Healing the self: The role of self-compassion and empathy in a mindfulness based modality for women survivors of interpersonal violence

by

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Abstract

The intent of this research was to study the role of self-compassion and empathy for healing the sense of 'self' with women who survive interpersonal violence. The study started with the theoretical premise for the connection and importance of empathy and self-compassion in how we come to understand the 'self'; then established the positive correlation between self-compassion and empathy using two psychometric scales, The Self Compassion Scale (SCS) (Neff, 2003) and the Balanced Emotional Empathy Scale (BEES) (Mehrabian & Epstein, 1972) with a population of university students. From there it evolved into a mixed-methods exploration of the effectiveness of two different modalities, one feminist-based and one mindfulness-based, for increasing empathy and self-compassion. The quantitative research showed that both modalities significantly increased the women's mean scores in both self-compassion and empathy, showing the positive healing effects of both modalities. When more layers were examined, data showed differences in the subscale scores of the Self Compassion Scale (Neff, 2003) that suggested a different kind of change was present, one modality compared to another. The qualitative data, analyzed using Doucet & Mauthner's (2008) *Listening Guide*, suggested that each modality had great strengths and ameliorating effects for the participants. The feminist-based group seemed to be better at facilitating story telling, breaking women's sense of isolation, reifying their experience for them and at the same time challenging internalized oppression and raising their political

consciousness. The mindfulness-based group helped women learn affect regulation skills, and arguably also gave them skill for attending and responding to others with 'true' empathy, that is not losing the 'as if' quality of sharing another's emotions. Theoretically then, this self-in-relationship becomes the interior working model of the securely attached 'self' capable of empathic, and therefore ethical, agency. The implications for these findings are that the tools that mindfulness-based modalities employ could be useful to feminist therapists and clients. The author therefore proposes Mindfulness Based Feminist Therapy (MBFT) as an integration of these two approaches.

Acknowledgments

This is perhaps the most pleasant and at the same time the most anxiety-provoking part of the dissertation process. The support and kindness that I encountered over the course of this journey have been pleasant for sure, and at times life changing. I have much for which to be grateful. The anxiety comes from my fear of forgetting someone, or not having adequate words to express my gratitude, or to capture the importance of each person's contribution.

I must thank first and foremost the women who contributed to this research as group participants. I am humbled and grateful that you shared and entrusted your stories to me. I want you to know that I have not forgotten what many of you said, that you wanted this research to help other women with their healing journey. It is my intention to translate the findings from this research into practice with survivors of trauma. Thanks also to the Board and staff of Ottawa Family Services who supported this research both in principle and with resources, and appreciation to all the community-based feminist services that provide invaluable support and resources to women and children who experience violence.

A very special thanks to my colleague Laura Cain, MSW. Laura was my co-worker at the Ottawa Rape Crisis Centre many years ago, and the group co-facilitator and yoga instructor for the mindfulness-based modality in this research. Also, thanks to a rare and special angel Nicole Haiduk who voluntarily transcribed my interviews. May you realize your karma in returned generosity and kindness!

There are a multitude of saints that have gotten me here academically. My life partner Latif likes to say that he 'blames' my friend Bessa Whitmore for my becoming an academic, because it was she who planted the notion early that I might be 'PhD material'. Bessa, Professor Emerita for the Carleton School of Social Work, was my MSW thesis supervisor, and continues to be a role model and mentor. Thanks and love from us both, Bessa. Not far down the hall at the School of Social Work is Karen Schwartz, my PhD dissertation supervisor. Her solid background in research and women's mental health was extremely helpful, and her belief in me, along with her great sense of humour, were crucial when things got hairy. My other committee members, Teresa DeCicco in Psychology at Trent University and Heather Menzies at the Carleton University School of Canadian Studies provided a perfect mix of perspectives from their respective disciplines, a balance of scientific rigor and accessible narrative so needed to convey the story I was trying to tell. I owe a debt of gratitude to my friend Kate Burns who spent countless hours listening and holding space as I processed my thinking and encouraged me to embody my knowledge. I also wish to acknowledge Wendy Donner in Philosophy at Carleton University for introducing me to feminist philosopher Diana Tietjens Meyers, whose work on empathy looms large in this dissertation and my life. As well, I am grateful that Catrina Brown at Dalhousie University generously agreed to be my external examiner and provided a thorough and thoughtful critique. I will carry her feedback

into future research and thinking about feminist epistemology, ontology, methodology and therapy.

To my formal mindfulness teachers, Nyingje Gloria Norgang, Jon Kabat-Zinn, Saki Santorelli, Zindel Segal and Susan Woods; and to my informal mindfulness teachers, who include my children Louise, Daniel and Herbert and their partners; my grandchildren Dylan and Brittany; friends, moon sisters, colleagues and students – pretty much everyone and everything – thank you and may I ever be your student.

To paraphrase the poem by Galway Kinnell (1980) that opens the first chapter of this dissertation, many people in my life have put their hands on my brow and blessed me with their kindness. No one more so than my life partner Latif Crowder, who has helped me find my self-blessing from within. He has earned this doctoral degree right along with me, along with my gratitude, love and respect. Through his generosity, empathy, compassion, kindness and patience, I gained my 'earned secured attachment.' That does not sound very romantic, but it was life saving.

And lastly, to come full circle, I dedicate this work to my mother Margaret Ellen Lock McCombe, with love, gratitude and forgiveness. We all need to remember our primary caregivers with kindness and empathy for the sake of our own self-compassion and self-forgiveness.

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The bud
stands for all things,
even for those things that don't flower,
for everything flowers, from within, of self-blessing;
though sometimes it is necessary
to reteach a thing its loveliness,
to put a hand on the brow
of the flower,
and recall in words and in touch,
it is lovely
until it flowers again from within, of self-blessing.

- Galway Kinnell (1980)

Chapter 1: Introduction

This research began as an exploration about what happens to our subjectivity when we experience interpersonal violence[1], how we might regain our sense of self through empathic relationships, and how a mindfulness-based therapy might contribute to that healing process. Through engaging in this research and reflection however, I also developed a new understanding of how much feminist therapy and mindfulness-based modalities have in common and yet have much to offer each other.

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[1] Interpersonal violence (IPV) includes various forms of family or intimate violence that include child maltreatment, woman and elder abuse. It can also more broadly include community and state-sponsored violence, such as gang violence, genocide and the use of rape as a weapon of war and terrorism.

Mindfulness is classically defined for western audiences by Jon Kabat Zinn (1994) as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (p. 4). Mindfulness is both a verb and a noun; the process it describes is an embodied, compassionate, present-moment, attentional training that engages all the senses, including what Buddhists refer to as the sixth sense 'knowing'; and the 'state' of being fully aware and engaged in the present moment with an open, generous, kind and curious attitude. The goal of mindfulness practice is liberation through embodied 'knowing' in community, achieved through cognitive non-dualism where "those of subject and object create and depend on each other. Moreover, with self and other, no one is only a subject or only an object" (Klein, 1995, p. 154). This is an experience many of us may recognize when we are absorbed in artistic, creative activities or immersed in nature in such a way that the boundaries between 'self' and 'other' disappear, as does the sense of linear time.

Feminist writers also remind us that we create our epistemologies embodied and in community, and for a useful purpose, for liberation (Code, 2000). I believe, and hope to convey through this study, that a different way of 'knowing' and understanding embodied subjectivity is the essence of what mindfulness has to offer feminist therapy; and that feminism has much to offer mindfulness based therapies in terms of social justice and political conscientization. When the elements of both are present, in what I would call a Mindfulness Based Feminist Therapy, the whole is greater than the sum of its parts.

Subjectivity and relationship are key in this exploration on healing the self after violence and abuse, and therefore it makes sense to me that I work from my own subjectivity and social location (Baines, 2002). Therefore you will 'hear' my voice strongly throughout. I locate myself as a Caucasian middle class woman who has, like many women, experienced interpersonal violence. I am a Canadian social worker and I practise as a therapist, educator, advocate and activist from a feminist framework that comes from training and working in grassroots women's services for over 20 years. Since 2006 I have committed myself to a daily practice of mindfulness (also known as vipassana) meditation, and have noticed first-hand the salutary effects of this practice on my sense of well-being and my ability to respond more skillfully to afflictive mind, emotional and body states and to my outer world as well.

This research, analysis, and reflection are as much about my own personal narrative of a journey to find congruency between my feminist practice and my mindfulness practice based in Buddhist philosophy and psychology, as it is about informing the art and science of feminist social work about mindfulness. Therefore, the logic of this dissertation is to provide a roadmap of my own journey of discovering and understanding the many ways we know and experience the 'self' and the importance of empathic relationships in this process; how subjugation impacts the self; how I came to develop a mindfulness-based group focusing on self-compassion for women who have experienced interpersonal violence; the outcome

of quantitative and qualitative research with women who participated in this mindfulness group compared to a community-based feminist group and the role of empathy and self-compassion in their healing process; and finally, how the process transformed my thinking about how we might practice trauma therapy with women.

Laura Brown (2004) says that one of the characteristics of effective feminist therapy is that it is theory-driven. I also discovered that like feminist therapy, the research methodology in this study is driven by feminist theories about situated knowledge (epistemology), subjectivity in relationship (ontology) and ethics based in empathic agency (axiology). This makes sense, as both feminist therapy and feminist research are meant to be personally and politically transformative. In this introduction I spend some time exploring feminist epistemology, ontology, attachment/regulation theory, and theories of change in therapeutic interventions with trauma survivors. The second chapter follows with a discussion of the mindfulness-based research modality. In the third chapter I reengage in the feminist epistemology/ontology/axiology discussion to explain the choice of the research methodology itself, and to present the quantitative data and analysis. The fifth chapter presents the gathering and analysis of data through face-to-face interviews with participants; the final chapter discusses implications of the findings for this and future research.

Interpersonal Violence, Trauma and the Self

> Traumatized people suffer damage to the basic structures of the self. They lose trust in themselves, in other people, and in God. Their self-

> esteem is assaulted by experiences of humiliation, guilt, and helplessness. Their capacity for intimacy is compromised by intense and contradictory feelings of need and fear. The identity they have formed prior to the trauma is irrevocably destroyed. The rape survivor Nancy Ziegenmayer testifies to this loss of self: "The person I was on the morning of November 19, 1988, was taken from me and my family. I will never be the same for the rest of my life." (Herman, 1997, p. 56)

During the more than two decades of working in feminist-based women's services including a rape crisis centre and a battered women's shelter, I have heard stories of interpersonal brutality that have made me ponder the nature of human morality. In spite of my personal witness to women's narratives of these events, it still seems incredible to me that such acts of cruelty can be perpetrated upon one human being by another. Yet, whatever the form of abuse – adult sexual assault, historical childhood sexual abuse or partner abuse – the stories never cease. In spite of generations of feminist consciousness-raising, political action, public education, gender analyses and so on, the emotional, psychological, spiritual and physical abuse of women and children[2] continues.

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[2] Boys also experience sexual violence at a rate - some say 1 in 6 before the age of 18 (Dube et al., 2005) - that requires not only acknowledgement but action; and I do not dismiss or discount the violence experienced by adult males either. However it is beyond the scope of this study to address their gender-specific issues. I would suggest however that much of the mindfulness that I advocate to be integrated into feminist trauma therapy would likely have positive effects for male survivors as well.

It's a well-known and often cited fact that just over half of Canadian women have experienced physical or sexual violence at least once in their adult life (Statistics Canada, 1993). Of the women interviewed in the Statistics Canada Violence Against Women Survey of 1993, 16% "reported being kicked, hit, beaten, sexually assaulted or having a gun or knife used against them; 11% reported being shoved or slapped; 2% reported only threats or having something thrown at them" (Bunge and Levett 1998 cited in METRAC, 2001). Spousal violence is the largest single category of convictions involving violent offenders in Canada from 1997 to 2002, and while violent crimes of all kinds have been declining between 1998 and 2007, over 40,000 incidents of spousal violence were reported to police in 2007 – representing about 12% of all police reported violent crime in Canada that year (Statistics Canada, 2009). Aboriginal women experience even higher rates of violence; and with the influx of immigrants and refugees from war-torn countries into Canada, women and their families from these countries sometimes come with a history of violent atrocities perpetrated against them in tow (Statistics Canada, 2006). In the Ontario Health Survey of 1990-1991, over 30% of surveyed adults reported they had experienced childhood sexual and/or physical abuse (MacMillan et al., 1997); and a higher incidence of health problems among this adult population was more prevalent in females and older adults (Chartier, Walker, & Naimark, 2006).

Thankfully, community-based women's services continue to respond to these women in crisis, offering safe shelter and the basic necessities plus an amazing wealth of compassionate, supportive counselling in the form of groups for survivors

and individual therapy. Women's advocates, shelter workers, crisis counsellors and feminist therapists do important work. There are over 500 women's shelters and over 600 services for victims of crime including 105 sexual assault centres in this country dealing with the aftermath of violence and abuse (Statistics Canada, 2006). However, there is still much violence that goes unreported and unrecognized, and we have much left to do in terms of the political aspects of woman abuse and systemic misogyny.

We also have much to do about the most personal impact of violence against women, the impact on the woman's "self," post-trauma. Feminist practitioners, including myself, do a good job helping women break the silence and the resulting isolation from their experiences, helping them personally and politically to regain their voice, standing in solidarity with them, supporting them to do whatever feels is the right thing to do at this particular moment in their lives. We provide information so women can make informed choices, and we help them get organized with other women to take back their power, take back their lives, and make a stand in the world, all with minimal amounts of public and private funding.

However, many women have said to me after weeks of group therapy, and sometimes months or years of individual therapy, that they need something more, often something they cannot quite express. Others just stop coming to group or therapy, or some become chronic callers on telephone crisis lines, frustrating social service agencies and their volunteers with their desperate need to connect, yet repulsing attempts to do so. Funding bodies are requiring social service agencies to

provide shorter term services, so at the end of ten or twelve weeks of group counseling or six months of individual counseling, we hope we have been able to provide women with some tools that they can use to continue their healing journey on their own. Some women are able to successfully carry on and find health and balance by themselves; others are not.

What makes the difference? I believe one of the crucial pieces of the puzzle has to do with the statement at the beginning of this section: "The person I was ... was taken from me and my family. I will never be the same for the rest of my life" (Herman, 1997, p. 56). The crucial 'I' and the 'me' in this statement is a woman's 'self' who is changed forever by violence, abuse and other forms of oppression and notably, the loss[3] of her 'self' to her intimate others. She, like many of the survivors I have met over the years, mourns the loss of both the relationship with her self and the people she loves and is loved by. Women who have been in long term abusive relationships also tell me they do not trust themselves to find a healthy relationship with an intimate other, given their past experiences of betrayal. I have often wondered if it is possible to regain trust and relationships with our intimate selves and others by reconnecting with that lost 'self,' and if so, how to go about facilitating that reconnection.

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[3] When referring to a 'lost' self, I am using the language of women trauma survivors. I do not believe that the 'self' disappears or is destroyed, and their choice of words is reflective of the limitations of language to describe life-altering experiences. Rather, the *connection* to the self is lost, or the 'self' is kept hidden or protected as a way to survive the trauma (Herman, 1997).

In 2006, I took professional training in Mindfulness Based Stress Reduction (MBSR) (Kabat-Zinn, 1990) and Mindfulness Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2002) and started facilitating MBSR groups. I did this in order to rekindle a long-time contemplative practice that had been idling during my academic pursuit of a post-graduate degree and because I was attracted to the 'stress reduction' aspect of mindfulness. I hoped it would help me better cope with my stress due the concurrent obligations to my PhD candidacy, university teaching, professional practice, and personal relationships. I was impressed by its holistic approach to wellness, its ethic of non-harming based on the interconnectedness of all beings, and the fact that compassion and self-compassion were integral to its philosophy. This was very compatible with my feminist values and structural social work training. I also discovered how its Buddhist-based psychology had been adapted into Western cognitive-behavioural modalities for stress, anxiety and depression (Baer, 2006) and other 'problems' including psoriasis (Kabat-Zinn et al., 1998) that were being shown by empirical research as highly effective. Other research with health care professionals showed that mindfulness training was effective for increasing empathy amongst nurses and doctors (Beddoe & Murphy, 2004; Shanafelt, 2005; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Schwartz, & Bonner, 1998). Intuitively it seemed reasonable to me that by teaching mindfulness meditation to women who had experienced interpersonal violence, especially if we emphasized the compassion and self-compassion that is integral to the practice, we might increase their capacity for empathy for self and others. It may

be a way to help them recover the 'self' that was lost to them and to their loved ones, to trust themselves to give and receive love in intimate relationships again. It reminded me of the old saying *you can't love others until you love yourself.* Buddhist philosophy also has a unique understanding, or rather a mindful curiosity, towards what constitutes the 'self' that is quite different from traditional Western philosophical traditions, which I thought was potentially compatible with postmodern feminist epistemologies of a fluid, ever-changing self-in-relationship.

The Situated Self in Research & Practice

In the Introduction to this study, I stated that subjectivity and relationship are key in this exploration of interpersonal violence and therefore it makes sense that I also situate my 'self' in relation to this research. I am not alone in this conviction to make my 'self' visible in my research, analysis, and conclusions; I stand on the shoulders of feminist epistemologists who also argue for the necessity to bring our personal embodied, everyday world experiences, as well as our collective wisdom, to the knowledge-making process[4].

Women have always produced knowledge. While this seems an obvious statement, the notion of 'feminist epistemology' is a rather recent one, as many feminist academics situate the beginning of the evolution of feminist epistemologies within the past few decades. Epistemology is the study of knowing and how knowledge is produced, and has its roots in the discipline of western philosophy. It

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[4] For examples see Hartsock (1983), Harding(1986) and Smith (1987, 1990).

is from this departure point that many western, white feminist academic writers launch their critiques of mainstream epistemology.

As the evolution of feminist epistemologies emerge, we see a journey starting with feminist empiricists' early critique of a western approach that 'discovers' knowledge from a disembodied or godlike perspective (Haraway, 1986; Harding, 2004; Hartsock, 1983) to standpoint theories which include the production of knowledge as a situated or 'located' activity (Hartsock, 1998; Smith, 1999), to postmodern feminist approaches that posit that no single standpoint can be privileged above another, that 'better' or 'power neutral' or 'truer' knowledge does not exist, a unitary 'feminist truth' does not exist (Ahmed, 1998). The best we can hope for is to construct multiple discourses that incorporate gender – which itself is a constructed category. During this process, academic feminists have had their views on feminist epistemologies informed greatly by women from marginalized backgrounds (Hill Collins, 1990; hooks, 2003), many of them non-academics, their theories inextricably linked to their lives as they are lived. Their epistemologies emanate from their worldly realities, even though they may not name it as knowledge-making or theory making. This knowledge and theory making develops from lives lived in resistance, from taking action, and from taking responsibility for their (in)action. It is from this basis that I argue that all these knowledge-making sojourners have much to offer us, and rather than rejecting one for the other – empiricism for standpoint for example – we can use the approach(es) that best serve(s) the purpose of the ethical journey.

The empirical methods employed – the use of psychometric scales for self-compassion and empathy in this research – were done with two purposes in mind. The first was to provide an overall 'forest' view that statistical data allow, which include some 'clues' that might be salient to follow in the qualitative research analysis. My second reason was more subversive. Most mindfulness-based modalities are of a medical model and the mainstream research literature on mindfulness employs empirical methods. Empirically based research is more likely to be taken 'seriously' by those authors and readers of this research. By infiltrating the well-established medicine- and psychology-based mindfulness community with qualitative data gathered with a feminist standpoint methodology, oppression and social justice are inserted into this medicalized mindfulness discourse. This potentially makes the research transformative on a political or structural level. On a personal level this methodology recognizes the everyday, multiple realities of women who have experienced violence; it also applies more broadly to other populations that have experienced trauma as a result of oppression and marginalization. A feminist standpoint methodology allows the researcher to recognize and connect with each woman's (person's) subjectivity. This act of recognition, as I will amplify in the pages following, embodies an ethic of empathy and therefore serves the purpose of the ethical research journey well.

Present era epistemologies – knowledge and theory making, the development of a sense of moral agency and ethical action are all-of-a-piece, and an on-going process, a journey toward truth rather than an 'arrival'. This

understanding of epistemology represents a paradigm shift from the 'modern' or individualist understanding of epistemology that seeks one unitary 'truth' observable by the neutral observer, a shift that has occurred in many disciplines including quantum physics where the 'observer' is more often referred to as the 'participator' in experiments. What marks epistemologies as 'feminist' is the deliberate and articulated inclusion of women's multiple realities, their political analyses, and strategies for change in the knowledge making process. What also marks them as feminist are the contributions that women bring to the discourse on moral epistemology, on how the experiences of girls and women offer a different version (or, some might claim, vision) of ethical decision making.

Lorraine Code (2000) writes:

> ... (t)he standards of objectivity and value-neutrality central to an idealized picture of physical science define the epistemologies of modernity. In these theories, objectivity is a disinterested approach to publicly observable subject matters, separate from knowers /observers and make no personal claims on them; and value neutral knowers have no vested interest in the objects of knowledge, no motivation beyond pure inquiry. Feminists argue such ideals could only regulate the knowledge-making of people capable of achieving a 'view from no-where' or a 'god-trick' (following Donna Haraway) to escape their own physical, bodily circumstances. (p. 170)

This 'invisibility' or dislocated epistemologies serve to hide androcentric epistemologies (white, male, able-bodied, heterosexual, ageless) as well as race, class and other 'centricities' of the knowledge makers, and thus reinforce male-stream ideas and ideals. It also serves as a template to validate whose knowledge is credible, in that credible knowledge is derived from replicable observational data. In this kind of empiricist model, knowers seek to know in order to manipulate, predict and control their environment. Only facts count, not emotionally-based 'values'. Positivists contend that value-laden (i.e. feminist qualitative) research is not legitimate because it is not objective. This upholds a hidden value system in which only 'legitimate' knowers i.e. positivists can produce knowledge in "'everyone's' interest while women and Others produce only subjective and partial conclusions" (Code, 2000).

Lorraine Code (2000) further argues that the gender of the knower is significant, because the realities of being of a certain gender influence greatly how the knower experiences the world and creates knowledge about it, in addition to whose knowledge is considered 'legitimate' (i.e. men's) or not (women's). She also argues that this furthers the problematic binary thinking plaguing epistemology, that in the epistemological project, both what and who exist in a mutually dynamic relationship. To not acknowledge this relationship is to not address the power that generates and shapes knowledge making, practices and teaching.

In the 1980's Sandra Harding (1986) distinguished feminist empiricism from feminist standpoint theory. Empiricists focus on evidence gathering, advocating a

method 'cleansed' of androcentrism while standpoint theorists concentrate on the historical-material positioning of women's practices and experiences. According to Harding, politically informed inquiry yields a better empiricism, based in 'strong objectivity'. Feminist empiricists are committed to 'objective' evidence gathering and justification, yet informed by feminist ideology convinced that it will produce a more adequate knowledge than classical empiricism which is ignorant of the sex/gender system. Some would say, to borrow a phrase, it uses the master's tools to dismantle the master's house (Lorde, 1984).

For standpoint theorists like Nancy Hartsock (1998), empiricists cannot address the historical-material diversity from which people produce knowledge. In western society, standards of knowledge have derived from white, middle-class, educated men with women (like the Marxian proletariat) occupying an epistemic underclass. In this theory, as capitalism naturalizes the subordination of the proletariat, so patriarchy naturalizes the subordination of women. And as in Marxist theory, analyzing the power structures from the standpoint of the proletariat or the oppressed 'denaturalizes' these assumptions, so does feminist standpoint denaturalize the patriarchal order (Smith, 1999). This process proceeds from 'consciousness-raising' and social-political engagement, which produces knowledge for the oppressed, helps in their survival and leads to social transformation.

Neo- or feminist-empiricism fails to fully address power issues of diversely located knowers, for example, is each person's knowledge as valid/legitimate as the

next, and who decides and on what basis? Whose knowledge is left out or suppressed in the process? In the absence of a unified feminism, can standpoint theory avoid obliterating differences? Its 'locatedness' offers a version of social reality as specific as any other, yet distinguished by its awareness of that specificity. Most feminists cognizant of the difference that differences make do not, in fact, hope to achieve a unified standpoint. Feminist standpoint theory is then discussed as perhaps being better considered as feminist standpoints (plural), to encompass notions like Afro-feminist epistemologies, or an 'outsider-within' black feminist standpoint (Hill Collins, 1990), which fosters resistance.

I think there is a place where feminists can effectively use empiricist methods for research, and ethically should do so; for example, quantitative social research[5] is much too important an area for feminists to avoid making an impact. Too much government policy and social work practice, and hence its effect on women, is (or has the potential to be) based on these studies to be ignored. I also think that empirical studies have much to offer in terms of 'big picture' clues and trends that standpoint(s) cannot see, rather like a 'forest and trees' phenomenon. Feminist empirical studies can balance studies using standpoint(s) methodologies. I advocate considering both, alone or in a mixed methods approach as I have done in this research. I also agree that honest researchers recognize that they owe a debt to those they research and that the knowledge we produce is not 'ours' but that of the

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[5] For example the *Canadian Incidence Study of Reported Child Abuse and Neglect* (Trocmé et al., 2005) which informs and influences Canadian child welfare policy and practice.

community we study. So the very least I can do as a researcher is to make every assurance that I accurately and fairly represent the community and individuals in my research. To that end I arranged, to the best of my ability, for the group participants to read and edit their transcripts for accuracy.

The Use of Self in Feminist Therapy

Based on this heritage of feminist epistemology, I think there is also a strong argument to be made for using both modernist and post modernist approaches to feminist therapy. But first of all, what constitutes 'good' feminist therapy? Feminist therapy has its roots in the second wave feminist anti-violence movement, when interpersonal violence was recognized as a gendered issue. Feminist approaches are based on the principle that the personal is political, and in terms of interpersonal violence that means that the violence we experience as women – and the resulting trauma – have their roots in the social. The causes are systemic. So feminist therapy, while not homogenous in technique, contain certain characteristics that are present in other feminist approaches to practice; practice that includes but is not exclusive to social work. Feminist therapies are practiced also in psychology, medicine, physical and occupational therapy, nursing and other fields, but the focus here is on feminist social work practice and specifically trauma therapy.

'Use of self' is central to feminist therapy. Laura S. Brown (2004) writes that what drives feminist therapy is the therapist's theoretical framework rather than any particular technique, and that the goal of feminist therapy is to help clients "develop *feminist consciousness*" (Brown, 2004, her emphasis) or an awareness that

their suffering is not because of personal deficits but by the way she has been "systematically invalidated, excluded, and silenced because of one's status as a member of a non-dominant group in the culture" (p. 464). As such, feminist therapists use an integrative or eclectic approach to trauma treatment with a political underpinning. The collaboration between the therapist and the client is a space not only where personal healing transactions occur, but also a political space, a space that is potentially transformative for the client, the therapist and society.

Other salient characteristics of feminist therapy are the therapist's aspiration to create an egalitarian relationship, where the client is respected for her expertise about herself, her life and her needs; the use of a strengths perspective, helping women identify their competencies, as well as attending to stories of distress and helping women find and reframe trauma related 'problems' as coping strategies to deal with intolerable thoughts, emotions and body sensations arising from the trauma. Coupled with these characteristic aspects of therapy is the "the feminist paradigm," Laura Brown (2004) writes, that "posits that individual change is impeded or difficult when societal and environmental changes do not also occur" (p. 465). Oppressive forms of violation are understood "as strategies for upholding oppressive cultural status quos . . . " (p. 465) and it is important to understanding the effects of a traumagenic environment on the recovery process. This has led to a particularly feminist understanding of trauma – "that what is traumatizing to a person is not simply the experience of threat to life or safety. Rather, it is what will be symbolically evoked by this experience and the manner in which the social

context responds to the person who has been traumatized" (p. 465). In other words, the woman who has experienced trauma is dealing with not only the personal effects of this violation but the societal stigma that is attached to interpersonal violence as well.

Feminists have also offered broader understandings of 'violence' as it relates to trauma. Two of these theories – insidious traumatization and betrayal trauma - are of particular importance when working with women who have been in abusive relationships where they have not been physically assaulted or experienced life-threatening situations. Insidious traumatization (Root, 1992, cited in Brown, 2004) occurs from the constant exposure to the *reminder of threat* that is present in women's lives in the forms of media representations of women, bias-based violence that is still present in society, and various forms of institutionalized sexism. "Feminist theorists argue that this model of insidious trauma may explain why experiences of sexual harassment and racial discrimination, whose dangerousness is not obvious to an observer, can become traumatic stressors leading to full-blown symptoms of PTSD" (Brown, 2004, p. 466). This is also the ethical basis for making social or systemic change part of the feminist mandate. "For feminist practice," writes Laura Brown, "it is insufficient to treat one client and return that person to the world in which her or his trauma will continue unchecked" (p. 470).

The second theory of trauma, betrayal trauma offered by Freyd (1996, cited in Brown, 2004) is based on experiences of survivors of child sexual abuse who have psychogenic amnesia "an adaptive response . . . (that) enables the child to maintain

an attachment with (an abusive) figure vital to survival, development and thriving . . ." (p. 308). Betrayal traumas can and are experienced in adult interpersonal relationships as well, but may be initially experienced as confusing or distressing rather than traumatic. The trauma arises in the cognitive appraisal that may take place some time after the occurrence or violation, and reflects the relational losses that have happened. Rather than the more familiar symptoms of PTSD (intrusive memories or hyperarousal for example) betrayal traumas are more likely to lead to dissociative or amnesia-based coping, emotional numbing and relational distress, for example, lack of trust and fear of intimacy.

To return to the question, "what constitutes good feminist therapy?" there are several models of feminist trauma therapy. In her analysis of feminist trauma treatment models, Laura Brown (2004) found the following characteristics (some of which have been discussed in detail, above) present in most approaches used by feminist therapists like Judith Herman (1997), Christine Courtois (2009) and others:

- Works contextually – socially and emotionally
- Is explicitly political
- Focuses on empowerment
- Strives to create an egalitarian, collaborative relationship
- Deep empathy for the client
- Strengths based – 'problems' reframed as strategies for survival and coping
- Attempts to meet clients where they are

- Creates networks for political change via "engagement with the world and empowerment of others" (L. S. Brown, 2004, p. 469)
- Believes the woman – "assumes that the intersubjective "truth" of survivor's experience will emerge" (p. 468)
- Psychoeducational – sharing information "about trauma's neurobiological, social and existential impacts so that the trauma survivor can feel less negatively unique and more able to cognitively appraise trauma response in a **compassionate non-judging manner.**" (p. 470)

I would like to pick up on the last two points, the 'intersubjective truth of the survivor narratives' and the 'psychoeducational' characteristics of good feminist practice. I would like to look at the emergence of narrative therapy as the therapy of choice for feminist and Anti-Oppressive Practice (AOP) social workers from a critical perspective, and then the emergence of science and psychoeducation as a tool for empowerment. Finally I would like to discuss how mindfulness is congruent with feminist approaches to trauma and at the same time provides some balance or fills some voids in our eclectic palette of interventions by adding Buddhhist perspectives on the body and the philosophy of 'not-self', and non-narrative, non-conceptual, non-dual ways of knowing.

Family therapists Michael White and David Epston, from Australia and New Zealand respectively, developed narrative therapy. It emerged in North America around 1990 and is considered a 'constructivist' therapy, signalling a change from a

modern to a postmodern approach to therapy. Modernist theory was based on "objectivity, rationality and knowing through observation. The postmodern view . . . recognizes many realities and truths co-exist and sees reality as being socially constructed rather than given" (Kelly, 1996, p. 462) or, as some would say, 'natural'. Pozzuto, Angell and Dezendorf (2005) call narrative therapy both a destabilizing critique and a therapy. It is a destabilizing critique as it challenges the client, together with her therapist, to critically examine her assumptions about the 'naturalness' of her social relations and worldview. The deconstruction of what is assumed to be natural or true creates a space within which possibilities arise for alternative stories and actions, including "modifying the continued reproduction of social relations" (p. 35). It is therapeutic in the sense that it creates these opportunities for alternative human actions that facilitate growth and development as well.

Many critical social workers endorse the notion of narrative therapy as potentially the modality 'par excellence' for anti-oppressive practice. "Narrative therapy, " write Pozzuto, Angell and Dezendorf (2005) "because of its critical, deconstructive elements, has the possibility of modifying the continued reproduction of social relations" (p. 35). Their analysis of narrative therapy is congruent with the feminist paradigm for simultaneously addressing the traumagenic environment, raising consciousness and building resiliency and coping skills with clients:

> First, the notion of working solely with an individual must be discarded. Individual and social context are inseparable. Further, the individual, recognized as an actual entity within a specific field of social relations, may not be in need of change. It may be the social environment, the continually reproduced network of social relations, that needs modification. Increased coping skills for the individual may be in order but not to relieve the strain within the social environment. An oppressive set of social relations requires change in the relations, not increased coping skills of the individual. *Increased coping skills, however, may be in order to enable the individual to function while they change their environment.*" (p. 34, emphasis added)

Canadian social work professor and feminist Catrina Brown (2011) posits in her analysis of narrative therapy that we should

> take a critical view of the stories people tell about their experiences in life and of the ideas that women (and men) hold about how they should behave and think in everyday life. This approach ensures that we do not unintentionally reproduce oppression through the therapy process. (p. 95)

Feminist narrative therapy contains the characteristics of 'good' feminist therapy mentioned previously. It is collaborative, political, and transformational. It recognizes the paradox of the client's agency alongside her oppression and victimization. The therapist is not neutral, but takes sides with her client, but is still

aware of the "potential constraining, controlling, regulating, and normalizing effects of therapy itself" (p. 98). Feminist therapy historically grew as a resistance to androcentric constructions of women's experiences and problems as pathology but "despite the major contributions" critiques Brown, mainstream feminist therapy suffers from three major limitations, "essentialism, subjectivism and reification of dominant stories" (p. 99).

Congruent with postmodern feminists who critique radical feminist ideologies as essentialist, feminist therapists must challenge any essentialist notions we may have about 'women's experience.' Challenging essentialism prevents us from treating gendered traits as though they were natural and common instead of socially constructed, and calls us to emphasize difference and diversity. But what of the political when we deconstruct that which we hold in common? The postmodern 'view from everywhere' makes social justice difficult at best. So Catrina Brown (2011) argues that we take an approach that blends modernist and postmodernist feminism, that allows us "to challenge rather than reinforce oppressive social discourses and that helps women re-story their lives" (p. 100).

Returning again to the notion of what constitutes 'good' feminist therapy, the idea of "a woman's intersubjective truth" requires some scrutiny according to Brown (2011). She critiques feminist therapy for sometimes slipping into 'subjectivism' when we affirm every aspect of a woman's experience without critical inquiry into what are the harmful constructions embedded in those narratives, and "linking them to larger social, economic, historical and political forces" (p. 100).

Some of that is apparent in the pre-treatment interview material that follows in the fourth chapter; that is, many women spoke about their experience and generalized it to 'how it is for women'. Brown says we must, with our clients, explore how experience is embedded in the social, and "challenge unhelpful aspects of stories that continue to foster oppression" (p. 101).

Third, Catrina Brown (2011) critiques the notion of the 'natural self' an analysis that is very salient to this study on how culturally or ideologically dependent our ideas may be about who we are and how we heal our 'self' after interpersonal violence. It is a common belief that there is an essential or authentic 'self' that needs to be liberated or will emerge by peeling back the layers of oppression.

> Most psychological approaches to 'the self' reinforce dominant social ideas that separate the individual from society or social context and, therefore, politics. Thus, they reinforce the notion that there is little people can do to change themselves or each other... Dominant culture relies on this unchanging concept of the self, for if we can't teach old dogs new tricks, we have little hope of changing social values, norms, stories, or ideas, let alone oppressive systems and structures. (p. 103)

Postmodern feminist understandings of 'the self' as constructed from ideas within a social context are congruent with the Buddhist philosophies of 'not-self' and one of the places where I believe mindfulness can provide an important role in feminist therapy. Anne Carolyn Klein (1995) makes perhaps the most elegant

argument for the congruency of postmodern feminist and Buddhist understandings of self:

> Mindfulness facilitates a centeredness and internal coherence akin to 'essentialist' forms of strength and at the same time is compatible with constructionist or postmodern sensibilities because of its intense awareness of the flow that constitutes mind and body, including itself. In this way, mindfulness and its associated states can ameliorate the tension between essentialist and postmodern perspectives in feminist contexts. Some feminists make a case for referring to 'woman' as an essentialized category when it is useful for political purposes, even though they recognize this term as a fiction. In contrast to such strategic essentialism, Buddhist theories and practices envision a subject for whom groundedness *and* a sense of the constructed nature of self can be simultaneous, so that there is never a necessity to 'choose' strategically between them. There is a place and a possibility for both. (pp. 68-69, emphasis in the original)

A full discussion of western and eastern models of 'self' and 'not-self' follows in the next chapter, but in the context of problematizing natural, essential or static ideas of the self, Catrina Brown (2011) critiques feminist therapy for this tendency to reify dominant oppressive social narratives when we accept women's stories of victimization or powerlessness carte blanche. Brown suggests that we need to unpack these stories as well as

> *reconstruct* client's stories rather than leave them intact. 'Reframing' in feminist therapy shifts unhelpful stories and enables the creation of alternative or preferred stories. It is also important to explore the question of women's agency or action, and the possibility for resistance and action outside dominant stories. (p. 105)

From a mindfulness perspective, I wondered if trading one story for another is really the answer. Does narrative therapy not just trade one reified 'self' for another? What if we were to open women's awareness to a different way of 'knowing', a different relationship to their 'stories' and 'self'? Narrative therapy is based on the constructivist philosophy that we cannot know objective reality, that we cannot have direct knowledge of the world (Brown & Augusta-Scott, 2007). Mindfulness-based or eastern epistemology and western neuroscience (Farb et al., 2007) challenge this idea. We can know phenomena, or 'objective reality' directly through non-dual, non-conceptual mindful awareness:

> ...another stream of awareness may exist beyond sensing the moment, observing ourselves and the constructed categories and concepts of our explanatory narrative selves. This stream is described by mindfulness practitioners as a non-conceptual awareness, a kind of 'knowing' before and beyond constructions, observations and even sensations. . . . Mindful awareness may also be seen as a way to alter our relationship with the self, with our own mind, so that we can create new states of information flow in the course of daily life.

(Siegel, 2007b, p. 262)

Trauma survivors have experiences and memories that are not 'narrative' or conceptual in nature when abuse and neglect happens in the preverbal[6] stage of human cognitive development (Perry & Hambirck, 2008). These traumatic memories are often somatized (Ogden, Minton, & Pain, 2006; Rothschild, 2000), which further begs the question, where is the 'body' in narrative therapy, and what is the therapist's role, one body to another? Additionally, if one refers back to Laura Brown's (2004) list of what constitutes 'good' feminist therapy, she includes psychoeducation, sharing information "about trauma's neurobiological, social and existential impacts so that the trauma survivor can feel less negatively unique and more able to cognitively appraise trauma response in a compassionate non-judging manner" (p. 470).

I believe that the mindfulness-based modalities that I was familiar with had these missing elements: an opportunity for women to cultivate an intentional, embodied, present-moment, non-judgemental awareness within a psychoeducational framework. There are also very effective mindfulness-informed behavioural (Hayes, 2004; Linehan, 1993), sensorimotor (Ogden, et al., 2006) and otherwise somatically-based interventions (Rothschild, 2000) that also involve educating trauma survivors on the latest brain science and affect regulation theories (Schore, 1994). However, I also felt that mindfulness-based interventions and

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[6] Similarly Piaget's sensori-motor stage of development that occurs 0-2 years of age (Atherton, 2011).

mindfulness-informed therapies have not incorporated all the 'best practices' of feminist therapy, including the benefits of unpacking oppressive narratives and perhaps most importantly acknowledging the importance of the therapeutic relationship for personal and political transformation.

I am proposing that we do just that – that we integrate mindfulness and feminist therapy, because there are congruencies and there are gaps. The reflective space of the compassionate observer that mindfulness imparts is liberating; it opens space for choosing new possibilities for being and agency (not just new narratives) instead of reacting from our wounds of oppression. Integrating feminist (or if you prefer, anti-oppressive) practices into mindfulness-based and mindfulness-informed approaches transforms these practices into justice work as mindfulness helps us – survivors and therapists – work skillfully with afflictive emotions and mindstates as we passionately and compassionately transform our community, our world, and all our relations. The 'why' of this transformation is grounded in the theoretical framework based in the review of the literature in the next chapter, and the 'how' is revealed in the data analysis that follows the literature review.

Chapter 2: Theoretical Framework and Review of the Literature

As I present the theoretical framework for this study, it is necessary not to take for granted that common concepts and terms have common understanding, like the concept of 'healing', 'self', 'empathy' and other concepts in the title of this work. Therefore, I define the 'common' concepts that I have used and contextualize each concept in the theoretical discourse in the literature as is relevant for this study. I draw from many theoretical threads to weave my framework, including feminist theories of subjectivity or the 'self', feminist moral philosophy, feminist therapy, dialectics, attachment theory, brain physiology, cognitive science, and Buddhist philosophy and psychology that are at the core of mindfulness. The chapter closes with a brief introduction to the theory of how therapy works through second-order change that unifies all effective treatments (Fraser & Solovey, 2007). This theory of change supports the choice of a mindfulness–based modality as an evidence-based practice like the one incorporated into the treatment modality created for this research called *Courage to Love.*

Healing

The Concise Oxford Dictionary (Pearsall, 2001) defines 'heal' as "(1) to make or become healthy again. (2) correct or put right (an undesirable situation)." This definition is an appropriate choice in this context because it speaks not only to the personal but to the political as well; it does not exclusively define healing to be a

human being's physical homeostasis; it also addresses *undesirable situations.* The term healing in the title of this study is used in the context of the 'self' and so encapsulates the idea that to make the self healthy again, and to put right one's situation, one must put relationships right again. Judith Herman (1997) describes healing, or specifically 'recovery' in the context of relationships, as it is within relationships that the survivor of violence renews connections with other people and through these "re-creates the psychological faculties that were damaged or deformed by the traumatic experience . . . the capacities for trust, autonomy, initiative, competence, identity, and intimacy. Just as these capacities are originally formed in relationships with other people, they must be reformed in such relationships" (p. 133).

Good mental health for the individual, as stated by the Canadian Mental Health Association (2008), has certain characteristics including resilience, balance, flexibility, the ability to enjoy life and 'self-actualization' or agency in one's life. Canada's Public Health Agency has developed a broad approach to understanding health as also having social determinants such as adequate housing, work and economic conditions, food security, education, and social inclusion (Raphael, 2009).

Aboriginal models of healing and health, based on the Medicine Wheel, offer a worldview in which the spiritual, emotional, physical and mental aspects of each human being are in balance, where human beings are in balance with the community, and the community in balance with the land and Creation, sometimes referred to as "all our relations" (Dapice, 2006). The key to recovery that is rooted in

one's environment and reconnection with humanity is remarkably present in the 'Theory of Dislocation' presented by Bruce Alexander in his work *The Globalization of Addiction* (2008) who understands that 'caring others' can also be your community, your tribe, the larger society. Dislocation is his term for the "enduring lack of psychosocial integration," which he says:

> . . . denotes interdependence between a person and a society (and) is experienced on several other levels as well. Psychosocial integration is experienced as a sense of identity, because stable social relationships provide people with a set of duties and privileges that define who they are in their own minds. It is experienced as a sense of oneness with nature, because members of viable societies share and reinforce a conceptualisation of their society's place in the natural world. It is quite often experienced as connection with the divine, because members of viable societies usually share a way of understanding unseen world beyond the mundane space and time that surrounds their social world." (p. 58)

Alexander credits Polyani with this notion of dislocation that not only implies geographic dislocation, but also includes psychological and social separation from one's society. In his study on the phenomenon of addiction, he posits that the global movement towards a free-market society has created the mass destruction of psychosocial integration and that addiction is a way of adapting to the pain of sustained dislocation. Canada's First Nations (as are aboriginal people around the

globe) are a prime example of severe dislocation or psychosocial disintegration (Alexander, 2008).

American psychiatrist Daniel Siegel (2010) writes that "science has shown that well-being and true happiness come from defining our 'selves' as part of an interconnected whole – connecting with others and with ourselves in authentic ways that break down isolative boundaries of a separate self" (p. 259). Siegel defines well-being as "occurring when a system is integrated" and that integration "involves cultivating both differentiation and linkage" (p. 268) and therefore embraces an idea of empathy where self and other are recognized and distinct, yet interrelated. So clearly the ideas emerge that the individual's healing and health are a balance of personal bio-psycho-social-spiritual wellness developed and supported by relationships with intimate others, their community and beyond. This is certainly compatible with the Buddhist worldview of the interconnectedness of all living beings, and the moral imperative that arises from this view (His Holiness the Dalai Lama & Cutler, 1998).

Mindfulness teacher and researcher Jon Kabat-Zinn (1990) takes the idea of healing further, writing that healing does not necessarily mean curing, but rather implies the possibility that we might *relate* differently to illness, disability, even death. Healing requires a "profound transformation of view . . . brought about by an encounter with one's own wholeness" (p. 172). This encounter is made possible through mindfulness practices, including formal meditation practice. It is important to note at this point that healing comes about when the practice is engaged as a way

of being, rather than a means to an end, even healing. Because, as Kabat-Zinn says, if we are already whole, "what is the point of trying to become what you already are?" (p. 171).

The Self

This section builds further on the modernist and postmodernist definitions and ideas about what constitutes the 'self' from the previous chapter, and I also explore theories of self, including how 'the self' is created, in feminist philosophy, psychoanalysis and psychology.

Considered to be one of the most important texts in the history of modern psychology, *The Principles of Psychology* is unique in the history of western human thought (James, 1890). James' influence can be detected in the ideas about human consciousness and 'the self' in many, if not all, of the postmodern authors that followed. It is also interesting to note the influence of Theravada Buddhism on James, present in Victorian Britain as a result of the British colonization of Sri Lanka and Burma (Scott, 2000). The Buddhist idea of 'dependent origination' is evident in many areas of his analysis of perception and thought, for example, as Wozniak (1999) explains:

> For James, thought contained no constant elements of any kind, be they sensations or ideas. Every perception was relative and contextualized, every thought occurred in a mind modified by every previous thought. States of mind were never repeated. Objects might be constant and discrete, but thought was constantly changing and

> sensibly continuous. 'Consciousness,' he wrote, '. . . does not appear to itself chopped up in bits. Such words as 'chain' or 'train' do not describe it fitly as it presents itself in the first instance. It is nothing jointed; it flows. A 'river' or 'stream' are the metaphors by which it is most naturally described.' (para. 7)

In his chapter on the self, James (1890) distinguished between the 'me self' or phenomenal self (the self as 'known') and the 'I self' (the self as 'knower'). James further distinguished three separate but interrelated aspects of the 'me self' or the 'self that is known': the material self, the social self and the spiritual self. The material self feels a strong sense of ownership, for example of our bodies, our accomplishments and our possessions; the social self is our felt sense of being in social relationships, within which James also articulated the principle of the multiplicity of social selves; and the spiritual self that contains feelings of our own subjectivity. For James (1890) the 'I self' was the 'self that knows', the feeling of self identity, continuity of self or the experience that "I am the same self that I was yesterday" (p. 332) and the judging and acting self, the self of individual agency.

In modernist western philosophy, the concept of the *self* performs numerous roles.

> In ethics and political theory, the self is the locus of agency and responsibility, and hence is that which comes in for either praise or blame. In epistemology, the self is that which takes responsibility for belief. As the primary subject of investigation in metaphysics, the self

> is that entity – that unity, whatever it is – whose persistence accounts for personal identity over time. (Code, 2000, p. 438)

According to Code the mind/body dichotomy and the "problem" of personal identity within traditional philosophy does not seem to trouble feminists in the same way, as feminists have not seen the mind and body as mutually exclusive, that "characteristically psychological dimensions of human life are in reality admixtures of physical and mental, in varying proportions" (Code, 2000, p. 438). The project that feminists have undertaken of late, says Code, is to rescue the notion of "autonomy" from being equated with separation from other human beings. Braidotti (2002) agrees with this notion of subjectivity-in-relationship, and says that in fact that the "truth of the subject is always in between self and society" (p. 14). The feminist idea of a "self" is one that is inclusive of whatever may be inherent and that which is inherited or learned. As we have come to know, "women's self-concepts and ways of knowing are intertwined" (Belenky, Clinchy, Goldberger, & Tarule, 1986), and as Nancy Hartsock (1998) has said, we cannot escape the teaching we have received from others, good and bad.

Diana Meyers (1994), draws on feminist psychoanalytic theory for her understanding of subjectivity and agency. Like Braidotti (2002), Meyers rejects the idea of a Kantian, unitary, individualistic subjectivity in favour of a fluid, interconnected, ever changing subjectivity that embraces both the interpersonal and

intrapersonal development of identity, and is the basis of a moral subjectivity[7] (Meyers, 1994). Feminist therapist Judith Herman (1997) also contextualizes the self in relationship, and what happens to the self as a result of trauma:

> A secure sense of connection with caring people is the foundation of personality development. When this connection is shattered, the traumatized person loses her basic sense of self... Trauma forces the survivor to relive all her earlier struggles over autonomy, initiative, competence, identity, and intimacy... Traumatic events violate the autonomy of the person at the level of basic bodily integrity. The body is invaded, injured, defiled. Control over bodily functions is often lost; in the folklore of combat and rape, this loss of control is often recounted as the most humiliating aspect of the trauma. Furthermore at the moment of trauma, almost by definition, the individual's point of view counts for nothing. In rape, for example, the purpose of the attack is precisely to demonstrate contempt for the victim's autonomy and dignity. The traumatic event thus destroys the belief that one can *be oneself* in relation to others. (p. 52-53)

Feminist philosopher Susan Brison (2002) understands the self to be "both autonomous and socially dependent, vulnerable enough to be undone by violence and yet resilient enough to be reconstructed with the help of empathic others" (p.

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[7] I will return to Meyers' ideas on the connection between intersubjectivity and moral agency later in this chapter.

137). In *Outliving oneself: Trauma, memory and personal identity,* Brison shares a compelling narrative and analysis of her own brutal rape and recovery. She calls this experience "outliving oneself," similar to the experience of the woman quoted at the beginning of the first chapter who said that the woman she was, no longer exists. In analyzing the self and how it recovers from this experience, Brison theorizes a triadic socially constructed self, consisting of an 'embodied self,' 'self as narrative,' and an 'autonomous self,' which coexist in a compatible and complementary relationship (2002, p. 140).

In describing the 'embodied self', Brison (2002) argues that the body and mind are intermingled, never more apparent as when trauma occurs. "Traumatic memory is not narrative" (Brison, 2002, p. 142) because traumatic memories are tied to and stored in the body, in a way that other memories typically are not, reappearing as flashbacks and other sensory replay and not under conscious control. Brison (2002) reminds us that not only is body awareness changed, but survivors may also attempt to change the body after assault. Dressing to disguise the body, self mutilation, eating disorders, cutting one's hair so short so as to appear masculine and other ways of changing one's identity are not uncommon. Some survivors even change their names. Brison remarks, that the "study of trauma does not lead to the conclusion that the self can be identified with the body, but it does show how the body and one's perception of it are nonetheless essential components of the self. It also reveals the ways in which one's ability to feel at home in the world is as much a physical as an epistemological accomplishment" (p. 143). In many ways

the body provides a physical boundary to the self, and when the body is violated – and especially when it is repeatedly violated over time, the survivor finds ways of dissociating herself from her body; and in extreme cases of child sexual abuse, to create multiple selves that enable her to separate from her body and her former self in order to survive the abuse (Herman, 1997).

Brison (2002) explains that in regards to the 'self as narrative', traditional philosophers have identified the self with a set of contiguous memories over the life-span that is expanded upon with each new experience and that includes an ability to imagine ourselves into the future, what John Locke (1700) referred to as a "continuity of consciousness." However, she asks, how does the survivor "remake a self from the scattered shards of disrupted memory?" (Brison, 2002, p. 149). A survivor's assumptions about safety, her relationship to her body and former emotional repertoire are severely altered after trauma – survivors are often numbed by the experience and often without hope, an essential ingredient in creating a future narrative, and ultimately stymied by the futility of words to convey their experiences. However, narrative is essential in order for the survivor to "integrate the traumatic episode into a life with a before and an after," and also to "regain one's voice, one's subjectivity, after one has been reduced to silence, to the status of an object, or, worse, made into someone else's speech, and instrument of another's agency" (p. 149). This is certainly true of the women I have worked with who have survived years of abuse from an intimate partner. Her identity is often so subsumed under the will of her partner (and often her children's demands too, as

they learn the behaviour from the abuser), that the abusive partner's desires and demands become hers, as she hardly has any awareness of her own desires anymore. Brison argues that it is important for survivors to tell their story, because talking about the abuse and violence does something to it, especially when they talk with other women with similar experiences. She notes, "just as one can be reduced to an object through torture, one can become a human subject again through telling one's narrative to caring others who are able to listen" (p. 151) and "to the extent that bearing witness re-establishes the survivor's identity, the empathic other is essential to the continuation of a self" (p. 152).

The third aspect of the self that Brison (2002) discusses is the 'autonomous self,' that view that is most central to ethics as well as other philosophies, the self as "the locus of autonomous agency" (p. 153). Post-trauma, survivors will often make statements like "I am no longer myself," or "I don't know who I am anymore." In an abusive relationship if a woman is constantly being brutalized for nearly every decision she makes, she will soon lose her desire to voice her opinion or make choices that differ from her abuser's. The autonomous self is so severely affected by trauma, the survivor often feels she has lost control over herself and her environment, and if, says Brison "one's self, one's *true* self is considered to be identical to one's will, then a survivor cannot be considered the same as her pre-trauma self, since what she is able to will post-trauma is so drastically altered" (p. 153).

The key to recovery is for the survivor to regain a sense of control of herself and her environment "and to be reconnected with humanity" because, Brison (2002) argues, it is the "loss of connection that trauma survivors mourn, a loss that in turn imperils autonomous selfhood" (p. 153) because of the relational nature of the autonomous self. To be invisible, to be unacknowledged or not recognized, is to not exist. In order for healing the autonomous aspect of the self to occur, a survivor must acknowledge her dependency on caring others as she learns to care for others and allow herself to be cared for by others (and I would argue, allow her to care for herself).

Diana Meyers' *Subjection and subjectivity: Psychoanalytic feminism and moral philosophy* (1994) contains another triadic model of self that is a further development of the work by feminist psychoanalysts Jessica Benjamin and Nancy Chodorow. Benjamin's model of subjectivity is based on the primary caregiver relationship, which is constructed of three components. This model of self is composed of two distinct subjects (in a healthy model that is a care giver and a care receiver) and intersubjectivity as the third component. The virtue of this theory, Meyers claims, "is the stress (Benjamin) places on the need for mutual recognition" (p. 125) because to know who one is, one must receive recognition from others. "People need *mutual* recognition," writes Meyers, "the child needs to recognize the caregiver, as well as to be recognized . . . But caregivers cannot be seen as recognizers unless they are and are perceived to be subjects" (p. 125). This latter part is an important concept, because when women are mothering children in an

abusive relationship or under the oppression of patriarchy, her subjectivity is not recognized, and she does not recognize it herself. This in turn compromises the subjectivity of her children. "Unable to recognize their mothers" Meyers writes, "children are (also) deprived of recognition" (p. 126). Violence and oppression – the social environment of these families – has a direct impact on a child's attachment to caregivers. These ideas also have political impacts in terms of women who suffer under the oppression of patriarchy and other abusive relationships. Meyers (1994) writes:

> The tragedy of peremptory, domineering parenting and, indeed, of **all sorts of oppressive social environments** is that they undermine and may even suppress self-recognition, and, when they do, they deprive individuals of others' recognition, as well. To receive recognition, one must recognize the other, and to recognize the other, one must recognize oneself. Adequately nurtured in childhood, people become self-recognizers who both give recognition to others and receive recognition from them. (p. 128, emphasis added)

Clearly subjectivity and intersubjectivity and its relationship to the very nature of the self is as much a political issue as it is a personal one. Oppression deprives one of one's subjectivity, including oppression in the form of violence and traumatic abuse, and the impacts of this on women, children and society in general are enormous. For example, some of the mothers whose narratives are captured in this study struggled with poverty and were otherwise tied to the abusive partner in

some manner through patriarchal child custody and access laws. These mother-led families dealt not only with a lack of external resources in terms of adequate income security, food and housing; mothers themselves were coping on little in the way of internal resources, as poverty and oppression chip away at a self that received, and continues to receive, little or no recognition. As Meyers has posited, when mothers – living under any kind of oppression - are unable to recognize their own subjectivity, their children are also struggling to be recognized, which directly impacts the development of their own subjectivity or self. Meyers contends that self-recognition undergirds all aspects of a person's identity, especially its moral component:

> To recognize one another, then, people must be capable of assessing the merits of social norms, and they must be capable of resisting these norms insofar as they prescribe domination and subordination and interfere with mutual recognition. Independent moral subjectivity, that is, **moral self-recognition, is required for mutual recognition.** (Meyers, 1994, p. 128, emphasis added)

Meyers believes that our 'selves' can only become moral agents when we develop 'empathic thought', that is we recognize and have a felt sense of our own and others suffering. That felt sense of suffering deters us from objectifying, oppressing, neglecting, abusing, and committing other forms of harm.

Meyers' (1994) statement brings to mind not only the condition of women under patriarchy, but to ethnic and racialized groups, especially Canada's Aboriginal population who are voicing their independent moral subjectivity, and demanding

recognition for their suffering as well. This is a population where intergenerational trauma and lateral violence has prompted workers within this community to work quickly and comprehensively to come to terms with why Aboriginal people inflict harm on each other and themselves, considering the high rate of suicide, and what can be done to stop it (T. Vincent, Minwaashin Lodge Ottawa, personal communication, 2008).

Meyers (1994) enlarges her model of the development of the self, using Chodorow's theory that empathy is "at the centre of adequate caregiving" (p.125). In a caregiving context, empathy is the capacity to enter imaginatively into a child's world without surrendering one's one identity as a responsible adult agent. Chodorow also observes that there are definite parallels between one's relationship with others and one's relationship with ourselves. Meyers contends that while we think of the skills we develop for caregiving as other-directed, they are also useful and necessary for caring for oneself. Indeed, as we develop into adulthood, we are expected to nurture ourselves; by "turn(ing) empathic and nurturing skills to the purposes of self-understanding, self-development, and self-validation" (p. 127).

Meyers (1994) develops the concept of "empathic thought" as a way of creating a moral response to another's subjective state. This empathic thought is used when an individual considers how to best respond to another in a way that sustains a relationship of mutual recognition. I think "empathic thought" is a useful way of thinking about how we engage in self-care and self-nurture and how we might teach the skill of "empathic thought." Mindfulness teaches "skillful

responding," a way of focusing one's compassionate (or if you will, one's self-empathic) awareness to one's own afflictive mind states, and further supports my argument for the importance of empathy and self-compassion in this endeavour, which I will return to again later.

Teaching skillful responding is also at the heart of Dialectical Behavioral Therapy (DBT) developed by Marsha Linehan (1993). A talented cognitive behavioral therapist with a Zen Buddhist mediation practice, Linehan works mainly with women diagnosed with 'so-called'[8] Borderline Personality Disorder (BPD). DBT is a mindfulness-informed intervention, that is, it incorporates some aspects of 'everyday' mindful awareness with clients but does not include meditation practice. Linehan has also developed a triadic model of self or 'three minds', but before exploring what that model looks like some explanation about dialectics might be helpful at this point as it illustrates an aspect of 'cognitive non-duality' that undergirds mindful awareness (Klein, 1995).

Linehan (1993) employs the theory of dialectics to her therapy, which in itself has three primary characteristics. The first piece of this is that dialectics stresses wholeness and interrelatedness. "Thus," she writes, "identity itself is relational, and boundaries between parts are temporary and exist only in relation to the whole; indeed it is the whole that determines the boundaries," (p. 31) echoing the thoughts of feminist philosophers that "the self is an ensemble of social relations"

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[8] Demonstrated as a problematic diagnostic category in the Diagnostic and Statistical Manual IV of the American Psychological Association (Graybeal, 2007).

(Lykes, 1985, cited in Linehan, 1993, p. 31). Linehan is highly critical of the BPD diagnosis, and remarks that "the problems encountered by the borderline individual may result in part from the collision of a relational self with a society that recognizes and rewards only the individuated self" (p. 32). Women are more likely than men to be diagnosed with BPD, so while Linehan does not identify DBT as a feminist therapy, she is aware of the gendered implications of the 'borderline' diagnosis, and the influence of gender on notions of the self and 'appropriate' interpersonal boundaries.

The second principle in dialectics, the principle of polarity, is that while dialectics focuses on the whole, it also recognizes the complexity of the whole. There is always polarity within any system, no matter how small. She correlates this to physics, where scientists, no matter how hard they try, cannot reduce the base of life to any single entity – for each element there is an equal opposite, "even the smallest element of matter is balanced by anti-matter" (Linehan, 1993, p.32). So in dialectical therapy, it is assumed that within "dysfunction" there is also "function" so that validation is a crucial aspect of DBT. Self-destructive behaviours are understood as coping strategies, and there is value in each person's point of view. This led to the construction of the "wise mind" aspect of the triadic model of self, and helps therapists trust that each woman "has within herself all the potential that is necessary for change" (p. 33).

The third principle of dialectics is continuous change. The very tension between forces in relationships produces change, and drawing on the philosophies

of Hegel and Kant, it is a process she calls thesis, antithesis, and synthesis. Within the synthesis there is also polarity (thesis and antithesis) and so the process continues. It is the essential nature of life, and so the nature of the self is one of a process of transformation over the lifespan. It is compatible, she says, with psychodynamic theory but different than client-centred therapy in that it recognizes that "the change engendered is also transforming the therapy and the therapist . . . The therapist helps the patient resolve crises by supporting simultaneously her attempts at self-preservation and at self-transformation. Control and direction channel the patient toward increased self-control and self-direction. Nurturing stands side by side with teaching the patient to care for herself" (Linehan, 1993, p.33).

Women with BPD tend to vacillate between rigidly held, yet contradictory points of view, seeing things "either/or" rather than "all" or to give a more subjective example, that the smallest fault makes them "bad." Linehan (1993) says that such dichotomous thinking can trap someone in the thesis/antithesis mode not allowing her to move toward synthesis. This unresolvable conflict between intense negative and positive emotions (e.g. I want to die / I want to live) is characteristic of BPD. Also characteristic is identity confusion, which arises, she posits, from their inability to experience relatedness to other people as well as the relationship of this moment to other moments in time. BPD, in Linehan's estimation, is primarily a problem with emotional dysregulation.

When working with DBT, Linehan (1993) explains the concepts of three primary mind states: "reasonable mind", "emotion mind", and "wise mind." These three states are manifestations of the thesis, antithesis and synthesis of dialectics. "Reasonable mind" cognitions are intellectual, rational, logical, focused and "cool" in approach to problems. "Emotion mind" cognitions are emotionally-based and "hot," facts are distorted or amplified to be congruent with current emotions or affect, the behaviour is likewise to be congruent with the current affect. "Wise mind" is the synthesis or integration of "reasonable mind" and "emotion mind" and goes beyond them, adding, "intuitive knowing to emotional experiencing and logical analysis" (p. 214). Linehan employs her Buddhist practice here, developing a way for women to develop the skill of 'stance' or "seeing or knowing something directly and clearly" (p. 215) by using the breath and letting the attentional focus settle into the body. From this centre of calmness the person is able to respond wisely rather than react from cold, raw intellect or hot, raw emotion. This skill – teaching a woman to care for herself by containing her emotions - is one that is central to any mindfulness based modality, and one of the essential pieces of the treatment modality, the *Courage to Love*, that was used with the women in this study.

Dusty Miller (1994), who worked for many years with women who self-injure, presents a pathological triadic model of self, typically internalized by survivors of childhood sexual abuse. This relational subjectivity, mirroring the woman's experience of growing up in a family where she was constantly physically and sexually abused and emotionally neglected, is composed of the self as victim, the

self as perpetrator and the self as non-protecting presence. This is good example of what happens in relationships of non-recognition, where children are subjugated by the destructive wills of others who do not recognize them as subjects as a result of the abuser's inability to engage in "empathic thought" and moral self-recognition, the requirement of mutual recognition (Meyers, 1994). The antidote to years of such abuse is the transformation of this triadic model of self from a pathological one to a healthy one. This is done within a transformative relationship with a caring other, usually a therapist, who Miller (1994) explains becomes "a temporary stand-in for what will eventually become an internalized Protective Presence . . . Finally the client will be able to develop an internalized Protective Presence of her own" (p. 252).

Since writing her book Miller (2003) has gone on to develop an understanding about the process of change that I think is very compatible with Linehan's dialectical theory of change. "The ripples that flow outward from every traumatic event don't have to sink us, define us, or assign us a single identity. 'Victim' ... describes a specific moment in time, not permanent self-definition. This is the comforting aspect of impermanence that transforms every emotional state" (Miller, 2003, p. 11). Not coincidentally, in the meantime, she has also developed a meditation practice and admits to being influenced by Linehan's work. She developed a way of working with survivors that

> taught them to turn to other members of the group for support rather than to the group leaders. They painted and drew. In brief guided

> meditations, we helped them connect to something bigger than themselves. That opened the door to developing a felt sense of Protective Presence, evoked from memories of protective adults, beloved pets, nature, and compassionate religious teachers like Jesus and the Buddha. They learned to reliably evoke this presence to remind themselves that even though they'd been victimized, they'd also been whole people all along. (p.10)

Miller's *Addictions Treatment Recovery Integrated Model* (ATRIUM) (Miller & Guidry, 2001) and Linehan's (Linehan, 1993) DBT have many aspects of a 'good' feminist therapy, but lack the characteristic feminist, social justice theoretical underpinning and strategies for structural change offered by Laura Brown (2004) earlier in the first chapter.

Clinical psychologist David Wallin (2007) synthesized ideas from attachment theory and mindfulness and developed a model of self that is even more multidimensional. He begins his work by explaining the history of attachment research and remarks that "the narrative of attachment theory has unfolded through a focus on intimate bonds, the non-verbal realm, and the relation of self to experience" (p. 2) but goes beyond that now to include intersubjective and relational theory, and affective neuroscience. Bowlby (cited in Wallin, 2007, p. 2) considered attachment a biological imperative necessary for evolutionary survival, as an infant's relationship to the caregiver is critical for the child's physical and emotional survival and development. Canadian developmental psychologist Mary

Ainsworth and American researcher Mary Main went on to clarify that it is the high-quality, non-verbal communication between the infant and caregiver that helps the child learn how to attend to and regulate his or her own affect. In the early 1990s Main conducted research with Peter Fonagy that led to the understanding of "the crucial importance of the self in relation to its own experience" (Wallin, 2007, p. 2), or how the capacity to adopt a reflective stance toward experience correlates with secure attachment. This is highly important for therapists to understand, Wallin says, because "the *relational/emotional/reflective process* is at the heart of an attachment-focused therapy (that) facilitates the integration of disowned experience, thus fostering in the patient a more coherent and secure sense of self" (p. 3). This describes the importance of the ability of the therapist to 'be with' and model for her client the ability to 'hold space' and modulate difficult emotions mindfully that arise in session, "a stance that involves deliberate nonjudgmental attention to experience in the present moment – that is, a stance of mindfulness," (p. 5).

This additional "stance" provides the fourth aspect of the multidimensional self that Wallin (2007) uses to explain "what is meant by the stance of mindfulness" (p. 5). He suggests that "attachment theory deals explicitly only with the elements represented by these first three rings: external reality, the representational world, and the reflective self. It seems to me, however, that there is a trajectory to the evolving narrative of attachment theory that points like an arrow to a fourth ring

inside the other three. This fourth ring represents what I am calling the mindful self" (p. 5).

In Wallin's (2007) model of a multidimensional self, the first ring represents an external self or *objective self* situated in external reality that includes events we co-create as well as those that happen "to" us and, perhaps most importantly, our relationships in the outer world. The second ring represents the *subjective self* in the representational world, the self that is understood and interpreted in terms of past experiences, and forms future expectations. This is the place of subjective experience, where "mental modes of previous experience that relieve of us the necessity to reinvent the wheel in every new moment" (p. 5). The third ring is the *reflective self*, the self that is capable of a reflective stance towards experience, or *metacognition*, the ability to think about thinking. Representations, including our interior working models and socialization are understood to mediate or filter our experience of external reality. From this stance "we can reflect, consciously or unconsciously, on the meaning of our experience rather than simply take that experience at face value. This affords us a significant measure of internal freedom" (Wallin, 2007, p.5). The fourth and innermost ring, the *mindful self* is capable of meta-awareness, or awareness of awareness. It is the self that is able to ask, "*who is it that is thinking the thoughts about thinking*" (p. 6). Wallin explains that this idea, this "paradox that the mindful self can be at once a secure self and no (personal) self at all but only awareness" is fundamental to Buddhist psychology of nonattachment. It is also reminiscent of Marsha Linehan's (1993) dialectical theory, that is, that both

the thesis and the antithesis are contained, so therefore attachment would also assume that nonattachment is present, as it would assume that a 'self' and a 'not-self' can be simultaneously present. The mindful self is capable of an awareness that "includes both . . . the depth and breadth of the self's experience and of the fact that the self is 'ultimately a fiction'" (Wallin, 2007). Wallin explains further that "the self that reflects on experiences attends to the contents of experience while the self that is mindful attends to the process of experiencing. Such mindful attention illuminates the process by which experience is constructed" (p. 6).

Why is this model important to bringing healing to the self? I will let Wallin (2007) speak first on this point:

> The regular exercise of mindful awareness seems to promote the same benefits – bodily and affective self-regulation, attuned communication with others, insight, empathy, and the like – that research has found to be associated with childhood histories of secure attachment. . . . Secure attachment relationships in childhood and psychotherapy help develop this reassuring internal presence by providing us with experiences of being recognized, understood, and cared for that can subsequently be ***internalized.*** Mindfulness practice can potentially develop a comparably reassuring internal presence by offering us (glimpsed or sustained) experiences of the selfless, or universal, self that is simply awareness. Such experiences are often

> marked by profound feelings of security, acceptance, and connection, in relation as much to others as ourselves. (p. 6, emphasis added)

We are who we meet – and we are who we already are, intrinsically whole. We have the capacity to create an interior model of self through mindfulness that represents a secure attachment relationship, or what Miller (1994) refers to as a "protective presence." It is perhaps a little easier to heal from trauma if we start off with an internalized securely attached relationship with a primary caregiver. However, as Wallin (2007) argues, and I agree, we are able to create an interior safe base, a reassuring internal presence, a model of a securely attached self (whatever you may wish to call it) for ourselves, through relationships of recognition, caring and understanding at any stage of our lives. Bowlby's co-researcher Mary Main called this "earned secure attachment" (Wallin, 2007, p. 87). Those "earned secure attachments" - or perhaps what Alexander (2008) might refer to as relationships of 'psychosocial integration' - can include not only therapists, friends, and spouses, communities and beyond, but also the relationship with our self, cultivated through mindful self-compassion.

In addition to the importance of mindfulness for liberating the self, evidence suggests that a more mindful self is also a more just and forgiving self. Demonstrating through a review of the literature that there are two commonly held models of self-construal, the independent self and the interdependent self, DeCicco and Stroink (2007) argue for a third self-construal construct called the metapersonal self. The construal of the independent self is based in the

philosophical Western paradigm of the individual as independent and self-contained. The interdependent self-construal is more evident in (but not exclusive to) non-Western cultures, and is highly concerned with fitting in with others and belonging. The proposed third construal, the metapersonal self, is one where self-references are neither bounded by personal attributes nor by social context. DeCicco and Stroink argue that, by example, people who hold an Eastern view of the self have a self-construal that is expansive and transcendent. With this argument in place they have developed a tool for measuring self-construal that includes all three models: the independent, the interdependent and the metapersonal self. Through testing of this measurement tool preliminary findings suggest that the metapersonal self-construal is associated with a "low intolerance to ambiguity, low racism, low anxiety" and that they "expect the metapersonal individuals to be forgiving because their belief is that they are connected to all others" (p. 96). Therefore one might conclude that if we can find a way to develop this metapersonal self, or a 'mindful' self as described by Wallin (2007) this would be not only self-liberating but other-liberating as well, an important skill in healing our self and 'all our relations.'

I have come to appreciate DeCicco and Stroink's (2007) triadic model of self as being easier to grasp conceptually than Wallin's (2007) four-part self. I also prefer DeCicco and Stroink's (2007) notion of the 'meta-self' rather than Wallin's (2007) 'mindful self' concept. DeCicco and Stroink's (2007) model seems more ontological in nature – a way of being that does not reference personal attributes or social context. Wallin's (2007) model seems to be more psychological or cognitively

based, asking the question *"who is it that is thinking the thoughts about thinking"* (p. 6). For me the DeCicco and Stroink (2007) model expresses better the feminist notions of a subjectivity-in-relationship as an internal working model of self, rather than Wallin's (2007) somewhat abstract, self-referencing question regarding meta-awareness.

Empathy, Compassion and Mindfulness

Empathy is a word that has a fairly recent usage in the English language, according to Daniel Goleman (2006). In 1909 the German word *einfühlung,* which literally translates as "feeling into" was coined to capture the experience of feeling another's emotions inside our own body. More recently, psychology has come to understand empathy as having "three distinct senses: *knowing* another person's feelings; *feeling* what that person feels; and *responding compassionately* to another's distress. These three varieties of empathy seem to describe a 1-2-3 sequence: I notice you, I feel you, and so I act to help you" (p. 58). Research has revealed the presence and importance of mirror neurons in human brains in "empathic resonance" or the mutually reverberating state between two people caused by the triggering of parallel circuitry in their brains. Empathy (know/feel/act) according to Goleman has a 'must act' part to it. Many mirror neurons operate adjacent to motor neurons, and "their location means that the areas of the brain that initiate a movement can readily act to activate even as we watch someone else make that same movement" (p.41). The mirror neurons do not only allow us to mimic actions, but also "feel the pain" when another receives a pinprick or is experiencing

emotional pain. The arising response or the 'must act' to suffering and a desire to end it is compassion. From a moral philosophy stance, Diana Meyers (1994) explains that in order to be a moral subject (moral in the sense of having the ability to discern between actions that cause harm and those that do no or less harm) one must be able to recognize situations that require a moral response as well be able to conceive of oneself as a moral agent; and in order for this to happen, one must be able to take others' feelings into account and the impact of one's conduct on others. "One's emotional life is an important resource in imaginatively reconstructing another's subjective state" (Meyers, 1997, p. 33).

Of course, "all communication requires that what matters for the sender also matters for the receiver" (Goleman, 2006, p. 59) and in cases where there is a lack of mirror neurons in the prefrontal cortex of the brain, as in autistic individuals, there is a lack of ability to imagine another's perspective and to empathize, called 'mind-blindness' by Baron-Cohen (1995). Spinella's (2005) study also shows correlations between prefrontal dysfunction and aspects of empathy. This is an important consideration when we look at the capacity for individuals to develop empathy (or self-empathy in the case of women in abusive relationships), when as a result of trauma they have had this circuitry 'short circuited.' Stress creates a thinning of the pre-frontal cortex of the brain (Shansky et al., 2007), which suggests that this thinning would create a loss of mirror neurons as well. Sarah Lazar's (Lazar et al., 2005) ground-breaking research with men and women who practiced an average of 40 minutes of vipassana (mindfulness) meditation per day "suggest(s) that

meditation may be associated with structural changes in areas of the brain that are important for sensory, cognitive and emotional processing. The data further suggests that meditation may impact age-related declines in cortical structure" (p. 1896). One begins to see the importance of mindfulness meditation for not only the psychological or emotional amelioration of posttraumatic stress, but for neurophysiological change as well.

So there is some debate, understandably, not only about the possibility to teach empathy, and if it is possible, whether that possibility is limited by congenital or acquired brain injury (Farrow & Woodruff, 2007). Paul R. Fulton, writing in *Mindfulness and Psychotherapy* about the importance of empathy and compassion in the therapeutic relationship, feels there is a lack of 'compelling evidence' that empathy can be taught, and even if it can be taught, may fall short of 'true' empathy (Germer, Siegel, & Fulton, 2005). Also, Decety, Jackson and Brunet (2007) posit that while humans have evolved a biological predisposition towards empathy in order for the species to survive, parents must be able to read their offspring's distress, and that empathy is unlikely to develop without this and/or other social interaction.

So what is 'true' empathy? Can empathy be taught? Psychologist Carl Rogers (1961) defined empathy as being able to accurately understand another's world as seen from the inside, "to sense the client's private world as if it were your own, but without losing the 'as if' quality" (p. 284). As previously discussed, empathy contains elements of both cognition and affect, but it appears from the literature that paying attention to the development of affect rather than cognition may be the key to

teaching empathy. Some of the literature on teaching empathy focuses on training medical professionals, mainly nurses and doctors. In their research with nursing students who participated in an eight week MBSR program, Beddoe and Murphy (2004) state that in their review of the literature, strategies to foster empathy amongst nurses show that there are two main approaches to teaching empathy – from a cognitive perspective (focusing on the nature and importance of empathy), and from an interpersonal perspective (focusing on behaviour and communication skills). "Researchers have repeatedly found," she writes, "that empathic response leading to helping behaviour is more related to affect than to cognition. In addition, trained empathy (i.e. learned skills focusing on behaviour and communication) may deteriorate over time" (p. 306). Therefore researchers have suggested that instead of a skills training approach, empathy is better fostered through "the intrapersonal domain" – that is, understanding and dealing with emotions in relationship to self. Here is a glimpse once more of the important connection between empathy and self-compassion, that perhaps they are really all-of-a-piece.

So the question arises, could it be that as we cultivate one, we also cultivate the other? Daniel Siegel (2007a) says that "mindfulness (is) a form of internal attunement" (p. 164) and how important it is "for each of us to be attuned to our own internal states in order to attune to others. Here is where mindfulness,

empathy, and interoception[9] seem to overlap. Each may reinforce the other" (p. 168). Back to Fulton (2005) who, while musing whether or not empathy can be taught, seems to also come down on the side of cultivating a relationship with 'affect' rather than cognition. He argues "mindfulness practice may be the most potent method" (p. 63) for the cultivation of empathy, including self-empathy or self-compassion, because:

> . . . empathy towards others is the natural extension of the compassion toward oneself that is cultured in mindfulness practice ... Compassion for ourselves arises in the practice of opening to our own suffering (by offering us) a way to change our relationship to it by surrendering our need to reject it. This is an act of kindness to oneself. Our own suffering offers an opportunity to become openhearted rather than merely oppressed. . . . Compassion for others arises from the recognition that no one is exempt from suffering and that everyone wishes to be safe from it. In addition, as mindfulness begins to dissolve the artificial boundaries that define our separateness, we begin to experience our innate infinity with all beings. Compassion toward others becomes a natural expression of this growing perception of our interdependence. Finally the tradition of

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[9] Interoception is the ability to sense stimuli originating from inside your body. Mindfulness modalities incorporate exercises (e.g. yoga) to help participants tune into body-based sensations that arise from emotional and stress arousal.

mindfulness meditation contains a number of practices deliberately intended to enable compassion to grow." (p. 63)

So perhaps thinking about training or teaching empathy as a "skill" as we understand that word in our western cultural context, that is, learning how to "do" something - is not quite accurate. It may be better described as a capacity, an ability to "hold" ones thoughts and emotions and those of others non-judgmentally (i.e., without pushing them away as 'bad' or grabbing on to them because they are 'good'); to know the difference between another's feelings and your own (and yet how interconnected we are); and to respond wisely or 'skillfully'. In Buddhist philosophy 'skill' is understood differently than the western understanding of skill as 'how to do something'. In mindfulness practice, the ability to cultivate that which leads to love and awareness of our intrinsic interconnectedness is skillful. We are unskillful when we fall into ignorance or habits of mind and behaviour that reinforces our false sense of separation, which results in suffering (Kornfield, 1993).

In Buddhist practice, followers cultivate love and awareness through meditating with any one of the four *Brahma-viharas* (Pali for 'Heavenly Abodes') that include 'lovingkindness' (*metta* in Pali), compassion (*karuna*), empathetic joy (*mudita*), and equanimity (*uppekha*) (Kornfield, 1993). Each one of the *Brahma-viharas* is a meditation practice in its own right, but *metta* is more commonly practiced than the others. *Metta* practice is a way to train that capacity to be empathic and respond wisely. Sharon Salzberg (2002) explains that the Pali word *metta* has its roots in two meanings, one for 'gentle' and the other for 'friend' and

really captures the feeling of being open-heartedly friendly towards the present moment. When we engage in *metta* practice we build our heart's capacity to be present and to hold thoughts and emotions[10] without judgment. It is also a way to build our capacity to respond to others, or to build empathy. There is a finer distinction in the Buddhist philosophical literature than in the western medical and psychology literature on how we respond when we cultivate empathy – it is assumed, mostly, that the response is compassion. The Buddhist tradition agrees that compassion (*karuna*) is one response – when we encounter suffering. But when the open heart responds to someone else's good fortune, we respond generously with empathetic joy (*mudita*). And regardless of what we are responding to – be it suffering or good fortune - we hold it lightly, with equanimity (*uppekha*). It is also said that each Brahma-vihara contains the essence of the others, so if you practice lovingkindness it contains compassion, empathetic joy and equanimity as well. If we compare the philosophy of the Braham-viharas and the practice of *metta* with Carl Rogers' (1961) definition of empathy – the ability to feel another's feelings as if they were your own, without losing the 'as if' quality – it seemed plausible to me that *metta* would be an excellent way to build the capacity for 'true' empathy, and was therefore incorporated into the treatment modality.

Interestingly, *metta* or lovingkindness meditation, in the traditional Pali Canon, was created by the Buddha to help his monks calm their fear of ghosts and wild

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[10] The Buddhist tradition does not make a distinction between thoughts and emotions or the heart and mind but rather refers to it as '*chitta*' or heart/mind.

animals when meditating in the forest (Salzberg, 2002). The Buddha, 2500 years ago, intuited what science now knows about how compassion effects the chemistry of the brain, in other words, that oxytocin down-regulates the stress response (Wang, 2005). Oxytocin also helps us feel safer and more open to relationships of caring, an important factor in cultivating a therapeutic relationship for both the client (or clients if in a group modality) and the therapist, so that 'mutual recognition' and 'earned attachment' may arise in these 'corrective relationships' (Turner, 2009).

My personal mindfulness practice has been an essential part of building a stronger attention span and lovingkindness meditation in particular has enabled me to be more present, open, and compassionate with myself as well as the individuals and groups that I work with. Mindfulness has been likened to a 'technology' for therapists to cultivate therapeutic qualities: deep abiding presence, attention, listening, kindness, self-compassion, attunement, empathy, and emotional regulation (Shapiro & Carlson, 2009). "In light of the importance of the therapeutic relationship characterized by presence, warmth, trust, connection, and understanding of the client," write Shapiro and Carlson, "it is not surprising that a number of authors have suggested mindfulness as a common factor across all successful therapeutic encounters regardless of theoretical orientation ... and have recommended meditation training as a support to develop core clinical characteristics" (p. 18). Concepts in this passage are important to explicate as they are very relevant to this research, that is the idea of the therapeutic relationship and so-called 'common factors' in successful therapeutic encounters, and the nature of

change – or 'healing' - itself. The feminist therapeutic relationship is best understood as one of intersubjectivity, so what follows is an exploration of intersubjectivity, empathic agency and attachment theory. The chapter closes with a discussion of the nature of change and evidence-based practice.

Intersubjectivity, Empathic Agency and Attachment Theory

I return to the work of feminist moral philosopher Diana Meyers (1994). In the earliest of relationships, Meyers says the self is created through the process of mutual recognition between the parent and child, where the child learns through the modeling of the parent that one comes to know oneself through relationship with the other by successfully recognizing the other as separate, and by recognizing oneself as separate. The ability to recognize oneself and the other as separate beings but in relationship, or in a state of 'intersubjectivity', is key to developing an empathic self. Meyers says that when the young (child) self is created through mutual recognition by an empathic other, an empathic self emerges that is able to be a moral agent in the world because it recognizes itself and others in mutuality, sharing common experiences including experiences of suffering.

Meyers (1994) also posits that this empathic self can be compromised when the person has experienced oppression, but can be restored through the presence of empathic other – a therapist, a friend, or any trusted and empathic listening other. Meyers writes: "(t)o recognize one another, then, people must be capable of assessing the merits of social norms, and they must be capable of resisting these norms insofar as they prescribe domination and subordination and interfere with

mutual recognition. Independent moral subjectivity, that is, moral self-recognition, is required for mutual recognition" (p. 128). One must value oneself in order to truly value others, and to resist the objectification of others and self. Here again is that important link between empathy and self-compassion in healing the self. In relationships where abuse and violence dominate, a woman may become disconnected from relationships and social networks that reinforce recognition and validation of self and others. These women are often socially isolated, or at the very least not recognized as a valued subject by partners and sometimes their children as well.

Meyers' (1994) theory of intersubjectivity and empathic agency helps us understand how we internalize early caregiving relationships and is congruent with attachment theory. David Wallin, in *Attachment and Psychotherapy* (2007), explains that attachment theorist John Bowlby "understood that the primal nature of attachment as a motivational system is rooted in the infant's absolute need to maintain physical proximity to the caregiver, not just to promote emotional security but in fact to ensure the infant's survival" (p. 12). While physical proximity is important on its own, Bowlby realized the symbolic significance of the comforting availability of the caregiver – so it's not just about physical protection from danger, but also the availability of an "empathic other" to use the words of Diana Meyers (1994). Wallin (2007) suggests that Bowlby's research partner Mary Ainsworth developed this idea of an emotionally available other, and the importance of the quality of early communication between infant and caregiver on secure attachment.

Ainsworth developed the 'strange situation' where she observed the interactions between children and parents when children under the age of six are in a strange environment, at times interacting with strangers when the caregiver is absent. She was responsible for the concept of the 'secure base' that early caregivers represent for children, based on what a child's expectation might be of their caregiver given their past experiences of the caregiver's responses to their distress. This secure base allows a child to explore and expand her environment, because she has the secure knowledge that she has an accepting, reassuring and comforting other to return to when needed. These experiences and expectations of the empathic (or non-empathic) caregiver eventually gel and become mental maps or representations that Bowlby named "internal working models" or the model for the "self".

In the context of this research, the importance of attachment theory is that it helps us to understand how we learn (or have not learned) to be reflective, that is "thinking about feeling and feeling about thinking" (Wallin, 2007). Early attachment relationships imprint upon us the impression of how our emotions and we will be responded to. Those of us who have experienced secure attachment have the sense or internal assurance that when we turn to those we care about, our 'self' will be recognized and our emotions accepted and contained. When secure attachment has not been the foundation of our early years, the research of Mary Main showed that we can attain 'earned secure attachment' through the presence of "emotionally significant relationships with close friends, romantic partners, and/or therapists" (Siegel, 1999, cited in Wallin, 2007, p. 87) or to repeat Meyers' (1994) phrase,

'empathic others'. The therapeutic relationship provides trauma survivors with that secure base from which to explore their world, a container in which their emotions are accepted and contained. This model of self-in-relationship that is recognized, safe and modulated – or the 'earned secure attachment' - is that which will in time become the interior working model of self.

It seems reasonable to me that if we have 'earned secure attachment,' it might also be possible to "dis-earn" secure attachment as a result of abusive relationships, sexual violence, and in other situations of oppression. A review of literature on adult attachment patterns and individual psychotherapy concludes that adult attachment patterns "cannot be taken as a reliable measure of the person's childhood relationship to parents" (Daniel, 2006), which supports the idea that attachment styles or patterns have the potential to change both ways (earned and dis-earned) in adulthood. Recall that Meyers (1994) also argues that the empathic self can be compromised as a result of any 'oppressive social environment.' This is an important connection between the personal and the political – it elegantly points out, for example, what happens to women under patriarchy. It would explain how oppression undermines the loving work of early caregivers, adult friends and other 'empathic others' and how oppression (including interpersonal violence and abuse) can separate our relationship with ourselves, our ability to 'recognize' our 'self' and our ability to be in a truly empathic relationship with others. That being said, many of the women I interviewed did not have secure and loving beginnings as

children and so childhood attachment issues probably complicated their adult relationships, manifesting in a lack of clear boundaries and a distinct sense of self.

The idea that empathy requires clear boundaries (i.e., the ability to recognize oneself as distinct from others) is echoed in some of the classic definitions of empathy, especially Carl Rogers' notion of empathy within a therapeutic setting. Rogers called empathy the ability "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers, 1961, p. 284). In more technical language of clinical psychology, empathy involves primarily three parts: "an affective response to another person which often but not always, entails sharing that person's emotional state; a cognitive capacity to adopt the perspective of another person; some monitoring and self-regulatory mechanisms that keep track of the origins of the self and other feelings" (Decety, et al., 2007, pp. 239-260). It is important, as I discovered over the course of interviewing the participants for this research, to have a clear understanding of empathy, especially the third aspect of "keeping track of the origins of self and other feelings" or as Carl Rogers (1961) said, never losing the 'as if' quality. Many of the women I interviewed felt that being empathic was to their detriment because it made them too vulnerable to abuse, or too vulnerable to being emotionally overwhelmed. What they were actually telling me, I believe, is how their 'empathic self' that by Meyers' (1994) definition includes the ability to differentiate between the sense of 'self' and 'other,' had been compromised by gendered socialization/oppression, interpersonal violence and/or through early childhood attachment experiences.

When we are in survival mode, and under the social conditioning of gender stereotyping that constantly tells women to direct our attention and care towards others and not to expect any kind of 'recognition,' we soon lose the sense of who we are, indeed the boundaries of where we stop and where the other begins. The antidote is not to withdraw from relationships, because as we have seen, we 'know' our 'self' through relating. The idea then, it would seem, is to include our own 'self' in that relationship of caregiving. "Although we think of the skills needed for caregiving to be other-directed," writes Meyers (1994), "it is clear that they can also be used reflexively . . . people can nurture themselves . . . maturity shifts the burden of responsibility for pursuing these aims to the individual. To care for oneself, one must turn empathic and nurturing skills to the purposes of self-understanding, self-development, and self-validation" (p. 127).

I would add self-compassion to that list of purposes. Interestingly, if we were to apply Rogers' (1961) definition of empathy to the self, it would mean to be with one's own private world as if it were one's own, without losing the 'as if' quality. While this may seem untenable, it is precisely what I am suggesting. I think it is actually workable, because in mindfulness practice we create a stance from which we can observe thoughts and emotions non-judgmentally and – ultimately – without identifying our thoughts and emotions as our *self*. Mindfulness can train us in the skill of empathy, as illustrated by research with therapists, medical students and nurses to name a few of populations that have been studied (Aiken, 2006; Beddoe &

Murphy, 2004; Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Shapiro, Morrison, & Boker, 2004; Shapiro, et al., 2005; Stepien & Baernstein, 2006).

Ameliorating Effects of Self Compassion

The practice of lovingkindness and compassionate mind training were important pieces of the 'alternative' mindfulness therapy attended by some of the women in this study. I had recognized that survivors often either had trouble identifying emotions, or chose not to be with difficult thoughts and emotions because these overwhelm them. To use therapeutic language, they had problems with *affect regulation* and so, I hypothesized that mindfulness practice might help these women create a more neutral space that they controlled, from which difficult affective states could be observed and contained. I felt that the lovingkindness meditation and compassionate mind therapy had the potential to provide a practice where the survivor had permission and a model from which to respond compassionately to their own suffering through self-nurturing activities.

Empathy is a skill we can learn – or more accurately a capacity we can attain, and that the natural response to this recognition of suffering in oneself and others – according to Buddhist philosophy undergirding metta or lovingkindness practice - is *compassion* (His Holiness the Dalai Lama & Vreeland, 2001; Salzberg, 2002). This idea of self-nurturance has gained ground with a group of British psychologists who use a combination of evolutionary psychology, attachment theory, neurophysiology and mindfulness in a recent intervention for people with high levels of shame and self-criticism, referred to as Compassionate Mind Training (Gilbert & Proctor, 2006;

Lee, 2006). Evolutionary psychology, in my view, is an approach that needs to be used with some caution because of its materialist bias and reductionist tendencies, illustrated in statements such as that from pro-evolutionary psychologists Edelman and Tononi: "Darwinian principles of variation in populations and natural selection are sufficient. ... Being human in mind and brain appears clearly to be the result of an evolutionary process. The anthropological evidence emerging for the evolutionary origin of consciousness in humans further substantiates the notion that Darwin's is the most ideologically significant of all grand scientific theories" (cited in Beauregard & O'Leary, 2007, p. 120). However, used critically, it postulates some interesting theories that combine cognitive psychology and evolutionary biology, and tries to understand how the development of 'the mind' (our individual and social psychology) is influenced by biological factors that have evolved over the development of the human species to support our success in survival. Daniel Siegel (2010) makes the argument that the mind continues to evolve as it has in the past, and furthermore that we must continue to evolve our *consciousness* if we are to survive:

> The mind uses the brain to create itself. As patterns of energy and information flow are passed among people within a culture and across generations, it is the mind that is shaping brain growth within our evolving human societies. The good news about this perspective from science is that we can use an intentional attitude in our modern lives to actually change the course of cultural evolution in a positive

> direction. Cultivating mindsight in ourselves and in one another, we can nurture this inner knowing in our children and make it a way of being for the world. We can choose to advance the nature of the mind for the benefit of each of us now and for the future generations who will walk this earth, breathe this air, and live this life we call being human. (p. 261)

Psychoanalyst John Bowlby, considered by some to be a modern herald of evolutionary psychology (Crawford & Krebs, 2008), based his theory of attachment on the notion that early attachment behaviours were essential to the safety, survival, and well being of infants, and that caregivers[11] are supported biologically with attachment mechanisms that are sensitive and responsive to signals of care and affection. Gilbert and Proctor (2006) state that responses to these signals with care, warmth, and affection create an experience of safety for the infant that in turn impacts the infant's brain development. Such responses, which include physical stimuli such as stroking, voice tone, holding, facial expressions, and social support, activate neurohormones like oxytocin and other natural opioids that have a regulating or calming effect on emotions, as well as the immune and digestive systems, and alter pain thresholds. "Activation and maturation of this system" Gilbert and Proctor write, "are especially important in the first years of life, where a parent acts as a reassuring and soothing agent . . . In doing so the caregiver creates

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[11] Problematically, Bowlby actually singled out *mothers* making his theories unpopular with many feminists.

experiences and emotional memories of safeness, and enables the infants (and later children) to understand and feel safe with their own emotions . . . Such emotional memories, with their neurophysiological mediators, may then become available in times of stress" (p. 355). The authors posit that lack of maturation of this system due to parental neglect or abuse, as well as the possibility that threat systems in such children may be over stimulated, make children more sensitive to threat, less able to regulate their own emotions. As adults they may not have a memory base from which to draw for self-soothing. These children also become hyper-focused on others as sources of threat, and become highly self-critical. Self-criticism leads to shame, the feeling of never being good enough, of being to blame for not being loveable or worthy of love by their parent(s).

It follows that if, as an adult, you are in an abusive relationship of non-recognition, where there is a lack of affection and caring and constant threat to sense of self and safety, your threat (or sympathetic nervous) system would also be over stimulated, and you would develop self-critical thoughts and shame as well. This is supported by research conducted by Buchbinder and Eisikovits (2003) with 20 Jewish Israeli women. Their findings show that shame was prevalent in the narratives of these women, and suggest that shame becomes an obstacle in leaving the violence. In another study on domestic violence (Sharhabani-Arzy, Amir, & Swisa, 2005), self-criticism significantly increased the risk of post-traumatic stress disorder. This is not to say that staying in an abusive relationship is a result of some sort of cognitive distortion or maladaptive schema. Gilbert and Proctor (2006) see

this rather as a safety behaviour, especially when blaming others for their abusive behaviour is risky and may evoke further abuse or violence. Self-criticism, in their view as evolutionary psychologists, is about safety and protection, but paradoxically it can increase the sense of internal threat, and the individual is unable to self-soothe (regulate their own affect) and be compassionate to self when threat, whether internal or external, occurs.

Several therapies are now focusing on this important aspect of helping people develop affect regulation skills and self-compassion. Though not necessarily taught explicitly, self compassion is considered integral to the many mindfulness-based interventions such as Mindfulness Based Stress Reduction (Kabat-Zinn, 1990), Mindfulness-Based Cognitive Therapy (Segal, et al., 2002), Dialectical Behavioral Therapy (Fruzzetti & Levensky, 2000; Linehan, 1993; Marra, 2004), and Acceptance and Commitment Therapy (ACT) (Hayes, 2004). Some of these modalities (the ones that have 'mindfulness based' in their titles) are interventions that incorporate formal meditation practice done as homework, whereas the others incorporate 'informal' mindfulness or everyday wakeful attentional awareness, but not formal meditation practice. In traditional Buddhist training in the Brahma-viharas,[12] practitioners are taught meditation practices that focus explicitly on evoking empathy and emitting compassion. The importance of teaching self-compassion and skills for self-soothing are central to Compassionate Mind Training (CMT) because

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[12] Also known as Lojong or mind training in the Tibetan tradition (Kyabgon, 2007).

they can help create feelings of safeness, and reduce the sense of threat (Gilbert & Proctor, 2006). CMT is one of the modalities that does not teach formal meditation practice, but uses psychoeducation to teach people about safety behaviours, daily mindfulness and acceptance skills to help with containing difficult affect, and journaling and imagery to evoke thoughts and feelings of self-compassion, warmth and self-soothing. Gilbert explains:

> The key is to develop a new self-to-self relationship based on warmth, care and compassion for self, with compassionate insight into how one arrived at one's current position unintentionally. Our abilities to be self-compassionate (we explain) may be under-developed for various reasons related to earlier experiences, and the fact that we have been mostly trying to defend ourselves in various ways. When we are highly threat focused, warmth can be difficult, even frightening. Thus, in the first instance we are less interested in *how much* a person may believe in an alternative idea or thought about themselves but more on the felt warmth and reassurance of any alternative. **It is the affect generated in / with an alternative that is key, rather than logical reasoning per se.** (p. 362, emphasis added)

The importance of the affect generated, rather than the logic per se, is one of the approaches that distinguish mindfulness-based from traditional cognitive therapy. In mindfulness, thoughts and feelings are perceived, known and accepted for just what they are – thoughts and feelings. In traditional cognitive therapy, one is

encouraged by one's therapist to look for evidence that these cognitions or feelings are true - or not. In mindfulness, thoughts and feelings are just that – thoughts and feelings: not the necessarily the truth, and not 'us' (the self). However, it is also acknowledged that on some level, our minds (mainly the part of the brain called the amygdala, or the brain's threat detector), may perceive those thoughts and feelings as if they are real (e.g. an internal threat as an external threat), and the impact our perception of those events has on our physiology is real. Our stress response is stimulated by threat that is real or perceived, resulting in a hyperactivation of the sympathetic nervous system – the fight, flight or freeze reaction, the hypothalamic-pituitary adrenal (HPA) axis, cortisol and glucose release - and an underactivation of the parasympathetic nervous system – the seat of relaxation, positive emotions, attention and decision-making (Arnetz & Ekman, 2006). We do not have much choice in whether our amygdala perceives a threat or not, but we can learn to respond to it differently. Instead of arguing with ourselves over its 'realness' we can learn to be open to the experience with gentleness and self-compassion.

Through CMT, we can learn that when we are kind with ourselves when we react to threat or fear, this has a calming effect (Gilbert & Proctor, 2006). From a neurological viewpoint, this makes sense because we now know from brain imaging studies that when we engage in acts of compassion our bodies create a hormone called oxytocin, the neurochemical that is responsible for attachment behaviours. Oxytocin is an important down-regulator of the stress response, lowers blood pressure, lifts our mood and increases our pain threshold (Arnetz & Ekman, 2006;

Goleman, 2006). Self-compassion practices have physiological benefits even when they feel false or forced or perceived as 'nothing is happening'. Oxytocin lowers the stress response hormone cortisol, a hormone that destroys brain structure (Arnetz & Ekman, 2006; Britton, 2005).

When stress is chronic, a condition called hypercortisolimia occurs (Britton, 2005). Cortisol is neurotoxic, and atrophy can occur in areas of the brain where there are many glucocorticoid (cortisol) receptors, mainly the hippocampus and the prefrontal cortex. The hippocampus is responsible for processing emotions (Maté, 2008), learning, memory and decision making – so during an acute stress response we often cannot remember things. In folks who have experienced chronic stress, the hippocampus actually loses structure, in the worst case - as happens sometimes in severe depression and posttraumatic stress disorder – the hippocampus shrinks to such an extent that *functional Magnetic Resonance Imaging* (fMIRs) reveal holes where the hippocampus used to be (Britton, 2005). In this case, individuals have difficulty remembering specific events of their past, and may have an over-generalized 'gist' of their history, a phenomenon psychologists refer to as "narrative smoothing." They often also find it difficult to concentrate, learn new things or make simple choices. The prefrontal cortex, responsible for down-regulating the acute stress response, can lose its ability to do so as a result of chronic stress, so eventually the adrenals are exhausted, the immune system becomes disrupted resulting in frequent illness and allergies – and so the mind-body connection is obvious (Britton, 2005).

The good news is that several interventions can reverse this physiological damage. It used to be thought that we were born with all the brain cells we would ever get, but this has proven to be not true (Eriksson et al., 1998). Our brains have plasticity, and neuronal regrowth and dendritic branching can be and are encouraged through the use of anti-depressant medication (Healy, 1997), exercise and diet (Pinilla, 2006), cognitive therapy and other healing relationships (Liggan & Kay, 1999), and meditation (Lazar, et al., 2005). But interestingly, even before we knew about brain plasticity, even before MRIs and neuroscience, over 2500 years ago the Buddha understood the benefits of kindness and compassion on the self and others. As previously mentioned, the Buddhist literature explains that the Buddha taught lovingkindness meditation to his monks as an antidote to fear (Salzberg, 2002) so the Buddha understood from his own experience that compassion for self and others creates calmness, or to use medical terms, activates the parasympathetic nervous system (the seat of relaxation, positive emotions, attention and decision-making) and "down regulates" the HPA axis (Esch & Stefano, 2005).

How Therapy Works

Debate has carried on for decades among human service professionals (social workers, psychologists, psychotherapists, etc.) about how therapy works. The dialogue is basically between two camps: the 'evidence-based' or 'best practices' group, and the 'common factors' or the 'therapeutic relationship' group. The first group argues that evidence abounds to support specific protocols for specific populations, e.g. cognitive behavioural therapy for depression, exposure therapy for

phobias etc. The second group says there is also compelling data that shows that as long as there is a strong therapeutic alliance, all mainstream approaches work equally well for most clinical populations (Fraser & Solovey, 2007).

Shapiro and Carlson (2009), among others (Fraser & Solovey, 2007; Graybeal, 2007), cite the works of Michael Lambert and his colleagues (Lambert, 1986, 2005; Lambert, Shapiro, & Bergin, 1986) who have been studying the process and outcome of psychotherapies for over 20 years. Lambert's 1986 meta-analysis found that only 15% of outcome variance "is accounted for by specific techniques unique to the treatment modality" (Shapiro & Carlson, 2009, p. 17); approximately 30% of the variance is attributed to so-called 'common factors' or 'relationship-mediated variables' present in most therapeutic relationships.[13] Wampold's 2001 meta-analysis using more advanced statistical techniques calculated the variance attributable to modality (or evidence-based approach) at a mere 8% (cited in Graybeal, 2007, p. 517). Wampold believed that the connection between the amelioration of suffering and the modality used to treat it was very weak, and felt instead that it was the healing context that was most important, or "the therapist's and the client's belief in therapy, the relationship between the therapist and the client, the rationale for treatment, the actions consistent with the rationale, and the meaning that the client attributes to therapy" (cited in Fraser & Solovey, 2007, p. 11). This echoes Laura Brown's (2004) statement that feminist therapy is "highly

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[13] Placebo effect (15%), extra therapeutic factors such as a client's support systems and other environmental factors (40%), account for the remaining outcome variances.

theory-driven in that the therapist's theoretical framework and epistemology in approaching the treatment process, rather than any specific technique, are what are considered essential to making practice feminist" (p. 464), and highlights the importance of the collaborative relationship.

Clearly 'common factors,' including the therapeutic relationship, is indeed pivotal in the healing process, and the modality provides a kind of language or meaning-making vehicle that supports the relationship and the healing work. However, Fraser and Solovey (2007) argue it is folly to dismiss the modality as a mere vehicle or language when the large body of evidence shows that certain kinds of modalities work extremely well with some clinical populations. They challenge us to embrace both as correct. The 'highly effective' modalities they profile are all mindfulness-based modalities where a counter-intuitive approach to problem solving is often used. For example, in the case of anxiety, our clients' 'solution' to coping with feelings of fear or anxiety is to avoid sensory experiences and/or thoughts which trigger those affective states, a first order change model. When we employ mindfulness, we suggest to clients they move in closer to their feelings of fear, stay with it, be curious about it and watch what happens. This is not just a problem-solving technique, but a second-order change that creates a paradigm shift by helping the client change their relationship to their fear through mindful awareness. They argue that *change itself is the common ground* and when we change our perspective to see this, that the "emphasis shifts from what is instrumental for change (techniques, common factors), to the underlying nature of change..." (p. 14).

Fraser and Solovey submit, "that a unifying perspective on change unites all effective psychotherapy, (which is) *the second-order change model* (that) weaves through all effective therapies" (p. 15, their emphasis).

Fraser and Solovey (2007) explain that *first order change* is a rational and logical approach to problem solving. It is often quite effective, and does not always give rise to failure: if the light in your lamp goes out, you change the bulb and (if the new bulb is effective) the light comes back on. It is a problem solving approach that relies on our repertoire of familiar responses, and at its core lies a basic belief about how the world works; however, that does not always work very well for addressing emotional and psychological suffering. For example, a person assesses that there is a stressor or challenge, and chooses an action or solution. They may decide to do nothing, they may decide to change the situation or themselves in some way, or they may decide to deal with it by avoiding it. "If the action or solution works," Fraser and Solovey write, "life goes on until the next 'damn thing' presents itself" (p. 23). But what happens if, next time, the solution does not work? Often what happens is that the person tries to apply the same solution again. And again. The situation deteriorates, more of the same attempt at solution is applied, does not work, provoking escalations of attempts at solution ... until the "solution actually becomes a bigger problem than the original problem it was meant to solve" (p. 24). This vicious cycle is exemplified by a bird, trapped in a windowed vestibule, constantly flying forward and up, hitting the window, trying to get out. An onlooker would be able to see that the real solution was simple – do the opposite, fly backward and

down toward the open door at the bottom of the vestibule. In a clinical setting, we may encounter people who attempt to control social anxiety by avoiding people, only to find that their world becomes increasingly smaller and lonelier and depressing, so that they now are not only more anxious, but also depressed. "This misguided and repetitive attempt to achieve a change for the better, by whatever means, is the hallmark of first order change" (p. 28). First order change is change within a system that itself remains the same.

Second-order change comes from taking a different perspective. As in the example of the bird caught in the vestibule,[14] it requires a different understanding of the problem and requires a solution that, from a first-order change perspective, is actually counterintuitive, paradoxical or opposite to our usual repertoire of responses. It is transformative. It changes the system itself by changing assumptions, worldviews, beliefs, and habits of mind. This happens because the therapeutic relationship itself is an intervention:

> The purpose of the psychotherapeutic relationship is to produce change – second-order change. Second-order change is effected through the relationship. All actions that therapists take with clients involve the relationship. In many instances, the process of building the therapeutic relationship produces second-order change. In other

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[14] Or the braided finger trap – the 'normal' reaction is to pull your fingers apart in order to get free, but it only makes the trap tighter. The real solution requires second-order change, a counterintuitive act – pushing your fingers together – to be liberated.

> instances, therapists and clients use the relationship as a vehicle for developing specific intervention approaches. Intervention approaches are effective when clients transfer the power of consensual validation[15] to therapists. A prerequisite for transferring consensual validation is that the therapist establishes herself as understanding, trustworthy, caring and competent. These therapist characteristics are contextual and therefore defined by the client. (Fraser & Solovey, 2007, p. 108)

The basis for second order change, Fraser and Solovey (2007) argue, is the therapeutic relationship. The client, through joining with her therapist, can see a different way of being – as modeled by her therapist – as possible. All of this speaks to the importance of the 'corrective' relationship that occurs in therapy, and supports the notion of 'earned attachment' in the therapeutic relationship. It is this therapeutic relationship that I would argue is not only present between client and therapist, but between clients in a feminist group modality as well, as I have witnessed how "consensual validation" has been granted between group members and have witnessed how group members sometimes challenge each other on tightly-held assumptions, belief systems and worldviews that are non-validating or counter-productive at best, and self-destructive at worst. It is also strengths-based

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[15] Fraser and Solovey (2007) say "consensual validation emphasizes that a person's most significant experiences are social ones, and most attitudes and values can be validated by checking them against the behaviour and attitudes of other individuals, especially members or groups to which a person belongs, or aspires to belong. This social comparison process exerts strong pressure on individuals to harmonize their assumptive worlds with those persons important to them" (p. 78).

and client centered, as the selection of strategies and skills to address problems is a collaborative process between the client(s) and the therapist. The true marker of successful second-order change is when hope is restored, demonstrated when agentic thinking (I can do it) and pathways thinking (I know how to do it) are both activated. Clients are now able to approach problems in new ways and are moving in a direction opposite to when they first came into therapy.

This theoretical framework provided the base upon which I constructed the treatment modality the *Courage to Love.* The next chapter describes that process of integration and reflection, as well as the protocol for implementation.

Chapter 3: The Treatment Modality: Creating the *Courage to Love*

I was introduced to mindfulness, not in a Buddhist setting, but while working in a rape crisis centre in 1991. One of my colleagues was, and is, a practicing Buddhist, and in her role as counselling coordinator introduced us to meditation and mindful bodywork. I also discovered and read *Full Catastrophe Living* (Kabat-Zinn, 1990) in the organization's library. Some of the breathing and awareness techniques were integrated into our crisis intervention training as a way to ground and focus ourselves and the callers on the telephone crisis line. *Full Catastrophe Living* presented a full description and rationale for Mindfulness Based Stress Reduction (MBSR), an eight-week program established in the early 1980s by Jon Kabat-Zinn at the University of Massachusetts Medical Center. Patients at the 'stress clinic' as it came to be called, were people who wanted relief from stress for personal and medical reasons, but also because many were referred by their doctors who felt they had nothing more to offer them because of untreatable chronic pain and/or terminal illnesses.

MBSR was – and still is - the initiation to mindfulness for many westerners, but Kabat-Zinn (1990) was not the first western practitioner of mindfulness meditation. He was and is, however, largely responsible for making eastern philosophy and Buddhist psychology palatable and popular for western (especially American) audiences by adapting it for use in a medical setting, using medical language. As Joan Borysenko writes in the foreword to *Full Catastrophe Living*, "the

success of his program comes in part from its unique synthesis of East and West – of meditation and yoga with science and mainstream medicine – and in part out of Jon's gift for making meditation and science exciting and clearly relevant to our health and quality of our lives," (in Kabat-Zinn, 1990, p. xvii).

Kabat-Zinn (1994) defines mindfulness as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally . . . The key to this path, which lies at the root of Buddhism, Taoism, and yoga, and which we also find in the works of people like Emerson, Thoreau, and Whitman, and in Native American wisdom, is an appreciation for the present moment and the cultivation of an intimate relationship with it through a continual attending to it with care and discernment. It is the direct opposite of taking life for granted" (1994, p. 5). Kabat-Zinn, and MBSR teachers that followed, approach teaching 'attending' with care and discernment in a variety of ways. Anyone who has ever heard of MBSR will likely also have heard about the famous 'raisin exercise,' an initiation into the eight week MBSR program that is not a meditation-based exercise per se, although some might call it eating meditation. Participants are guided through a slowly-paced process where they mindfully examine a raisin as if they have never seen it before, place it in the mouth, chew slowly and swallow, being fully present to the sensations, thoughts and feelings that arise.

It is a powerful reminder of our tendency to do everyday activities like eating while on 'automatic pilot' in contrast with the experience of really paying attention to what is at hand right here, right now. It is also a powerful illustration of the

importance of grounding ourselves in the body, and that we can only truly be in touch with the present moment by coming home to our senses (Kabat-Zinn, 2005). These lessons are important for us all, especially those of us who tend to 'zone out' rather than be with our thoughts, our body sensations and emotions, which tends to include the majority of survivors of abuse and violence. This is why yoga and/or other body-based practices like Tai Chi are integrated into MBSR and other mindfulness meditation-based modalities. Through mindful attention to body movement, which takes the form of very slowed-down yoga in MBSR, our body-centred practice and breathing become the focus of our attention and awareness. Appreciation of the body as a door into the emotions is discussed in class, and for many MBSR learners the yoga practice is one that remains the most important practice that they will continue after the eight week program is finished (Baer, 2003).

After the raisin exercise, to reinforce the importance of the body as the ground and anchor of our meditation practice, students are introduced to the Body Scan, a formal meditation practice done lying down. The guided meditation practice lasts about 40 minutes, and after this and every meditation practice, there is an opportunity for 'practice inquiry' where the teacher invites meditators, using Socratic questioning, to make observations about their practice and in turn to ask the teacher questions. Invariably students fall asleep during the body scan, feel embarrassed (especially if they snored), and generally lament about how impossible it is to keep their attention focused. The response of the teacher models kindness

and compassion: e.g. *'It's not unusual for people to fall asleep; notice how tired you are . . . the mind wanders, that's the nature of the mind; and when it wanders just notice where it has gone, and gently and caringly come back to the body, come back to the breath.'* The notion of compassion, especially self-compassion, is implicit and integral to the teaching and learning of mindfulness meditation. It is only much later in the eight week program, usually during the Day of Mindfulness retreat between week six and seven, that students are given an introduction to lovingkindness meditation, where the intentional practice of compassion for self and all beings becomes more explicit.

The two and a half to three hour weekly sessions are only a very small part of the commitment that MBSR students are asked to make. Each week they are assigned homework, consisting of about 30 to 40 minutes of formal meditation practice with the help of audio recordings, a written assignment and a challenge to find a way to bring mindfulness into everyday life by, for example, walking the dog or taking a shower *mindfully*, paying attention on purpose, in the present moment, and non-judgmentally. Because of this high commitment to time I conduct a basic screening with potential participants that is similar to motivational interviewing. I believe that stating ones intention towards making significant change in our habits and routine and an acknowledgement of the great effort that change involves, improves the chances of success. However in spite of this approach taken by myself and other MBSR teachers, the drop out rate is quite high, about 15-20%. This may not be the fault of the MBSR modality per se, as a randomized trial of cognitive-

behavioural therapy (CBT) with women with child sexual abuse (CSA) related post traumatic stress disorder (PTSD) had a significantly greater drop-out rate than a 'problem-solving' or present-centred therapy (McDonagh et al., 2005). The authors speculate, "building and strengthening of personal and interpersonal problem-solving skills can address many of the fundamental problems in psycho-social functioning that are endemic to CSA-related PTSD" (p. 522). MBSR has many features of CBT approaches, and this is where I believe it can be informed by feminist approaches that are more narrative based and provide more interaction among and between group members that help to build 'personal and interpersonal problem solving skills' recommended by McDonagh and colleagues (2005).

The mindfulness-based program is psycho-educational in nature, and so any kind of sharing in the group setting is completely voluntary, in contrast to a therapeutic group where sharing of thoughts and feelings is expected. Therefore the screening process also gives me a chance to offer my encouragement and support, to answer any questions or fears the participant may have, and to allow her or him to disclose any information about themselves that they feel might be useful or helpful for me to know. It also gives me a chance to talk to the participant and assess their general mental health especially in regards to their ability to be present in the moment, to focus their attention and if they are comfortable closing their eyes. The developers of MBCT (Segal, Williams and Teasdale) recommend that participants with severe depression or dissociative tendencies wait until their symptoms are not so severe before taking a meditation-based program (Segal, et al., 2002). I explained

to participants that it was not because they were not suitable for the program but rather that they would not get the full benefit of the program until they were able to manage some present moment awareness and attentional focus.

In preparation for this research a much more formal screening was done with the women for this reason. The Beck Depression Inventory (Beck & Steer, 1987) and the Dissociative Experiences Scale (Carlson et al., 1993) were administered to each woman in the mindfulness-based group (*Courage to Love*) as both a criteria for joining the group, and also for being a research subject. The participants in the non-research group (*Woman Abuse Group*) were also tested using these scales to screen them for the research, but the screening did not affect their group participation since I was not responsible for the intake for this community-based program. I will return with more detail about the screening process in the methodology chapter.

MBSR and subsequent mindfulness-based modalities such as Mindfulness Based Cognitive Therapy (MBCT) involve both concentration (samatha) and insight (vipassana) meditation practices. The first pillar – samatha or concentration practices - are important for steadying the mind and training the mind to focus and concentrate and when experienced, result in a feeling of calmness and well-being (Rahula, 1974). Research has also illustrated the medical effects of concentration practices including lowered blood pressure (Leserman et al., 1989), insomnia relief (Jacobs, Benson, & Friedman, 1996) and ease of post-operative pain for heart patients (Miller & Perry, 1990). Concentration practice pre-dates Buddhism, but is

considered an important training and support for the second pillar of mindfulness, vipassana or insight meditation. Rahula (1974) reports that the Buddha "discovered the other form of meditation known as vipasanna ... 'Insight' into the nature of things, leading to the complete liberation of mind ... It is an analytical method based on mindfulness, awareness, vigilance, observation," (pp. 68-69). So important was this teaching on mental development or meditation, the Buddha gave an important discourse on the Four Foundations of Mindfulness known as the Satipatthana sutta, which is recited in Buddhist monasteries and the homes of devoted Buddhist families. These foundations are awareness of the body and senses, awareness of the heart and feelings, awareness of the mind and thoughts, and awareness of the principles that govern life (Kornfield, 1993). MBSR and MBCT also incorporate these foundations into its programs, but as mentioned, does so without any reference to Buddhism, as illustrated by the core aims of the MBCT program:

- To help people who have suffered from depression in the past to learn skills to prevent depression from coming back
- To become more aware of bodily sensations, feelings and thoughts, moment to moment
- To help patients develop a different way of relating to sensations, thoughts and feelings – specifically acceptance and acknowledgement of unwanted feelings and thoughts, rather than habitual, automatic, preprogrammed routines that tend to perpetuate difficulties

- To help patients be able to choose the most skillful response to any unpleasant thoughts, feelings or situations they meet (Segal, et al., 2002, p. 86).

The MBCT program as designed by Segal, Williams and Teasdale is contained in their book *Mindfulness Based Cognitive Therapy for Depression: A new approach to preventing relapse* (2002). This book served as a training manual when I took the MBCT training with Dr. Segal and his team in 2006, which followed the MBSR training I did with Jon Kabat-Zinn (1990) a month earlier. Both modalities are very similar. MBCT was fashioned after MBSR and in consultation with Kabat-Zinn, but focuses mainly on depression and the prevention of relapse, and does not feature the day-long 'Day of Mindfulness' that is a part of the MBSR program. It is during the Day of Mindfulness that MBSR participants are introduced to lovingkindness meditation, so in the MBCT program there is no specific self-compassion practice taught. I find the fact that this important practice is taught only once in MBSR and not at all in MBCT very curious, and others have questioned this as well. When Kabat-Zinn was queried as to why this was so in MBSR, his response was that he feels that lovingkindness and compassion are communicated throughout the teaching of MBSR, so to make it more explicit than the addition of lovingkindness practice in the Day of Mindfulness, in his mind, is really not necessary. His concern also was that new students may be confused given the emphasis on the non-striving and non-doing aspect of mindfulness, and also by "throwing too many new things at them in a short period of time" (Kabat-Zinn, 1990, p. 286). Coming out of the

experience of creating and facilitating the mindfulness group for the purposes of this study, I tend to agree that introducing a lot of different practices to new meditators in a short period of time has a down side – Kabat-Zinn says it's like trying all the various doors to a building and not spending any time inside. In retrospect, when conducting the *Courage to Love Program* in the future, increasing the group length to ten or twelve weeks would be recommended for this reason.

So what exactly is lovingkindness meditation – what does one do, how does one do it and why? Western Buddhist teacher, Sharon Salzberg, says "'to reteach a thing its loveliness' is the nature of metta (lovingkindness)" (Kinell, 2002, cited in Salzberg, 2002, p. 18). Lovingkindness (*metta* in Pali, the language of the Buddha) is one of the Four *Brahma-viharas* or translated from Pali, the Four 'Heavenly Abodes,' the other three being compassion (*karuna*), sympathetic joy (*mudita*) and equanimity (*uppekha*). Each one of these is a separate practice of its own, but each one contains elements of the others as well. The Buddha taught these practices as a path that leads to liberation, an "integrated path that moves the heart out of isolating contraction into true connection" (p. 1). Salsburg (2002) explains:

> Spiritual practice, by uprooting our personal mythologies of isolation, uncovers the radiant, joyful heart within each of us and manifests this radiance to the world. We find, beneath the wounding concepts of separation, a connection both to ourselves and to all beings. We find a source of great happiness that is beyond concepts and beyond convention. Freeing ourselves from the illusion of separation allows

> us to live in a natural freedom rather than be driven by preconceptions about our own boundaries and limitations. (p. 1)

The teaching of lovingkindness meditation has a traditional trajectory that starts with guiding students to silently repeat four basic and adaptable phrases of kindness – for example, *May you be happy and free from suffering, May you be healthy and in touch with your wholeness, May you be safe from inner and outer harm, May you live your life with ease* - starting with the self (*May I be happy* etc.). However, teaching the practice of lovingkindness mediation to a Western audience can be challenging since many, maybe most, are socialized to be independent (DeCicco & Stroink, 2007). It is also a sad fact that many Western beginning meditators are filled with self-loathing and low self-esteem, so much so that it took the Dalai Lama several attempts with his translator to understand what was meant by 'low self esteem' as this concept is mostly absent from Tibetan meditation pupils (Germer, et al., 2005). Therefore, we often start the practice by directing lovingkindness to another for whom we have positive feelings because it is often easier to generate warm feelings for others than for ourselves. I have also had feedback from women that this practice feels fake or insincere to them. However in spite of these feelings both Salzberg (2002) and Kabat-Zinn (1990) insist that it is the intention (the inclination of the mind towards lovingkindness) that is important to realize the positive healing effects of this practice:

> I always thought (lovingkindness meditation) was a little strange and contrived until I saw the power it held. When practiced regularly,

> lovingkindness meditation has a softening effect on the heart. It can help you to be kinder to yourself and to others in your own mind, to see all beings as deserving of kindness and compassion, so that, even if disputes do arise, your mind can see clearly and your heart does not close down and become lost in self-serving yet ultimately self-destructive negative feeling states. (p. 184)

This is another reason why I am quite stymied by the absence or lack of emphasis on lovingkindness meditation in MBSR and MBCT, so I, like some other Western teachers, have integrated this practice more intentionally into my MBSR/MBCT classes and decided that this is a key aspect of healing not only our Western "trance of unworthiness" (Brach, 2003), but to heal the self after the trauma of interpersonal violence.

This is the background to the *Courage to Love* treatment modality created to teach self-compassion practices to women who have had their sense of 'self' shattered by violence, abuse and other trauma. Principally based on MBSR and MBCT with an extra infusion of lovingkindness practice, supported by some ideas and exercises gleaned from Compassionate Mind Training (Gilbert & Proctor, 2006) and The Perfect Nurturer modality developed by Deborah Lee (2006). The decision to include these exercises was based on the MBSR / MBCT model (and predated by cognitive-behavioural therapy and psychoeducational group models) of weekly group work supported by individual homework. Gilbert and Proctor (2006), and Lee (2006), included examples of homework activities for working with people with

high shame and self-loathing resulting from traumatic childhood experiences in their publications. The final *Courage to Love* modality is outlined in the week-by-week chart that follows (Table 1). The 'Theme' category describes the didactic component for that week, the 'Agenda' describes the mindfulness-based activities (e.g. guided meditation, yoga, art), and 'Handouts and Homework' are the activities and reading that the participant engages in between group sessions (see Appendices D through F for example handouts from the modality).

Table 1 *Courage to Love* Group Agenda

Week	Theme	Agenda	Handouts & Homework
1	Automatic Pilot	Raisin exercise Introduction to mindfulness Yoga/Body scan	Body scan, mindful daily activity (CD1 Body Scan)
2	Barriers to Practice "Thoughts are not facts"	Yoga/Body scan Dealing with Barriers "Thoughts and Feelings" exercise Mindfulness of Breath Meditation	Body scan, Pleasant Event calendar (CD2 Sitting Meditations)
3	Mindfulness of Breath & Body	Awareness of hearing – using focused awareness Sitting – breath & body Working with unpleasant body sensations	Sitting, Unpleasant Events calendar
4	Stress Reactivity & Safety Seeking	Yoga/Walking Meditation Sitting Meditation – Mindscape Working with the 'thought stream' W. Britton video	Sitting/Yoga/Walking (CD3 Yoga) Reflection exercise on historical influences that trigger threat and self-criticism (threat conditioning)
5	"Letting Be" Staying with Difficult Emotions	Yoga/Sitting - Mountain Working with difficult emotions "The Guesthouse"	Sitting Guided & Unguided (CD4 Silence with bells) Journal: Compassionate reframing
6	Using Compassion to Change our Minds	Yoga / Lovingkindness meditation Building a compassionate image in the heart/mind	Sitting (CD5 Metta & Mountain) Journal: More compassionate reframing with the perfect nurturer
7	Building Self-Compassion	Yoga/Lovingkindness mediation Compassionate imagery – Art as meditation	Create your own practice configuration Journal: Consequences of Becoming a Compassionate Self
8	Living a Compassionate Life	Yoga/ Body scan /Walking metta Stating Intentions for Future Practice Compassionate Affirmations	The rest of your life: Stick with your intentions for practice!

As a point of comparison, the community-based *Woman Abuse Group* is advertised on the agency's website:

> Support groups offer a place for women to break isolation, to help develop support networks, to identify and explore options and to place abuse in a societal rather than an individual context. The Support Group offers a place for women to share experiences with other women who have been abused. The goal of support groups is education and support, to encourage self-confidence, and enhance decision-making capacity. Women who attend the group may have left an abusive relationship or can still be with their partner.
>
> The Support Groups are held once a week for 12 to 14 weeks. The following issues are covered:

- What is abuse?
- Impact of abuse for women and children
- Personal safety and safety planning
- Warning signs for future relationships
- Developing a life plan

(Family Services Ottawa, n.d.)

Therefore with what I thought was a sound theoretical framework for working with women with trauma, I was curious to discover what *was* the connection between empathy and self compassion, and what effect if any this empathy and self compassion connection might have on healing using a

mindfulness-based modality compared to a well-established feminist community-based women's group. What would the women and their data have to teach me? The following two chapters present the data gathered and analyzed from this process.

Chapter 4: Quantitative Methods

Feminist Research Methodology

Sociologist Marjorie DeVault (1999) says that we should "distinguish between 'methods' (i.e. particular tools for research), 'methodology' (theorizing about research practice) and 'epistemology' (the study of how and what we can know). For the most part feminist researchers have modified, rather than invented, research methods; however, feminist researchers have produced a distinctive body of writing about research practice and epistemology, and that is where I locate 'feminist methodology'" (p. 28). The 'feminist methodology' for this research is rooted in the theoretical framework presented earlier, much the same way that Laura Brown (2004) has said that 'good' feminist trauma therapy is driven by the therapist's theoretical framework and epistemology. I would argue feminist research has many of the same characteristics of 'good' feminist trauma therapy as well, in that it is critical, reflective, relational, and a tool for empowerment.

For this study I chose a mixed-methods approach. According to Mertens (2005), mixed methods designs are most commonly rooted in pragmatism and "rarely, if ever, consciously rooted in philosophical assumptions or beliefs" (p. 294). Pragmatic researchers reject an either-or choice between post-positivist and constructivist paradigms and consider mainly 'what works?' Mertens contrasts the 'pragmatic' design with a transformative or emancipatory paradigm that de-

emphasizes the researcher's values and emphasizes the inclusion of the viewpoints and values, especially of marginalized populations, leading to social change both at the personal and political level. It not only considers the question of 'what works?' but also 'works for whom?' noting that pragmatism may lead us to serve the ends of policy makers and clients. It is better, she says, that "(research) should be premised on higher social goals than being useful to those in power" (House and Howe, 1999, cited in Mertens, 2005, p. 295). The mixed methods design that was used in this research fits with Mertens' transformative or emancipatory paradigm, which in turn is congruent with feminist epistemologies that are comfortable with integrating modernist and postmodernist models of 'self' that are reflective, critical and liberating. This chapter contains the quantitative methods used in this study, and is followed by the qualitative methods in a separate chapter.

Quantitative Methods: Phase One

What is the connection between self-compassion and empathy?

In the previous chapter the literature review suggested the importance of empathy and compassionate nurturing in early childhood by caregivers and how this early attachment relationship is internalized to become our interior working model of self. Empathic recognition (I feel you, I see you, and I respond to your suffering) by a primary caregiver – or a significant other in an adult relationship – gives human beings the sense of self as distinct and valued, yet in-relationship. This internalized relationship, in turn, gives this securely attached self the ability to recognize, value and empathize with others and with self, or to become a 'moral

agent' in our interior and exterior world (Meyers, 1994). We become moral agents through compassionate responding to suffering, our own and others. This is subject-in-relationship or intersubjectivity through developing empathy and self-compassion and is the path we need to take to reclaim or heal our sense of 'self' post trauma. So the link between empathy and self-compassion seemed clear, and even an old idea as major religions have taught for millennia that 'to love others, one must love oneself'. However, I could not find evidence that this link between empathy and self-compassion had been measured or tested scientifically. The closest study is one that correlates a high empathy score with a greater likelihood to forgive others, but not necessarily to forgive oneself (Macaskill, Maltby, & Day, 2002). While self-forgiveness may be a component or characteristic of self-compassion, it does not fully define the meaning of self-compassion. Neff (2003a) writes that self-compassion:

> ...entails three components: 1) extending kindness and understanding to oneself rather than harsh self-judgment; 2) seeing one's experiences as part of the larger human experience rather than as separating and isolating; and 3) holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them. These aspects of self-compassion are experienced differently and conceptually distinct, but they also tend to engender one another (p. 225).

A convenience sample of students was recruited through local universities. I utilized two user-friendly and psychometrically sound surveys to measure self-compassion and empathy. The Self-Compassion Scale (SCS), is a 26-item, self-report measure created by Kristin Neff (2003a). The scale yields a single score for self-compassion, as well as six subscale scores: three positively-scored scales for self-kindness, common humanity, and mindfulness; and three negatively scored scales for self-judgment, isolation, and over-identification. Cronbach's alpha coefficient for the overall scale was .92; test-retest reliability coefficient for the overall scale was .93 (Neff, 2003a). The Balanced Emotional Empathy Scale (BEES) is a 30-item, self-report scale created by Mehrabian and Epstein (1972), comprised of 15 positively-worded and 15 negatively-worded questions, which yields a single score. The BEES has good internal consistency (alpha is .87); test-retest reliability coefficient for the scale was .77 (Mehrabian, 2000).

Based on my theoretical framework, including the few studies that have been made (directly and indirectly) on self-compassion and empathy (Shanafelt, 2005; Steckal, 1994), I hypothesized that there should be a positive correlation between self-compassion and empathy in the general population. It made sense to me that given the feminist, psychological and philosophical understandings of how we develop our sense of self in an empathic relationship of mutual recognition (Meyers, 1994), and how this empathic, secure attachment relationship becomes our interior working model of self (Wallin, 2007), our recognition of self and self compassion (self empathy) should develop in step with 'other-empathy.'

Self-compassion as a therapeutically-related concept has not had much exploration in the literature until recently, most notably with the work of Kristin Neff (Neff, 2003a, 2003b, 2004, 2009; Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). Self esteem has been deemed a more important concept in understanding psychological well-being, but as Neff (2003b) points out, self-esteem is more related to ideas of how good one is compared to a set of internalized social standards and is inherently problematic. I would add self-esteem is especially problematic for women who are constantly reminded that we do not measure up to oppressive, gendered, and socially constructed standards.

Neff (2003b) defines self-compassion as a healthy self-attitude, and is more closely related to compassion in general. Compassion, as described by Neff, is a non-judgmental awareness of the presence of pain or suffering in others, and the ability to be present to that pain or suffering without avoiding the experience or shutting down one's emotions. It is accompanied by a desire to alleviate the other's pain or suffering, remembering Goleman's (2006) explanations of the closeness of motor neurons to mirror neurons in the brain, with the understanding that suffering is a human condition that we all share. Therefore, Neff (2003b) concludes, self-compassion has three main components, which she used to operationalize self-compassion in her psychometric survey:

> (a) self-kindness—being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical, (b) common humanity—perceiving one's experiences as part of the larger

> human experience rather than seeing them as separating and isolating, and (c) mindfulness—holding painful thoughts and feelings in balanced awareness rather than over-identifying with them. (p. 85)

Neff (2004) argues for the important role mindfulness plays in self compassion; that it allows a nonjudgmental distance or stance that allows for less self-criticism and more self-kindness, and allows a balanced perspective-taking that enables us to see our interconnectedness with all humanity and lessens a sense of social isolation. She argues that the reverse is also true – that an increased sense of interconnectedness and self kindness can further increase mindfulness, an increased awareness of our own thoughts and emotions. This latter ability – to increase awareness of thoughts and emotions leads to greater affect regulation, an important life skill the lack of which being one of the main reasons people seek therapy (p. 91).

The Self Compassion Scale is a 26-item scale that contains within it six subscales, which measure the positive attributes of self compassion already named above, for example self-kindness (5 items), common humanity (4 items) and mindfulness (4 items); and measures the 'mirror' negative attributes present in people with low self-compassion, for example, self-judgment (5 items), isolation (4 items), and over-identification (4 items). The results coming out of the development and testing of the Self Compassion Scale (SCS) (Neff, 2003a) show that self compassion is significantly correlated with positive mental health outcomes including less anxiety and depression as well as greater life satisfaction.

The other psychometric test used was the Balanced Emotional Empathy Scale (BEES) (Mehrabian & Epstein, 1972). Scales to measure empathy, and the concept of empathy and its connection to mental well/illness are more researched (Caruso & Mayer, 1998; Chlopan, McCain, Carbonell, & Hagen, 1985; Davis, 1983; Farrow & Woodruff, 2007; Hogan, 1969; Jolliffe & Farrington, 2006; Mehrabian, Young, & Sato, 1988 ; Schuster, 1979). Before the development of Mehrabian's (1972, 2000) BEES, scales had mostly been developed to measure the predictive accuracy of another person's thoughts, feelings and actions, or "levels of cognitive social insight" also referred to as role taking (Mehrabian, 2000, p. 525). More recently Mehrabian and others have understood empathy as an affective experience of another's emotional state. Chlopan et al. (1985) in their review of measures of empathy, observed that most measures are either of the cognitive/role taking type, or the emotional/vicarious arousal type. As they remark in their review, the choice of definition has a profound effect on the operationalization of empathy for testing purposes. The Hogan Scale (Hogan, 1969), for example, stems from the cognitive position of predictive accuracy, whereas the BEES (Mehrabian, 2000) is from an emotional arousal perspective. An effort was made to find a scale that combined the two stems, such as the Basic Empathy Scale (Jolliffe & Farrington, 2006), but the actual tool was not available. I chose to use the BEES (Mehrabian, 2000) as it is a widely used and validated instrument, and is congruent with Beddoe and Murphy (2004) who, if you recall, said "researchers have repeatedly found that empathic response leading to helping behaviour is more related to affect than to cognition" (p.

306). Therefore, researchers have suggested that instead of a skills training approach, empathy is better fostered through the intrapersonal domain. Based on this recommendation I felt that measuring affect was more important than measuring cognition in determining the benefits of the group modalities for increasing empathy, which made the BEES (Mehrabian, 2000) a logical choice.

Phase One participants were recruited from two Ottawa universities over a three-month period. Three talks were presented to undergraduate classes introducing the research study and they were encouraged to share the information and research flyers (Appendix A) with friends. After the initial collection of data from the undergraduate students and after filtering for gender (n=49), I noticed that the ages of the female students were very close in range (M=21.38 years, SD=6.04). I purposely broadened my recruitment strategy from targeting just undergraduate university populations to include a large graduate university class and their friends and relatives in an effort to expand the age and maturity range of the participants. This decision was supported by Neff (2003b) who concluded from the developmental literature that it is "likely that adolescence is the period of life in which self-compassion is the lowest" (p. 95), perhaps because this is a period of their lives when peer pressure and peer/self judgment is so present. By broadening the recruitment strategy the resulting sample (n=92), the mean age was increased (M= 29.65 years, SD=12.37).

Both psychometric scales were uploaded on-line through an internet-based service (Survey Monkey), which allowed respondents to reply anonymously. Since

my targeted research population was with women, I used only female respondents' data; most of the respondents were female since the classes from which I recruited were in female-dominated areas of study (e.g. social work, woman studies). The gender filter is important for both psychometrics. As one might expect, women "tend to be generally more emotionally empathic than men" (Mehrabian, 2000, p. 3). On the other hand, the Neff (2003a) found that women generally had lower self-compassion than men, and scored significantly higher levels of self-judgment, isolation and over-identification and significantly lower levels of mindfulness. Self-judgment, isolation, over-identification and mindfulness are four of six subscales in the SCS – the other two are self-kindness and common humanity. "Interestingly, women were not less likely than men to be kind and gentle to themselves, or, to see their experiences as part of common humanity. Given social norms requiring males to be tough and independent (Deaux & Kite, 1993), perhaps it is not surprising that males do not evidence a greater sense of kindness and connectedness in their self-attitudes than women" (Neff, 2003a, p. 235).

Results

Phase One raw data were collected from the on-line survey site and entered into IBM SPSS Statistics Version 19 for statistical analyses. After deleting data from incomplete surveys and filtering for gender, the resulting number of female university-based respondents totalled 92. Pearson correlation coefficient was the statistic used to analyze the respondents' scores from the Neff (2004) Self Compassion Scale and Mehrabian's (2000) Balanced Emotional Empathy Scale

(BEES), using a significance level of .05. As expected, there was a significant positive correlation between the self-compassion and empathy scores (r = +.234, n = 92, p =.013, one tailed). The Pearson correlation coefficient was also used to analyze the relationship between the two scales and the ages of the participants. There were significant and positive correlations between empathy and age (r=+.280, n=82, p=.011. one-tailed) and self-compassion and age (r=+.560, n=82, p=.000, one-tailed).

Discussion

The correlation between empathy and self-compassion scores is considered weak since it is less than .24 (Cohen, 1992). A larger sample would likely have produced a stronger result, but this was not feasible under the time constraints. However, given the significant Pearson product moment coefficient, exploring the relationship between self-compassion and empathy is warranted. The importance of empathy and self-compassion, it has been argued, is essential for healing or reconstrual of 'self' post-trauma (Brison, 2002; Gilbert & Proctor, 2006; Meyers, 1994; Wallin, 2007). Therefore, Phase Two of this study was conducted to examine if a self-compassion focused mindfulness-based modality would help women increase their empathy and self-compassion.

The findings also show that empathy and age are positively correlated, as are self-compassion and age, suggesting that as we age and gain life experience and perspective, we regard ourselves and others more kindly. It also suggested me that I needed to be aware of age as a possible confounding variable when looking at the

ages of participants in the 'Phase Two' comparison groups, especially if the mean age of one group was significantly higher than the other.

Quantitative Method: Phase Two

Does a self-compassion focused mindfulness modality increase trauma survivors' empathy and self-compassion?

Phase Two of the research involved an exploration of another level of the relationship between empathy and self-compassion. In this phase of the research I was attempting to assess if a mindfulness-based intervention focusing on self-compassion training is an effective modality to help women increase affective empathy. Research tells us that empathy is a skill that can be learned (Keefe, 1976; Shapiro, et al., 2004) as is self-compassion (Gilbert, 2005). Even though one cannot assume causality given the positive correlation between self-compassion and empathy, the ability to be self-compassionate may be a key factor in reclaiming or developing the skills of empathy, or vice versa, remembering the importance of empathy and self compassion for reclaiming ones 'self' post-trauma.

I was curious to find out if a mindfulness-based group intervention incorporating 'lovingkindness' or metta meditation might increase measures of empathy and self compassion, compared to an established feminist-based, (non-meditating) women's group in the community. It is hypothesized that this might be the case. This second phase used mixed methods: pre- and post-group psychometric measures of self-compassion and empathy (those used in Phase One of this

research) and personal interviews[16]. Psychometric scores of women attending a well-established *Woman Abuse Group* offered by a community agency were compared to the score of women attending an alternative treatment modality called the *Courage to Love* described in the previous chapter, based on MBSR (Kabat-Zinn, 1990) and MBCT (Segal, et al., 2002) with an additional infusion of lovingkindness meditation, and selected modules and practices based on Compassionate Mind Training (Gilbert & Proctor, 2006; Lee, 2006).

Phase Two was a quasi-experimental, non-equivalent group design. Mertens (2005) remarks that this design resembles the pretest-posttest control group design, where the experimental group receives the treatment and the control group receives either no treatment or an alternative treatment, and that the pretest measures establish if the two groups differ significantly on the dependent variables; in this case, those dependent variables are empathy and self-compassion. Where this design differs from the standard experimental design is in the random assignment of the participants to the group modalities. I was not able to randomly assign participants to the groups studied because the 'control' (or comparison) group was a well-established, twelve week *Woman Abuse Group* (WAG) specifically for women who are, or have been, in an abusive intimate relationship of some length. Usually this means conjugal same-sex or heterosexual relationships, but can include abusive dating relationships as well. The 'experimental' (or treatment) group the

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[16] The details of the qualitative research follows in the next chapter.

Courage to Love (CTL) was one I designed based on Jon Kabat Zinn's (1990) Mindfulness Based Stress Reduction (MBSR) model, Mindfulness Based Cognitive Therapy (Segal, et al., 2002) and some Compassionate Mind Training exercises (Gilbert & Proctor, 2006; Lee, 2006).

Phase Two involved the help of a local social service agency, Family Services Ottawa. After reviewing my university research ethics application approval[17], the Executive Director and Board very generously allowed me access to the Anti-Violence Program staff through whom I recruited volunteers from the WAG for my comparison group. I was known to the agency staff through a three-year contract in the Anti-Violence Program as a co-facilitator of the Building Bridges group for women and their children who have experienced violence. Trust is a key factor in allowing access to clients, especially vulnerable clients, and since I had an established relationship in this facility, the group facilitators allowed me to come into the WAG on the first day to explain my research and ask for volunteers for the study.

Volunteers in both groups were offered confidentiality, a small monetary honorarium for participation[18], the offer to review their data before publication of the research, and the understanding that they could withdraw from the research without penalty at any time. I was able to recruit five participants from this group

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[17] Ethics approval for this research was obtained through the Carleton University Research Ethics Committee under Tri-Council guidelines.

[18] Monetary honorarium of $20 per interview was provided out-of-pocket by the researcher, as permitted by Tri-Council policy.

who agreed to complete the two psychometric tests and submit to an interview pre- and post-group. Fortunately, there were no drop-outs; all five remained in the group for the full duration of the 12 week program. I was able to complete the pre-group testing and interviews before the second week of group, and the post-group testing and interviews within two weeks of the group end date. Testing and interviews took place wherever the women were most comfortable – some of it took place at the agency, some women opted for their home or some other mutually agreed-upon location. All but two participants took the psychometric surveys on-line.

The group facilitators also sent out the research information to women on their wait-list for services, and women who had previously attended the *Woman Abuse Group* (WAG) [19] in order to recruit participants for my comparison, mindfulness-based, *Courage to Love* (CTL) treatment group. The agency also allowed me to run my CTL group in their agency, and even provided a small budget for childcare, transportation, and incidentals, so the environment of the two groups was nearly identical, as well as the financial resources offered to support the women. The WAG had two facilitators, which is common practice especially in feminist group work. I was fortunate to have a colleague from a local rape crisis centre volunteer to co-facilitate the CTL group who, in addition to being a social worker, happened to also be a certified yoga instructor, a welcome additional expertise in the mindful stretching activities that are a feature of MBSR. One notable difference

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[19] Only one participant who came to the CTL group had previously attended the WAG group; the others were all wait-list.

between the two groups was that the WAG modality was 12 weeks in length, whereas the CTL group was 8 weeks.

Criteria for joining the *Courage to Love* (CTL) group was similar to the *Woman Abuse Group* (WAG); since both were clients of the Anti-Violence Program they had to have been in an abusive relationship. However, my selection criterion for the CTL was different. At the time of recruitment, Segal, Teasdale and Williams (2002) who modified MBSR into Mindfulness Based Cognitive Therapy (MBCT) for the prevention of depression relapse, recommended screening out people who are severely depressed. Until recently[20] it was thought that meditation-based modalities such as MBSR and MBCT required an ability to focus and be present, an ability not available to people with severe depression or other-attention related difficulties. Women who have experienced interpersonal violence and abuse are known candidates for posttraumatic stress (Herman, 1997; Miller, 1994; Najavits, 2007). Therefore, pre-screening for depression and dissociative-related disorders for inclusion in the mindfulness-based treatment group was deemed necessary, since it was thought women would not benefit from this modality if they were not able to focus or remain present.

Because the pre-screening was done for the CTL group it was also done for the participants from the WAG group to test for that potential 'non-equivalent' characteristic. It was made clear to participants that being screened out of the

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[20] Research published since the recruitment date has shown, however, that MBCT is beneficial to even severely depressed participants (Barnhofer et al., 2009).

research did not screen them out of participation in the WAG group. The Beck Depression Inventory (BDI) (Beck & Steer, 1987) and the Dissociative Experiences Scale (DES) (Carlson, et al., 1993) were used, and it was further explained to the respondents before they were tested that these scales were being used to establish that they met the research inclusion criteria only, and not being used diagnostically or for eligibility for treatment. After pre-group testing, test sheets and scores were destroyed, and were not part of the research study. A score of more than 30 on either scale excluded women's data being gathered for the research study. Only one potential candidate was screened out of the CTL research due to the severity of her depression. During the conversation with her about her Beck Depression Inventory score, I ascertained that she was in counselling for clinical depression at that time, discussed with her whether participation the CTL modality would be appropriate for her, and we agreed that the WAG modality would better suit her needs at that time. I began with eight participants for the CTL group, and had one drop out after the first group session. This reduced the sample size of the CTL group to 7. Psychometric testing and interviews were also completed within a two-week window before commencement and after termination of the CTL group.

Once eligibility for inclusion was established, research participants from both groups were administered the pre-group psychometric tests, the Self Compassion Scale (SCS) (Neff, 2003a) and the Balanced Emotional Empathy Scale (BEES) (Mehrabian & Epstein, 1972) either in person or on-line, according to the

participant's preference. Both scales were administered again after participants finished their respective group treatment modalities.

Results

It was a necessary precaution to test for 'non-equivalence,' that is, to assure that both groups started off from approximately the same place in terms of the dependent variables, empathy and self-compassion. Phase Two data from the pre- and post- psychometric surveys conducted with the *Woman Abuse Group* (WAG, n=5) and the *Courage to Love* group (CTL, n=7) were manually inputted into SPSS for statistical analysis. An alpha level of .05 was used in all analyses (Table 2). Pre-treatment mean scores for Balanced Emotional Empathy Scale (BEES) for the CTL group were lower (M=64.14, SD=35.88) than the WAG group (M=72.4, SD=17.27) but the difference was not significant ($t(10)$= .472, p=.65, two-tailed). Pre-group mean scores for self-compassion (SCS) for the CTL group were slightly higher (M=3.35, SD=.83) compared to the WAG group (M=3.15, SD=.43), but the difference was not significant ($t(10)$=.480, p=.64, two-tailed).

It was also deemed important, given the positive correlations between age and empathy and age and self-compassion, that the difference in the mean age of each group be tested for significance. A significant difference in mean age between the two groups could be a confounding variable in the results of the independent T-tests of the pre- and post-treatment scores. The pre-group mean age of the WAG group was lower (M=39.2, SD=9.3) than the CTL group (M=47.4, SD=9.8) but the difference was not significant ($t(10)$=1.46, p=.176, two-tailed).

Table 2 Pre-Treatment Independent Samples T-Tests

	WAG n=5		CTL n=7		T-test		
Variable	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*
BEES	72.4	17.27	64.14	35.88	.472	10	.647
SCS	3.15	.43	3.35	.83	.480	10	.641
Age	39.2	9.3	47.4	9.8	1.46	10	.176

Differences in means were not significant, alpha level .05, two-tailed.

In the post treatment condition, the mean score for the Balanced Emotional Empathy Scale (BEES) increased in the CTL modality (M=74.86, SD=35.65). The mean score also increased in the WAG modality (M=83, SD=15.41); increases were significant in the CTL modality [$t(6)$=1.977, p=.048, one-tailed] and significant in the WAG modality [$t(4)$=3.805, p=.01, one-tailed) (Table 3). The difference in mean BEES scores between the two treatment groups was not significant post treatment, [$t(10)$= .487, p=.32, one-tailed] (Table 4).

Post-treatment, the mean score for the Self Compassion Scale (SCS) increased in the CTL modality (M=3.93, SD=.61) significantly [$t(6)$ = -2.694, p=.036, one-tailed]. The WAG modality mean score increased (M=3.5, SD=.66) significantly [$t(4)$ = 2.987, p=.02, one-tailed] (Table 3). The difference in mean SCS scores between the two treatment groups was not significant after treatment, [$t(10)$=1.163, p=.14, one-tailed] (Table 4).

Table 3 Paired Samples T-Tests for BEES and SCS Scales

Woman Abuse Group (WAG) Post Treatment (n=5)

	Pre-Post		T-test		
Variable	*M*diff	*SD*	*t*	*Df*	*P*
BEES	10.6	6.23	3.81	4	.01*
SCS	.354	.265	2.99	4	.02*

*Differences in means are significant at the .05 alpha level, one-tailed

Courage to Love (CTL) Post Treatment (n=7)

	Pre-Post		T-test		
Variable	*M*diff	*SD*	*t*	*df*	*P*
BEES	10.71	14.34	1.98	6	.048*
SCS	.588	.577	2.69	6	.018*

*Differences in means are significant at the .05 alpha level, one-tailed

Table 4 Post-Treatment Independent Samples T-Tests

Post Treatment Independent Samples T=Tests

	WAG n=5		CTL n=7		T-test		
Variable	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*
BEES	83.00	15.41	74.86	34.65	.487	10	.32
SCS	3.51	.66	3.93	.61	1.16	10	.14

Differences in means were not significant, alpha level .05, one-tailed.

There were post-treatment differences within the SCS psychometric, revealed by the six SCS sub-groups: three positively scored categories of self-kindness, common humanity, and mindfulness; and three negatively scored categories of self-judgment, isolation, and over-identification. The WAG group

experienced a significant decrease in sense of isolation [$t(4)$=-2.449, p=.04, one tailed]. The CTL group, showed a significant increase in their sense of common humanity with others, [$t(6)$ = 2.714, p=.02, two-tailed]; a significant increase in mindfulness, [$t(6)$ = 2.456, p=.02, one-tailed]; and a significant decrease in over-identification with others, [$t(6)$ = -3.792, p=.01, one-tailed], (Table 4).

Table 5 Paired Samples T-Tests for SCS Subscales

Woman Abuse Group (WAG) Post- Treatment (n=5)

	Pre-Post		T-test		
Variable	*M*diff	*SD*	*t*	*Df*	*p*
Self-Kindness	.08	.335	.535	4	.311
Common Humanity	.50	1.00	1.12	4	.163
Mindfulness	.50	.968	1.56	4	.156
Self-Judgement	-.24	-.297	1.81	4	.073
Isolation	-.75	-.685	2.45	4	.035*
Over-Identification	-.05	-.570	.196	4	.427

*Significant at the .05 alpha level, one-tailed

Courage to Love (CTL) Post- Treatment (n=7)

	Pre-Post		T-test		
Variable	*M*diff	*SD*	*t*	*Df*	*p*
Self-Kindness	.71	1.04	1.82	6	.059
Common Humanity	.64	.626	2.71	6	.02*
Mindfulness	.71	.769	2.46	6	.02*
Self-Judgement	-.23	-.770	.786	6	.231
Isolation	-.46	-.698	1.76	6	.065
Over-Identification	-.786	-.548	3.79	6	.004*

*Significant at the .05 alpha level, one-tailed

Discussion

It is important to note that due to the small sample size in each modality, these statistics are tentative at best as there is insufficient *n* present for a statistical power analysis (Cohen, 1992). However, the quantitative data do point us towards information that is worth noting with respect to what happened in these two treatment groups. Tests for significance revealed that mean scores for self-compassion and empathy increased significantly in both modalities, but the increases in self-compassion and empathy were not significant when comparing one modality over the other. This would indicate that positive change in the overall levels of empathy and self-compassion occurred with the women of both modalities. It would further suggest that both modalities are supportive environments for helping women regain a sense of well-being and a new sense of self–in-relationship.

In the context of Fraser and Solovey's (2007) argument about the 'Golden Thread that unifies all effective therapies' each modality should be effective in facilitating second order change. They state that effective therapists facilitate second-order change with the following in mind,

> "that second-order change may begin with a shift in the relationship of the therapist with the client(s) involved. This shift may itself represent a second-order change to the client, or it may be the precursor for it to follow. Therapists may facilitate changes in the client's assumptions, frames or premises. They may also block, reverse, or re-direct first-order solutions. They may prescribe the

> formerly problematic interactions for therapeutic purposes. Finally they will look for and support new assumptions and solution patterns and reinforce and amplify them as they are found or initiated." (p. 52)

Fraser and Solovey (2007) are describing many of the characteristics of the 'good' feminist therapy discussed previously. I was not present in the WAG modality while the participants in this study were, therefore I cannot speak specifically to the structure of group, but I am very familiar with grassroots, feminist therapy. Those of us who have worked for decades in feminist-based agencies know intuitively and empirically that we do good work, and that our interventions are effective and help the women with whom we work. We also know that the 'therapeutic relationship' is a key aspect of the collaborative, strengths-based approach we take with clients, and that this relationship in itself can be very healing. The therapeutic relationship in a group modality is also expressed within the relationship that the women build with each other through sharing stories and normalizing each others experiences, perhaps even more so than with the formal 'therapists' or group facilitators. Fraser and Solovey also talk about how therapists "facilitate change through challenging assumptions, frames or premises" reminiscent of the work of feminist narrative therapy described by Catrina Brown (2011). Given that context it makes sense that a change – using self compassion as a general indicator of well-being and 'positive health outcomes' (Neff, 2003a) – would be measureable in the WAG modality. A significant increase in empathy also makes sense given the affect-raising nature of sharing stories, and the fact that this did not occur to as great an extent in the CTL

modality would account, I believe, for the stronger increase in BEES scores in the WAG participants.

In the CTL modality, while there was not the same emphasis on narrative story telling, my co-facilitator and I were, as Laura Brown (2004) suggested, "theory-driven" as 'good' feminist therapists should be, i.e. working from a critical framework and epistemology. In addition to this therapeutic relationship, there were other characteristics of Fraser & Solovey's (2007) second-order change that were facilitated as well. Recall that they said that therapists "may also block, reverse, or re-direct first-order solutions. They may prescribe the formerly problematic interactions for therapeutic purposes" (p. 52). Mindfulness-based modalities return consistently to the attitude of acceptance in meditation training and in the psychoeducational portions of the intervention. Using the example of generalized anxiety disorder (GAD) Fraser and Solovey endorse mindfulness as an intervention:

> (M)indfulness nips the vicious cycles of first-order change in the bud by eliminating any need to control, fix or act upon the worry, thought, situation, or experience associated with anxiety ... Paradoxically, when clients attempt to use mindful acceptance as a way to control or eliminate their anxiety, they may actually increase their anxiety rather than decreasing it. Only when full acceptance is embraced will the client either experience less anxiety or be able to function effectively with the awareness of anxiety. This intervention is the essence of second-order change." (p. 135)

The emphasis on self-compassion in the CTL modality is an invitation to embrace a radical act of self-acceptance. As will become evident in the interview data, some of the women in this intervention found self-compassion and empathy particularly challenging, however I believe that the quantitative data suggests that overall the mindfulness-based modality supported second-order change for these women, albeit in perhaps a different way than in the WAG modality. So this led to the next logical research question; what *kind* of change occurred?

The *kind* of change that happens in the different treatment modalities (see Table 2) emerges from the analysis of the SCS subscales for both the WAG and the CTL groups. The only significant change within the SCS subscale for the WAG participants was a decrease in their sense of isolation. This should come as no surprise, as one of the main benefits of sharing stories of abuse and survival is the normalizing and connecting effect this has for women, and for the majority of women in this first-stage group, this would have been the first time they would have told their story. Also, interesting to note, the increased BEES mean score for the WAG group was not only significant but stronger [$t(4)=3.805$, $p=.01$, one-tailed] than the significant increase in the CTL group participants' mean score [$t(6)=1.977$, $p=.048$, one-tailed]. I believe that this may be due to less peer-to-peer interaction in the CTL modality because of its cognitive-behavioural/psychoeducational design. Given the research results, it appears that this is an important area to pay attention to in creating a 'good' mindfulness-based feminist group therapy design. There appears to be a 'therapeutic relationship' benefit that arises from women attending

to each other's stories, questions and thoughts, including the arousal of affect that builds empathy.

On the other hand, I think the CTL group results may suggest that it also has benefits in how it helps women build empathy and their sense of self that is different from, and an important balance for, the 'affect arousal' of sharing stories. In the SCS, the CTL group showed a significant decrease in over-identification with afflictive emotions, and a significant increase in mindfulness, which Neff (2003a) describes as the mirror-opposite of over-identification. I think these findings suggest a second-order change for the women in the CTL modality in the way women were able to change their relationship to difficult thoughts and emotions through developing the skill of emotional regulation as part of the mindfulness training process. This may also indicate further growth towards 'true' empathy which, according to Carl (1967), is the ability to sense another person's "private world as if it were your own, but without ever losing the 'as if' quality" (p. 264). This skill is an essential component of creating that interior working model of a loving presence that is able to care for and protect the self. As we have seen in the early caregiving relationships, being recognized by the other as a distinct and loveable person is essential for knowing ones 'self' as a separate and ethical agent. We learn that recognition of ones feelings and personal boundaries is necessary in order to see and sense that in others, to be treated as a subject is necessary so that we treat others as subjects and not objects (and vice versa). This is essential for any present and/or future intimate relationships. Through mindfully attending to our 'self,' we

can also attend mindfully to others without being overwhelmed by their afflictive mind, body, or emotional states. This is not only important in intimate adult relationships but also an important skill for being an effective parent.

Another of the SCS subscales for the CTL modality also suggests that these participants gained significantly in their sense of common humanity, the mirror opposite to isolation. This is perhaps an indication of a stronger sense of self-in-relationship as well and a further expression of 'moral agency' when we can see ourselves as part of an interconnected whole. Evident in the interviews with some of the CTL participants, these women seemed to emerge with a 'metaself': more compassionate towards and passionate about the injustices in the world and, by their own words, more present to spirituality in their lives.

Conclusions

The analyses of the quantitative data show the general positive effects on self-construal and healing of both modalities. These findings are supported by the literature that shows that 'common factors' underlying all therapies account for about 70% of healing change, of which the therapeutic relationship accounts for approximately 30% (Fraser & Solovey, 2007) and about 40% is attributable to 'extratherapeutic factors'. However, the kinds of change and the modality effect (which accounts for 8 – 15% of healing change) may be revealed in the details of the self-compassion subscales. Therefore, I believe the quantitative findings support an integration of a compassion-focused mindfulness-based modality and 'good'

feminist trauma therapy to take advantage of the strengths that each has to offer women who have experienced interpersonal violence.

Chapter 5: Qualitative Method

Data Collection

Each woman from both modalities[21] was interviewed face-to-face pre-treatment, using a semi-structured interview guide designed to contain mostly open-ended questions. Demographic information was kept minimal, except for name, age, racial/ethnic identification and previous therapeutic group experience, including any mindfulness or meditation experience. Self-disclosed statements of socio-economic status, disabilities and sexual orientation were observed and recorded over the course of the interviews. Five women from the WAG group participated in pre- and -post interviews; data from interviews with six of eight women from the CTL group is presented and analyzed[22].

Questions were structured to ask women about the experience and duration of the abuse and the abuse-related issues that still affected them, e.g. flashbacks, affect regulation, somatic difficulties, depression, anxiety. I asked them to describe how they felt the experience of the abuse affected their ability to: identify their feelings (awareness of affect); to express her feelings to others (expression of affect); to comfort or share the feelings of someone who is in pain (empathy); to be kind to herself (self-compassion); to create positive change in her life (agency); and

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[21] The Woman Abuse Group (WAG) and the experimental modality group called the Courage to Love group (CTL).

[22] The CTL group started with 8 participants, but I had one participant drop out of the group after the first session and a mechanical recording failure for one of the final interviews. I felt it was methodologically problematic to use only their pre-treatment data in the analysis, so chose not to do so.

her sense of 'self' (subjectivity). At the conclusion of each group, I repeated the latter set of open-ended questions reframed around how the group experience had affected awareness and expression of affect, empathy and self-compassion, agency and subjectivity.

Analyzing narrative interview material is challenging. I had originally thought that I would only use a grounded theory approach to analyses, but since writing my thesis proposal I discovered the work of sociologists Andrea Doucet and Natasha Mauther (2008). I found their article, *What can be known? Narrated subjects and the Listening Guide,* "a multi-layered way of tapping into the methodological, theoretical, epistemological, and ontological dimensions of the narrated subject" (p. 399) a helpful framework for approaching the data. Not only helpful and practical, their approach was congruent with my theoretical and philosophical understandings of the 'self'. They ask the question, "what is *inside* or *outside* narratives and *how* we can come to know them" (p. 399) and state they feel it possible to address both. They use, as an example, feminist philosophers like Benhabib's concept of subjects constituted/constructed by language, or 'subjects-in-relation' that act with agency and intentionality; but also put forth the idea that "there are subjects beneath, behind or beyond narrated subjects (and) as researchers, we cannot come to fully know them" (p. 399). Their ability to hold these two 'dialectics' of constructed subjects (known through conceptual narratives) and critical subjects (known through ontological narratives) seemed a sensible way to look at those interview questions that were both constructed (her story or 'abuse

narrative'), critical (her analysis of the affect it has had) and ontological – her sense of 'self' before and after.

Doucet and Mauthner (2008) recommend four readings of the data, "which intertwine reflexively constituted narratives, relational narrated subjects, and constructed and critical subjects" (p. 405). The first reading, *Relational and Reflexively Constituted Narratives* employs a grounded theory approach by asking 'what is happening here' with some elements of narrative analysis (recurring words, themes, events) while at the same time reading reflexively, whereby the reader keeps notes on personal interpretations, reactions, assumptions, world view etc. The authors suggest using a worksheet, but I found I was able to do this using NVivo, using coding for the words themes and events, and the notes and memo functions of the software for reflexive reading notations.

The second reading, *Tracing Narrated Subjects* is applied to find out how the person speaks about herself in her social world, by tracing the use of the pronoun "I". "Its simple yet powerful effect" write the authors, "is in reminding us to listen to how narrators speak about themselves before we speak about them" (Doucet & Mauthner, 2008, p. 406) and gives us some insight into the person's ontological narrative, their perceptions of self, and their sense of identity. I used the software to put brackets around the pronoun 'I' in the interview material to keep me aware of the speaker's thoughts and ideas about her 'self' present within the data.

The third reading - for *Relational Narrated Subjects* – is a reading for social networks, or the self-in-relation, "narrated subjects who are not constituted in

language or discourse, but rather in relation to other subjects"(Doucet & Mauthner, 2008, p. 406). This is an area where I hoped to see women's interior working models of self, since hypothetically we create our 'self' in the context of empathic others (Meyers, 1994).

The fourth reading is for *Structured Subjects;* that is, how dominant ideologies and relations of power frame narratives. In this reading I was hoping to glimpse 'the political is personal' in women's lives, and with my social work grounding in critical and structural theory it not only made sense but was also compatible with the previously mentioned theories of how living under oppression effects the development of an ethic of empathy and moral agency.

Analysis Process

Even after deciding on the approach – using the Doucet and Mauthner (2008) article as a guide - I struggled with how to apply it to the qualitative data from the interviews. This is not your usual sociological research where the researcher presents a set of questions, records and analyzes the narrative of the respondent that represents a snapshot of experience and knowledge. That is not to say that there is not some of that sociological research element, but rather there were other considerations because (a) this is a quasi-experimental design and so there is a before and after element involved, so two snapshots of experience and knowledge; (b) there is a quantitative element to the design that informs the qualitative analysis; and, (c) the analysis is looking at the data mainly in aggregate as well as

highlighting some individual voices, but is not a case by case study[23]. My other challenge was to do justice to the women's experience, to make the analysis deep enough to honour the multitude of layers that are present in the women's lives, while remaining present to my own assumptions and biases that inevitably colour my interpretations. I struggled also with feminist and Buddhist notions of subjectivity and the self, and so I felt I also needed to present my synthesis of that struggle to find common ground in these two philosophies that underpin and guide not only the research, but also my life and practice.

I ultimately adapted a methodology that I believed suited my purposes. It is an approach that itself is a result of two feminist sociologists struggling with the tensions that have arisen over the concept of subjectivity in feminist theory, in particular the ontological and epistemological question of 'what can be known' about others, and whether or not we as researchers can truly "access any degree of authenticity of our research subjects" (Doucet & Mauthner, 2008, p. 399). Doucet and Mauthner considered the idea that it is possible to blend post-modernist and poststructuralist approaches with feminist critical theory critical "so that 'a culturally constructed subject can also be a critical subject'" (Fraser, 1995, cited in Doucet & Mauthner, 2008) but in the end rejected this as epistemologically untenable as they feel it denies and reinstates agency at the same time.

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[23] One could also argue that there is also an element of program evaluation in this study since I framed the post treatment questions as, "how did the group experience affect .... "

From an Eastern epistemological perspective, one could argue that this *is* a tenable position. Dialectical theory also would posit that agency and non-agency can be held in tension. The Farb (2007) study shows that we can separate the streams of narrative and non-narrative awareness so that we can be present to both a constructed sense of self and the 'not self' as well. This point of tension or dynamic that this represents is addressed in Klein's (1995) understanding of Buddhist philosophies of 'non-self' or 'selflessness' or 'emptiness'. It is beyond the scope of this chapter to do justice to the centuries of Buddhist discourse on this topic, but to summarize and quote Klein, the self as we understand it in everyday life is the person or 'I' that appears to our minds that seems permanent, unitary and under its own power, separate from, but in charge of, mind and body. The task of mindfulness practice is to observe this ordinary sense of self that is so much taken for granted. The more we observe the more we come to see that 'self' can appear to be the sensations, thoughts, feelings we experience – this is the self that is created as a result of *dependent arising*, the self that identifies with phenomena that are constantly changing. "Yet," writes Klein (1995):

> when one looks through the mind and body for the self one has previously identified, one does not find it. The Fifth Dalai Lama compares this searching and not finding with the situation of the farmer looking for a bull (the self previously identified) in his upper and lower pastures (mind and body). Once he has determined that the bull is not in either, he knows the bull is not on his property; that is, he knows the absence of

> that particular, perhaps very valuable, bull he has been seeking. In the same way, once the self previously identified cannot be found in one's own mind and body, one knows that *this* kind of self does not exist." (p. 126)

It would be a mistake to assume that no self whatsoever exists, but correct that the self we assumed exists and cling to does not exist. Klein warns that confusing the negation of the self in general rather that the specific notions we have of our self as mentioned is not only incorrect, but also dangerous. Doucet and Mauthner (2008) reject postmodernist ideas of a purely constructed subject for the same reasons that Klein (1995) argues is the connection between self and moral agency:

> Questions about how or whether the self exists are typically not raised until Buddhist practitioners have been well imbued with the importance of ethics, the power of mindfulness, and the significance of compassion, a vitally important context that is often overlooked in Western discussions of "selflessness" ... emptiness should not be taught to those who will construe it to mean that the self does not exist, or that one's actions and relationships do not matter because there is no karmic cause and effect, no ethical consequences. They would miss the central point that emptiness and selflessness are fully compatible with dynamic personal agency, as well as with material cause and effect. (p. 127)

Wallin (2007) would also add that the constructed subject – or the subject in relation – is critical to our sense of well-being and should not be dismissed or down-played. The reflective or mentalizing self that "emerges through a relationship in which experiencing the attachment figure as a secure base makes it safe for us to explore the world, including the internal world," (p. 67). This attachment experience is the basis of the therapeutic relationship that provides the platform to safely explore second-order change. When we successfully interiorize this secure attachment relationship as our working model of 'self' this becomes our safe base when the therapist or other attachment figures are no longer present. From this secure interior base we can trust and explore our exterior and interior worlds and modulate our own affect. So I definitely wanted to be present to clues around this ontological shift happening for women as a result of their group experience.

It is also important to be present to what Doucet and Mauthner (2008) refer to as the critical subject, the moral agent which I understand is equivalent to what Wallin (2007) calls the mindful self. "For if mentalizing promotes internal freedom by enabling us to act as mental agents, mindfulness fosters freedom by enabling us to act as "attentional agents" (Wallin, 2007, p.68). The mindful self is aware of awareness itself rather than just afflictive thoughts, emotions or sensations that we are aware of and often identify with or mistake as our 'self'. This greater awareness and resulting metapersonal self-construal is associated with less anxiety and fear of the unknown, and therefore a more tolerant and forgiving person (DeCicco & Stroink, 2007).

Data Analysis

Therefore Doucet and Mauthner's (2008) *Listening Guide* provided a methodology that I felt was sympathetic to both feminist and Buddhist understandings of the self and subjectivity, and offered a practical roadmap for approaching the analysis of this rich material. They suggest reading the material four times with four distinct purposes that I related earlier but will describe here in light of the previous discussion. The first reading is for *Relational and Reflectively Constituted Subjects*, which is a fairly straight-forward reading based on grounded theory to examine 'what is happening here' and to also allow the researcher to reflect on assumptions and worldviews brought to the interpretation of the respondents' words. I used my interview guide as a basis for initial coding that included, in the case of pre-group interviews, basic demographics, previous group and meditation experience, her narrative of the interpersonal violence she experienced, and so on. For both the pre- and post-group interviews I also allowed myself to be present to 'what is happening here' and subsequently coded up from the data some additional themes I saw emerging. I made notations of assumptions that I brought at the outset[24], as well as my reactions and reflections on reading the material in a journal. Since I was using NVivo to code the data, I was also able to import the recorded interviews, and I found that particularly useful when I felt I did

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[24] Including the fact that I was the facilitator of the group modality and recognized my desire for the treatment modality to produce positive (and superior to the Woman Abuse Group) outcomes for the participants, an issue I will discuss in more depth later.

not fully understand the written narrative; I could replay the recording to hear the nuances of the conversation.

The second reading is *Tracing Narrated Subjects,* is to examine how the particular subject speaks about herself. The authors suggest circling the pronoun "I" in the transcripts to amplify how the woman talks about herself and who they believe they are. I did this using a search and replace function in a word processing software in addition to coding the data in NVivo, but really it proved unnecessary since the whole interview really focused on the woman's subjectivity. Additionally, I asked explicit questions about how each women felt about her sense of 'self' as a result of her experience of interpersonal violence, and as a result of her group experience. So her answer to the question about her ability to identify her feelings was one of the areas where I expected to see changes in self-awareness, a more mindful self, and a developing skill for regulating emotions. In congruence with the theoretical frameworks presented, I also assumed that changes in sense of agency should also be evident here.

The third reading is for *Relational Narrated Subjects* that looks at social networks and interpersonal relationships. This is a particularly important area given the hypothesis that has been put forth about the relationship between outer relationships and the relationship with ones self and the relationship to empathy and self-compassion. The interview questions about how their experience of abuse (pre-group) or their experience of the group affected empathy, compassion and self compassion was expected to be particularly pertinent here.

The fourth reading for *Structured Subject* fits well with a structural social work theoretical framework. This reading seeks to capture conceptual practices of power (Smith, 1999) by focusing on dominant ideologies and relationships of power that happen at the macro level and impact micro-level narratives, in other words how the political is personal. There were no specific interview questions that focused on structural issues, nor were women asked to critically analyze their social location or situations with a structural lens, but these issues and reflections emerged on their own as I expected they would given the feminist framework in which their therapy was couched. The entire body of interview data was read sensitive to interwoven and intersectional oppressions of race, gender, class, physical ability, sexual orientation, mental health etc.

The interviews were conducted in person by the researcher with each participant before she experienced her particular group modality, and then again after her group experience, using a Qualitative Interview Guide designed for this purpose by the researcher (Appendices B & C). The Interview Guide in Appendix B shows how the pre-group questions were reframed for the post-group interviews. I recorded the interviews using an unobtrusive MP3 style recorder, and I gave participants the choice of environment for their interviews. I thought this choice of locale would help the women feel more safe and relaxed but in retrospect the 3 women who chose to be interviewed in their homes or the 1 woman at a public location (a restaurant) were interrupted and distracted more often (e.g. by children, telephones, restaurant staff). The additional noise also made listening to the

recordings challenging for transcription, but not inaudible. In future I think I would opt for a more neutral and controlled environment. When all interviews were completed and transcribed, transcriptions were sent to each interviewee for her to review, edit and clarify if she so wished. Revised transcripts were used for the final analysis along with the original voice recording.

I decided to do the 'four readings' suggested by Doucet and Mauthner (2008) in two 'rounds'. That is, I read and analyzed the pre-treatment data as a whole chronologically and the post-treatment data layer by layer comparing the aggregate responses from each group. Specifically, the first round was a reading and analysis of both groups' pre-treatment interviews, following the four layers of narrative suggested by Doucet and Mauthner; followed by the second round, the suggested 'four readings' of each groups' post-treatment interviews, read comparatively layer by layer (see Table 6).

Table 6 Analysis process for interview data per Doucet & Mauthner (2008)

Layers of narrative	Round One	Round Two
1st Reading *Relational & Reflectively Constituted Subjects*	All participants Chronologically Pre-treatment	CTL Group / WAG Group Comparatively Post-treatment
2nd Reading *Tracing Narrated Subject*	All participants Chronologically Pre-treatment	CTL Group / WAG Group Comparatively Post-treatment
3rd Reading *Relational Narrated Subjects*	All participants Chronologically Pre-treatment	CTL Group / WAG Group Comparatively Post-treatment
4th Reading *Structured Subjects*	All participants Chronologically Pre-treatment	CTL Group / WAG Group Comparatively Post-treatment

For the first round, my assumption was that because the two groups started off similarly in terms of their reasons for being in group (experience of interpersonal violence) that there would be similarities in the psycho-social-emotional-spiritual after-affects of the violence. Congruently, the quantitative analysis of the pre-treatment data showed that there were not significant differences in the women's scores for empathy and self-compassion between the Woman Abuse Group (WAG) and the Courage to Love (CTL) group. They were also asked the same set of questions. Approaching data collection this way would make for an easier reporting of the data from pre-treatment interviews from similar groups because at this point I was not analyzing for difference between groups, however sensitive I might be to individual differences of experience and expressions of 'self' and subjectivity. Other assumptions I made were that issues of historical childhood abuse would probably emerge from the women's narratives, as well as addictions, somatization, emotional dysregulation and other indications of post traumatic stress based on my experience of working in this field.

The second round constituted the 'four readings' of the post-treatment interviews, and it was assumed that there would be a difference between the WAG and the CTL modalities and so attention was paid to differences that might emerge from the responses between groups. I also expected narratives of subjectivity to be different than the pre-treatment group, so this round also involved intermittent comparison of the before and after, much of which was offered by the participants themselves as they reflected in the post-treatment interview. Part of this

expectation was informed by the quantitative findings in significant changes in measures of self-compassion in both groups, and also the subtle differences in the subscales in the CTL modality as compared to the WAG group.

Results Round One: All Participants Pre-Treatment

First reading for relational and reflectively constituted subjects.

This first reading of the transcripts gave me a general sense of the women that constituted the two groups. This reading reminded me that I usually spent a bit of time engaging in general small talk to help us relax and prepare for questions that would be very personal in nature. After introducing both the research project and me, I went over the Informed Consent[25] and answered any questions she had before signing. If she had not done the screening and research surveys on-line[26], she completed those before we engaged in the qualitative questions. I also gave each woman a small honorarium[27] for participating in the research project with a personalized thank you card. I asked general demographic questions about age, racial/ethnic identity, previous group and meditation experience. More personal questions about her experience of violence were asked, the nature of the interpersonal violence, when it happened and for how long. I then questioned how

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[25] If she had done the pre-group surveys on-line she would have seen it before.
[26] The screening surveys were the Beck Depression Inventory and the Dissociative Experiences Scale. When she completed those I scored them as she was completing the research surveys, the Balanced Emotional Empathy Scale (BEES) and the Self Compassion Scale (SCS). All the participants who did the screening surveys in person met the criteria for inclusion, and so all qualitative interviews proceeded.
[27] The honorarium, approved by the Carleton University Ethics Committee, was $20 and supplied out of pocket by the researcher.

she felt the abuse still affected her at the present time, with prompts about her personal safety, intrusive memories, eating or sleeping difficulties, emotional regulation and somatization.

The first group of five women I interviewed was about to start a 12 week Woman Abuse Group (WAG) at a local social service agency in the spring of 2008. The youngest was 26, the oldest 47, and the average age was 39. The second group of 6 women[28] was interviewed in the fall of the same year before commencing the eight-week Courage to Love (CTL) treatment modality. Their average age was slightly higher at 45, as ages ranged from 35 to 54. About half the women in each group had some form of previous group experience, like Alcoholics Anonymous, anger management, and prior woman-abuse focused groups. Some women were presently seeing or had seen counsellors for one-on-one therapy. None of the women had a meditation practice nor had they participated previously in a mindfulness program, except one who was in the CTL group who had done an MBSR course almost a decade ago. All women were no longer living with their abusive ex-partners, and most had been in very long term abusive relationships, (except for the two youngest women, one in each group, were in their respective relationships for approximately 2 years) from 8 to 31 years or an average of about 16 years. I did not discern a marked difference between the two groups of women regarding the length of time they had been out of their abusive adult relationship; in each group some

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[28] I actually interviewed 8 women initially but as previously mentioned I used the data from only six.

had left the relationship within that year, some had left as long as ten years previously. However, the women who had children (all but one in the WAG group and 2 participants in the CTL group) were still dealing with their ex-partner over support and custody issues and so were still very much prone to continued emotional and sometimes verbal abuse. There will be further discussion regarding this issue when I review the findings about the impacts that continue for the women as a result of the abusive relationship.

Because the question about experiences of interpersonal violence was framed broadly to invite the woman to speak about all her experience of abuse, eight of the eleven women (unprompted) started with histories of violence, child sexual abuse and alcoholism in their families of origin. Three of those women reported experiences of incest, one recalled witnessing her father beating her mother, another recalled verbal abuse between parents, and several reported parents' mental health issues and addictions including alcoholism in their memories of growing up. A common theme amongst the women were rigid standards of social roles, gender roles in particular, as one woman, the daughter of immigrants to Canada stated, "I'm here because my father wanted a son; he already had two girls and he wanted a boy ... maybe age 4 or 5 I got wind of the fact that I was not what I was suppose to be, and that complicated things." Her mother was prone to rages and depressions, and she witnessed verbal fights between her parents, which resulted in her hiding in a closet to escape. She conceded that her parents had fled Europe during the height of World War II, and were likely dealing with war-related

trauma. Another woman, who coincidently was also the child of immigrants, explained that there were no sons and because she was the oldest and her parents did not speak English, "I had to take care of everything, like when I was 15 we bought a house and I had to do everything" including dealing with real estate agents and lawyers. Her mother, she says, was alcoholic and addicted to Valium. At least two of the women (one was an incest survivor) came from families who had high 'moral' or religious standards and expectations of achievement from their daughters.

As unique as each one of these women's experience of her childhood experiences might be, their stories had many commonalities with narratives I have heard over the years of working with women who have experienced violence. As I mentioned in the introduction where I cited the "famous" 51% statistic (Statistics Canada, 1993), violence is an all too common experience for women. So in reflecting on these family-of-origin narratives I confess to not being surprised by any of the stories the women shared, but I am saddened that it seems the reality of women's lives have changed so little since the 1993 Canadian Survey on Violence Against Women.

Likewise, the recollections women shared about their abusive adult interpersonal relationships rang true and familiar for me as well. During my reading of the women's narratives of interpersonal violence, I recalled an important journal article that I and other counselors in the field have used for many years with women who are in or escaping abusive relationships. This document was co-authored by two women I had known for many years in my association with my community's

Interval house (Martin & Younger-Lewis, 1997). The article was written as a guide to help Canadian physicians identify and understand the scope of male perpetrated partner abuse. Fern Martin was the Public Education Coordinator for Lanark County Interval House, and compiled a list of types of abuse (featured in the article) starting with one that had been done by a men's group called *New Directions,* a group for men who had been convicted of assaulting their partners. They listed behaviours that they used to control their spouses; in addition after Martin had staff and women from Interval House and other shelters as well as members of the Lanark County Coalition Against Family Violence added their experiences, the list doubled. Martin and Younger-Lewis categorized these into the "Eight Types of Abuse" which include emotional (includes psychological/verbal abuse), environmental (includes harming pets, destroying possessions, driving too fast or recklessly), social (isolating her, public humiliation, not giving her privacy), financial, religious (using religion to justify his behaviour, or mocking a women's religious beliefs), physical, sexual and ritual abuse.

This document is a very familiar one to me and framed my analysis of 'abuse' related questions. Therefore in coding the data I was sensitive to all eight kinds of abuse. While I did not prompt or offer any definition of abuse to the women, I allowed them to tell their stories their own way. As has been my experience bearing witness to women's stories, I was not surprised (as I mentioned before) by the stories I heard, but I was, as always, shocked by the brutality, cruelty and senselessness: "he beat me all the time – broke my nose - those kinds of things ...

when I tried to break up with him he stalked me . . . he stole all my money . . . my entire savings account"; "my partner was a drug addict and alcoholic . . . it was verbal abuse, emotional abuse, physical abuse, financial abuse, everything but sexual abuse and how I got around that one I don't know"; "I worry about my safety . . . he did a good job of isolating me"; "violence did ensue which was occasional, it wasn't often, and then it started to include the children more and more . . . he creates chaos . . . he flipped me over his head to the basement floor and then, what his pattern was, he'd get on my shoulders and he'd bang my head against the floor . . . he was a binge drinker, he was in the military and he's very, very controlling"; "I felt really stuck in the relationship because he would always tell me that I wasn't good enough for anybody else and you know that sort of thing just like put me down a lot and made me think that he was my only friend"; "throwing objects, throwing phones . . . drive, drive like crazy . . . a lot of jealousy . . . he's strangling me, he had me up against the wall and had me, you know, lifted off my feet with his hands around my throat . . . a lot of punching holes in walls, a lot of screaming . . . destroying mutual property"; " he was a cocaine addict for twelve years solid . . . he actually became like a psychotic . . . (he would) isolate me from everybody in my family except for my brother . . . he was extensively jealous and very insecure . . . all the time I would go to a family event, he'd have me crying before I got there." I offer the women's own words, because they are more descriptive and powerful than any summary I could offer. I believe from this small sampling of

quotes it is apparent that there have been significant levels of traumatic events in these women's lives, and in many cases, the lives of their children too.

There is also a similarity between spousal abuse and torture (Amnesty Internatonal USA, 2005; Herman, 1997) and many of these women also have a history of child abuse, so I expected some resulting indicators of post traumatic stress disorder (PTSD) – and likely Complex PTSD to emerge in the narratives. Briere and Scott (2006) write that indicators of PTSD, as described in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association. & American Psychiatric Association. Task Force on DSM-IV., 2000), are generally divided into three clusters. The first, re-experiencing flashbacks and intrusive thoughts and/or memories; the second is avoidance of trauma-related stimuli that reminds her of the event(s), usually through numbing, avoiding environments and people and/or suppressing thoughts, feelings and memories; and the third cluster, hyperarousal in the form of sleep disturbance, attention and concentration difficulties and/or irritability. The authors comment that the first cluster (re-experiencing) is the most likely to be first to fade over time. The other two clusters (avoidance and hyperarousal) are likely to be more enduring. The interview data seemed to confirm this as only one of the participants reported experiencing recent flashbacks, but all participants reported experiencing many – and some had all - of the indicators from the second and third clusters.

The DSM-IV-TR also acknowledges in its discussion of Complex PTSD 'associated features' of PTSD "that are especially prevalent in following

interpersonal victimization. These include dissociation, cognitive distortions, and more personality-like difficulties in areas such as identity and affect regulation. In addition" they write, "up to 80% of those with PTSD have at least one other psychological disorder ... include major depression, substance abuse, and the various anxiety-related disorders" (Briere & Scott, 2006, p. 23). Therefore my interview schedule question, "What do you feel are the abuse-related issues that still affect you?" and the additional question-prompts reflected some of this understanding of the characteristics of PTSD, including the more serious Complex PTSD and its associated features.

The prompts included asking about personal safety, flashbacks/intrusive memories, self-injury, sleeping/eating difficulties, affect regulation (getting triggered, numbing flooding, anger etc.), depression, anxiety and somatic indicators (indigestion, fibromyalgia, dysmenorrhea, headaches, other). As previously mentioned, one participant had experienced recent flashbacks, however she reported them as 'body feelings' rather than cognitive memories, as a feeling of being terrified. Other women related the long-term effects in terms of their bodies as well, often as a feeling of disconnection. One woman reported, "I would rather be quasi-disconnected on a daily basis" and another said, "I feel pretty detached most of the time . . . I don't feel like I'm in my body . . . I have to work to stay in my body."

One theme that was constant in the narratives of almost all the women, was depression - sometimes expressed as "overwhelming exhaustion," "emotional exhaustion . . . hope exhaustion" and "I do run on fatigue." Not surprising, since

depression and sleep patterns are interrelated (Britton, 2005), sleep was also problematic: "I don't sleep properly," I definitely have a sleep disorder," "I sleep too much," and, "for quite a few years I had nightmares," were some of the complaints. Some women had been diagnosed by their doctors and were prescribed anti-depressants. Another woman, who did not self-diagnose as having depression, identified feelings of high anxiety to the point of 'panic.' Many of the others reported high levels of anxiety "generalized anxiety levels that are too high, irritability ... inability to adapt easily," including hypervigilance "you're always afraid of what is going to happen"; and fears for safety for self and/or children, which in many cases was well-founded, not necessarily a symptom of PTSD: "I worry about my safety in terms of what he would do, but I am not obsessively fearful."

Anger and flooding emotions were also an issue of concern for several of the women. The myriad of reports included: "I hate the feeling of anger, it's my worst emotion I try to avoid," and "I have anger issues . . . I have trouble controlling my actions sometimes when I'm angry . . . I have lashed out at people I've like broken things." "I can't handle almost anything . . . I just burst into tears and people think I'm crazy . . . it's hard to contain, I am more of a flooder." A couple of the women also confided that they used cutting or other forms of self-injury, "I put my hands under boiling water," to cope with difficult feelings.

The other side of the coin – avoidance, or not being able to feel and express emotions - was also a difficulty for many of the women: "I taught myself to forget events and then even after I would dig up evidence that the thing happened I would

forget again," "my grandmother died last year and I just felt completely, really, really numb . . . when something big happens, I don't react the way people would expect me to . . . I've always felt like a weirdo."

Eating difficulties were also evident, reported by two of the women who had also experienced childhood abuse. "I've always had eating difficulties," claimed one woman "sometimes I cry when I eat because I feel like I don't deserve food." Another who was an incest survivor was bulimic in her teens and early twenties, and still has to have "clear boundaries about it. I do not go on a scale. I do not think about the calories I am eating. And as long as I stay within those rules, I'm fine you know."

Some of the most difficult stories to bear witness to were women's descriptions of somatic pain. "I've come to realize that my body is very traumatized," said one participant. "Somatization" write Briere and Scott (2006):

> ...has been linked repeatedly to a history of childhood maltreatment, especially sexual abuse (for example, Walker et al., 1993), as well as other traumatic events (Beckham et al., 1998; Ursano, Fullerton, Kao, & Bhartiya, 1995). The reason for the connection between trauma and somatization is unclear. Possibilities include the effects of sustained autonomic arousal on organ systems especially responsive to sympathetic activation, and preoccupation with somatic vulnerability when the trauma involved the survivor's body, such as chronic pelvic pain in sexual abuse survivors. (p. 27)

As the authors conclude some of the painful somatization is probably the result of chronic stress or "sustained autonomic arousal." The list of somatic complaints from the participants included sciatica, fibromyalgia, "joint pain . . . inflammation . . . everything below the hips was inflamed," painful and irregular menstrual periods, headaches, teeth grinding, upper back and neck pain, irritable bowel, and stomach problems. However, some pain is probably related directly to past injuries from violence: "I have degenerative disks in my neck" explained one woman whose partner pinned her down and repeatedly banged her head on the floor.

The remainder of the questions in the research interview questionnaire (Appendix B) changed the focus from the general, demographic and historical, to the specific and the present moment ontological questions related directly to the woman's sense of 'self.' I paid particular attention to the responses to these questions for the next three layers of readings in my analyses, as those readings deal directly with how each woman speaks about her relationship with her interior life: her perceptions of herself in her world through social networks and intimate relationships; and the dominant structures and ideologies that frame her narrative.

Second reading for tracing narrated subjects.

The second reading (Doucet & Mauthner, 2008) suggests circling or highlighting the pronoun "I" in interview transcripts as a way to amplify the participant's perceptions of self, or the ontological narrative. "Narrative provides subjects with identities and allow them to speak about who *they believe they are.*

'Ontological narratives make identity and the self something one *becomes*' (Somers, 1994: 61), and reading for the 'I' gives us access to this emerging sense of self" (p. 406, emphasis in the original). The ontological narrative of the participants is particularly salient to this research because of the focus on the impacts of abuse on the women's sense of self, as well as if – and what – changes are perceived as a result of the treatment modalities they experienced.

I did not need to dig very deeply into the pre-treatment narrative of the women to find their reflections on how their sense of self (including their sense of agency or personal power) was negatively impacted by family-of-origin and/or intimate partner abuse. Lack of self-esteem or self-confidence was the language most often used and a consistent theme for all participants. "I'm really hard on myself," observed one woman, "I think it affects your self-esteem too. You're kind of down on yourself a lot, or you wonder, what did I do to deserve this?" Others said, "I am still hard on myself as I always was" and "I've always been pretty hard on myself, and like if somebody says something bad about me, I believe it . . . I feel like crap a lot because I feel like crap about myself."

Some women's sense of identity was affected by their feelings of incompetency, that they had lost some abilities or skills that they had before, "I still don't feel myself as very powerful, I don't feel like – it's complicated because I – was gonna say – I don't feel entitled to success"; "I just don't finish things, I just sort of start something and I'll get all excited and I don't follow through and finish," or they were not able to cope as they once had been able to: "I'm not able to organize myself.

I know there's something wrong because that's something I've always done very easily and naturally, so that's my sign that (there's just too much)."

As a theme, many of the women expressed boundary issues – not being able to distinguish where she, or her wants and needs, ended and those of others began. For some this was evident to them before they entered their adult relationships: "I didn't have a sense of self when (ex-husband's name) walked into my life . . . I don't think I had a sense of who I was or what I was or what I wanted and I didn't know if I wanted to get married – he wanted to get married, so I got married. I didn't know if I wanted children, he wanted children so we had children. I didn't have a say." Another woman confessed, "I was searching for an identity. I think and I fulfilled that identity by being someone's girlfriend." Some women related feeling this loss of sense of self or boundaries during or after the adult abusive relationship: "I remember when I first left my relationship that I had, you know, no boundaries" and another woman echoed, "I think I've always known who I was but I disappeared over the years, you know the domination – I felt very suffocated." As for the future, "in terms of a personal relationship" articulated one participant; "I'm not looking for another man in my life for a long, long time. It's time for me to learn who I am again . . . I lost myself totally and I have a hard time understand how I let someone suffocate me so much."

These statements bring to mind Meyers' (1994) *Ethic of Empathy* and her assertions about how important it is to be 'recognized' and as a distinct, separate and valued subject, in order to practice ethical agency. As one woman articulated,

> I don't feel I had no choices or agency, but I also feel like I was completely – I had no ability to predict that people would behave in that manner because there was no model in my map of the universe for human beings actually doing theses things and feeling these ways...

A profound sense – as illustrated by this statement – of cognitive dissonance emerged, which embraced a disorientation to the world once known, or as the woman above encapsulated, a feeling of "fundamental lossness." During the group process this was also expressed to me by this participant (and at least one other) as a reluctance to increase her level of empathy since she felt it was her empathy that got her into trouble in the first place. As mentioned early in the theoretical framework for this study, Paul Gilbert (Gilbert & Proctor, 2006) notes that when working with people with high levels of shame we need to be aware that these individuals often have an ambivalent or anxious attachment style, and so that any kind intimacy, in a personal or therapeutic relationship, can trigger high levels anxiety. This has been a part of their survival strategy since childhood. The tragedy for me is that they mistake 'empathy' as an invitation to harm, because they cannot experience "the emotions of others as if they were (their) own without ever losing the 'as if' quality," to quote Carl Rogers (1967). It further illustrates the importance of being recognized as a *separate*, distinct and valued subject-in-relation that can exercise ethical agency (Meyers, 1994) because the agent can see the other as a *separate*, distinct and valued subject as well. There is no 'giving away' of oneself,

and therefore no threat of harm, but one needs to be able have that (earned) secure attachment, that safe, soothing base from which to explore the world, in order to know oneself as a worthy subject and to know others as subjects worthy of empathic regard as well.

The interview protocol did not ask women to make sense of their experiences of abuse and violence. However, one of the women who had very complex post trauma issues reflected on the purpose of her life experience in a way that illustrates a meaning-making process towards some kind of self-redemption. She said,

> Maybe these experiences have turned me into the person that I need to be. I am trying to look at that. Not that anyone deserves to be abused. I don't mean that. But would I have been so compassionate, would I have been so aware of the pain other people feel? You know, what's my purpose for having gone through that?"

Another woman reflected:

> It destroyed my sense of self, so wondering who I am and what I'm doing here and what do you want out of life. And so that's what I'm working on one step at a time; every journey starts with the first step you know, and I've taken that first step.

These two meaning-making statements were an exception in the pre-treatment interview data, perhaps because I did not ask the question directly. There was more

evidence of meaning-making of experiences post-treatment, as will be reported in the section that compares post-treatment narratives.

Third reading for the relational narrated subject.

The boundary issues women experienced in the section above (where the analysis was of women's narratives focuses on her relationship to herself) could just have easily been related in this "Third Reading" analysis of the women's narratives of intimate relationships and social networks. Because of the theoretical framework employed that includes Meyers' (1994) ideas about the ethical agency as well as attachment theory (Wallin, 2007), it is challenging to tease out the self-to-self relationship without including the self-and-other(s) relationship, since both elements make up the interior working model of the self. It is, therefore, important to clarify at this point that it is important not to forget *the process of recognition* that is the third element in this model of self, and we cannot form a clear notion of 'self' without the reflections and recognitions of 'others.' This reading for self-in-relationship has some overlap with the previous reading, but at the same time has some distinct characteristics and importance in the development of self as a child, and as it turns out, as an adult as well.

The women in the study expressed a profound loss of trust. Some felt that the loss of trust began in their families of origin, citing the unpredictable, unreasonable high expectations and/or 'double-bind' behaviour of parents:

> I had spent my childhood with my father who expected you to know what he wanted before he knew it, meet his needs and respond like

> that (snaps fingers) and to think like him, and be like him, and that was the only right way to be; (but) only he could be angry.

Others attributed their loss of trust in people to being bullied in school or because they felt 'different' as children, "I've always had trouble making friends and trouble just fitting in ... I always felt like the weirdo."

For many who may have had a supportive network of friends at one time ("when I was younger I had tons of friends") they experienced the profound loss of trust as a result of their adult intimate relationships, articulated particularly well here:

> I don't feel close to people – that's been the most damaging. I used to, but I don't anymore. I have a very hard time feeling close to somebody. It's like, 'ya sure you really like me.' I don't believe it you know, when people say that to me anymore. I've had people say, 'I love you' and hit me. 'I love you' and they're stealing from my bank account. Like, I'll believe it when I see it.

For all the women, this profound sense of not trusting others had a direct impact on their present relationships: ". . . would it ever occur to me that, for instance, I could ever have a partner that wasn't in some way broken like me?" and hopes for future intimate relationships: "I don't feel good enough for anybody. I'm afraid to get into another relationship in the sense because I'm figuring well, they're gonna think I'm not good enough." Women learn not to trust their judgment: "well it's even worse if you question your judgment all the time - that's worse because

even if your arm is broken and never heals you can do a great deal, but if you don't trust you judgment ..." The same woman recognized that this betrayal of trust was being perpetrated intergenerationally when her daughter witnessed her father's violence against her mother, that her father relabeled as "your mother fell and I was helping her up" and further commented that it was this kind of atmosphere of lies and denial that led her to question her own version of reality. Another woman felt that she was not 'authentic' in public, that while she did not have an 'alter' personality nor was she dissociative, she felt she performed in a kind of 'parallel reality,' and regretted that she could not be that "zippy and wonderful" person at home for the people who actually love her. Having a personal version or reality dismissed or questioned by others – or even by 'self' - renders the subject invisible or, at best, inauthentic. Other women made similar statements about this phenomenon, for example "I seem to attract people who dismiss me." Invisibility, rejection or other forms of not 'recognizing' the woman's subjectivity (Meyers, 1994) makes her feel uncared for, unlovable: "I worry about abandonment, I guess because I think I'm unlovable I guess."

This sense of mistrust also permeated women's experience within social networks. "I guess you lose communication skills somewhere" commented one woman, "probably because you just don't share your feelings so that you just shut down . . . so when you are in a better or healthier situation, you don't know how to. You sort of forget what's normal even." Another woman avoided parties and her partner's friends out of mistrust:

> I don't know, I just don't trust her friends - I think they make her do things that she wouldn't do otherwise I guess, or they have a bad influence on her ... even though I know she is fully capable of making her own decisions . . . I guess I'm protecting because I know I've been manipulated so I think sometimes people are manipulating her.

For the women who *were* able to reach out to social networks, their stories relate how this had a great impact on how the woman came to perceive herself. One woman reflected that after her therapist recommended that she attend a group for abused women,

> . . . it was like, wow, it's not who I imagined I was. I'm a feminist and I have a feminist analysis and I'm strong and you know to realize that I've been in an abusive relationship! I guess maybe that's why I spend so much time figuring out why, figuring out what made me susceptible to it.

"We'd always lived outside (the province)" another woman recounted, "so I hadn't been around friends and family so much, and it is the feedback that I've gotten from people who've known me for a long time that allowed me to see myself differently." This phenomenon of connecting with others in this way, and the impact that had on their sense of self, was related again in the stories of many of the women, as will be seen in the next section on post-group treatment narratives.

Fourth reading for structured subjects.

This reading focused on analyzing structured power relationships and dominant ideologies. Not surprising, narratives of gendered experience and patriarchal relationships played large in the stories of these women's lives. Again, there is overlap with the other categories – for instance, family of origin relationships have been related in other categories as these relationships have great impact on attachment, the development of self, and the self-in-relation. However, in this part of the analysis I looked specifically at how not only early socialization informs these women's subjectivity, but values and ideologies that undergird the structures and institutions women continue to deal with on a day-to-day basis that send her messages about her subjectivity.

One may already have a sense from the preceding narratives about the values and ideologies – for example the dominant gender-role ideology that permeates some women's families of origin where men – fathers - are allowed special, unquestioned behaviour, authority and privileges. Violence and abusive behaviours between some of the women's parents was noted, sometimes including drug and alcohol use. In some families of origin, very high moral expectations in religious families or an unreasonably high work ethic left women with the feeling of never being good enough, never doing enough, never being allowed to claim time for herself or a sense of identity. Two women grew up in immigrant families – for one woman whose family did not speak English, that meant being forced by her father to take on an adult role – at age 12 - in negotiating legal and retail transactions on his

behalf. In the other, the woman was aware at a very early age that her father had hoped before she was born that she would be a boy, and had to deal with his disappointment with her "not being a boy" all her life. Two of the women disclosed child sexual abuse or suspected sexual abuse – as one women reported, "My older sister was sexually abused by my father . . . I am not sure if I was . . . I have body memories, but don't have my memories of it."

In the women's narratives, the patriarchal institutions like the legal system, the courts in particular, serve also to dismiss and disempower. In one woman's case, the police had been called to the home and had witnessed the abuser's behaviour, only to later dismiss the charges against her husband because, she was told, "basically, you know, he says something different than you say." Women with children reported being vulnerable to continued verbal, emotional and financial abuse by ex-partners who use the opportunity to control them through what used to be called custody and access orders, now 'parenting orders.' "I think he needs to be in control of the situation," was one woman's evaluation of her ex-partner who had never taken an interest in the daughter they had together, until she left him.

> Two and a half years (I) didn't hear a word from him, he questioned paternity, he was out of my life – boom! He decides to follow me to Ontario and we're in the Ontario courts at this point; so what is his reason for this? His tactic (I guess) of not being there didn't work, so now he's gonna try and be in my face and see how that flies for him . . .

Another woman who had been in a long-term common-law relationship was pointed about the financial abuse that added insult to injury:

> He would never marry me, right? And now he wants to pretend we're married because he wants my assets and me to take his debts so I have to pay. Looks like I'll have to pay a whole lot of money so I can get out.

She found it difficult if not impossible to defend herself in court since her ex-partner had worked under the table, making it appear that she had supported him during their relationship, and now he was suing her for support. In this case, ironically, a woman's 'visibility' in a financial/conjugal relationship (because she was honest and reported her income) worked against her, and her ex-partner (who lied and pleaded poverty) claimed he was a victim and might just succeed in having the courts aid and abet his abusive behaviour.

In a wage-based capitalist society such as ours, citizenship or 'the cultural process of subjectification' (Fiske, Belanger, & Gregory, 2010) is defined by workforce participation: receiving money for work and paying taxes. Women who were not 'attached' to the workforce spoke about the humiliation of being 'dependent' on income assistance:

> One of the things I have a hard time with is when people will ask me questions and, you know, they say things like 'well are you looking for a job?' (It) just really hurts because I do I mean I've never been dependent on anyone – I paid my own way through university, I did

> all of it I always took care of myself ... I do feel embarrassed not to be (working).

Another woman also expressed a pushback against people who would judge her, "I have a purpose. There's something going on," she asserted. "I'm not just some loser on Ontario Disability."

Round Two: Post Treatment Interviews Comparatively

Post treatment interview transcripts were read, again using Doucet and Mauthner's (2008) suggestions for layered reading of the narratives. The difference in post-treatment interviews was that these women had progressed through different treatment groups, either the community-based feminist *Woman Abuse Group* (WAG) or the mindfulness-based *Courage to Love* (CTL) group. So instead of reading the narratives of these women as a total aggregate, the post-treatment narrative data were read, analyzed and compared in aggregate by treatment modality, layer by layer (see Table 2).

First reading for relational and reflexively constituted narratives.

The first reading for relational and reflexively constituted narratives looks for central storylines, so the narratives from each group of women were read comparatively to look for similarities and contrasts of experience. The main question, "What were the top three things you learned about yourself" in the context of the group modality they were in, was asked of each woman. The intention was to give each woman an open stage to retell her 'story' after treatment to see if she had 'reconstructed' her experience of her self and the abuse she had experienced. This is

important in anti-oppressive feminist therapy, which supports an approach that deconstructs not only the narratives that women tell about themselves but also the negatively constructed identity that goes along with them (Brown, 2011). A second question analyzed within this first reading for relational and reflexively constituted narratives was, "What do you feel are the abuse-related issues that still affect you?" This question was also asked pre-treatment, so was relevant for benchmarking changes pre- and post-treatment from each woman's perspective. Answers were analyzed for dominant themes, as well as individual insights from each woman's perspective that further amplified or nuanced the group's overall experiences.

The quantitative data and analyses added another dimension to the analysis of the qualitative data, since it became clear from the statistical analysis of the psychometric scales that while both modalities were conducive to significant 'change' for participants, the data suggested that the kinds of change were different in each group as well. The Self Compassion Scale (Neff, 2003a) in particular seemed to indicate that participants in the WAG group felt that their sense of isolation decreased, and that women's level of empathic emotional arousal (demonstrated in the analysis of the BEES) (Mehrabian, et al., 1988) increased. These findings were supported by the analysis of the interview data. The majority of WAG participants reflected on the validation they received from others in the group about the reality of the abuse they experienced, exemplified in statements like "I can accept now that I was abused, but not to own it, that that was done *to* me," and "I felt a sense of what I went through – it is not to be forgotten, it's not to be shoved under a carpet, it's not

be ashamed of, it's very real." Another WAG woman also talked about her decreased sense of shame since being in the group, and the reification of her experience: "before it seemed like something that I dreamt, because there had been times when I tried to tell people about it and they wouldn't listen ... " she felt she was living in an 'alternate universe' until the group. Telling her story and hearing others tell theirs made it "a lot more real now" and being able to connect her abuse with the other problems she was experiencing now lifted a 'huge weight'; she now knows others recognize how she feels – in other words her subjectivity - her 'self', her feelings and her experience - are recognized by others.

"I discovered that don't know myself very well," was a common response amongst WAG participants. More than one woman also spoke of how the group had provided her with a different perspective of herself, that she had strengths she was not aware of: "I am stronger than I think . . . I can be funny," said one woman, then added emotionally, "and I deserve more." Another commented that the group helped her become aware of the positives in her life circumstances, not just the negatives.

In comparing the answers to this question with the CTL participants I became aware that the WAG women seemed more externally referenced, that is they looked more to others for approval, than the CTL women post-treatment. I think this observation is supported by statements from the CTL women that they had let go of how other people may have judged them:

> I just don't care about certain things anymore. I just learned to let a lot of stuff go. Even the house – like right now about a month ago if you

> would have come over here I would have freaked frantically and tried to clean before you came, you know what I mean? But you know what? This is our life and who cares? I'm starting to realize these little things . . . just relax and enjoy the now, because that's all you have.

Another woman commented similarly,

> I was very hard on myself with everything . . . I would force myself to stay up until three o'clock in the morning if there was something I had to do. I don't do that now. . . I don't force myself to proceed to do something against what my body is telling me to do . . . (I'm) able to know the difference between something that is important that you should be really fired up about, and something that, you know, *oh, ya, the dirty laundry is still gonna be there tomorrow* . . . I'm not gonna put myself in the grave for that or others things in life that are equally as perturbing.

Another woman, though not able at that point in time to change her behavior as the previous women had, did say that she noticed behavior in herself for the first time:

> It was very interesting for me to observe . . . I'm very judgmental too – always sort of scanning other participants, scanning the room and I don't know if that's – I don't want to dignify that with saying that it's trauma-related hyper-vigilance . . . I couldn't ever just chill.

One CTL participant had quite a remarkable reversal of her symptoms of depression and anxiety, to which she attributed her newly developed skill of attending to her feelings.

> I wasn't listening to my feelings. I wasn't paying attention to how I felt. I learned that feelings are the greatest indicators of what is right or wrong for you. If I felt bad, then it would kidnap me... I would be at its mercy as opposed to looking at it . . . and just being curious and saying, *OK come in and sit down. We're gonna sort this out* or not even if we don't sort it out *we're just gonna deal with it,* you know? So I was totally ignoring that. I didn't even know. So that was one of the things I learned, was how to deal with those things which has made a tremendous difference in my life because it just shortens the amount of time I feel bad by – there's no comparison.

By the time I conducted this interview with her, she was no longer taking her prescribed medication and had also quit smoking. In her pre-treatment interview this same woman had confided in me that at that time she was terrified to go off her medication for fear of returning panic attacks and depression.

> I don't dare go off them. I feel I need it because I just start going into a dark place without it after I've been out of it for a week or two. I start going into a dark place where I just start losing the desire to do anything except nap on the couch.

Another CTL participant who had disabling chronic depression noticed a difference in her affect as well. Normally, she explained, at that time of year (the interviews were done in December) she would be in

> . . . such a severe depression. I'd be crying all day. It's not as bad as usual. I am depressed but it's not – I'm managing it . . . I think it's partly because I tell myself *this is depression*. I accept that I have it instead of trying to go *I don't want depression* – getting all panicky. I just go, *Oh, now I'm depressed* – I don't like it but I just try to tell myself *this is the way it is* – I'm way kinder to myself when I'm depressed than I used to be, you know. I've learned to balance my energy better whereas before I would just exhaust myself and the depression would be worse.

There were some interesting contrasts between the two groups when I inquired about the abuse-related issues that they felt still affected them. The main WAG participants' responses to this question contained references to anger, regret and what appear to be symptoms of posttraumatic stress. Three of the women were rightfully angry about the abusive treatment that they had received, and in some cases continued to receive, from their ex-spouses; angry about the toll the abuse was taking on them (and in some cases their children) and finding it difficult to get beyond the anger and aftermath. "I'm finding it very hard to be forgiving," explained one woman, "certain things are just wrong and I could see that they could have been avoided . . . I'm still dealing with the hurt . . . the unfairness . . . I didn't get my fair

share of anything . . . I think that's why I am so fatigued all the time." Another participant remarked that she was not comfortable with her angry feelings, and sometimes she got angry "about the wrong things, or small things, but really it's like I'm angry about something else." Her way of coping with her angry feelings was to distract herself instead of going "into these dark places," by renting a movie or exercising. One participant was also extremely angry at both her abusive ex-spouse and her family-of-origin:

> So I just feel like I have these two chains around each foot and I can't get rid of them until they die. I just cannot see a way to get rid of them, not intellectually; I can't see a way, not emotionally. I can't see a way. It's like I have these two growths, and they're inoperable, you know? I know I should go and see a psychiatrist . . . and maybe I will someday but you know, I don't know. I've been trying to do the best I can.

Another woman worried that her son "probably will be an abuser after living with his dad and having his dad as a role model." Another was still in the middle of dealing with "the practical part of when you are in an abusive situation – you know, finding lawyers that really get it."

Many of the WAG women also continued to deal with flashbacks and anxiety, including panic attacks, as well as eating and sleeping problems. One woman found her memories and trauma triggered at work by a loud and aggressive supervisor.

> Oh my God he's like an exact replica of my ex-husband. I'm just superimposing one over the other because they're both intimidating

> people . . . I'm still always trying to get myself not to overreact to it because of my past you know, so I'm always trying to catch myself with doing a lot of second guessing on what I'm telling my director above the supervisor.

CTL participants' responses to *what they felt were the abuse-related issues that still affected them* focused on safety and boundary issues in intimate relationships. Mentioned previously was the woman who was dealing with abuse-related chronic depression, but felt that it wasn't as severe as she thought it might normally be for that time of year. She and others commented on still dealing with relationship issues, mainly of trust. "I find it very difficult to be in any intimate relationships even friendships," she said, It's hard for me to trust that way." Another framed her fear of intimacy as a safety issue, and her difficulty trusting *herself,* whom she referred to as her internal lead or guide:

> I would say that my internal lead is, I would say, pretty much gone entirely under the radar. It's pretty buried at this point which probably only compounds its power and its irrationality, right? . . . the internal guide is so wrapped up with anxiety and safety it's like the emergency support system rather than some sort of intuitive all-loving inner voice.

Another framed her difficulty with relationships in terms of not being able to set her boundaries:

> I still have a hard time knowing how not to be taken advantage of. I'm very slowly still in the progress of learning how to stop giving people the shirt off my back, but that is a result a direct result of abuse, of having to forcibly give people what they want . . . I'm still in the process of learning how to say no.

Unlike the WAG participants, the CTL women did not report dealing with overwhelming anger or anxiety; sometimes quite the opposite:

> I'm sleeping better and I'm not as worried (or as) anxious as I was before, even with the whole (ex-partner) thing. I now (laugh) *it's just there; it's always gonna be there, and it's just how I deal with it . . .*

Only one CTL participant still seemed to be overwhelmed with the legal process of divorcing an abusive husband, his continued manipulation of their teenaged child and the unfairness of it all. In fact reading and analyzing her transcripts was next to impossible because her answers were so illogical and diffuse, revealing perhaps how chaotic and oppressive her circumstances continued to be. It may also be her way of relating to the interviewer/ therapist that provides protection and safety (Briere & Scott, 2006). However overall I felt that the mindfulness modality had given most of the participants new skills for dealing with the lingering effects of their trauma, including a new awareness of thoughts, emotions, moods and fears (including boundary issues) that she had not been able to recognize previously.

Second reading for tracing narrated subjects.

"A second reading of interview transcripts attends to the particular subject or narrator in the interview transcripts, and how this person speaks about her/himself and the parameters of their social world" (Doucet & Mauthner, 2008, p. 405). Post-treatment questions allowed the women to speak about *who they believe they are.* These included questions that prompted reflection the impact of their group modality on: self-awareness (*your ability to identify your feelings?*); self-compassion (*the ability to be kind to yourself?)*; self-concept (*your sense of who you are?*); and agency *(ability to create positive change in your life?)* According to Catrina Brown (2011), if women have engaged in anti-oppressive forms of therapy, we should see a re-authoring of ontological narratives post-treatment:

> Rethinking power includes unpacking ways that both feminist therapists and clients keep oppressive stories alive. If we want to avoid solidifying dominant and oppressive cultural stories, we need to unpack and reconstruct clients' stories rather than leave them intact. 'Reframing' in feminist therapy shifts unhelpful stories and enables the creation of alternative or preferred stories. It is also important to explore the question of women's agency or action, and the possibility for resistance and action outside of dominant stories. Using these approaches, feminist therapy can acknowledge and support women's self-determination, agency and power." (p. 105)

The Woman Abuse Group (WAG) or 'traditional' feminist modality participants spoke about their *increased ability to identify their feelings* in the context of the in-group experience. Other group members acted as a mirror through which they could identify and normalize their thoughts and feelings:

> You know, you go around in a circle and everybody says things ... it's just like, you know, you're looking into a reflection sometimes and I think that had been a big help because ... there wasn't a single feeling that I mentioned in that group that nobody could relate to.

Another woman reflected, "hearing my words come out of *their* mouths, maybe not exactly the same words but the same stories, simply validated that, you know, it happened to me." This perception was echoed by another woman who observed, "I think hearing other peoples' thought processes when they were going through situations was important to recognize that I'd also thought the same things."

I was not able to discern from the dialogue with these women whether the narratives of victimization had been challenged within the WAG group setting. However, I think these narratives points toward the breaking of isolation that was indicated in the Self Compassion Scale that accompanies the normalization of experience. It is reminiscent of Brison's (2002) observation[29] that it is important for

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[29] "Just as one can be reduced to an object through torture, one can become a human subject again through telling one's narrative to caring others who are able to listen" (p. 151) and "to the extent that bearing witness re-establishes the survivor's identity, the empathic other is essential to the continuation of a self" (p. 152).

survivors to tell their story, because talking about the abuse and violence does something to it, especially when they talk with other women with similar experiences.

By contrast, the women in the CTL group responded to the question about their *increased ability to identify their feelings* from quite a different perspective, one that might be described as personally reflexive and mindful. One woman, for example, stated that she felt she was always aware, perhaps too aware of her feelings. She often referred to herself as 'over sensitive' but noted that she had a new perspective on this:

> ... yes sometimes being sensitive can be painful but it's also an aspect of my personality that I'm very glad I have you know, because being sensitive is not very popular in the west but you know it is in other cultures . . . I think being sensitive is part of having compassion and stuff you know so I'm OK with that, but it can be very painful sometimes.

Another participant responded about her ability to identify her feelings within a story about a 'mood disorder' diagnosis she received from a psychiatrist when she was a young woman:

> . . . but maybe he made a mistake and misdiagnosed me and I'm not that way at all you know I just thought, well isn't everybody high strung? Because at the time he said to me *'oh well the layman's term for (diagnosis) is high strung,'* and I said, 'well, isn't that most women

> walking around out there? Isn't that my mom, isn't that my sister, isn't that my teacher, isn't that every woman – high strung? That's how we get things done!'

The participant who had identified that she was no longer depressed, remarked that she was now, for the first time in a long time, able to identify positive feelings:

> I'm also able to not just (identify) the negative feelings but, like this morning I opened the blinds and I just stood there, so not only am I able to identify when I have a negative feeling because you can put the negatives into perspective ... you have more room, you have more time, you have more – what do you wanna call it – you are more open to enjoying the good feelings ... sometimes you just look outside and it's like *wow* you know, walking to work in the snow, in the bright sunshine, you know?

In reading and analyzing the responses to the questions around *sense of self, agency, and self-compassion,* it became clear especially around self-concept and agency, that these concepts were interwoven for many of the respondents. Women seemed to see themselves as both emerging and as agents in that emerging process. This example from a WAG participant put this emergence in the context of finding a lost self, an emergent subjectivity:

> we've talked about finding ourselves again. You know it's a journey, like you know after leaving a relationship to find yourself again 'cause you get squished down to this teeny tiny person, you know? You start

> begging, you end up real small. But I think I always did have a good sense of myself, it's just broadening again... I want to go back to school, but I want to pick something that's gonna make me happy. I'm not exactly sure that that journey is. One step at a time; but some of it's still vague to me, but I know that I'm on a journey, you know, and that I'm happy now . . .

Within the context of the WAG group experience, women often discovered aspects of themselves that they had forgotten about or did not fully appreciate they had:

> Well I have a sense of self now that I don't even think I had one when I started I think I remember coming in here before and telling you like I didn't know who I was (laughs) . . . and I have felt like that a lot. I think the part that was missing was that I wasn't linking things . . .

Another echoed this sentiment in a story she related about conflict between herself and a supervisor at work, "so (the group members) affirmed to me that no, like, that's unrealistic and you deserve a better place to work – I mean it's just a job and it's not part of who I am," and also talked about how the group had given her perspective on 'the journey . . . to accept and take care of myself."

Many of the WAG women discussed feeling validated in the group around self care and self compassion. One woman commented that she internalized oppressive, gendered narratives of "self" that were unpacked and challenged:

> I learned about the word self (as) describing a woman that's selfish, it's selfish, self-absorbed self, it's all followed by something not positive, self-centred self . . . I suppose those words are used for men too but I don't think they're used in the same connotation . . . you have to turn that around and say *no the self is very important* cause if you're not functioning right you can't help anybody else. It's like they always say, if you're in an airplane you put the oxygen mask on you first, then you help others . . . a light bulb went off . . . you know I'm entitled to that, I'm entitled to, you know, if I'm working on something that's mine, and somebody comes in and I don't necessarily have to put mine aside . . . this group has taught me that what I want is not a bad thing, it's not a selfish thing, it's my right and so I think I'm getting better all the time, I'm getting better subconsciously all the time, and I am really looking forward to what's gonna happen in the next few years or so.

When the WAG women were asked about self-compassion, including being able to forgive themselves when they've made mistakes, a couple of them tended to speak somewhat abstractly. One woman remarked:

> I can only use a basis of comparison. Lots of people have it worse than I do . . . (that) doesn't necessarily forgive myself for where I'm at, but at least I was able to, you know – it could have been worse, so I was able to get out early on, where other they've been there a lot longer than me . . .

The second woman wrestled with the concept in the context of self-compassion in intimate relationships:

> . . . understanding that in a man's world what happens to women, and that we need to be kinder to ourselves, you know . . . it's not an easy place to be, that's for sure, and nobody else is going to do it for you . . . you have to learn to love yourself first and teach our children how to love themselves so that they'll have love in their life. Love comes on multiple levels in your life, you know? It's not just through sexual relationships with men.

Two others from the WAG group were able to personalize the idea of self compassion, observing that it was a work in progress for them:

> Being able to open up to people more, being able to find validation in what I was feeling and everything so I think those are baby steps to getting there . . . I'm not being as hard on myself as I was because when I would make a mistake before I would be mortified, especially if it was a social mistake.

"I kind of had the perfectionist thing going on for a while," remarked the other participant, "it's easier to accept my limits, I guess."

Like the WAG participants, the CTL women also spoke of self as emerging. One CTL participant explained:

> I think I'm getting there. I think I sort of lost myself in my 20's and I kind of didn't really figure out who I was and then the relationship

> (with her abusive spouse) and (the subsequent birth of their child) and I just never really became who I should be or I never found my little path in life, so I think I'm starting to get on some kind of path and just go forward and figure it out. It's not easy.

At one point in the conversation with her I remarked that I had noticed that she seemed more radiant with each successive week of group. "Ya, (my boyfriend) noticed that too," she replied. "He's like *you're glowing. Are you pregnant?* (laughs). No, but no, I don't know, it's it's good I guess . . ." Another CTL participant used an analogy of new organic growth to describe her emergence:

> I would definitely say I was stagnated for very, very long, and when I tried to evolve I was stuck back you know, the roots - maybe I was trying to shoot out and they were - the shoots - were stuck back into the ground, *how dare you,* and I walked away from the *how dare you*s and now even if there is a *how dare you* I'm just fine, I'm not listening to you. It's the simplest thing in the world and it's one of the hardest things to learn, the right to say I'm not gonna take on your demons or I'm not responsible for your actions . . . I'm feeling better about myself ... you learn to surround yourself with positive people – I've learned that's very important to surround yourself with positive things and then I just think it's a natural – it just evolves, it's an evolution.

I appreciate how this participant was able to change her relationship to her oppressive interior narrative and how that translated into a different way of being in the world, by surrounding herself with positive people and experiences.

Two of the CTL women expressed not only a re-authored story of an emergent self as agent, but also an expansive sense of self, much like the metapersonal self described by DeCicco and Stroink (2007). One woman reflected:

> Instead of seeing myself as a weak person who couldn't cope, I'm starting to see myself as a strong person who can survive, and that's a huge change ... I've changed my life around in a way that I'm living my life purpose in a way I feel like I'm getting close to this somehow. I think I mentioned this to you last time that I'm getting somewhere towards a life purpose and I think it has to do with the books I read and the mindfulness and I'm heading towards something . . . I try to only take from the world what I need. I'm very concerned about the environment. It's made me more aware of the big picture, instead of just me, me, me, you know . . . I used to think (of) my sensitivity, *I just can't cope, I'm bad.* And now I'm seeing that this is a spiritual gift and I need to be kind to people, you know? Like when I die, I'm not going to ask myself, how much stuff did I do? I'm going to ask myself, did I heal? Did I do the best I could to heal –was I kind to people? Did I forgive? You know, those are the questions I am going to ask myself.

The second woman described her emerging and expanding sense of self – or 'metapersonal self' - in the context of a new year's reflective journaling process during which she would celebrate a 'significant' birthday:

> I was going to put aside, you know, the fact you know *oh, the fading youth, if I don't have a man now I better hurry up* . . . I was going to give myself a reprieve. OK, this year was going to be for me and mine . . . I was going to concentrate on me and I was not gonna worry about those things that you know can worry you . . . so this all came out really, really nice and I thought, *hmmm you know what? This sounds really good! I think I'll take my own advice!* (laughs) So that's what I decided with this year that I'm not going to be looking for that man because you know nobody wants to be alone, but I'm not going to close myself to it either . . . I'm gonna take a year from that . . . and really live in the moment and really see what happens at the end of the year and if I wanna take up the reins again then I guess I will . . . maybe I won't, who knows.
>
> I like me more now. I don't necessarily get lonely at night anymore like I used to or if I'm on my own, whereas before I always needed someone around to respond to or something you know? If I was alone I would – it's almost like I didn't exist for me, there had to be someone else in order for there to be something going on in life,

and now even if I'm on my own something *is* going on in life, and *it's my life* and it's *I like it*, you know?

And I do count my blessings. I look around and say look, this is yours, you earned this, you left a marriage with nothing, you know and you started over and look you could have gone down the drain with your depression and whatnot, but you didn't, you somehow found yourself and with things that make you feel damn good, you know! And, and follow and keep surrounding yourself with things that make you feel good, with people that make you feel good, and those that make you feel bad, well, that's your system telling you hey, maybe this isn't the right thing for you . . . there is still a struggle though with the um, if you deny the negative then you are being irresponsible, you're sticking your head in the sand, you are not facing reality. That is the reality, that there are lots of people that are hungry and you should face it yes, but facing it and feeling hopeless and feeling impotent about that doesn't help. If you're going to face it use methods to alleviate what you are facing otherwise what's the point? Like what's the point of staring and stamping your feet? Do something – so the thing I've done is picked three charities . . . and hopefully I'm doing something good.

A CTL participant who had been diagnosed with a mental illness, and continued to struggle with the label, commented that mindfulness had given her the space with which to respond to her difficult mindstates in a skillful way,

> . . . an improvement in the respect of having more control, if we once again want to use that word control; having more control over our faculties which naturally improves your self-esteem, because you don't feel like such a nutcase all the time, if you can think of it that way . . . how to respond to things, coping mechanisms puts you in a better frame of mind in terms of how you feel about yourself because you know, oh ya, I learned that because *these thoughts are thoughts* I don't have to react like a crazy woman when something happens. And by virtue of that (it) will improve my self-esteem, because I won't make a fool out of myself in public by blurting out or something, on the bus or in the grocery store.

She also had re-authored her former story of 'self' into a position of strength.

> I don't wanna be someone else who doesn't have those kind of things (high and low moods) 'cause I don't know how deep their brains go, how deep their waters run. What kind of life experience are they having? Do they actually experience life or do they actually deny so much of what is going on around them that they don't fully live the experience that they could be living by having these two different (levels of mood) . . .

However, not every participant had a positive experience of group. One woman was not able to re-author her experience:

> I don't know if I believe in recovery. What story can I tell that I can live with? . . . you know I haven't found one . . . I think the other piece that kind of haunts me is I keep thinking it's a bit of a head trick right . . . if I didn't believe it was traumatic, it wouldn't be, if I could just think, *oh, it was harmless, it was whatever* then it would lose its power as a source of shame or anxiety or whatever . . . but you'd have to change your beliefs all around it and I don't know how to do that . . . my question is, well, am I just invested in being broken because it's more interesting or it's I can't actually deal with the identity loss, if you know what I mean.

The fact that this was the first group she had ever attended, caused me to reflect on a couple of things. The first is that this woman should probably have gone into a first stage feminist group like the WAG, if she was ready for group work at all. I suspected that she had issues that required work in a trusting, one-on-one therapeutic relationship; and given her level of distrust of therapy and therapists (note above that she said she did not believe in recovery, and in other parts of our conversation she said she did not trust therapists to not mistreat her as others had in the past) this might take years to establish. I also considered whether the CTL modality needed in fact to include some feminist narrative therapy techniques as a way of challenging internalized oppressive characterizations of self.

Third reading for relational narrated subjects.

Many of the participants of both groups contextualized themselves in relationships from the micro to the macro: intimate partners and children, their own family-of-origin, social networks of friends and co-workers, to suffering in the whole world, creating an overlap with the second reading (for narrated subjects). This overlap was evidenced in some of the quoted narratives above, and the third reading for relational narrated subjects that follow in this section.

It is evident that for the WAG women, their subjectivity was highly relational and this subjectivity became problematic for them as a result of being in an abusive relationship. For many of the women, empathy and compassion towards others was complicated as a result. They offered a number of examples of how they coped (or did not cope) with strong affect as a result of bearing witness to the difficult stories of others during group. One woman articulated this well:

> You put them (emotions) aside, because you're just trying to survive, right? And you can't deal with the intensity of the emotions that are coming up so we tend to shut down emotionally which is what makes it difficult for us to be available for other people's pain as well, because we can't bear to even be available for our own pain.

Another WAG woman remarked that even post-group "(I am) really surprised at how little energy I have for emotions, like very strong emotions . . ." Another woman said that she carried a violent movie scene in her head for months. "I can't let it go," she said, "I'm still very bothered and that was months ago. I'm still very much

carrying that." One of the WAG participants stated that she thought the group generated a negative effect on her in terms of dealing with strong emotions, and that it impacted her relationship with her child:

> Definitely I'm worse – I do think I'm worse but I don't know, I'm not sure why, maybe it's because you hear all the sad stuff and you're not able to sluff it off . . . I do notice that like even right now with my daughter having sleep issues and a bunch of other things coming from the supervised access visits, it's like she's really wigging out in the evenings and I'm not the person to go in there and calm her down, like I literally have no ability at all to speak calmly to her.

It seems logical that if women are exposed to others' traumatic stories, it would have the effect of increasing their emotional empathy as well as heightening their stress response. This is a good example of where I think the integration of compassion-focused mindfulness meditation could be beneficial to women within a feminist trauma therapy group. It would give them the space and skills for holding their difficult emotions and the emotions of others that was evidenced in the interviews with the CTL participants that follow.

Evidence of complicated relationships as a result of the abuse surfaced among the CTL participants also, but post-treatment in the mindfulness modality they seemed to be able to reframe their experience in a way that was different from the WAG women. One CTL woman who had been brought up in a religious family-of-origin was highly distrustful of empathy and compassion:

> I spent most of my life being taught to be basically in that place, you know: don't find fault, don't fight back, always look on the positive, and I got hosed because of it. Because it left me completely unprepared to deal with the reality of how people treat each other, and what they're willing to do in this world, and left me way too naïve and also way too guilt ridden about how I knew myself to be . . . because I'm not all sweetness and light and loving and kind all the time . . . and nor is anybody else, and so I have a complicated reaction to being told to be, you know, to feel love and kind about things. I also feel my compassion has been used against me very effectively and continues to be by my ex, and I have a conflicted relationship with it because I need to feel lovingkindness in order to be a person that I like, and in order to be in the world the way that I want to be . . .

She offered that she also wants to be loving and caring towards her children, so she 'knows' cognitively that love and kindness are important in her relationship with her children, so even though

> I'm skeptical ... I used a lot of the language and the concepts anyway. So I would talk with them about things like *where are you feeling that in your body* and *just breathe* and bla bla you know . . . I don't know whether they find that useful, but what I think they find useful is . . . the full attention that they get when they're engaging in that, and I

> think because it's in a relationship of trust and intimacy, that's soothing for them.

She paused and reflected, "Now *I* don't have the option of getting that from *my* mommy right now (laugh) ... I'm sort of called upon to be my own mommy at this point." This statement suggested to me that this woman had grasped from her CTL group experience the importance of how we heal in relationship when we are recognized, held in a space of compassion where we are soothed, i.e. emotionally regulated, and how that task is now hers to perform for herself, the way she does for her children.

It was humbling to listen to these women put a positive frame on some of their most terrible experiences, in terms of the humility, humanity, compassion, and the empathy that they expressed. One CTL woman who had been brought up – and traumatized – in a wealthy family found herself, as an adult, living in a women's shelter, trying to get clean from alcohol and drugs. Her time in the hospital and the shelter had a huge impact on her perspective on life:

> I met all kinds of people I never ever would have met, you know, like people from walks of life, from jail, and kinds of things I would never have done – uh, prostitutes, people like that; but I got very close to them and now you know, if someone's in a women's shelter I don't think anything (bad) of them . . . I know how it feels to be there . . . it's a tough journey and you know I've learned more about all different people and where they come from, and so I feel more I can fit in all

> over the place now you know, like I can fit in at Holt Renfrew, I can fit in with the government doing stuff but I can also fit in with somebody who's living in a women's shelter, or when I see a homeless guy on the street, you know I don't just go *oh you poor little thing* . . . I (go) *how are you?* Like I have a conversation, he goes, *I'm having a rough day. Ya* I go *I know, I'm sorry you're on the street, like that's not a good thing are you OK?* . . . I don't feel like oh, he's not as good as me. I feel like I can be on the street. I know that.

I believe this suggests that this participant's experience is an example of how mindfulness can lead to the creation of a larger perspective of her life in relation to others, and of a 'metaself' that is more compassionate and forgiving. Combined with a structural analysis – that this can happen to anyone, including herself – leads to conscientization, personal moral agency and action.

Fourth reading for narrated structured subjects.

This reading "focuses on structured power relations and dominant ideologies that frame narratives" (Doucet & Mauthner, 2008, p406). Many women made the connection between their sense of self, agency and their 'material conditions' – talking in some cases about how their former spouses, who were financially abusive, had held them responsible for their materially impoverished circumstances; how the system continued to be filled with barriers to improving their lives: from the combative legal and court system that bled them of money and custody battles that bled them of emotional well-being; to municipal politics that resulted in a bus strike

during the research project; wrestling with mental health institutions and practices particularly mental illness diagnoses; and to social assistance that provide way too little money, and way too much stigma. I believe that one of the main strengths of the feminist WAG group was the opportunity for women to talk about and unpack their experiences of abuse from the personal to the political, and to frame it in a narrative of strength, survival and ingenuity. As one WAG participant stated,

> . . . so both improving your material conditions if you like, you know, your day-to-day environment and your means in the world. Also, sort of the inward environment with a feeling of more self-esteem and feeling a little more empowered and self-confident.

The women from both groups touched on the political in their analysis of their circumstances, the women who attended the WAG modality more so after their group than the CTL women. That's not to say the CTL women were less politically astute, just that I don't believe that their participation in the CTL modality was directly responsible for their politicization. However, that being said, as the modality therapist I do (and did) identify myself as a feminist and it is probable that my language, comments and didactic content reflected that. All the CTL women with the exception of one had been in at least one community-based (and probably feminist) group before, and the one who had not been in a group before had received some post-secondary education in women's studies, so these participants often reflected upon their experience of self with a gendered analysis, like this example:

> I mean women are so programmed to *you're a daughter, you're a mother, you're a wife, you're* - you know? and if there's time left over - and of course society makes sure there is no time left over - then you can be *you*, you know? and then by that time you have no idea . . . so no wonder we all end up psychotic, you know? (laughter).

Discussion

Using the Doucet and Mauthner (2008) model for analyses of the data was a good decision because it allowed for a structured and logical way within which to analyze the material while being mindful of all the layers that the narrative offers. It also highlighted how overlapping and interconnecting the narratives are, much like the working models of self-in-relationship to which we arbitrarily assigned 'parts' but are really all-of-a-piece. We should also be aware of the gaps in the narrative, the 'silence' that is present in the conversation. This is the perhaps the part of the woman's 'self' that cannot be known in the sense that Doucet and Mauthner talked about, and that we must be careful that we do not confuse her story for who she is. Those two threads or modes of self-reference (the 'narrative' self across time and the 'non-narrative' self in the present moment) are not so easily discernable for 'western' minds as research has discovered (Farb, et al., 2007), but are made more discernable through mindfulness meditation training.

Was there a difference in the levels of self-compassion and empathy before and after treatment? Potentially, the quantitative evidence is matched by the qualitative evidence, that the women's empathy in both modalities was increased by

their group experiences. The increase in empathy for the women in the WAG modality seems to have been a mixed blessing. Empathic arousal from the listening to each others' narratives might have been instrumental in breaking down their sense of isolation and 'craziness', but as the women said themselves they also had a hard time 'holding' and processing the disturbing stories that others recounted, some to the point that there was negative spillover into familial relationships. Some women also reported a decreased tolerance for their own emotions such as anger and regret, and a blurring of boundaries. When asked about self-compassion, most of the WAG women could only speak abstractly about it at best.

By comparison, the CTL participants seemed more internally referenced and tolerant. They seemed to display greater skill in letting go of what others thought of them, more time and care in paying attention to and processing their emotions and mental health issues. One woman was quoted as relating her new relationship to herself and her on-going mental health challenges to mindfulness meditation.

Was there a difference in the way the women in both groups conceived of themselves post-treatment? I would say yes – both groups of women gave compelling narratives of their emerging selves. For many of the WAG women, the narrative was in the context of reconnecting with or re-finding a lost self. There was a strong sense of these women being the empathic 'other' for each other in group, of recognizing each other into subjectivity and challenging each other on internalized oppressive stories of self. In the CTL modality, this sense of emergence was also present, but the participants also spoke of themselves in expansive terms, akin to

the 'metapersonal self', as an agent for social change, or as being part of 'something bigger.' I think that this beautifully illustrates the strengths of the different modalities. One excels in supporting the women to be empathic – and political - listeners for each other, and the other provides women with the mindful holding skills to be able to bear witness and act without becoming overwhelmed by afflictive emotions. In this way we can build upon a dynamic, dialectical understanding of the self as both constructed and non-constructed.

In the final chapter I will explore how to apply the lessons that these women have offered from their experiences of the two different modalities. My thoughts are, based on the theoretical frame work and the evidence suggested by the data, that a Mindfulness Based Feminist Therapy could combine the strengths of a feminist anti-oppressive narrative therapy as proposed by Catrina Brown (1984) and a compassion-focused mindfulness-based cognitive therapy.

Limitations of the Research

The research would have benefitted from stricter inclusion criteria in the group modality samples. There was one overlap in membership, that is, one woman had participated in the WAG modality before being accepted into the CTL modality, possibly influencing the pre- and post-test measures. Also, as the researcher, I might have benefitted from more first-hand experience of the WAG modality, in order to conduct a more thorough comparison of the two modalities. The modalities were also of different lengths; the WAG modality was 12 weeks compared to the 8 week CTL modality. If the CTL modality had been the same length as the WAG

modality, there may have been a significant difference in mean scores in one or both scales between the groups post-treatment. Changing the design of the CTL modality to a 12 week format is a consideration for future iterative research.

In the process of analyzing the interviews I realized the privileged place that I occupied with the women in their healing process, especially with the CTL women. I was not only the researcher but also their therapist, and so I admit I was more invested in their post-treatment outcomes than the WAG women, which made collecting and analyzing their data challenging. I also realized as I listened to the interview data that I had a hard time turning off my role as therapist (and educator) as an interviewer. Over the course of the eight-week program I had built a relationship with the CTL women that did not happen with the WAG women, and I am aware that this would have an impact on their responses to me as well, as we do wish to please those with whom we have developed a caring relationship and/or perceive as wiser, more powerful etc. I am also a survivor of interpersonal violence, and while I was mindful of my own thoughts and emotions during the collection and analyses of data, I am aware that my history has a potential for creating unintended bias. A blind rater would have eliminated some of this bias, but resources did not allow the hiring of a research assistant for this purpose.

During my analyses I was mindful of these issues, and I identified my bias towards 'my' treatment modality and made note of them in my NVivo journal. I feel it was helpful that I analyzed the quantitative data before the qualitative analysis, as the quantitative analysis provided sobering (to me) results that suggested that the

CTL modality was not 'superior' to the WAG modality. The mixed-methods used helped triangulate the data and analysis; the use of NVivo to analyze, track, make notes, and its auditability; the member-checking of the transcribed material; and the use of the Doucet & Mauthner (2008) *Listening Guide* that required multiple readings of the same material, all contribute to the reliability of this research. However, the combined group-facilitator-as-researcher role is, on reflection, a limitation of this study; this research design would likely benefit from separating out those roles as there would be less risk of participants responding to the researcher's questions in alignment with the researcher's bias.

Chapter 6: Conclusions

Implications of the research findings for practice with women

The intent of this research was to study the role of mindfulness in activating and nourishing self-compassion and empathy for healing the 'self' with women who survive interpersonal violence. The study started with the theoretical premise for the connection and importance of empathy and self-compassion in how we come to understand the 'self' and the self as relational; then established the positive correlation between self-compassion and empathy using two psychometric scales with a population of university students. From there it evolved into an exploration of the effectiveness of two different modalities, one feminist-based and one mindfulness-based, for increasing empathy and self-compassion. The research suggested that both modalities increased the women's mean scores in both areas, and offered an initial glimpse into the positive healing effects of both groups in spite of their slightly different interventions. When more layers were peeled back and analyzed, the data suggested some interesting differences in the subscale scores of the self-compassion scale that hinted at the different kind of change that may have been happening, one modality compared with another.

Laying the two modalities side-by-side, the data suggested that each had strengths, and each had something to offer the other in terms of ameliorating the effects of abuse for the participants. The feminist-based group seemed to be better at facilitating story telling, breaking women's sense of isolation, reifying their

experience for them and at the same time challenging internalized oppression and raising their political consciousness. The feminist-based group also increased women's emotional empathy, sometimes to the women's detriment as at times they found containing and processing the stories and emotions difficult.

The mindfulness-based group, like the feminist-based group, helped women see themselves differently. They were able to see themselves more kindly, were able to potentially let go of what others thought about them and many of their self-judgments as well. There was an increase in mindfulness, an increase in their sense of common humanity, evidence of an emerging 'metapersonal self' that was more aware of the suffering around them and the interconnectedness of all beings. And finally, there was a decrease in over-identification with others, which is in sharp contrast to the women in the feminist group who were often overwhelmed by their emotions and the emotions of others. The mindfulness training seemed to help women learn affect regulation skills, and arguably also gave them skill for attending and responding to others with 'true' empathy, that is not losing the 'as if' quality of sharing another's emotions. Theoretically then, this self-in-relationship becomes the interior working model of the securely attached 'self' capable of empathic agency.

The implications for these findings are that the tools that mindfulness-based modalities employ could be useful to feminist therapists and our clients. Many feminist trauma therapists are already using mindfulness-informed modalities that employ informal mindfulness practices very successfully, and so they should continue. I would argue that we should also be making use of the formal meditation

practices of mindfulness-based modalities when they are appropriate because of the liberatory affects that have been suggested by this research, and because the underlying theory and values are congruent with feminist epistemologies and complement anti-oppressive modalities like narrative therapy.

Feminist-based therapies have much to offer mindfulness-based modalities in turn. Mindfulness-based modalities have been adapted in the west under a medical model, and so are fashioned on a diagnose, prescribe and cure pattern not unlike the way the Buddha diagnosed human suffering (the Four Noble Truths) and prescribed the Eightfold Path in order to achieve the cure (nirvana). Therefore this approach can also be interpreted, if not used critically, to simplify complex problems by locating the 'problem' in the person. Feminist and anti-oppressive approaches reject this, noting famously that the personal is political. Critical Buddhism, or engaged Buddhism also has a history of political engagement.

> Buddhists generally agree, for example, that their path entails an inner transformation in which the painful aspects of the three mental poisons – greed, hatred and delusion – are reduced in the life of the practitioner. And they agree that this change will have beneficial ripple effects in society. But engaged Buddhists, while affirming these teachings, are likely to press on, to seek the harmful *social, institutional* and *collective* expressions of these mental states in the policies and programs of corporations and governments, and to

address them at the social, institutional and collective levels. (Queen, 2002, p. 325)

From my experience of mindfulness-based modalities like MBSR, social justice may be inferred but is not explicit. That is, unless it is facilitated by a feminist therapist or someone working from an anti-oppressive theoretical framework. This has more to do with the 'theory-driven' nature of feminist practice (Brown, 2004) than the modality per se. So far in my experience, political conscientization and social action have not been a part of mindfulness-based modality training, although it is present in the writings of Kabat-Zinn (2005) and others as noted by Queen in the previous quote. However, we may be witnessing the leading edge of change towards integrating social justice into mindfulness-based approaches. The Center for Mindfulness (founded by Jon Kabat-Zinn) hosted a conference in 2011 on 'Mindfulness in Society', which explored and facilitated dialogue about social justice and political change through mindfulness. My hope is that this signals a nascent willingness to change mindfulness-based modalities (like MBSR) from an individual, medical model to a more structural/critical approach, and that this research might contribute to that shift.

Mindfulness Based Feminist Therapy

What I am proposing therefore is a Mindfulness Based Feminist Therapy that appears to be 'good' feminist therapy as described by Laura Brown (2004) and critiqued by Catrina Brown (2011). I am affirming 'good' feminist therapy's eclectic

approach by suggesting that mindfulness-trained[30] feminist therapists include guided mindfulness meditation focusing on self-compassion at the appropriate times within the feminist modality. By doing so the practitioner will enhance women's affect regulation skills and most importantly help her change her relationship to her oppressive and traumatic experiences and her narrative of 'self'. Potentially she also leaves with a new working model of self, an internalized 'earned secure attachment' that basically becomes her own therapist. It is yet another tool that can be offered to women on their path to liberation. It is also a change that lasts, since by changing our minds we change our brains (Begley, 2007; Doidge, 2007).

Being the higher brain functioning animal that humans are, and thanks to brain plasticity, we can shape our brains with our minds. This can work to our detriment or our betterment. This fact - and the potential liberation it contains – is beautifully illustrated in the work that Jeffrey M. Schwartz (Schwartz & Beyette, 1996) is doing with his clients who have Obsessive Compulsive Disorder (OCD). Schwartz has done research in this area for many years, and is known for introducing the concept of 'brain lock'. Schwartz's research confirms, from a neurophysiological perspective, how we get stuck in repeating 'first order change' solutions to our problems. When we engage in first order change – problem solving – we are responding to our brain's perceived need for change (the orbital frontal

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[30] It is important to note here that formal training in mindfulness is essential, and a regular daily mindfulness meditation practice is preferable to be an effective mindfulness-based therapist (Shapiro & Carlson, 2009). I address this issue in more depth in the section on *Implications for broader practice.*

cortex is responsible for this). The orbital frontal cortex sends a signal to the cingulated gyrus, and we feel something is wrong. We apply our best knowledge to fix the problem, our brains reward us with neurochemicals that lower our stress response, and for most of us the caudate nucleus, located deep in the centre of the brain, allows the brain to switch gears and we go onto the next task. For individuals with OCD, the caudate is very sticky resulting in 'brain lock'. The behaviour is complicated and engrained by a plastic brain that changes and gets stronger with each repetition of the compulsive behaviour by reinforcing neural pathways.

Schwartz now employs a second-order change approach using mindfulness. His clients first re-label what is happening *to* them, or to see the problem as external to them (similar to externalizing the problem in narrative therapy) as a malfunction or a faulty circuit of their brain – an OCD attack. They are taught to mindfully hold themselves in compassionate awareness, to take the stance of a non-judging observer of what is going on without identifying personally with it. From this less entangled place, his clients then have the choice to respond in a different way – to engage in second order change. They can manually switch gears and turn their attention to something else, to refocus on something positive and wholesome, which lays down new neural pathways. "I feel like wow, this is something everybody should know" one of his clients reports. "If I could go on a mountaintop and shout how great it is I would do it. I feel like mindfulness is the way to peace - peace inside of you" (CBC, 2010).

This awareness of a new way of being so enthusiastically expressed by this woman reminded me of the CTL participants that I interviewed post-treatment who had experienced liberation from their previous ideas or thoughts about who they are, how they should be and act, and a new way of relating to 'self'. Some weeks after interviewing the participants, I received a note from one of the CTL participants that stated this so poignantly,

> Meditation has definitely helped me cope better in my life and with my particular challenges. I appreciate so much your dedication to this simple but amazing way of life, for that is really what it is, not just a technique, but a different way of seeing ourselves. Nothing has ever worked for me as well as mindfulness meditation, and I thank you for helping me to reinforce it in my life . . . (CTL participant, personal communication, January 2009)

While I am advocating the integration into feminist therapy as part of its eclectic approach to practice, I think there is value in creating a manualized Mindfulness Based Feminist Therapy (MBFT). While practising in the field, I found manualized group modalities very helpful as a framework for working in the field, using it as a ground to start and return to within a woman-centred paradigm. What I mean by that is a manual helps you focus and set your intention for that day's group session, but my facilitators and I were always open to meeting women 'where they were at'. The manualized content was always in the background – it informed the agenda, but never overtook the agenda. It provided us as therapists with a reminder

of important material that needed to be covered (especially in terms of psychoeducational topics) and goals, but we chose to teach or share those in the context of whatever emotional or situational events arose as a result of the intervening week or during group interactions.

A manualized MBFT would use the familiar tried and true MBSR and MBCT formats, based on the *Courage to Love* treatment modality with inclusion of the characteristics of what makes 'good' feminist therapy mentioned previously. I would, for instance, make more time in the modality (when some mindfulness skills have been attained) for women to share experiences of their abuse. I would consider expanding the eight-week to a ten-week program; I would increase the amount of psychoeducation on trauma and neurophysiology. Other additions might include a detailed screening process to help the therapist determine whether the woman is a candidate for group work in general, or if she needs some preliminary time one-on-one with a therapist; and some tools for helping the therapist(s) and the candidate decide if a mindfulness-based modality and meditation practice are appropriate for her. These pre-group interviews are as much about building rapport and the therapeutic relationship as they are about assessing the right fit for the potential participant. We know from Lambert and colleagues (1986) that the therapist and the client both need to believe that the modality is the 'right' one and will work for them for it to be effective.

Implications for broader practice

This research reinforces the importance of the therapeutic relationship and the 'use of self' that is embodied by the therapist in any kind of modality. Laura Brown (2004) talked about the theory-driven, or alternatively the value-driven nature of feminist therapy. Our 'selves' - our knowledge, embodied experience and values - are what have the greatest impact on this transformative relationship. Arguably mindfulness can and should inform the feminist therapeutic relationship as well, even if the therapist does not teach formal mindfulness meditation practice to her clients:

> In light of the importance of the therapeutic relationship characterized by presence, warmth, trust, connection, and understanding of the client, it is not surprising that a number of authors have suggested mindfulness as a common factor across all successful therapeutic encounters regardless of theoretical orientation (Germer et al., 2005; Martin, 1997) and recommended meditation training as a support to develop core clinical characteristics (Anderson, 2005; S.L. Shapiro et al., 2008). (Shapiro & Carlson, 2009, p. 18)

Mindfulness training is also extremely helpful for resiliency and self care for social workers working with traumatized populations (Crowder, 2011) whether you are working clinically with individuals and groups, or doing anti-oppressive community development and activism (Lysack, 2009; Todd, 2009). The

development of a 'metaself' has also been cited as important in changing our relationship to the earth and environmental justice issues (Arnocky, Stroink, & DeCicco, 2007), such as the poisoning of air and water through oil and gas extraction, unsustainable manufacturing practices, and the misuse of non-renewable resources. Therefore mindfulness philosophy, psychology and practice provide a supportive framework and skill set for the practice of social work at all levels, including 'mindfulness-based culturally competent social work practice' (George, 2009). It would be wise to incorporate mindfulness into social work curriculum and professional development programs given this evidence.

We sometimes narrowly conceive of feminist practice as that which focuses exclusively on women. Sometime earlier I mentioned that I thought that this approach to working with victims of trauma could cross gender boundaries, and I still do. Mindfulness approaches are already being used successfully with traumatized (mostly) male clients in prisons where they enhanced well-being, reduced substance use and recidivism (Himelstein, 2010). DBT is being used increasingly with abusive male partners in domestic violence, although no randomized trial studies have been done to determine its effectiveness for reducing violent behaviour (Waltz, 2008). There is emerging evidence that mindfulness is being used in LGBTTQ groups as well (Tan & Yarhouse, 2010).

Mindfulness-based interventions with children are also increasing, in schools in particular (Glass, 2006). I co-facilitated the Building Bridges groups for many years through Family Services Ottawa, a program for women who were in abusive

relationships and their children. This program ran a mothers group and a children's group simultaneously with similar topics being covered at the same time. It has been an intention of mine for some time to create a mindfulness-based group for mothers and children who witness violence on that same format, and this is presently in development.

Implications for future research

Because of the small numbers in the Phase One of the research with university students to determine the correlation between self-compassion and empathy, this part of the study should be repeated with a larger sample.

Any iteration of this research should also require that both modalities be of the same length (12 weeks, for example) and that attention is paid to the ages of the participants. A longitudinal study on the WAG and CTL modalities should also be considered to find out if there is maintenance of gains in self-compassion and empathy for each modality. This would further confirm whether or not there was lasting second order change and if not, what were the circumstances for this loss. A longitudinal study may also give more insight into a sequential and cyclical healing process that seems to require time for a new sense of 'self' to emerge, capable of stronger boundaries and reduced over-identification with afflictive thoughts and emotions; and a sense of a greater, interdependent, interconnected self or 'meta-self'.

Once a manualized version of Mindfulness Based Feminist Therapy (MBFT) is completed, it should be studied in a controlled randomized fashion to see if it stands on its own as an effective modality. It could also be studied against other

mindfulness-based modalities to see how MBFT compares when you add other components from feminist therapy as suggested by this research.

Final Reflections

At the beginning of this journey I stated that I was attracted to this research because I sought congruency between my feminist practice and my mindfulness practice, but the truth lies somewhat deeper than that. It is also my story about how I fo

und my 'self' after surviving childhood sexual abuse. I could not have told the story of this thesis had it not resonated with me personally, and I know that I was driven to this research because I also needed at one time to 'make meaning' from an experience that left me with no sense of self, and burdened me with depression throughout my adolescence and early adulthood. I know from first hand experience how it is to struggle with PTSD, with despair, shame, and loneliness.

Gratefully, I also have known the wondrous healing power of the therapeutic relationship, the ameliorating effects of an 'earned secure attachment' with my significant other, and the peace and equanimity that emerged as I encountered and practiced mindfulness. At the core of that latter emergence has been learning to be compassionate with myself and with others. It has been an interesting experience to witness from the inside how the paradox works – that as you learn to love your 'self', you are able to let go of your 'self' at the same time. The mindfulness training has been instrumental in that skill – as Farb and colleagues described (2007) – to be able to separate the narrative and non-narrative strands of awareness so that we

can take the stance of the compassionate observer of our selves as we go about living our everyday lives. I thank all my teachers – all beings – for helping me become free. May all beings be well.

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Appendix A Research Advertisement

Self Compassion and Empathy – How Do You Measure Up?

Rachael Crowder, MSW and Instructor of SOWK1000 at Carleton University is conducting Phase One of her PhD research for the purpose of **understanding and assessing the connection between self-compassion and empathy**. This phase consists of two survey questionnaires, the Neff Self-Compassion Scale (NSCS) and the Balanced Emotional Empathy Scale (BEES). Each survey contains about 25 questions and should take about 6 minutes each to complete. Each scale will ask you to indicate how often you behave in the manner stated, using a given scale.

All data gathered will be held in strict confidentiality – only the researcher will see the results. Once the statistics are compiled, the original data with any attached identifying information (like Internet Provider (IP) addresses) will be erased from the computer system. Only aggregate data will be reported.

For more complete information about this study go to **www.fauxwebsite.ca and click on 'Research'** where you will find the link to connect to the complete information about the surveys* (including the Carleton University Ethics Committee approval for it). Read the Letter of Information and Informed Consent, click on "next' if you consent, and you will then be able to see the surveys and complete them. Participation in this study is entirely voluntary. At any point during the study you have the right to not complete certain questions or to withdraw without penalty. You have until April 30, 2009 to participate.

This is Phase One of the three phase research on the effects of a mindfulness-based intervention on self compassion and empathy with women who have experienced interpersonal violence and abuse. If you are interested in more information about my entire PhD thesis research project, you can check that out on my website www.fauxwebsite.ca including the aggregate data from these surveys when they are available.

Please contact me if you have any questions.
Thanks for your consideration!
Rachael Crowder, msw
PhD Candidate Canadian Studies
crowder@XXXXX.XXX
(XXX) XXX XXXX

* Survey Monkey is a U.S. hosted website and as such comes under the U.S. Patriot Act which means the Office of Homeland Security can monitor and review the data.

Appendix B Pre-Treatment Interview Guide

Participant's Name
Age (pre-group question)
Race/Ethnicity (pre-group question)
Nature of interpersonal violence (pre-group question)
When it happened (pre-group question)
Duration (pre-group question)

Previous group experience (pre-group question)

What do you feel are the abuse-related issues that still affect you? (Pre-and-post group)

Prompts:
- Personal safety
- Flashbacks / intrusive memories
- Self injury
- Sleeping difficulties
- Eating difficulties
- Affect regulation (getting triggered, numbing flooding, anger etc)
- Depression
- Anxiety
- Somatic (indigestion, fibromyalgia, dysmenorrhea, headaches other)

Please describe (by giving examples if you can) how you feel your experience of abuse (or post group, how the group experience) has affected your:

ability to identify your feelings? (self awareness)

ability to comfort, or share the feelings of, someone who is in pain? (empathy)

ability to *thoughtfully* communicate or express your true feelings about others or for others? (compassion)

ability to be kind to yourself when you fail or make mistakes? (self-compassion)

ability to create positive change in your life? (moral agency)

sense of who you are? (i.e. self esteem / self concept)

Appendix C Post-Treatment Interview Guide

Participant's Name

Please name the top three things that you learned about your self as a result of participating in this group.

What changes have you made or will make as a result?

What do you feel are the abuse-related issues that still affect you?

Prompts:
- Personal safety
- Flashbacks / intrusive memories
- Self injury
- Sleeping difficulties
- Eating difficulties
- Affect regulation (getting triggered, numbing flooding, anger etc)
- Depression
- Anxiety
- Somatic (indigestion, fibromyalgia, dysmenorrhea, headaches other)

Please describe (by giving examples if you can) how the group experience has affected your:

ability to identify your feelings? (self awareness)

ability to comfort, or share the feelings of, someone who is in pain? (empathy)

ability to *thoughtfully* communicate or express your true feelings about others or for others? (compassion)

ability to be kind to yourself when you fail or make mistakes? (self-compassion)

ability to create positive change in your life? (moral agency)

sense of who you are? (i.e. self esteem / self concept)

Appendix D Courage to Love Modality Handout: Courage to Love Session Five Handout – "Letting Be" and Compassionate Reframing

What form does your self-critic take? If you could give a shape or a feeling to your inner critic, what would it look or sound or feel like? Does it have a gender? Is it solid or somewhat 'misty' or undifferentiated?
Do you worry about what would happen if you lived without self-criticism? What might be the cost of not criticizing yourself? What function does self criticism play?

- pushes us on to achieve
- rid ourselves of unwanted traits or behaviours
- to protect ourselves
- castigates us for mistakes so we don't make them again
- to do it before others do – atonement
- to stop us from doing things that could result in harm
- to protect someone else

However, it is important to:
Distinguishing Shame-Based Self-Criticism from Compassion-Based Self-Correction

Shame Based Self Criticism	Compassion Based Self Correction
The desire to condemn and punish	The desire to improve
Punishing past errors and is often backward looking	Growth and enhancement
Given with anger, frustration, contempt, disappointment	Given with encouragement, support and kindness
Focuses on deficits and fear of exposure	Focuses and builds on positives e.g. seeing what one did well and then considering learning points
Focuses on self as a global sense of self	Focuses on attributes and specific qualities of self
Focus on high fear of failure	Focus and hope for success
Increases chances of avoidance and withdrawal	Increases the chances of engagement
Self critical reaction when a transgression has occurred: Shame, avoidance, fear Heart sink, lowered mood Aggression	Self compassionate response when a transgression has occurred: Responsibility, approach, engagement Sorrow, remorse Reparation

Adapted from Gilbert, Lee & Welford (2006).

Appendix E Courage to Love Modality Handout: Using Compassion to Change Our Minds

"We need to feel congruent affect (emotions) in order for our thoughts to be meaningful to us. Thus, emotions 'tag' meaning onto experiences. In order for us to be reassured by a thought e.g. "I am loveable" this thought needs to link with the emotional experience of "being loveable". If the positive affect system for such linkages is not activated there may be little feeling to the thought. People who have few memories/experiences of being loveable or soothed and safe may thus struggle to feel reassured and safe by alternative thoughts. Compassion focused therapy therefore targets the activation of the soothing system so that it can more readily accessed and used to help regulate threat-based emotions of anger, fear, disgust and shame" (Gilbert, Lee & Welford, 2006).

Next week we will begin our practice with Metta – Lovingkindness Meditation.
In lovingkindness (metta) practice, we practice using images and/or feelings of self and others to cultivate kindness and compassion. Metta practice can sometimes feels artificial – you may think you are not feeling any kinder or compassionate, and in fact, sometimes other very strong feelings can emerge when we practice. This is normal. One metta teacher explains that this practice is like dragging a magnet over the heart – it pulls out all kinds of stuff (including fear, grief, anger etc.) besides – eventually – lovingkindness.

Sharon Saltzberg, a highly regarded Metta teacher, tells the story of when she first started practicing metta, she was away on a retreat and had spent a whole month sending herself lovingkindness – and not feeling anything like compassion come up for her in her practice. Or so she thought – she had to leave the retreat for a family emergency, and while packing in haste, she knocked over a jar in her bathroom that shattered itself and all its contents all over the floor. The thought immediately rose in her mind, "You are such a klutz," but, to her surprise that thought was quickly followed by another, "but I love you anyway." It was then she realized that her month long "physiotherapy training for the mind" had had an effect after all. She had laid down those positive neural pathways in her brain, and was able to positively reframe her self-critical voice.

So in the coming week we will be practicing some 'being with' difficult thoughts and emotions and compassionate reframing of self-critical thinking. This will be our homework using the chart provided in the handout. It is also an opportunity to continue to practice the breathing space while observing upsetting thoughts and using the breathing space to step back and become the 'compassionate observer' of your life. Also read the enclosed handouts on working with and allowing difficult emotions. You will find this helpful when reframing difficulty emotional and mental 'events' with compassion.

Appendix F Courage to Love Modality Handout: Journaling Exercise

Depressing, Upsetting Events, Thoughts, Images or Feelings	Helpful, compassionate thoughts and behaviours
What went through your mind? What are thinking about others, and their thoughts about you? What are you thinking about yourself, and your future?	*Note how your thoughts might be related to key fears. As best you can, try to 'allow' and be with your thoughts and emotions, just as they are. Use your 'breathing space' if this helps, saying 'Let me feel it.'* *Now focus on creating your compassionate image or sense of self and think about how you could look at this with understanding and warmth.* *What would you say to a friend? What might a more balanced view be?* *What would be the most helpful and compassionate thing to do for you right now?*

Appendix G Informed Consent Letter and Form

Carleton UNIVERSITY
Canada's Capital University

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Letter of Information and Informed Consent for MBSR Group Participants

Rachael Crowder, MSW and PhD Candidate in Canadian Studies at Carleton University is conducting phase three of her thesis research for the purpose of understanding and assessing the healing connection between self-compassion and empathy with women who have survived interpersonal violence. The researcher (Rachael Crowder) has done anti-violence work in the community for many years, at the Ottawa Rape Crisis Centre, Lanark County Interval House, Ottawa Interval House, Oshki Kizis Lodge and elsewhere.

In this phase of the research, a group for women who have experienced interpersonal violence and abuse are being offered an eight week Mindfulness Based Stress Reduction (MBSR) group at Family Services Ottawa (the 'research group') called 'The Courage to Love: Healing the Self' ***at no cost to participants***. (Similar courses in the community are available privately for between $200-$400.) This research group is based on similar groups developed by Jon Kabat Zinn and offered through the Center for Mindfulness at the University of Massachusetts Medical Center near Boston, USA for more than twenty years. The researcher has trained with Dr. Kabat Zinn (and others) and has facilitated numerous such groups in the community. Research has found that participation in these groups has numerous health benefits for people dealing with stress, depression and anxiety.

This phase of the research consists of two survey questionnaires and some open ended questions asked in person by the researcher. This should take no more than an hour in total to complete. You will be asked to complete this twice: (1) before the group starts and (2) when the group finishes. The researcher is offering compensation of $20 at the completion of each cycle. You will receive your money at the completion of the interview portion of the cycle whether or not you complete all of the survey and face-to-face questions.

Each survey contains about 30 questions and should take about 10 minutes each to complete. The Neff Self Compassion Scale will ask you to indicate how often you behave in the manner stated, using a given scale. Some sample statements are:

When times are really difficult, I tend to be tough on myself.
When something upsets me I try to keep my emotions in balance.

Similarly, the Balanced Emotional Empathy Scale will ask you to indicate agreement or disagreement with statements that describe how you are, generally, in given situations, using another scale. Some sample statements are:

I very much enjoy and feel uplifted by happy endings

I cannot feel much sorrow for those who are responsible for their own misery.

The interview involves open-ended questions that will ask you to describe how you feel your experience of violence and/or abuse has affected your relationships with others. The before-group interview portion should take about a half an hour; the after-group interview may take slightly longer since you may have more to say. You have the option of taking these tests and the interview at separate times, and those times can be arranged with the researcher. All testing and interviews will take place at Family Services Ottawa.

There is a potential risk in this process: some people may become uncomfortable or stressed when asked to reveal their general behaviour and emotions in given situations or asked to recall past traumatic events. The researcher is trained in crisis intervention in case you need immediate help, and Family Services Ottawa is also available to help you if you require longer term help.

The final report of the research will not name the agency or the group where the research took place, but others in the group may talk about it and it may be known within the community that the research is taking place at Family Services Ottawa. However, the data collected in this study will remain confidential. That means that only the researcher will have access to the information you share through the interview and questionnaires, with the exception of information that reveals a serious threat of harm to yourself or others, and disclosures of child abuse. Family Services Ottawa and the researcher are required by law to report such disclosures, and if such reporting is necessary, every effort will be made to include you in the reporting process.

When the research report is made, none of your identifying information will be used and you will be given an opportunity to review a draft of the research findings. If you feel your identity may be revealed by the data reported you may request that the researcher edit the report. You may also withdraw from the study at any time. Should you decide to withdraw, you may decide at that time if the researcher may use the information you have provided to that point, or you may request that it be destroyed.

Informed Consent The purpose of an informed consent is to insure that you understand the purpose of the study and the nature of your involvement. The informed consent must provide sufficient information such that you have the opportunity to determine whether you wish to participate in the study.

Study Title: "Phase Three, Part Two: understanding and assessing the healing connection between self-compassion and empathy with women who have survived interpersonal violence."

Researcher: Rachael Crowder, MSW PhD Candidate, Canadian Studies, Carleton University.

Phone: xxx-xxx-xxxx Email: crowder@xxxxx.xxx.xx

Supervisors:

Wendy Donner PhD Department of Philosophy Carleton University 520-2600 ext 3943 wendy_donner@carleton.ca	Karen Schwartz PhD School of Social Work Carleton University 520-2600 ext 3514 karen_schwartz@carleton.ca

This project has been reviewed and has received ethics clearance by the Carleton University Research Ethics Committee. Participants with concerns or questions about their involvement in the study should contact the committee chair:

Prof. Antonio Gualtieri, Chair
Carleton University Research Ethics Committee
Carleton University
1125 Colonel By Drive
Ottawa, Ontario K1S 5B6
Tel: 613-520-2517
E-mail: ethics@carleton.ca

Thank you for your consideration.

_____
Rachael Crowder, Researcher

I _____ have read the above description of the study entitled "Phase Three, Part Two: understanding and assessing the healing connection between self-compassion and empathy with women who have survived interpersonal violence," I am at least 16 years of age, I understand that I am participating in a research project and I voluntarily agree to participate.

X_____

I agree also to have my interview audio-recorded with the understanding that I may request the recording device to be turned off at any time during the process.

X_____