17%</td>
<td>□ Uncomfortable</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>□ How give or receive pleasure</td>
<td></td>
<td></td>
<td>□ Takes control</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>- Give</td>
<td></td>
<td></td>
<td>o Uncomfortable</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>o Anxiety</td>
<td>1</td>
<td>8%</td>
<td>o Vulnerable</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>o Cautious</td>
<td>1</td>
<td>8%</td>
<td>□ Pleasure during sex - any difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Disgusting</td>
<td>1</td>
<td>8%</td>
<td>- No or not as much</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>o Fun</td>
<td>1</td>
<td>8%</td>
<td>- Recognition of rape as crime</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>o Out of body</td>
<td>1</td>
<td>8%</td>
<td>- Yes – always</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>o Powerful - In control</td>
<td>3</td>
<td>25%</td>
<td>- Yes but some anxiety</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>o Specifies oral sex</td>
<td></td>
<td></td>
<td>□ Present in body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Can't give - okay receive</td>
<td>1</td>
<td>8%</td>
<td>- Not present</td>
<td>7</td>
<td>58%</td>
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<tr>
<td>□ Comfortable</td>
<td>1</td>
<td>8%</td>
<td>- Present</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>□ Disgusting</td>
<td>1</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Submissive</td>
<td>1</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Trigger</td>
<td>1</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Unrespected</td>
<td>1</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Used and dirty</td>
<td>1</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Unrespected</td>
<td>1</td>
<td>8%</td>
<td></td>
<td></td>
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<tr>
<td>Q4-Changes in sexual fantasies</td>
<td>No. of Docs</td>
<td>% of Docs (12 total)</td>
<td>No. of Docs</td>
<td>% of Docs (12 total)</td>
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<td>-------------</td>
<td>----------------------</td>
<td>-------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>□ Changes in sexual fantasies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Does not have sexual fantasies</td>
<td>3</td>
<td>25%</td>
<td>– Fantasies most exciting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Dominance - pain</td>
<td>1</td>
<td>8%</td>
<td>– Bisexual - Multiple partners</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Dwindled</td>
<td>1</td>
<td>8%</td>
<td>– Dominated - controlled</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Guilt-ridden</td>
<td>1</td>
<td>8%</td>
<td>– None recognized</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– More complicated after therapy</td>
<td>1</td>
<td>8%</td>
<td>– Non-participatory observer</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– No face</td>
<td>1</td>
<td>8%</td>
<td>– Sadistic</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Non-erotic</td>
<td>1</td>
<td>8%</td>
<td>– Safe – loving</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Oral sex</td>
<td>1</td>
<td>8%</td>
<td>– Teasing participation</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Sadistic - Pain pleasure</td>
<td>1</td>
<td>8%</td>
<td>– Unobserved sex in public</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Same sex</td>
<td>1</td>
<td>8%</td>
<td>□ Fantasies scare disturb feel ashamed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Unconventional - more intense</td>
<td>1</td>
<td>8%</td>
<td>– Arousal – orgasm</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Violent to regular</td>
<td>1</td>
<td>8%</td>
<td>– Focus on partner</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Young guys - loving relationships</td>
<td>1</td>
<td>8%</td>
<td>– None</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>□ Fantasies kept secret</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Depends</td>
<td>3</td>
<td>25%</td>
<td>– Rape - BDSM - Sadistic</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>– No</td>
<td>5</td>
<td>42%</td>
<td>– Recumbent or uninvolved partner</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Yes</td>
<td>5</td>
<td>42%</td>
<td>– Same sex</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

205
<table>
<thead>
<tr>
<th>Q5-Beliefs about orgasm</th>
<th>No. of Docs</th>
<th>% of Docs (12 total)</th>
</tr>
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<tbody>
<tr>
<td>□ After assault</td>
<td>10</td>
<td>83%</td>
</tr>
<tr>
<td>□ Before assault</td>
<td>11</td>
<td>92%</td>
</tr>
<tr>
<td>□ Orgasm - Pleasure - do you deserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Maybe</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– No</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Yes</td>
<td>10</td>
<td>83%</td>
</tr>
<tr>
<td>□ Orgasm experiences now</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Addictive</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Before assault</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Feeling of release</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Hyperstimulates</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Out of control</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Pleasurable</td>
<td>7</td>
<td>58%</td>
</tr>
<tr>
<td>– Pressure to achieve</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Scary - overwhelming - holding back</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>Q6-How is relationship to your body different</td>
<td>No. of Docs</td>
<td>% of Docs (12 total)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>□ Body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Immediately after assault</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>– Today</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>□ Relationship with food and exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Negative</td>
<td>10</td>
<td>83%</td>
</tr>
<tr>
<td>o Positive</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>– Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Negative</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>o Positive</td>
<td>8</td>
<td>67%</td>
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<tr>
<td>□ See when look in mirror</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Negative</td>
<td>10</td>
<td>83%</td>
</tr>
<tr>
<td>– Other</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Positive</td>
<td>10</td>
<td>83%</td>
</tr>
<tr>
<td>Q7-Sexual health</td>
<td>No. of Docs</td>
<td>% of Docs (12 total)</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>□ About you or encompass relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Encompasses - Others</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Encompasses - Sexual partners</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>– Exceptions</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>□ How will you know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Acceptance</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Balanced</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Comfortable</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Connected and present</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Healthy expectations</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Not afraid</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Open communication</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Sexually active</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Trusting</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>□ Support in maintaining</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Children</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Counselor - Rape Crisis Center</td>
<td>5</td>
<td>42%</td>
</tr>
<tr>
<td>– Do not talk to them for support</td>
<td>5</td>
<td>42%</td>
</tr>
<tr>
<td>□ Support in maintaining, continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Friends</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>– Husband - Fiancé</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Media</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>– Naturopath</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Self - Self-reflection - Journaling</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Sexual partner</td>
<td>7</td>
<td>58%</td>
</tr>
<tr>
<td>– Therapist</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>□ What does term mean to you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Boundaries</td>
<td>1</td>
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</tr>
<tr>
<td>– Comfortable</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>– Connected and present</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>– Faithful to one partner</td>
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<td>8%</td>
</tr>
<tr>
<td>– Healthy expectations</td>
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<td>8%</td>
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<tr>
<td>– Open communication</td>
<td>4</td>
<td>33%</td>
</tr>
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<td>– Proud</td>
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<td>– Self-acceptance</td>
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<td>– Sexually active</td>
<td>2</td>
<td>17%</td>
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<tr>
<td>– Shared space</td>
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<tr>
<td>Q8-Anything else</td>
<td>No. of Docs</td>
<td>% of Docs (12 total)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------------</td>
<td>----------------------</td>
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<tr>
<td>How did you get from there to here</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>How feel now - need additional support</td>
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<td>100%</td>
</tr>
<tr>
<td>See results of study</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>What has been most helpful</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Why not ask for help at that time</td>
<td>1</td>
<td>8%</td>
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