# Incarcerated Women's Understanding and Experiences of Self-Compassion

by

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**Abstract**

Incarcerated women are a rapidly growing population with complex mental health issues such as mental illness, substance abuse, and trauma. These difficulties contribute to challenges with emotion regulation, in which individuals struggle with adaptively identifying and expressing emotion responses. Difficulties with emotion regulation can result in risk-taking, aggressive and violent behaviours. Self-compassion, which involves relating to oneself in an accepting and kind way during times of distress, has been shown to promote psychological well-being and adaptive emotion regulation skills. To date, there are no studies examining self-compassion from the perspectives of incarcerated women. Research in this area may inform the development of gender-responsive, compassion-focused interventions tailored to unique needs of this population. The present study investigated how self-compassion is understood and experienced by incarcerated women using Interpretative Phenomenological Analysis. Semi-structured in-depth interviews were conducted with nine women at a medium security provincial prison in Alberta. The findings are demonstrated through six superordinate themes: (a) honouring oneself, (b) adopting a new mindset, (c) gaining self-awareness and insight, (d) accepting and letting go, (e) desiring self-improvement and enacting change, and (f) flow of self-compassion. Clinical implications for integrating compassion-focused approaches with women in prison, methodological considerations, and future avenues for research are discussed.

## Preface

This thesis is an original work by Lara E. Hiseler. This research project, of which this thesis is part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name, "Incarcerated Women's Understanding and Experiences of Self-Compassion," No. Pro00035738, February 26, 2013.

## Dedication

I would like to dedicate this work to the inspiring women at the correctional institution with whom I had the privilege of hearing their stories.

## Acknowledgments

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Finally, I would like to thank the staff at the Alberta provincial prison who helped with the implementation and data collection logistics of this research. The collection process was smooth and seamless due to their timely support and assistance. Thank you.

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## Chapter One - Introduction

The number of women incarcerated in Canadian correctional institutions is on the rise. Female admissions to Canadian federal facilities have increased 35% from 231 in 2000/2001 to 313 in 2009/2010, whereas male admissions have increased by only 21.9% (Public Safety, 2010; Statistics Canada, 2008). These statistics are even more staggering for Aboriginal women, whose admissions to federal institutions increased by 87% from 1999 to 2009. In addition, the proportion of female admissions to provincial and territorial forensic institutions in Canada ranges from 6% to 15%; Alberta's rate of 14% is the second highest in the country (Statistics Canada, 2010).

Research shows that people who engage in criminal behaviour typically have difficulties with impulse control, distress tolerance, and emotion regulation (Krakowski, 2003; Walsh, DeLillo, & Scalora, 2011). Emotion regulation is the ability to manage one's emotions and includes identifying, labeling, and expressing one's emotional responses (Gross & Muñoz, 1995). Emotion regulation allows people the flexibility to adapt to their environments (Barrett, Gross, Christensen, & Benvenuto, 2001; Gross & Muñoz, 1995). While this ability has wide-ranging implications for positive psychological health, such as fostering resiliency in the face of stressors and cultivating healthy personal growth (Bonanno, Papa, Lalande, Westphal, & Coifman, 2004; Gross & Muñoz, 1995; Hopp, Troy, & Mauss, 2011), it may be stunted by challenging life circumstances. Experiences of trauma (Bonn-Miller, Vujanovic, Boden, & Gross, 2011; Brewin & Holmes, 2003), mental illness (Chapman, Dixon-Gordon, & Walters, 2011;

Derkzen, Booth, Taylor, & McConnell, 2012; Joormann, 2010), and substance abuse (Johnson, Bonn-Miller, Leyro, & Zvolensky, 2009) have all been shown to reduce the extent to which individuals are aware of their emotional states. Challenges with emotion regulation are common among incarcerated women, who often have histories of trauma, mental illness, and substance abuse (Chesney-Lind, 2006; Daly, 1992; Wood, Foy, Goguen, Pynoos, & James, 2002). Difficulties with emotion regulation can also contribute to maladaptive behaviours such as risk-taking, anger, and violent behaviour (Axelrod, Perepletchikova, Holtzman, & Sinha, 2011; Cooper, Flanagan, Talley, & Michaes, 2006; Gilbert, 2005, Krakowski, 2003; Roberton, Daffern, & Bucks, 2012).

To help individuals develop healthy emotion regulation skills, researchers have examined the adaptive properties of self-compassion. Self-compassion consists of being kind, accepting, and gentle with oneself, particularly during times of distress (Gilbert, 2009; Neff, 2011). In particular, it involves "holding one's feelings of suffering with a sense of warmth, connection, and concern" (Neff & McGehee, 2010; p. 226). Self-compassion has been shown to help individuals find hope and meaning when faced with difficult life circumstances and to ameliorate mental health concerns, particularly anxiety, depression, and trauma (Neff, 2011; Neff, Rude, & Kirkpatrick, 2007; Thompson & Waltz, 2008). Self-compassion has also been shown to improve psychological well-being by addressing emotion regulation difficulties (Leary et al., 2007; Neff, 2003a; Neff et al., 2007). Adopting self-compassion is an adaptive way to cope with challenging

emotions since it helps individuals address rather than avoid painful experiences (Allen & Leary, 2010; Pauley & Macpherson, 2010).

While a number of quantitative studies have pointed to the psychological benefits of self-compassion (Leary et al., 2007; Neff, et al., 2007; Thompson & Waltz, 2008), there is currently very little research on the subjective experience of this practice and no research exploring the phenomenon of self-compassion from the perspectives of women in prison. Incarcerated women have unique needs, such as mental health challenges and emotion dysregulation that contribute to their involvement in the criminal justice system. Since women's rate of incarceration is steadily increasing and mental health problems remain pervasive, there is clearly a need for additional gender-responsive therapeutic interventions targeted at enhancing emotion regulation skills. The development of compassion-focused interventions are a potential implication of research attempting to build knowledge and understanding on the phenomenon of self-compassion.

**Statement of Purpose**

The purpose of this study was to explore the phenomenon of self-compassion in incarcerated women. I was interested in learning from the participants the ways in which they understand and experience self-compassion, ways in which they have been self-compassionate since incarceration, and ways in which their self-compassion (or lack thereof) may have influenced their feelings towards themselves and their lives. This study contributes to knowledge by opening up a new, much needed area of inquiry, at the intersection of female offending and self-compassion research. Finally, this study provides data to

inform and develop gender-responsive, compassion-focused approaches to help incarcerated women develop essential emotion regulation skills.

**Research Question**

This study addressed the following research question: How do incarcerated women understand and experience self-compassion? In answering this question, I developed a rich and deep understanding of the lived experiences of self-compassion from the perspectives of the women interviewed. This was accomplished through interpretative phenomenological analysis (IPA; Chapman & Smith, 2002; Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2008). This inductive methodology was appropriate as it allowed me to understand how incarcerated women gave meaning to the phenomenon of self-compassion.

**Researcher's Background and Position**

I am a Caucasian woman of Estonian and English descent working towards a doctoral degree in counselling psychology. My desire to advocate for the well-being of women influenced my desire to pursue such an education. I have co-facilitated psychoeducational groups with men charged with intimate partner violence, educated university students on how to prevent sexual assault in campus residences, and conducted therapy with sexual assault survivors. I have also completed two doctoral practica and a pre-doctoral internship in a psychiatric hospital with adults found not criminally responsible due to mental disorder. Finally, I have research experience utilizing qualitative methods with youth and adults in correctional settings.

The conceptualization and rationale of this research is strongly influenced by my feminist identity and the integral role of gender in understanding offending behaviour. I believe that prison is a constructed system informed by patriarchy. This is evidenced in the construction and implementation of policies and procedures that create power structures that oppress women. I believe that knowledge has historically been constructed by men in positions of power, with race and class privilege, and that my research is an opportunity for marginalized women to contribute to knowledge production in the area of self-compassion. My ontological and epistemological standpoint for this research is constructivist, which is congruent with IPA. My assumptions and beliefs regarding feminism and knowledge construction with incarcerated women were areas I made notes about while completing this research.

Half of the participants in this study identified as Aboriginal, which creates a unique subgroup in this study. Aboriginal women are a further marginalized group among women in prison with unique context set apart from Western women. Aboriginal women have experienced numerous forms of oppression by the dominant, Caucasian, Western culture. The colonization of Aboriginal culture by Westerners has had profound, deleterious, transgenerational impact on Aboriginal culture, education, employment, addictions, and incarceration. The implications and recommendations from this work do not represent the voice of Aboriginal people, but rather, represent my personal interpretation of the data in collaboration with the study participants through the lens of IPA.

In both my clinical and research experience, I have found that compassion is not a word often associated with offenders. I have been privy to discussions about the purpose of prison, whether it is a space for rehabilitation, a method of punishment to deter future behaviour, or both. There are often strong beliefs, by both society and those working with offenders, that an individual in prison cannot simultaneously experience punishment and compassion. These terms, on the surface, may appear mutually exclusive. I believe cultivating compassion is a concept worth exploring for its multitude of benefits for psychological well-being for some offenders. Conversations in different correctional settings often take place regarding the gender-neutral/gender-responsive treatment debate, which in essence, is a dialogue about whether treatment of offenders should be the same for both men and women or whether one's gender should be a primary conceptualizing factor in treatment. There is currently no agreed upon solution to this debate. Thus, the concepts of compassion and psychological treatment of women in correctional settings continue to be a rich area of debate and exploration. I hope to contribute to this research area by creating an intersection between self-compassion and feminist criminology literature.

**Outline of the Study**

This dissertation includes five chapters. Chapter two is a literature review of the characteristics of incarcerated women, the psychological challenges women in prison face, correctional treatment approaches for incarcerated populations, and self-compassion. The third chapter outlines the methodology of IPA, data collection, data analysis, study trustworthiness, and ethical considerations. The

fourth chapter presents the analysis of the themes of self-compassion and the fifth and final chapter is a discussion of the results, limitations, methodological considerations, and implications of this study.

# Chapter Two - Literature Review

## Profile of Incarcerated Women

Providing a profile of incarcerated women establishes a greater context for understanding the challenges women in prison experience. This includes unique gendered pathways of offending, mental health problems, substance abuse, and trauma.

**Gendered pathways of offending.** A plethora of evidence suggests that women have unique life experiences that may create unconventional pathways to crime (Chesney-Lind, 2006; Chesney-Lind & Shelden, 1992; Daly, 1992; Wood, Foy, Layne, Pynoos, & Boyd, 2002). Two feminist scholars, Kathleen Daly and Meda Chesney-Lind, are well-known for their investigations of how women become involved in criminal activities. After reviewing court records of 40 female offenders, Daly (1992, 1994) proposed five distinct profiles of incarcerated women and pathways that brought them into contact with the correctional system: (a) "harmed and harming" women, who experienced abuse or neglect as children, which contributes to externalizing behaviours in school and eventually to substance abuse and mental illness; (b) "street" women, who run away from home (often to flee abusive environments), and for whom life on the street leads to addiction, involvement in prostitution, and other criminal activities; (c) "battered" women, whose involvement in the criminal justice system is due to the abuse they experience from violent intimate partners; (d) "drug-connected" women, who develop an addiction to substances through family relationships; and

(e) "other" women, who have no histories of abuse, addiction, or violence, but whose crimes are economically motivated.

Whereas Daly determined specific profiles of women who become involved in the correctional system, scholar Chesney-Lind focused on the interaction and complexity of factors contributing to offending behaviour (Chesney-Lind, 1989, 2006; Chesney-Lind & Pasko, 2004; Chesney-Lind & Shelden, 1992). Chesney-Lind proposed that trauma and victimization contribute to the development of mood disorders, as well as substance abuse, which may function as self-medicating behaviour (Chesney-Lind, 2006; Chesney-Lind & Shelden, 1992). Contact with the criminal justice system often occurs as a result of involvement with illicit drugs, and the need to finance such a habit often leads to running away from home, prostitution, and other dysfunctional relationships (Chesney-Lind, 2006; Chesney-Lind & Shelden, 1992). Daly and Chesney-Lind's work provided a much needed theoretical framework for understanding the complex factors that contribute to women's offending.

Although research on women's pathways into criminal activity has historically been qualitative, researchers have also examined pathways to crime through a quantitative lens. Salisbury and Van Voorhis (2009) examined the relationship among three different pathways to crime and recidivism in 313 women on probation in the United States. Three specific gendered pathways were examined: (a) the trauma and victimization pathway, which contributes to mental illness and substance abuse (Chesney-Lind & Shelden, 1992; Daly, 1994); (b) the relational pathway, informed by relational developmental theory (see Baker-

Miller, 1993) in which women's dysfunctional intimate relationships contribute to trauma, decreased self-efficacy, mental illness, and substance abuse; and (c) the social and human capital pathway (Giordano, Cernkovich, & Rudolph, 2002), in which women's challenges in education, family support, relationships, and self-efficacy contribute to employment/financial difficulties and subsequent incarceration. Multiple regression was used to test these pathways to determine their relationship to continued criminal behaviour. The authors considered the following factors: financial needs, educational strengths, family support, historical substance abuse, dynamic substance abuse, history of mental illness, current anxiety/depression, childhood/adult victimization, self-efficacy, and relationship dysfunction. These results largely support the findings of previous qualitative studies (Holsinger, 2000; Rumgay, 2004) that observe a nexus of trauma, mental illness, substance abuse, and dysfunctional relationships. A particularly noteworthy finding was that childhood trauma and victimization created five indirect pathways to continued offending due to their resulting psychological and behavioral effects. Women who engaged in abusive and/or dysfunctional relationships and lacked self-efficacy were at an indirect risk of continued criminal behavior. Mood disorders and substance abuse were directly related to incarceration (Salisbury & Van Voorhis, 2009).

Brennan, Breitenbach, Dieterich, Salisbury, and Van Voorhis (2012) also utilized a quantitative approach to further test and provide greater precision to the common pathways to crime for incarcerated women. Women who were within 60 to 180 days of being released onto parole for the first time were the sampled

subpopulation of interest within a California prison. A total of 718 women completed 40 assessment scales measuring both gender-responsive (unique context of women) and gender neutral (similar context for males and females) factors. Criminal histories were also obtained for each participant. Analyses included multiple quantitative procedures, including bootstrapping to identify homogenous pathways and the McIntyre-Blashfield cross-validation method test to determine pathway replication. The analyses revealed the stable replication of eight reliable pathways that loaded into four broad, superordinate pathways: (a) "Normal functioning" path, characterized by women addicted to drugs; however, women were less marginalized, had a limited criminal history, no abuse history, and no mental health history; (b) "Victimized/battered" path, including high prevalence of childhood and adulthood sexual abuse and substance abuse, (c) "Socialized-Subcultural" path, which is demonstrative of women with low self-efficacy, less stable housing (frequently living in a high crime area), high crime involvement (including drug use and trafficking), less trauma and mental health challenges, and (d) "Aggressive-Antisocial" path, which includes women with an antisocial personality and low self-efficacy, homelessness, high prevalence of trauma and abuse, limited or no family support, and extensive criminal history including violent crimes.

It is clear through both qualitative and quantitative investigation that women's pathways into crime were influenced by a number of complex interconnected factors, including trauma, substance abuse, mental illness, antisocial personality, housing problems, and poverty.

**Mental health challenges.** Gendered pathways research highlights how many women suffer from mental health problems both prior to and while residing in correctional institutions in both Canada and the U.S. (Chesney-Lind, 2006; Crisanti & Frueh, 2011; Daly, 1992, 1994; Kimonis et al., 2010; Sarteschi & Vaughn, 2010; Tripodi & Pettus Davis, 2013; Veysey, 2010). In an American context, 75% of women incarcerated in U.S. prisons have mental health problems (James & Glaze, 2006). Research by Lewis (2006) observed the following mental disorders in a sample of incarcerated women in the U.S: substance abuse 65.4%, major depressive disorder/dysthymia 40.8%, post-traumatic stress disorder (PTSD) 40.8%, antisocial personality disorder 32.3%, anxiety related disorders 9.2%, and psychotic disorders 6.5%. Incarcerated women often demonstrate emotion lability and frequently meet diagnostic criteria for borderline and antisocial personality disorders (Komarovskaya, Booker Loper, & Warren, 2007). Self-harming behaviours, such as cutting and burning, are also common among incarcerated women coping with mental health symptoms (Mangnall & Yurkovich, 2010).

Gender differences were found in mental health symptomology among offenders in the U.S. Drapalski and colleagues (2009) examined 360 male and 154 female offenders in a U.S prison to determine gender differences in mental health symptomology. The authors used the Personality Assessment Inventory (Morey, 2007), a broad measure of psychiatric symptoms. Women reported greater clinically significant symptoms of anxiety, borderline personality disorder, somatic concerns, and trauma-related symptoms than did men.

In a Canadian context, prisons are also a repository for female offenders with psychopathology. Upon admission to federal institutions, the number of women presenting with a current mental health problem has risen significantly from 13% in 1996/1997 to 29% in 2008/2009 (Correctional Services Canada, 2009). Female offenders are estimated to be twice as likely to have a mental health diagnosis at the time of admission as men, specifically 21.8% of women and 10.4% of men (Public Safety, 2009).

Recent research by Derkzen and colleagues (2013) lends further support for the significantly high rates of psychopathology of female offenders in Canada. The authors evaluated for symptoms indicative of a psychiatric diagnosis and patterns of psychological distress across the lifespan in a sample of 88 incarcerated women across Canada's eight federal correctional institutions. Data were collected with a screening version of the Computerized Diagnostic Interview Schedule, a structured interview which evaluates for the presence or absence of psychiatric diagnoses as defined by the DSM-IV-TR. Overall, 85.2% of the sample had a lifetime experience of more than one clinical disorder. The most predominant diagnoses included PTSD (52.4%), major depressive disorder (69.3%), alcohol/substance dependence (80%), and antisocial personality disorder (83%).

It is clear that incarcerated women experience numerous mental health challenges that are multifaceted and complex. Unfortunately, despite the prevalence of mental health problems of women in prison, there currently exists no national standardized process to evaluate for mental health problems in prison

in either country (Correctional Services Canada, 2009; Gallagher, Carbonell, & Gotfried, 2013).

**Substance abuse.** Research into mental health challenges of incarcerated women has also revealed that substance abuse is a widespread phenomenon. One study indicated that 80% of women in Canadian prisons have substance abuse problems (Grant & Gileno, 2008). A recent Canadian study by Buchanan and colleagues (2011) also revealed important insights about incarcerated women's drug and alcohol usage. A mixed-method design, including interviews as well as demographic and drug use questionnaires, was used to research 72 women in a minimum-medium security prison in a Western Canadian province. Four main themes were gleaned from interviews: (a) catalysts for initiating of substance use, which included being in a difficult personal relationship, affiliating with an antisocial peer group, experiencing loss, and lacking self-motivation; (b) reasons for continuing drug usage, which included normalizing by other family members, having easy access to drugs, experiencing power and control when using, and suppressing negative emotions; (c) consequences of substance dependency, which included perceived loss of relationships, compromised physical and mental health, changed sense of self, increased criminal activity, and increased denial about the impact of substances ; and finally (d) reasons to abstain from substance abuse, which included becoming incarcerated , making a personal commitment to change, wanting an education, and a desiring connection with friends and family.

The negative consequences and distress associated with substance abuse is also corroborated in other countries. El-Bassel and Gilbert (1996) examined

factors leading to cocaine abuse among 158 incarcerated women in a New York City correctional facility. The authors used multiple regression to determine the association between adult psychological trauma (childhood sexual abuse, childhood physical abuse, intimate partner violence, parental alcohol abuse, homelessness, sex work, and loss of custody of children) and regular cocaine usage. Women who suffered from trauma not only demonstrated negative coping behaviours and lacked emotional support, but were also more likely to regularly use cocaine.

In an Australian prison, Johnson (2006) explored the presence of concurrent drug use and mental health challenges in a sample of 471 incarcerated women using a comprehensive interview and questionnaire. Drug dependency was present in 41% of offenders, and 55% of them suffered from both substance abuse and mental health problems. Statistically significant associations were found between drug dependency and the following life experiences: growing up in a family with drug and alcohol problems, having spent time in juvenile detention, previous instances of adult incarceration, being the victim of child or adult sexual and/or physical abuse, and abusing prescription medications (e.g., benzodiazepines and amphetamines). Research across different countries demonstrates both the prevalence and complex nature of incarcerated women's relationships with substance abuse.

**Trauma.** The experience of trauma is seemingly ubiquitous in the lives of female offenders. As noted previously, numerous types of physical, sexual, and emotional trauma have been reported by incarcerated women, including childhood

sexual abuse (Belknap, 2007; Chesney-Lind, & Pasko, 2004; Crisanti & Frueh, 2011; Peltan & Cellucci, 2011), sexual assault, including rape (both vaginal and anal penetration) and sexual coercion (forced sex acts) during adulthood and adolescence (Barrett et al., 2011; Cook, Smith, Tusher, & Raiford, 2005; McDaniels-Wilson & Belknap, 2008; Raj et al., 2008), physical abuse (Milligan & Andrews, 2005), intimate partner violence (Bradley & Davino, 2002; Zust, 2009), and family violence (Flemke, 2009; McDaniels-Wilson & Belknap, 2008). Such abuses have primarily been perpetrated by male family members/acquaintances, with a minority committed by female assailants (McDaniels-Wilson & Belknap, 2008; DeHart, 2008; Raj et al., 2008). In a study by DeHart, (2008), the author shared one woman's trauma narrative:

> Laura wasn't an alcoholic until she was 15. She found out that if she was drunk, it was easier to deal with the sexual abuse. She would see her stepdad looking at her like he was going to do it, and she'd drink a half bottle of vodka. (p. 10)

Numerous studies have detailed exceedingly high prevalence rates of traumatic experiences among incarcerated women. Cook and colleagues (2005) explored the presence of traumatic life events in a random sample of 403 women entering a U.S prison using the Traumatic Life Events Questionnaire (Kubany, et al., 2000). Ninety nine percent of the sample reported they had experienced at least one traumatic event, and 81% experienced five or more. More than 50% of the sample reported the unexpected death of a loved one, physical abuse by a partner, death threats, and family violence in childhood. McDaniels-Wilson and

Belknap (2008) found that 70% of women in a sample of 391 incarcerated women in the U.S. reported types of sexual abuse that would qualify in most U.S and Canadian jurisdictions as rape and/or sexual assault, and most women reported multiple instances of abuse and multiple abusers. In a random sample of 247 incarcerated women in a U.S. prison, Clements-Noelle and colleagues (2009) found that, childhood trauma was frequently reported including emotional abuse (58%), physical abuse (54%), sexual abuse (51%), emotional neglect (53%), and physical neglect (41%). Bradley and Davino (2002) found that incidents of sexual assault/rape by intimate male partners were so high that more than a third of 65 incarcerated women perceived prison to be a safe place, as it provided protection from further intimate partner abuse.

Experiencing trauma has also predisposed incarcerated women to develop additional mental health problems. Tripodi and Pettus-David (2013) examined the prevalence of childhood victimization and its association with adult mental health problems, substance abuse, and further sexual victimization. One hundred and twenty five incarcerated women participated from two prisons in the United States. Information was collected through standardized interview protocols including the Substance Abuse Module (Cottler, Robins, & Helzer, 1989), Addiction Severity Index (McLellan et al., 1992), Childhood Trauma Questionnaire (Bernstein et al., 1994), Experiences of Sexual Victimization Scale (Koss & Oros, 1982), Abuse Behavior Inventory (Zinc et al., 2007), and analyzed with binary logistic regression. Results indicated that childhood victimization was related to severe mental health problems, substance abuse, and further sexual

victimization. The offenders who experienced sexual abuse as children were more likely to have attempted suicide, been sexually victimized as adults, and have a substance use disorder than those women who were not.

The high prevalence of past trauma among incarcerated women not only increases the likelihood of developing comorbid mental health concerns, but it also has an impact on criminal behaviour (Ardino, 2012; Fournier, Hughes, Hurford, & Sainio, 2011; Harner & Burgess, 2011; Moloney, Van Den Berg, & Moller, 2009; Worthington, 2012). Barrett and colleagues (2011) examined the presence of comorbid PTSD symptomology in 102 incarcerated women with substance abuse problems, to ascertain its relationship to criminal behaviour. Women in the sample had been victims of a minimum of five types of trauma, namely, threat with a weapon, physical assault, rape, witnessing a death, and childhood sexual abuse. Results determined that higher levels of aggression and more severe PTSD symptomology were independent predictors of violence perpetration. Those who committed a violent crime in the month prior to incarceration endorsed more severe PTSD symptoms, specifically in the hyperarousal symptom cluster (difficulty falling/staying asleep, irritability/anger, difficulty concentrating, hyper-vigilance, and exaggerated startle response).

Sullivan and colleagues (2005) studied a sample of 108 incarcerated women who perpetrated violence on their male partners, to determine whether a relationship exists between childhood trauma and PTSD in adulthood. The authors found a strong relationship between childhood abuse and adult post-traumatic stress, which suggests that childhood trauma may serve as a predictor

for women's use of violence against their intimate partners. Not only does trauma complicate the lives of women, it is also a strong predictor of predisposing women to several pathways to crime (Brennan et al., 2012; McCartan & Gunnison, 2010).

**Psychological Challenges Faced by Incarcerated Women**

It is not surprising that incarcerated women experience numerous psychological problems as a result of mental health challenges, substance abuse, and trauma. Shame and emotion dysregulation are a few of the pernicious sequelae experienced by incarcerated women (Andrews, Brewin, Rose, & Kirk, 2000; Axelrod, Perepletchikova, Holtzman, & Sinha, 2011; Bonn-Miller, Vujanovic, Boden, & Gross, 2011; Harman & Lee, 2010; Van Vliet, 2010).

**Shame.** Shame is a self-conscious emotion experienced when a core aspect of the self is judged to be inferior and inadequate (Gilbert, 2003; Hisazaki, 2003; Tangney & Dearing, 2002; Van Vliet, 2009). It is associated with feelings of inadequacy or being flawed and an overwhelming desire to withdraw from other people due to a painful sense of exposure (Dickerson, Gruenewald, & Kemeny, 2004; Gilbert, 2003; Tangney & Dearing, 2002). Shame is complex and involves a mixture of behaviours, affects, and cognitions.

To further understand the phenomenon of shame, it is important to contrast the differences between shame and guilt. Guilt is typically conceptualized as the distress or dissonance one feels when one has violated a moral standard and feels responsibility for that violation (Braithwaite, 1989; Neidenthal, Tangney, & Gavanski, 1994; Takai, 2004). The most salient

difference between guilt and shame is that guilt involves negative judgment of one's own behaviour (i.e., "what I did was bad"), whereas shame involves negative judgment of one's self (i.e., "I am bad"). Shame is believed to be "self-focused," whereas guilt is associated with concern for others, or "other-focused" (Dickerson et al., 2004; Gilbert, 2003; Lewis, 1971; Van Stokkom, 2002). As Wilson and colleagues (2006) stated, "shame damages the soul of the person, his or her most cherished and inner sense of identity and humanity" (p. 139).

Shame is also conceptualized as a biopsychosocial affective response to social-evaluative threat (Dickerson et al., 2004; Gruenewald, Dickerson, & Kemeny, 2007). This type of threat occurs when a person's identity is perceived to be negatively judged by others, and there is a potential for a loss of social esteem, acceptance, or status (Dickerson et al., 2004; Gilbert, 2010; Gruenewald et al., 2007). In other words, shame results when a person's perception of negative social evaluation is transformed into negative *self*-evaluation (Dickerson et al., 2004).

Shame can also be activated through negative internal evaluation. Gilbert (2003) proposed the presence of both internal and external types of shame. External shame is related to thoughts and feelings of what others think about the self, whereas internal shame is related to the person's private negative self-appraisals and critical thinking styles (Gilbert, 2003). Negative internal thoughts can have the same deleterious impact as external stimuli (Gilbert, 2003). This further illustrates the complexity of shame since it can be induced not only from others but also from the self.

From a psychoevolutionary perspective, shame is conceptualized as a hardwired emotion essential for human survival (Gilbert, 1997; Keltner, Young, & Buswell, 1997). Its genesis is a personal desire to appear attractive to others as this helps ensure access to resources necessary for survival. Shame results when there is a perceived loss of social attractiveness in the eyes of others. The adaptive and protective functions of shame are that it can motivate individuals to develop socially responsible behaviours and remediate their loss of status in society (Gilbert, 1997; Izard, 1991; Tangney & Dearing, 2002). Keltner and colleagues (1997) further argued that shame is adaptive because it arises when social rules are violated, potentially disrupting social relationships. The resulting withdrawal and submissive behaviours exhibited by the shamed individual are known as "safety behaviours," which externally signal defeat and internally motivate the individual to withdraw from social contact in order to avoid further harm (Gilbert, 2003; Keltner et al., 1997). Such submissive behaviours can help maintain social order and reduce hostility.

Although shame has adaptive functions for the social self, prolonged unaddressed shame can have destructive emotional and behavioural impact including anxiety, depression, narcissism, post-traumatic stress, self-harm, and anger (Braithwaite, Ahmed, & Braithwaite, 2006; Gilbert, 2003, 2005; Hosser, Windzio, & Greve, 2008; Kim, Thibodeau, & Jorgensen, 2011; Lee, Scragg, & Turner, 2001; Neff et al., 2007; Takai, 2004; Tangney, Wagner, Fletcher, & Gramzow, 1992).

Research examining the destructive impact of shame and anger has particular relevance for incarcerated populations. Theoretical notions about shame and anger are posited by Lewis's (1971) seminal work on shame-rage theory and Gilbert's (1997) social rank theory. Shame-rage theory proposes that feelings of shame may instigate a hostile type of anger known as "humiliated fury," which is a defensive response to the powerlessness that accompanies shame (Lewis, 1971). Tangney and Dearing (2002) have built upon Lewis' (1971) shame-rage theory and proposed that this rage may be attributed to the perception of disappointing others, which may result in blaming the other person and responding with anger. By shifting blame and becoming angry towards another, the shamed individual is able to gain some sense of control and relief from the devastating feelings of shame. Social rank theory (Gilbert) conceptualizes anger as a defensive strategy employed when one's status and resources are threatened. Status can be maintained by strategies that increase social attractiveness through prosocial behaviour, competence, or signaling power through anger and aggression (Gilbert, 1997).

While the negative impact of shame and anger has relevance for all incarcerated populations, only one study to date examined the deleterious impact of shame among incarcerated women. Milligan and Andrews (2005) examined the relationships among childhood abuse, shame, anger, and self-harming behaviours in 89 incarcerated women. Fifty percent of the women reported engaging in self-harming behaviours just prior to or during their current sentence. All shame, anger, and abuse variables were significantly related to self-harm.

Both childhood sexual abuse and bodily shame were significant independent contributors to self-harm; however, bodily shame demonstrated the strongest effect. This was the first study to demonstrate a statistically significant relationship between shame and self-harming behaviour in incarcerated women.

Shame is one of the most basic human emotions since maintaining the integrity of the social self is essential to self-preservation and well-being. Although shame has numerous adaptive functions, it comes at a considerable cost to incarcerated women because of its etiological contribution to psychological problems. It remains clear that there is a need for possible strategies for alleviating shame in incarcerated women, for example, through self-compassion.

**Emotion regulation.** Emotion regulation is a complex process that involves initiating, inhibiting, and monitoring subjective emotional states, as well as emotion-related behaviours, physiology, and cognitions (Gross & Muñoz, 1995; Gross & Thompson, 2007). This evolutionary skill allows humans the ability to demonstrate appropriate emotions in appropriate circumstances and the capacity to tolerate sensations of distress (Barrett et al., 2001; Gross & Muñoz, 1995). Gratz and Roemer (2004) proposed four dimensions of emotion regulation: (a) awareness and understanding of one's emotions, (b) acceptance of negative emotions, (c) the ability to successfully engage in goal-directed behaviour and control impulsive behaviour when experiencing negative emotions, and (d) the ability to use situationally appropriate emotion regulation strategies.

According to Gross and John (2003), there are two types of emotion regulation strategies: antecedent- and response-focused. Strategies used prior to a

distressing emotional situation are known as antecedent-focused and include pre-emptive coping activities (e.g., exercising before a stressful task to feel less nervous). Strategies used to cope with active distressing emotions are known as response-focused (e.g., deep breathing to feel less angry). Emotion regulation can be conscious (e.g., suppressing sadness during a distressing movie) or unconscious (e.g., immediately shifting one's attention away from an upsetting image; Gross & Thompson, 2007). Individuals develop consistent styles of emotion regulation that include both adaptive and maladaptive strategies (Gross & Muñoz, 1995). Adaptive emotion regulation strategies have wide-ranging implications for positive psychological health, including resilience to stressful life events and healthy personal growth (Bonanno et al., 2004; Gross & Muñoz, 1995; Hopp, Troy, & Mauss, 2011), whereas maladaptive strategies contribute to distress.

Researchers have proposed a number of explanations of the etiology and function of maladaptive emotion regulation (also known as emotion dysregulation). For example, Pennebaker and Susman (1988) proposed a psychosomatic theory of inhibition, which purported that the ability to inhibit one's thoughts, feelings, and behaviours requires considerable physiological effort. Short-term changes may include increased autonomic nervous system activity, such as increased firing in specific areas of the brain. However, long-term inhibition acts as a cumulative stressor and interferes with one's ability to organize and process events, which can ultimately contribute to an increase in stress-related psychopathology. For example, persistent inhibition of distressing

traumatic thoughts about an event produces a dysfunctional feedback loop of rumination, which impairs proper integration and consolidation of the event (Pennebaker & Susman, 1988).

Emotion dysregulation has also shown particular significance to violent behaviour. Risk taking, violence, and aggressive behaviour have been conceptualized as a maladaptive attempt to regulate one's emotions (Cooper, Flanagan, Talley, & Michaes, 2006; Krakowski, 2003; Roberton et al., 2012). Early conceptualizations of emotion regulation, anger, and violent behaviour were psychodynamic in origin. Megargee (1966) explained the relationship between violent behaviour, anger, and emotion regulation by proposing that individuals fit one of two personality types: (a) under-controlled aggressive, which categorizes individuals who are impulsive and have difficulties controlling their behaviour; and (b) chronically over-controlled, which categorizes individuals who excessively inhibit their behavior, thus, resulting in a cumulative effect of anger arousal leading to violent behavior.

More recent research has moved away from psychodynamic explanations and applied cognitive and physiological models to further elucidate the relationship among emotion regulation, anger expression, and violent behaviour. Davey, Day, and Howells (2005) applied Pennebaker and Susman's (1988) psychosomatic theory of inhibition to explain anger expression. They proposed that the inhibition of anger expression might suggest that the individual develops anger-related thoughts after a triggering incident, such as experiencing provocation. The individual then acts to inhibit these thoughts, which may result

in a persistent rumination feedback loop of distressing thoughts (e.g., 'I have to prove myself,' 'I have to teach that person a lesson'), that further contribute to ongoing distress. In turn, such distress may result in dysfunctional behavior in an attempt to alleviate the distress, potentially in the form of violence. This theory has been empirically supported by more recent research (Roberton, Daffern & Bucks, 2012).

Researchers have also highlighted the relationship between emotion regulation and treatment outcomes. Howells and Day (2006) proposed that attention to emotion regulation factors (namely over/under-regulation of anger, impulse control, access to emotional states, ability to express emotional states adaptively) early in treatment is likely to promote engagement, reduce attrition, and improve treatment outcomes overall for violent offenders. Emotion regulation is therefore an integral component of correctional treatment with incarcerated populations. Unfortunately, there is a dearth of literature specifically examining treatment of emotion dysregulation with incarcerated women. This current research intends to expand this specific area, by proposing additional approaches for targeting emotion dysregulation in treatment with incarcerated women.

Although theories of emotion regulation have implications for incarcerated men and women, emotion regulation has also been investigated specifically with incarcerated women. Walsh and colleagues (2011) examined the relationship between childhood sexual abuse, adult sexual victimization, and emotion regulation difficulties in a sample of 168 incarcerated women. Women victimized

in both childhood and adulthood reported significantly greater difficulties with emotion regulation (namely, emotion non-acceptance, difficulties engaging in goal-directed behaviour when distressed, and impulse control problems) when compared to victimization in either childhood or adulthood, and non-victimized women. Women victimized only in childhood or adulthood did not demonstrate greater emotion regulation challenges when compared to non-victims. This research highlights the cumulative nature of trauma and its deleterious impact on emotion regulation for incarcerated women.

Emotion regulation research with incarcerated women has also focused on its relationship with self-harm behaviour and trauma (Jeglic, Vanderhoff, Donovick, 2005; Roe-Sepowitz, 2007). Mangnall and Yurkovich (2009) proposed a model to explain the relationship between deliberate self-harm and emotion regulation with incarcerated women. A four-stage model was elucidated through a grounded theory methodology that revealed a circular process of self-harm: (a) the individual experiences shame, anxiety, and anger which induces an increase in tension; (b) the individual engages in self-harming behaviour in an attempt to regulate distressing and overwhelming emotions, which results in temporary relief; (c) the individual experiences negative consequences in the correctional environment for demonstrating such behaviour (e.g., punishment through solitary confinement); (d) the individual once again becomes overwhelmed by feelings of shame, anxiety, and anger which are difficult to regulate, and the cycle then repeats itself. This research provides insight into the

inter-related relationship among shame, self-harm, and emotion regulation with incarcerated women.

It is noteworthy that psychological research has examined the psychological, cognitive, physiological, and emotional factors of emotion regulation, whereas criminology research has primarily focused on the role of the regulation of anger and criminal behaviour (Pickover, 2010). Many key findings in emotion regulation have therefore not been incorporated into the criminology literature (Roberton, Daffern, & Bucks, 2012). Greater collaboration between these disciplines could promote knowledge generation by integrating emotion regulation theory into research with correctional populations, including incarcerated women. This current research not only specifically intends to help bridge this knowledge gap, but also intends to provide a more robust understanding of developing gender-responsive compassion-focused treatment approaches to address emotion dysregulation with incarcerated women.

**Treatment Approaches with Incarcerated Women**

The plethora of challenges experienced by incarcerated women creates a compelling rationale to design treatments that address incarcerated womens' complex needs. There exists an ongoing debate in the criminological and psychological literatures about the preferred way to address different treatment factors, particularly the role of gender (Derkzen et al., 2013; Griffiths, & Cunningham, 2000; Saxena, Messina, & Grella, 2014). Correctional treatments are classified in two broad areas: gender-neutral and gender-responsive treatment approaches.

**Gender-neutral treatment approaches.** Gender-neutral approaches view offenders in aggregate terms; gender is viewed as a moderating factor in treatment (Andrews, Bonta, & Hoge, 1990; Hubbard, 2007; Rettinger, & Andrews, 2010). Such approaches address criminogenic needs, which are factors that contribute to violence in both genders (Andrews et al., 1990). Examples of criminogenic needs, as conceptualized by Andrews and Bonta (1998), include "The Big Four" and "The Modest Four," which create "The Central Eight" static and dynamic criminogenic factors in gender-neutral theory. "The Big Four" include (a) history of criminal behavior; (b) antisocial attitudes, values, and beliefs; (c) cognitive-emotional states; and (d) antisocial peers. "The Modest Four" include levels of human interaction in (a) family, (b) marital/romantic relationships, (c) school/work, and (d) leisure and recreation (Andrews & Bonta, 1998). Research has indicated that criminogenic needs are positively correlated with criminal behavior. Thus a major goal of the gender-neutral perspective is to reduce criminogenic rather than non-criminogenic needs (Andrews & Bonta, 1998; Monster & Micucci, 2005). Non-criminogenic needs refer to psychological variables not deemed to be correlated with criminal behaviour, including anxiety, trauma, depression, and low-self-esteem (Monster & Micucci, 2005).

Gender-neutral treatment approaches are founded on two central principles: risk-need and responsivity. The "risk-need principle" purports that treatment services must match the level of risk and need such that higher levels of service are required for higher needs offenders (Lowenkamp, Latessa, & Holsinger, 2006). Treatment also considers the responsivity principle, which

dictates that treatment must match the learning styles and abilities of the offenders (Andrews et al., 1990). This includes consideration of the offender's readiness and ability to change, mental health status, learning disabilities, criminal lifestyle, and history of institutionalization (Andrews et al., 1990). All of these factors are considered when working towards the ultimate goal of decreasing recidivism.

Gender-neutral theory and principles have influenced the development of specific psychological interventions aimed at reducing shame (Schaible & Hughes, 2011; Stuewig & Tangney, 2007; Walker & Knauer, 2011). Addressing socially appropriate shame and guilt is an integral part of the principles of restorative justice, particularly through reintegrative shaming approaches (Braithwaite, 1989; Harris, Walgrave, & Braithwaite, 2004; Prelog, Unnithan, Loeffler, Pogrebin, 2009). Reintegrative shaming is based on the belief that if attempts are made to strengthen the moral bond between the offender and the victim, the outcome will be the offender's entry back into society as a law-abiding citizen (Braithwaite, 1989). Reintegrative shaming communicates disapproval of the violent act while simultaneously respecting the offender and encouraging active involvement in the reintegration process. This theory highlights the importance of understanding the effects of social disapproval and requires that the offender experience self-conscious emotions of guilt and shame (Braithwaite, 1989).

The reintegrative shaming approach has shown some effectiveness with predominantly youth offenders (Gal & Moyal, 2011). This approach has begun to be explored with sexual offenders, although its use with this population at present

is far from widespread (McAlinden, 2005). Criticisms of reintegrative shaming with this population have been that sexual offenders often have difficulties experiencing socially appropriate shame and guilt (Blair & Mitchell, 2009; Day, Casey & Gerace, 2010) and that more punitive treatment approaches generally tend to prevail (Giustina, 2009; McAlinden, 2013).

Despite the potential of the reintegrative shaming approach with some populations, problems may arise if the offender develops not only guilt, but also a pathological sense of shame. This phenomenon is known as disintegrative shaming, or stigmatization (Braithwaite et al., 2006; McAlinden, 2013). This type of shaming can occur when the treatment emphasis is on punishment rather than on reintegration, which can result in the offender feeling isolated and shunned from others (Braithwaite et al., 2006; Malouf, Youman, Harty, Schaefer, & Tagney, 2013). This type of shaming does not result in desired prosocial outcomes, but rather, it may produce potentially negative outcomes that inadvertently reinforce the criminal behaviour it is attempting to decrease (Maxwell & Morris, 2002). In relation to the negative effects of the reintegrative shaming practice, Harris and colleagues (2004) asked the poignant question: "Can we feel bad for our actions without feeling bad about who we are?" (p. 7).

Supplemental educational approaches have been proposed to circumvent the development of disintegrative shaming. In an attempt to reduce the potential for disintegrative shaming, Sherman (2003) recommended including in treatment a component termed "Shame Transformation" to complement restorative justice approaches. The purpose of such programming is to help offenders acknowledge

guilt as a distinct emotion from shame through a variety of approaches, including cognitive-behavioural, psychodrama, and role-play. The ultimate focus of treatment lies on the processing and emotional release of shame (perhaps initially masked as guilt). This includes nurturing honest self-expression and restoring a sense of lost dignity. It is hoped that the offender is then better prepared to participate more deeply in restorative justice strategies, such as apology, restitution, mediation, and conferencing (Bazemore & Schiff, 2001).

While some research examining Shame Transformation has taken place, it is predominantly with male offender samples. Loeffler and colleagues (2010) evaluated the efficacy of Sherman's (2003) Shame Transformation programming with male offenders of intimate partner violence. Outcomes of participants in a Shame Transformation treatment approach (n=52) were compared with those of a control group, who received the customary cognitive-behavioural therapy (n=63). Analysis of Covariance was utilized to measure between-group differences for self-esteem, empathic concern, locus of control, perspective taking, and personal distress. Results indicated that Shame Transformation treatment was more effective in promoting shifts in offenders' self-esteem and empathic concern than was cognitive-behavior therapy alone. There were no significant differences among the remaining variables. This suggests that utilizing such an approach geared at changing antisocial attitudes and behaviors can improve self-esteem and concern for others.

More recently, Malouf and colleagues (2013) proposed and implemented an Impact of Crime group therapy intervention, which is founded on a "guilt

inducing and shame reducing" (p. 15) restorative justice model. In this approach, guilt is conceptualized as the moral emotion that is desired to be instilled in offenders, and shame is actively targeted for reduction of its negative impact. Noteworthy is that there is a considerable dearth of literature specifically examining shame in treatment specifically with female offenders.

**Gender-responsive treatment approaches.** A major critique of the gender-neutral approach is that it is informed by work with male offenders in a male-dominated correctional system, and thus cannot be applied in the same way to women (Chesney-Lind & Irwin, 2007; Hollin & Palmer, 2006; Mazerolle, 2008). Feminist criminologists advocate for the study of female offending in order to understand the diversity of crime and the impact of women's marginalization on treatment. The study of female offending led to the development of gender-responsive treatment approaches (Chesney-Lind & Irwin, 2007). These approaches propose a shift to viewing offenders in terms of more specific factors such as gender, which is viewed as a central factor in theory, explanations, and responses to criminal behaviour (Chesney-Lind & Irwin, 2007; Sorbello, Eccleston, Ward, & Jones, 2002). Gender-responsive approaches consider a pathways perspective to criminal behaviour and unique criminogenic needs of women (Blanchette & Brown, 2006; Bloom et al., 2003; Franklin, 2008).

Although there are criminogenic factors common to men and women, there are important considerations that are taken into account in gender-responsive treatment. Hollin and Palmer (2006) reviewed the literature on criminogenic versus non-criminogenic needs among incarcerated women. They

concluded that although there are criminogenic factors that impact both men and women, it is essential to ascertain whether these factors have the same etiology and level of impact with men and women. This further supports the rationale for considering specific factors in treatment.

Research into gender-responsive correctional treatments has thrived (Belknap, 2011; Franklin, 2008; Lewis, 2006; Marcus-Mendoza, 2011; Van Wormer & Kaplan, 2006). An approach is considered gender-responsive if it views gender as an integral factor in treatment and not simply if it focuses on women (Chesney-Lind & Irwin, 2007; Willison & Lutter, 2009). Such approaches often involve integrative mental health, substance abuse, and trauma-related approaches geared to the unique needs of women. These approaches typically supplement treatment with ancillary services such as parenting assistance, child care, and intimate partner violence intervention (Bloom et al., 2003; Stalans, 2009). Treatments tend to utilize theoretical perspectives more relevant to women, such as relational theory (Baker-Miller, 1993; Calhoun, Messina, Cartier, & Torres, 2010). Therapeutic approaches specifically target concerns like substance abuse (Finfgeld-Connett, & Johnson, 2011; Grant 2009; Laux et al., 2008; Tripodi, Bledsoe, Kim, & Bender, 2011) and mental illness (Black et al., 2008 ; Jordan et al., 2002; Sacks et al., 2008; Salina et al., 2007), with an emphasis on gendered experiences. Various risk-need assessment instruments and protocols have been retailored to address gender responsive needs, for example, conceptualizing criminal behaviour from a pathways perspective (Caulfield, 2010; Covington, & Bloom, 2007; Shearer, 2003).

Treatment of trauma is one particular area in which gender-responsive treatments have flourished (Gillece, 2009; Harner & Burgess, 2011; Lewis, 2006; Lynch, Heath, Mathews, & Cepeda, 2012; Messina & Grella 2006; Pollack & Brezina, 2007; Zlotnick, Johnson, & Najavits, 2009). A well-known gender-responsive trauma treatment is known as Seeking Safety, which was developed to address comorbid substance abuse and PTSD with a focus on gender differences in symptom presentation and experiences (Najavits, 2002). It provides psychoeducation about trauma and explores how symptoms of trauma contribute to substance abuse from a cognitive-behavioural perspective. Lynch, Heath, Mathews, and Cepeda, (2012) examined the effectiveness of Seeking Safety with 59 incarcerated women who completed the intervention and 55 women who were waitlisted, and thus received no treatment. Participants in the Seeking Safety program demonstrated greater symptom improvement in PTSD and depression, as well as improved interpersonal functioning and coping compared to waitlisted offenders.

A study by Saxena, Messina, and Grella (2014) examined the effectiveness of a gender-responsive trauma-informed substance abuse treatment approach versus a relationship supportive therapy (treatment-as-usual). Women residing at a California state prison were randomly assigned to each group. Results indicated that the female offenders who reported prior abuse who attended the gender responsive programming (n=60) had lower odds of depression and substance abuse at 6 and 12 months post-parole than those who were randomized to a gender-neutral treatment approach (n=55). Such results provide a compelling

rationale for gender-responsive approaches that integrate trauma in treatment of substance abuse and other mental health challenges.

Researchers have also examined gender-responsive trauma programming and its impact on emotion regulation with incarcerated female adolescents. Ford and colleagues (2012) examined the efficacy of two trauma treatment programs and their impact on emotion regulation with 59 delinquent adolescent females suffering from PTSD. Participants were between the ages of 13 and 17, met diagnostic criteria for PTSD, and had formal contact with the juvenile justice system. A randomized clinical trial was conducted to compare the outcomes of a gender-responsive therapy called Trauma Affect Regulation Guide for Education and Therapy (TARGET) with a relationship supportive therapy (treatment-as-usual). TARGET consisted of twelve, 50-minute sessions of individual therapy focusing on cognitive-behavioural skills for emotion regulation. Treatment-as-usual was manual-based relational therapy that did not teach emotion regulation skills or provide PTSD psychoeducation. The latter was person-centered and provided solution-focused approaches for managing stressors and relationships. Results indicated that TARGET programming was more effective than treatment-as-usual in reducing intrusive re-experiencing and the avoidant/numbing symptoms of PTSD. TARGET participants also experienced almost twice the reduction in PTSD symptom severity as those undergoing treatment-as-usual. In addition, TARGET participants demonstrated an improvement in emotion regulation skills, whereas treatment-as-usual showed no evidence of change in this area.

Researchers also attempted to examine differences between gender-responsive and non-gender responsive approaches with incarcerated women. Messina, Calhoun and Braithwaite (2014) combined data from two previous studies of women offenders in order to provide greater statistical power in examining the trends from individual studies. Women in a gender-responsive trauma-informed treatment for substance abuse (n = 135) were compared to women in non-gender responsive treatment (n = 142) to determine the change in PTSD symptomatology from baseline to follow-up. Between group comparisons indicated that the two groups were similar at baseline. However, comparisons of the prevalence of PTSD at follow-up indicated significant differences for each of the measures of PTSD symptoms between the groups, with fewer symptoms of re-experiencing and avoidance occurring during follow-up in the gender-responsive group than the gender-neutral group. It was suggested that perhaps the gender-responsive approaches created a safe environment for women to explore trauma in the context of their substance abuse and unique needs.

**Culturally-responsive treatment approaches.** Culturally-responsive programming exists for Aboriginal peoples in some Canadian prisons (Hyatt, 2013; Martel, Brassard & Jaccoud, 2011; Yuen & Pedlar, 2009). Examples include spiritual ceremonies, sweat lodges, pipe ceremonies, sacred circles, sun dances, and smudging. Elders also play an integral role in helping Aboriginal offenders reconnect to their cultural identifies, by providing teachings about culture, intergenerational trauma, addictions, and systemic oppression of colonialism (Duran, 2006).

While Canadian prisons attempt to make an effort to provide culturally-responsive programming, it is not without its critics. Those within Aboriginal communities believe that the cultural programming offered is just another form of colonialism and is insensitive to within-group differences (Duran, 2006; Kirmayer, Simpson, & Cargo, 2003). As evidence of this, proponents point out that programming is designed and implemented by the federal or provincial Canadian correctional systems and not necessarily in collaboration with Aboriginal peoples (Cox et al., 2009). These generic programs are offered to all Aboriginal peoples and are not typically gender-sensitive (Martel et al., 2011), leaving much room for improvement.

Gender-responsive and culturally-responsive treatments to address mental health challenges, such as trauma and substance abuse, are beginning to garner significant support. However, there has been little attention to emotion regulation skills with incarcerated women. Investigating different therapeutic approaches for helping incarcerated women learn adaptive ways of coping with their emotions would be fruitful. One such approach worthwhile of investigation is self-compassion.

**Self-Compassion**

An understanding of self-compassion rests on the definition of compassion. Compassion is an ability to be sensitive to the pain and suffering of others; in other words, being aware of others' painful experiences (Brach, 2003). It is a concept that incorporates themes from various religions, including care for well-being, acceptance, and non-judgment of others (Brach, 2003). Goetz and

colleges define compassion as "a distinct affective experience whose primary function is to facilitate cooperation and protection of the weak and those who suffer" (p. 351). Key attributes of compassion also include nurturing sensitivity, sympathy, distress tolerance, and empathy (Gilbert, 2009). Self-compassion is "compassion turned inwards" with the desire to nurture and promote the well-being of oneself (Gilbert, 2009; Neff & McGehee, 2010). Adopting a compassionate stance towards the self is an adaptive emotion regulation strategy that enables people to cope with challenging emotions with a greater degree of understanding and kindness (Allen & Leary, 2010; Germer, 2009; Pauley & Macpherson, 2010).

Although the concept of self-compassion is not new, the scientific study of self-compassion is relatively new in Western psychological science (Neff, 2003a; Gilbert, 2009). A decade of research has demonstrated numerous psychological benefits of self-compassion (Barnard & Curry, 2011; Macbeth & Gumley, 2012; Neff, Kirkpatrick, & Rude, 2007, Neff, Rude, & Kirkpatrick, 2007). Two researchers, Kristin Neff and Paul Gilbert, are leading pioneers in the scientific study of self-compassion, bridging philosophy with psychology.

**Neff's conceptualization of self-compassion.** According to Neff (2003a), self-compassion involves "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and heal oneself with kindness" (p. 87). Neff's (2003a) definition of self-compassion is influenced by Buddhist philosophy and practice and consists of three components: self-kindness, common humanity, and mindfulness. Self-

kindness is the ability to be kind and non-judgmental rather than critical toward one's experiences. Human experience is embraced no matter how distressing. This open acceptance of one's emotional states helps people treat themselves with tenderness during difficult times rather than retreating into fear and self-hatred. Common humanity involves seeing one's struggles in the context of greater human suffering, rather than as an isolated experience. This recognition of common humanity helps provide a perspective where one recognizes that struggles, suffering, and failure are experienced by everyone. Self-compassion means embracing one's personal flaws and inadequacies as part of what it means to be a fallible human being. Mindfulness is simultaneously holding in one's awareness painful and non-painful experiences and emotions, rather than over-identifying or dissociating to avoid unpleasant internal states. Adopting a mindful standpoint allows people to distance themselves from distressing thoughts to safely observe the thoughts and feelings that arise. This allows for an objective evaluation of a distressing situation without feeling overwhelmed (Neff, 2003a). Neff's research provided foundational understanding of how self-compassion can help people cope with distressing emotions in a healthy way. Given that incarcerated women are a population plagued with distress, this current research intends to expand knowledge specifically on how self-compassion can be of benefit in treatment with incarcerated women.

**Gilbert's conceptualization of self-compassion.** While sharing aspects of Neff's understanding, Paul Gilbert's conceptualization of self-compassion has salient differences. Gilbert proposed a biopsychosocial model of self-compassion,

which is informed by evolutionary psychology, attachment theory, neurobiology, and Buddhist and religious philosophies (Trower & Gilbert, 1989; Gilbert, 2003, 2009). The foundation of Gilbert's theory is the belief that people must first understand the way in which their minds have evolved to fully appreciate and understand their emotions from a place of self-compassion (Gilbert, 2009). Gilbert views emotion regulation challenges within a framework of human evolution. Distressing emotions such as anger, disgust, and fear result from the brain's hardwired design to promote survival. Gilbert (2009) viewed self-compassion as caring, empathy, sympathy, non-judgment, distress tolerance, and sensitivity demonstrated towards one's own suffering. Self-compassion is a skill of evolutionary value that can be learned in order to self-soothe and develop healthy emotion regulation skills (Gilbert, 2009).

Gilbert (2009) proposed that humans have evolved three types of emotion regulation systems: (a) threat and protection, (b) incentive and resource seeking, and (c) soothing and contentment. The threat and protection system is responsible for recognizing a threat and quickly and generating self-protective, yet painful feelings of anxiety, anger, and disgust. The system is also responsible for triggering the "fight, flight, or freeze" responses that marshal protective systems involving the amygdala in the brain and the stress hormone cortisol, both of which play a major role in sensitivity to threat. The incentive and resource seeking system activates positive feelings that motivate humans to seek important rewards and resources. This includes resources essential for survival, such as food, sexual opportunities, shelter, and social status. This drive system essentially guides

people towards the achievement of important life goals, and is associated with feelings of excitement, curiosity, and pleasure. It is hypothesized to function through the secretion of dopamine (Gilbert, 2009), a neurotransmitter that is associated with the experience pleasure. Finally, the soothing and contentment system helps humans self-soothe, feel peacefulness, affection, kindness, and contentment. Contentment is associated with calmness, not just an absence of threat. This system is activated when one is not in a state of threat and resource-seeking; it is a central focus in self-compassion. The hormone oxytocin is believed to be associated with this system (Depue & Morrone-Strupinsky, 2005; Gilbert, 2009), and when released, oxytocin creates feelings of social safeness.

Social safeness is facilitated through secure attachments with others (Gilbert, 2009). For example, when a baby cries and the parent displays caring and kindness, this activates positive feelings of safeness and connectedness in the infant. It is this sense of security that helps humans effectively cope with distressing emotions. Receiving warmth, kindness, and compassion signals to the brain that the world is safe and triggers the reduction of stress hormones, such as cortisol. Gilbert (2009) stated that "kindness, gentleness, warmth, and compassion are like basic vitamins for the mind" (p. 44).

Gilbert's three emotion regulation systems are designed to serve different purposes; they can either work in balance or counterbalance one another. In times of threat, the soothing and contentment system can be easily overridden by the other two systems because they are both necessary for survival (Gilbert, 2009, 2011). Psychological challenges, such as mental illness, substance abuse, and

trauma, can also cause an imbalance of these systems leading to distress. For example, people who have experienced trauma often have difficulty self-soothing and are in a constant state of threat; they experience challenges accessing their soothing and contentment systems (Gilbert, 2009, 2011). In order to cope with their distressing emotions in a positive way, it is necessary to develop the soothing system through the practice of self-compassion. Healthy emotion regulation is attained when the three systems are balanced. This theory may apply to incarcerated women; however, there is currently no research in this domain.

**Compassion-focused therapy.** Gilbert's theory of compassion has applications in a clinical context, particularly in the development of compassion-focused therapy (CFT; Gilbert, 2010a, 2010b). CFT is a multi-modal therapeutic approach applying the psychoevolutionary model of affect (Gilbert, 2009) to psychotherapy. CFT also integrates emotion-focused and cognitive-behavioural strategies (Gilbert, 2010a, 2010b).

CFT's primary tenet is to promote adaptive emotion regulation skills so individuals learn to cope with and soothe their distress in healthy ways. It originated from work with individuals who exhibited high levels of shame and self-criticism, as they were noted to have significant difficulty exercising kindness, warmth, and compassion towards themselves (Gilbert, 2009; Gilbert & Proctor, 2006; Lee, 2009). Demonstrating self-compassion changes the way one relates to the self through a shifting of cognitions, attention, affect, behaviors, images, and sensations (Gilbert, 2010a). Shame and self-criticism are replaced by a compassionate stance towards their distress (Gilbert, 2009; Gilbert & Proctor,

2006). Self-compassion is viewed as a skill that can be learned through a process called compassionate mind training, wherein people practice specific activities designed to develop compassionate attributes and skills, such as self-soothing, nurturance, kindness, warmth, non-judgment, and empathy (Gilbert, 2010a, 2010c).

CFT has been used in the treatment of numerous psychological problems. Research exists illustrating CFT's effectiveness in treating depression, anxiety, eating disorders, traumatic brain injury, psychosis, bipolar disorder, anger, and other psychological issues associated with shame and self-criticism (Ashworth, Gracey, & Gilbert, 2011; Gilbert & Procter, 2006; Goss & Allan, 2010; Gumley, Braehler, Laithwaite, MacBeth, & Gilbert, 2010; Kolts & Gilbert, 2012; Lee, 2010). There is a plethora of literature examining CFT's efficacy. Beaumont and colleagues (2012) examined the effect of treatment for trauma with 32 participants who received either 12 sessions of cognitive-behavioural therapy (CBT) or CBT coupled with compassionate mind training (CMT). Participants in both groups experienced a statistically significant reduction in anxiety, depression, avoidant behaviour, intrusive thoughts, and hyper-arousal symptoms post-therapy. However, participants in the combined CBT/CMT group developed statistically significant higher self-compassion scores post-therapy than the CBT only group. This illustrates the notion that CMT approaches may be a useful supplement to CBT for people who experience trauma, such as incarcerated women.

**Self-compassion and well-being.** Research has demonstrated a variety of benefits to cultivating self-compassion. Self-compassion is positively associated

with psychological well-being, positive mood, optimism, social connectedness, agreeableness, emotional intelligence, and the ability to cope with stress and failure (Hall, Row, Wuensch, & Godley, 2013; Leary et al., 2007; Neff et al., 2007; Neff, Hsieh, Dejitthirat, 2005; Neff & McGehee, 2010). Self-compassion is also negatively associated with depression, anxiety, shame, anger, self-criticism, and symptoms of PTSD (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Gilbert & Procter, 2006; Johnson & O'Brien, 2013; Kolts & Gilbert, 2012; Neff, 2003a; Neff et al., 2007; Thompson & Waltz, 2008; Woods & Proeve, 2014). Gilbert (2005) posited that self-compassion promotes well-being by helping individuals feel connected to others and emotionally calm. Neff (2003a, 2004) proposed that self-compassion is a healthy emotion regulation strategy since distressing feelings are held in kind awareness rather than harsh self-judgment. Self-compassion promotes healthy emotion regulation by lowering defensiveness and reducing distressing emotional states and self-blame (Allen & Leary, 2010; Terry & Leary, 2011). Leary and colleagues (2007) suggested that self-compassion may act as a psychological buffer from the impact of negative life-events by helping individuals more positively and adaptively evaluate themselves and their experiences.

Self-compassion has also been in relation to personality traits. Hollis-Walker and Colosimo (2011) investigated the relationships between self-compassion, mindfulness, and happiness with the five factor model of personality in 123 men and women in the general population. All participants completed self-report measures of self-compassion, mindfulness, psychological well-being, and

selected personality traits. Participants who scored high on mindfulness also scored high on self-compassion, psychological well-being, agreeableness, extraversion, openness, and conscientiousness, and low on neuroticism. Self-compassion also partially mediated the relationship between happiness and mindfulness. The authors suggested that the practice of mindfulness facilitates well-being, and also cultivates a compassionate attitude, which in turn safeguards against the destructive effects of negative feelings like guilt and self-criticism.

Neff and colleagues (2007) also examined the relationship of self-compassion, positive psychological health, and the five factor model of personality. One hundred and seventy seven undergraduate students were recruited to complete self-report questionnaires measuring self-compassion, wisdom, personal initiative, curiosity and exploration, happiness, positive and negative affect, and optimism, as well as the personality traits included in the Neuroticism, Extraversion, and Openness to Experience (NEO) Five Factor Inventory (Costa & McCrae, 1992). Results of a correlational analysis indicated that self-compassion had a significant positive association with self-reported measures of happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness. It also had a significant negative association with negative affect and neuroticism. Self-compassion predicted significant variance in positive psychological health beyond that which can be attributed to personality. This illustrates that self-compassion not only predicts positive psychological strengths, but also deters psychopathology. Similar results on the five factor model and self-compassion

have been found by other researchers, thus providing further support for the positive relationship between self-compassion and psychological well-being (Saricaoglu & Arslan, 2013).

Recent research endorses self-compassion as an adaptive emotion regulation strategy for adults coping with major depression. Diedrich and colleagues (2014) provided the first experimentally-based evidence for the efficacy of the instructed use of self-compassion (versus habitual use of self-compassion). The study compared the effectiveness of self-compassion with a waiting condition, emotion regulation strategies of cognitive reappraisal and acceptance in a clinically depressed adult sample. The hypothesis tested was that the intensity of depressed mood would moderate the differential efficacy of these emotion regulation strategies. In the experimental group (n=48), depressed mood was induced at four points in time in individuals meeting diagnostic criteria for major depressive disorder. After each mood induction, participants were instructed to wait, reappraise the situation, accept their negative emotions, or employ self-compassion to regulate their mood. Self-ratings of depressed mood were assessed at baseline and after each mood induction and regulation phase. Results indicated that the reduction of depressed mood was significantly greater in the self-compassion condition than the waiting condition. Such results lend further support the self-compassion as an adaptive emotion regulation strategy, associated with greater positive emotions and a decrease in depressive symptoms.

Another recent study has expanded our understanding of the relationship between self-compassion and depressive symptoms, by examining the role of

shame. Johnson and O'Brien (2013) found a strong negative association between self-compassion and depression symptoms in a sample of 335 university students. A test of multiple mediation revealed that shame was a significant mediator of this relationship (along with rumination and self-esteem). Those students who were high in shame were then randomly assigned to one of three groups (a) write about shame self-compassionately, (b) express feelings about shame in writing, or (c) do neither (control condition). Participants were instructed to complete this task three times in one week. Results indicated those individuals who used self-compassion to process shameful experiences experienced an immediate decrease in intensity of feelings of shame and overall negative affect than those in the other two conditions. At the two-week follow-up, participants in the self-compassion condition alone showed reduction in shame-proneness and depressive symptoms. These results indicate self-compassion promotes soothing by reducing the threat system activation and depressive symptoms.

Recent self-compassion research has examined the relationship among shame, guilt, and self-compassion. Woods and Proeve (2014) examined the relationships of shame-proneness and guilt-proneness with mindfulness and self-compassion with 212 undergraduate students. Scales used were the Test of Self-Conscious Affect (Fontaine, Luyten, Boeck, & Corveleyn, 2001), Self-Compassion Scale (Neff, 2003b), and Five Facet Mindfulness Questionnaire (Baer et al., 2006). Results indicated shame-proneness was strongly negatively correlated with all aspects of mindfulness and with self-compassion, whereas guilt-proneness was weakly positively correlated with self-compassion and some

aspects of mindfulness. Regression analyses revealed that self-compassion (but not mindfulness) predicted shame-proneness. Such results have compelling implications for nurturing guilt and decreasing shame in treatment as a method of cultivating self-compassion in incarcerated women.

Newly emerging literature has shown self-compassion may alleviate the deleterious effects of trauma (Lee, 2009, 2010; Thompson & Waltz, 2008). Thompson and Waltz (2008) explored the relationship between self-compassion and post-traumatic stress symptoms with the intent to inform trauma treatment. Participants were 100 undergraduate students who met criterion A for the diagnosis of PTSD (that is, endured at least one trauma in which they feared physical injury or death for themselves or others, and experienced feelings of helplessness and/or terror) as outlined in the DSM-IV-TR (American Psychiatric Association, 2000). Participants completed the Self-Compassion Scale (Neff, 2003b) and the Post-Traumatic Diagnostic Scale (Foa, Cashman, Jaycox, & Perry, 1997). Avoidance symptoms of PTSD were negatively correlated with self-compassion, but intrusive re-experiencing and hyper-arousal symptoms were not. The authors suggested that individuals who scored high in self-compassion may engage in less avoidant coping strategies, thus allowing for a natural exposure process following trauma. These results support previous work examining the relationship of self-compassion and emotion regulation, where higher self-compassion is associated with a lower need to avoid painful experiences (Leary et al., 2007). These insights have relevance for incarcerated women, who are plagued by the distress of trauma.

Miron, Orcutt, Hannan, and Thompson (2014) expanded further on the literature of self-compassion and trauma. They examined the relationships of abuse during childhood, subsequent problems with alcohol, and levels of self-compassion with a sample of 667 undergraduate females. Through a path analysis, it was found that a history of childhood sexual abuse and physical abuse directly predicted later alcohol abuse, whereas a history of childhood emotional abuse was indirectly related to alcohol problems mediated by low levels of self-compassion. These results lend further support to the utilization of self-compassion as a worthwhile target in treatment for women exposed to emotional and psychological abuse, a profile that is also indicative of many women in prison.

While numerous studies have examined the relationship between self-compassion and different facets of mental health, Macbeth and Gumley (2012) completed a meta-analysis to elucidate the strength of the relationship between self-compassion and symptoms of psychopathology. They examined 20 eligible samples from 14 studies. Random effect analyses of Fisher's Z correction for attenuation arising from scale reliability occurred. A large effect size was observed for the relationship, specifically higher levels of self-compassion were associated with lower levels of mental health symptoms, such as depression, anxiety, and stress ($r = -0.54$ [95% CI = -0.57 to -0.51; $Z=-34.02$; $p<0.0001$]) Such results strongly support self-compassion as an integral explanatory variable in alleviating psychopathology and increasing resilience.

Research evaluating the benefits of self-compassion has primarily been quantitative in nature, with scarce qualitative inquiry into the concept. An exception is a phenomenological study conducted by Pauley and MacPherson (2010), who examined the meaning and experiences of self-compassion with individuals diagnosed with depression and anxiety. Individuals who met DSM-IV-TR (American Psychiatric Association, 2000) criteria for a depressive or anxiety disorder were eligible to participate. Ten participants completed semi-structured interviews and answered questions informed largely by Neff's (Neff, 2004) conceptualization of self-compassion. Participants perceived the concept of self-compassion to have two qualities: kindness and action. Participants also reported they believed that self-compassion was a useful way to cope with their anxiety and depression. In addition to reporting considerable obstacles to self-compassion, participants viewed their psychological diagnoses as negatively impacting their ability to be self-compassionate. This kind of detailed information could only be obtained by qualitative methodology.

**Self-compassion, empathy, and compassion towards others.** There is a disagreement in the literature about the relationship between self-compassion and compassion towards others. Gilbert (2009) proposed that people can be very comfortable demonstrating compassion towards others, but not comfortable or willing to extend compassion towards themselves. He posited this can be due to beliefs of the primary importance of putting others first or believing that self-compassion is a form of self-indulgence and weakness. In contrast, Neff (2003a) noted that cultivating an attitude of self-compassion may help people develop

compassion towards others. She proposed that self-compassion does not mean that people are self-centered, but rather that self-compassion enhances feelings of concern for the self *and* others. Understanding one's suffering as a common part of humanity helps foster an awareness that people are interconnected and worthy of compassion (Neff, 2003a).

Recent research by Neff and Pommier (2013) empirically evaluated the relationship between self-compassion and concern for the well-being of others in three unique samples: 384 undergraduates, 400 community adults, and 172 practicing meditators. Measures included Neff's (2003b) Self-Compassion Scale, Compassionate Love for Humanity Scale (Hwang, Plante, & Lackey, 2008), Interpersonal Reactivity Index (Davis, 1980), Rushton Altruism Scale (Rushton, Chrisjohn, & Fekken, 1981), Heartland Forgiveness Scale (Thompson et al., 2005), and Marlowe-Crowne Social Desirability Scale – Short Form (Strahan & Gerbasi, 1972). Results indicated among all participant groups that higher levels of self-compassion were significantly linked to greater perspective taking, less personal distress, and greater forgiveness. Self-compassion was linked to compassion for humanity, empathetic concern, and altruism among community adults and meditators, but not undergraduates. The strengths of the association between self-compassion and other-focused concern varied according to participant group and gender; strongest links were found among meditators, while women tended to show weaker associations than men. Such results provide support for the interconnectedness of self-compassion and concern for others, which has direct relevance for women in prison. Similar empirical research has

demonstrated further support for such interconnectedness, particularly that one way to increase self-compassion is to demonstrate compassion towards others (Breines & Chen 2013). However, this perspective is somewhat inconsistent with Gilbert's (2009) view on the relationship between self-compassion and compassion, in which people can be very comfortable demonstrating compassion towards others, but not comfortable or willing to extend compassion towards themselves.

Compassion towards others is also related to empathy. Although various definitions of empathy have been proposed, there is no single agreed-upon definition in the academic community (Goetz, Keltner, & Simon-Thomas, 2010). A broad definition is that empathy includes cognitive and affective components of being able to imagine another person's perspective and experience resultant thoughts and feelings (Davis, 1994; Lazarus, 1991). There are salient differences between compassion and empathy. Gilbert (2009) conceptualizes that empathy is one of several aspects of compassion, including caring for the well-being of others, sensitivity, non-judgment, sympathy, and distress tolerance. Empathy has been labeled by some scholars as a compassion-related state (along with sympathy and pity) since it is based on a concern for ameliorating the suffering of another individual (Ekman, 1992). Empathy has been shown to have positive associations with well-being (Tan, Zou, He, & Huang, 2011; Wei, Yu-Hsin Liao, Ku, Shaffer, 2011) and is a moderately strong predictor of psychotherapy outcome with the general population (Elliot, Bohart, Watson, & Greenberg, 2011).

Empathy has been extensively studied in correctional populations as researchers work to understand the connection between cruelty and empathy and their relationship to explain antisocial and criminal behaviour (Baron-Cohen, 2011). This is particularly prominent in research involving persons diagnosed as psychopaths and sexual offenders as these individuals often lack empathy towards their victims (Geer, Estupinan, & Manguno Mire, 2000; Hanson, 2003; Roche, Shoss, Pincus, & Menard, 2011; Varker, Devilly, Ward, & Beech, 2008).

Welp and Brown (2014) empirically examined whether self-compassion predicted empathy for someone in a difficult situation, along with the willingness to provide help. Self-compassion was measured with the Self-Compassion Scale (Neff, 2003b). Participants read a vignette about a man who was stranded with a flat tire. Participants then had to rate, on a Likert-type scale, various emotions experienced as well as the likelihood they would stop and help. A manipulation check took place examining how much participants felt the person was to blame for his situation. Those who were high in self-compassion reported a greater willingness to help the hypothetical person, yet felt less empathy for him and assigned more responsibility to him at the same time. Empathy was specifically measured by ratings of feeling sympathy for the target, distress upon seeing the target, and distress if in the target's situation. Possible explanations were that if highly self-compassion participants are not distressed by their own mistakes, then perhaps they do not feel distressed if they were placed in the target situation. The lack of empathy was not perhaps from cold-heartedness, but rather, from a different appraisal of the situation. Another possible explanation is that those

high in self-compassion initially experience pain but are able to regulate that pain in healthy ways. Results as such suggest that the relationship between empathy and self-compassion is much more complex and nuanced than anticipated and require further research to understand.

While recent empirical research is only just beginning to elucidate the relationship between self-compassion and empathy, there is currently a limited understanding of empathy and self-compassion specifically with incarcerated women. Further exploration into empathy and the broader concepts of compassion and self-compassion is warranted in order to tailor appropriate interventions for this population.

**Self-compassion and incarcerated populations.** Whereas empathy has been extensively studied with correctional populations, the investigation of self-compassion and offenders is scant. Only two quantitative studies are known to date that have examined self-compassion with offenders. Lo (2008) explored the impact of self-compassion and self-esteem on empathy, shame, and social functioning in 53 male adolescent sexual offenders aged 12 to 18. The male offenders were sampled from six Canadian youth residential treatment programs for sexual offending and were compared with a control group of 49 male (nonoffending) youth, who were sampled from local high schools. All participants completed a battery of psychological inventories on the variables of interest. Mediational models were utilized to determine the relationship of empathy and shame to social functioning, with either self-compassion or self-esteem as a mediator. Results indicated that self-compassion fully mediated the

relationship of both empathy and shame to social functioning in adolescent sexual offenders, but not in the control group. Self-esteem was not a significant mediator for either group. Self-compassion was also a stronger predictor than self-esteem for personal distress, shame, and social functioning in offenders, and not in the control group. These results suggest that self-compassion, rather than self-esteem, may underlie the effect of empathy and shame on social functioning in adolescent sexual offenders. Self-compassion, therefore, holds promise in ameliorating distress and shame with adolescent sexual offenders.

Bristow (2011) examined self-compassion and its relationship to indicators of psychological health with 122 female and male offenders four years after their release from prison. Indicators examined included shame, guilt, aggression, substance dependence, and antisocial attitudes. Self-compassion was examined using the Self-Compassion Scale, Short-Form (Raes et al., 2011). Self-judgment and isolation were inversely related to self-control, self-esteem, and life satisfaction and positively related to depression and anxiety. Self-kindness was the only variable negatively correlated to multiple types of aggression. Empathy partially mediated the relationship between self-kindness and aggression, indicating that self-compassion may help ex-offenders with the ability to take the perspective of others. Findings from Bristow (2011) and Lo's (2008) studies highlight the importance of continued self-compassion research especially with offenders. To date, no research on self-compassion has focused on a qualitative investigation with incarcerated women examining the intersections of self-compassion and emotion regulation.

**Summary**

The present chapter has illustrated how incarcerated women experience a plethora of challenges, such as mental illness, substance abuse, and trauma. Such challenges not only cause distress, but also contribute to problems with shame and emotion regulation. Both gender-neutral and gender-responsive treatment approaches have been developed in an attempt to provide specialized rehabilitation. There is limited research examining treatment of emotion dysregulation with women in prison. A growing body of literature has demonstrated a positive relationship between self-compassion and psychological well-being. However, there is a dearth of literature specifically examining self-compassion with incarcerated women. Since self-compassion has been demonstrated to help people cope more adaptively with distress, this creates a strong rationale to explore how this concept can be utilized in treatment with incarcerated women. Self-compassion may play an important role in recovery from shame and emotion dysregulation that plagues women in prison. The current study intends to illuminate how incarcerated women understand and experience self-compassion through qualitative inquiry.

# Chapter Three - Methodology

Qualitative inquiry was utilized to investigate incarcerated women's understanding and experiences of self-compassion. A qualitative methodology was ideal because it seeks in-depth, contextualized understanding of the varied meanings people attribute to their experiences (Creswell, 2007). While numerous qualitative methodologies exist, Interpretative Phenomenological Analysis (IPA) was chosen as the methodology due to its main goal of describing and interpreting lived experience, or the *essence* of phenomena, as much as possible (as Smith, 1996). IPA encourages participants to provide open and detailed descriptions and understanding of phenomena, rather than making specific *a priori* predictions about what phenomena will be encountered (Chapman & Smith, 2002). This methodological framework was the best fit for this study because it allowed me to elucidate detailed descriptions and interpretations of self-compassion with incarcerated women.

## Philosophical Foundations

IPA is informed by the theories, assumptions, and practices underlying phenomenology, hermeneutics, idiography, and constructivism.

**Phenomenology.** Phenomenology is both a philosophy and a method of studying the essential features or essence of experience (Moran, 2000; Smith et al., 2009). Founded in the early 20$^{th}$ century, phenomenology is concerned with understanding an individual's personal perceptions, "lived experience," or the "lifeworld" of human experience. Experience is seen as a "person-in-relation-to" phenomenon often evoked by the term "being-in-the-world" (Moran, 2000).

Philosopher Edmund Husserl is considered the founding father of phenomenology. He applied a rigorous framework to phenomenology to establish it as a methodology (Moran, 2000). Husserl viewed phenomenology as the science of consciousness and its objects; the individual is viewed as a conscious agent whose experience must be studied from a "first-person perspective" (Husserl, 1907/1966). Husserl aspired to describe experience in its purest unbiased form since he believed there was nothing more fundamental than experience itself (Husserl, 1907/1966). He posited that to know lived experience one must step back from the "natural attitude" of being unreflective, and adopt a "phenomenological attitude", which involves turning one's gaze inwards and directing thoughts to a reflective and examined immersion of experience (Husserl, 1907/1966).

**Hermeneutics.** Hermeneutics is the theory and practice of interpretation, an area shaped by philosopher Martin Heidegger (Shinebourne, 2011). Heidegger was interested in the "question of being," and the everyday manner in which individuals make sense of their lives (Heidegger, 1962). A student of Husserl's, he eventually rejected many of his teacher's perspectives. Heidegger was critical of Husserl's beliefs that knowledge about lived experiences can be ascertained in an unbiased way (Heidegger, 1962). Heidegger proposed the essence of experience cannot be fully known without any presupposition and that language is the vessel in which the question of being can unfold (Heidegger, 1962). In other words, consistent with constructivist epistemology, knowledge is shaped by people's educational, historical, political, cultural, and linguistic contexts

(Creswell, 2007). Heidegger is most well-known for bridging phenomenological description with hermeneutic interpretation, a prominent aspect of modern phenomenological approaches like IPA (Smith et al., 2009).

**Idiography.** Idiographic psychology was described by the humanistic psychologist, Gordon Allport, who stated that psychology should not neglect the uniqueness of individual experiences (Ashworth, 2008). An idiographic approach develops insight into how the individual ascribes meaning to a phenomenon (Smith et al., 2009). This is generally achieved by a close, detailed examination of a small number of participants. After individual cases are examined, the researcher can examine across cases for themes of convergence and divergence (Smith, 2004). Understanding the details of individuals allows for a greater understanding of aspects of shared humanity (Smith & Eatough, 2007).

**Social constructivism**. My epistemological stance for this research is situated within the social constructivist paradigm. This philosophical approach to research posits that realities are subjective for each individual and that reality is socially constructed by interaction with others through language and meaning-making (Lincoln & Guba, 1994; Raskin & Bridges, 2002). A social constructivist approach is appropriate to answer my research question because the goal of this research is to understand subjective experience, not measure or verify objective truth (Lincoln & Guba, 1994).

One of the most basic assumptions of the social constructivist paradigm is that the researcher cannot completely remove one's values from the process since the individual and the researcher co-construct the data together (Merriam, 2002).

Rather, the researcher's values are to be embraced as adding richness to the data. For example, I value that prison systems utilize approaches that are evidence-based and therapeutically relevant for women. The results of such study are intended to materialize this value through providing suggestions to improve treatment for women in prison.

**Methodological Framework**

IPA is a methodological framework that is congruent with a social constructivist epistemology. An apt metaphor for the methodological framework is the researcher's "reading glasses" (p. 486), since it is the framework of how to view the study (Malterud, 2001). IPA is systematic phenomenological approach to the interpretation of first-person accounts of experience (Smith et al., 2009). IPA was first proposed by Smith (1996) who advocated that psychological research can be both experimental and experiential. This design allows researchers to investigate an individual's personal and lived experience to understand how people make sense of their social world by walking in the shoes of the participant (Smith & Eatough, 2007). IPA is described as an idiographic mode of inquiry as opposed to the nomothetic approach that is dominant in psychological research (Smith, 1996; Smith et al., 2009). In other words, IPA is interested in how individuals describe and interpret subjective phenomena rather than generalization of objective phenomena. IPA is grounded in the assumption of social constructivism; humans construct their world through language, meaning-making, and social interactions (Raskin & Bridges, 2002; Smith et al., 2009).

IPA is concerned with the hermeneutics of intersubjective meaning-recollection, which seeks faithful disclosure from the individual of the nature of one's experience of specific phenomena (Smith et al., 2009). The two-stage process of interpretative activity in IPA is known as the double hermeneutic (Smith et al., 2009). In this process, the participant is attempting to make sense of one's world and the researcher is trying to make sense of how the participant makes sense of the world (Smith & Eatough, 2007; Smith et al., 2009). This process involves "exploring, describing, interpreting, and situating the means by which participants make sense of their experiences" (Smith et al., 2009, p. 11).

**Method**

**Selection criteria.** Purposeful sampling is a method of gathering individuals who meet the inclusion criteria in the particular context desired (Creswell, 2007; Marshall & Rossman, 2006). IPA does not purport there is a right size for every study since this depends on several factors (Smith & Osborn, 2008). An adequate sample size is achieved when the researcher has enough information to ascertain meaningful points of similarity and difference among the participants (Smith et al., 2009). A goal of IPA is for the sample to maximize variability. In the present study, this was achieved by recruiting 9 participants, which was within the ideal range of participants suggested for IPA studies (Smith et al., 2009). Variability was also maximized by recruiting women from different cultural groups, women who committed different types of crimes, women with differing mental health concerns, and women incarcerated for different lengths of time.

The inclusion criteria for participants were as follows: (a) female, (b) a minimum of 18 years of age, and (c) currently convicted and serving a sentence at a medium secure provincial correctional facility in Alberta.[1] Exclusion criteria were participants who were: (a) remanded status (awaiting trial, thus, accused of a crime and not convicted), (b) actively homicidal and/or suicidal, and/or (c) under isolated supervision from staff so as not to pose excessive risk to self and others. Safety protocol exclusion criteria were also set forth by the correctional institution for all research to ensure the safety of the researcher and all parties involved (i.e., women lacking privileges, identified as actively homicidal and/or suicidal, or under isolated supervision were not deemed eligible to participate).

**Participant recruitment.** Participants were recruited from a medium security provincial prison in Alberta throughout May and June 2013. This secure custody setting houses men and women ages 18 and older serving sentences of two years less a day. There are two units exclusively for female offenders and participants were recruited through a correctional institution staff member who helped facilitate access to participants. This staff member ensured that multiple copies of the participant information letter (see Appendix A) and consent form (see Appendix B) were available on the units for the women to easily access. The facilitator also ensured a recruitment flyer (see Appendix C) was posted on the

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[1] The name of the correctional institution has been intentionally withheld to protect participants' anonymity.

female units advertising the study. The staff facilitator also provided me access to the female units, so that I could give a brief presentation about the study to the women and answer any questions. Those who were interested in participating submitted a written request of interest (adhering to correctional institutional protocols) to the facilitating staff, who sent an email to inform me of potential participant interest. I then visited the correctional institution at an agreed upon time and met with participants to discuss the participant information letter, consent documentation, and screen participants to confirm whether they met inclusion criteria. Those who did not meet inclusion criteria were informed they were not eligible to participate and were escorted back to the unit. If deemed appropriate to participate, the participant signed the consent form, and the first interview took place immediately.

**Sample demographics.** Nine participants, aged 21 to 63 years, took part in the study. Seven women participated in the member check (see section on "Credibility" for a description of member-checks); two women could not be reached to do this and thus, did not complete the member-check. Four women identified as Caucasian, two as Aboriginal (Cree nation), three as having both Caucasian and Aboriginal ancestry (one Cree and two not identifying with a specific Aboriginal nation). As for religion affiliations, three women identified as Christian (no specific sect), three as Christian (Catholic), one as Christian (Protestant), and one identified with "spiritual energies" which she described as connected to Aboriginal cultural beliefs. Four women identified as single, three in common law relationships, one widowed, and one divorced. Prior to

incarceration, three women owned their own home, two rented, one lived in a room and boarding house, one woman lived on a reserve, and two women had no fixed address. Regarding education, one woman completed elementary school, three partially completed high school, two women completed high school, two women partially completed a college diploma, and one woman completed a college diploma. Prior to incarceration, one women was engaged in full-time employment, one woman was on maternity leave from full-time employment, two women were engaged in part-time employment, and four women were not employed. Seven of the nine women identified as having biological children.

The length of sentences to be served in prison ranged from 45 days to 18 months. Types of sentences included theft, trafficking, impaired driving, assault with a weapon, assault, break and enter, and dangerous driving causing death and bodily harm. For three of the participants, the current sentence was their first sentence.

**Data collection.** Data collection consisted of two interviews. The first interview was the primary source of data and elicited information about participants' meaning and experiences of self-compassion; the second interview was a member-check, as described below. Interviews were semi-structured, the preferred data collection method for IPA (Smith & Eatough, 2007; Smith et al., 2009; Smith & Osborn, 2008). This format provided the structure of an interview protocol, which not only helped guide the interview, but also allowed for conversational tone and flow. This fluidity allowed for follow-up on relevant points raised by the participant (Smith et al., 2009).

I began the initial 1 to1½ hour interview by providing the participant with an overview of the research process and asking her to complete a demographic form (see Appendix D). The interview consisted of a number of open-ended questions aimed at illuminating the essence of self-compassion (Appendix E). After the completion of the interview, there were 15 minutes of unstructured small talk with the participant prior to conclusion of the interview. The intention of this activity was to help ground the participant and help her transition back to her daily routine in the prison population. The interviews took place in a secure and private interviewing room at the correctional institution arranged by the staff liaison.

After the transcription of the first interview, a second interview took place, where I read through the transcript with each participant and provided a summary of what was discussed. The participants were asked to comment on the accuracy of the transcription, whether there were aspects of the interview they wished to be removed from the transcript/analysis, and whether they had further thoughts they would like to add. This second interview served as a member-check (Merriam, 2002) and lasted from 45 minutes to an hour. The member check also provided me with the opportunity to pursue emerging questions, ask for further details, and discuss preliminary emergent findings. The multiple interview process demonstrates how data collection and analysis happens simultaneously within IPA.

In adherence to IPA methodology, all interviews were audio-recorded. This ensured that all verbal information was collected, which facilitated accurate

transcription of the interviews. Transcription included listening to the recording and typing out the interview verbatim onto a computer. Transcribing an interview allowed ease of understanding the interview and facilitated analysis. The transcript was also an integral part of the second interview. Field notes were also made, which included documentation of what audio-recording cannot capture, such as the participant's body language, facial expressions, and my overall feelings and questions about the participant and the experience.

As the researcher, I attempted to bracket my personal biases and presuppositions about the research at every stage of the process. This process is known as analytic memoing and attempts to minimize the impact of the researcher's beliefs and biases on the research (Creswell, 2007). While preconceptions have been acknowledged, it was unrealistic to think that my personal biases and assumptions would not influence the research process, which was consistent with Heidegger's beliefs on hermeneutics (Heidegger, 1962). Please see the section entitled "My Background and Position" for documentation of my beliefs and biases.

**Data analysis.** IPA does not have rigid practices for data analysis but rather offers a set of flexible guidelines that can be adapted by researchers. Analysis within IPA has five broad stages according to Smith and colleagues (2009).

(a) Stage one of the analysis began during the transcription process, where I formed initial impressions of the data. Prior to transcribing the interview, I listened to each transcript multiple times to help immerse in the participant's

experiences. I made initial notes known as free textual analysis, which included initial thoughts of areas of significance, such as the language used by participants, contradictions, and initial conceptualizations of what the participant was trying to say. I also memoed on personal thoughts and biases. These notes were returned to at a later stage in the analysis and compared across transcripts.

(b) The second stage included making in depth notes in the margins of the transcript, with the assistance of qualitative software Atlas.ti. I paid close attention to the specific language used by the participants and interpreted language at face value by highlighting the objects which appeared to structure the participant's thoughts and experiences. This included particular attention to key words, phrases, or explanations the participant used, such as rich descriptions, assumptions, figures of speech, and emotional responses. This involved careful line-by-line examination of each transcript for any linguistic and conceptual statements that appeared to encapsulate understandings and experiences of self-compassion. I made numerous notes at this stage, including identifying phenomena within the data and writing memos capturing my thoughts about the analysis.

(c) Stage three involved returning to the notes and creating low-level themes, also known as codes, in which to capture the data at a relatively low level of abstraction. This stage was more abstract since I was attempting to capture the psychological quality in the notes and the participant's words. It became increasingly important to actively memo my biases so that the connection between the participant's words and my interpretation was not lost.

(d) Stage four involved a further iterative and selective process of reducing the data by clustering low-level themes into higher order themes. This included looking for connections and patterns among the low-level themes and clustering those together into themes of greater abstraction. Some themes were removed at this stage since they were not sufficiently grounded in the data and other themes were merged where there was conceptual overlap. Themes were included in the overall analysis if they were recurrent, meaning a theme was endorsed by at least half of the participants (i.e., at least five of nine women; Smith et al., 2009). This was congruent with IPA methodology, which dictates that when there is a larger sample size (i.e., over six participants), the emphasis shifts to assessing the key emergent themes for the whole group (Smith et al., 2009). Determining patterns in themes across all interviews was the last part of this process in order to elucidate shared experiences among participants.

(e) The fifth stage involved labeling each cluster with a superordinate theme title, which communicated the conceptual nature of the themes. There were multiple overarching themes that captured related themes at the greatest level of abstraction.

The entire data analysis process was an iterative process rather than linear; I moved back and forth between the analytic stages (Smith et al., 2009), which also occurred during the write up of the results. I worked to preserve the details from the individual experiences even when presenting data from a number of participants. I was an active member in the double hermeneutic process, where in one way I was like a participant, drawing on the mental processes we share, while

also engaging in second order sense-making of someone else's reality (Smith et al., 2009). This interpretative and constructive activity continued during data analysis and member-checking with participants, ensuring that the research account was as faithful as possible to the women's intended meaning (Smith et al., 2009).

**Determining Trustworthiness of Study**

**Credibility.** The data collection and analysis process was completed adhering to the principles outlined by IPA. To ensure credibility of the analysis, member checking, peer review, and reflection took place. During the second interview, a member check was conducted, which encouraged participant feedback on the transcript by asking participants to comment on the accuracy of the transcription. For those participants who had difficulty with reading, I discussed how the participant responded to each question and asked how this fit or did not fit with what she recalled. I was also able to explore preliminary interpretations of what the participants said and meant during the first interview. This allowed for greater certainty that what was captured what the participant intended to convey, and helped maximize the accuracy of my interpretations (Creswell, 2007).

The purpose of the peer review was multifaceted. As the primary researcher, I completed the coding and thematizing, and then discussed the different iterations with my supervisor. This peer review process afforded the opportunity to compare and contrast similarities and differences between codes and themes, check for consistency and clarity of codes and themes, and determine

fit with the data. Such discussions strengthened the analysis by allowing for consideration of different perspectives, which helped modify existing codes/themes, identify new codes/themes, and remove codes/themes.

Reflectivity also assisted with credibility. Reflectivity is both a contemplative state of mind of information after the fact and an intentional activity aimed at generating knowledge (Ben-Ari & Enosh, 2011). Reflective practice included maintaining memos, which provided an audit trail of the research process, such as particularly significant methodological and procedural decisions, my behaviours, thoughts, and emotions throughout the study, insights I was developing, and any questions I had. Re-reading of memos throughout the research process was an act of reflection since it helped me develop an awareness of my own processes so as not to misinterpret data on personal biases and values. This component also included reflection on my self-care while working with a challenging population.

A final consideration for credibility is a record of all documentation of the study (memos, interviews, demographics, consent forms, digital audio recordings) that is available for an independent audit. Such an audit ensures that the final report is credible since there is evidence of a step-by-step process through a chain of evidence (Smith et al., 2009). This was achieved by keeping physical documentation (consent documentation) organized in a folder, as well as copies of the audio recordings, transcripts, analysis, and demographics on an electronic, password protected, portable hard-drive at the University of Alberta.

**Transferability.** Transferability is the process of applying results of research in one situation to others in similar situations or contexts. It involves consideration of what populations will benefit from the findings (Malterud, 2001). The findings from IPA studies are not thought of as facts that are applicable to the general population, but rather as descriptions and interpretations applicable within specified settings (Smith et al., 2009).

While not allowing for generalization of results, the results and implications of this study may indeed be transferable to similar clinical contexts. This may include any setting in which women experience restriction of their liberty, including Canadian provincial and federal correctional institutions (including minimum, medium, and maximum security); women on probation/parole, girls under age 18 in the youth justice system; and women in the community who have been in contact with the law at some point in their lives, but not currently serving a custodial sentence. Transferable contexts may also include broader contexts of restriction of liberty, including women serving sentences in a forensic hospital for being found Not Criminally Responsible due to Mental Disorder, and women of non-voluntary status in psychiatric hospital due to being evaluated to be a significant and imminent risk to self and others.

When published and presented at conferences, this research intends to reach the audience of primarily practitioners and researchers in counselling psychology, correctional psychology, forensic mental health, and other related fields. To maximize transferability, rich descriptions from participants about the phenomena of self-compassion have been reported. This may allow the intended

audience to develop a thorough understanding of the phenomena to facilitate application in other contexts and with other populations.

**Ethical Considerations**

This study was examined by two ethical boards to determine suitability and overall soundness of design and implementation. I obtained approval by the University of Alberta's Research Ethics Board (REB 1) and then from the correctional institution's Research Application Process. The latter is a standard research application system, set forth by the Solicitor General and Public Security Correctional Services Division, for researchers to complete in order to pursue research in provincial correctional institutions in Alberta. I followed the ethical principles, values, and standards of practice for psychological researchers pursuing research with human participants as outlined by both *The Canadian Code of Ethics for Psychologists* (Truscott & Crook, 2004) and the Canadian *Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans* (CIHR, NSERC, & SSHRC, 2010). The rights of research participants were maintained while ensuring my safety during data collection. This included considerations during and after data collection.

Working with incarcerated populations invariably placed me at some degree of risk. I adhered to the established safety protocols for staff at the correctional institution: (a) staff awareness of my location when interviewing a participant, (b) I sat with my back to the door (closest to the exit), (c) awareness of where distress alarms were located in the room, (d) the staff liaison office was next door to the interviewing room, and (e) awareness of any items in the room

that could be potentially used as a weapon (e.g., ensuring the participant is able to use a pen safely). No threats to my safety occurred throughout the data collection process.

Efforts were made to ensure the participants fully understood that their role in the proposed research was voluntary and not court-mandated. It was made clear (through consent documentation and discussion with myself) that participation or lack thereof did not have any impact on the women's current treatment or sentencing, and that this research did not provide direct psychological intervention.

During the consent process, I explicitly discussed the limits of confidentiality (e.g., confidentiality would be breached if anything was revealed about intended suicide, harm to someone else, child abuse; if a crime was intended on being committed, or if records are subpoenaed by the court). It was also be made clear that any other information would not be disclosed to staff at the correctional institution and that files were stored at the University of Alberta, not the correctional institution. I remained sensitive to questions appearing to overwhelm participants and always reminded participants that consent was a fluid and ongoing process.

Throughout the interview, I frequently checked in with the participant to determine how she was feeling about the interview process. This included asking the participant how she was doing, informing her she could take a break or stop the interview at any time, and attuning to her behaviour. My training in counselling psychology provided an expertise to assess distress and provide

appropriate assistance during the interview if a participant became distressed, angry, or cried. I discussed a self-care plan of action for the participant to cope with distress if it was needed. This included what she planned to do directly after the interview for self-care, and the importance of discussing her concerns with the correctional institution psychologist, psychiatrist, or social worker. All of the participants left the interviews feeling settled, and no agitation was noted.

Specific provisions were made to ensure participants contacted me in a safe manner. Participants informed the staff liaison through appropriate correctional institution protocols that they wanted to participate, and the liaison contacted the researcher on their behalf. After greater than five women voiced interest, specific times and dates were arranged for the researcher to visit the correctional institution for interviewing to take place. The participants were then brought by a correctional officer to the interviewing room. These precautions ensured an extra level of distance from participant and me, since use of my personal phone number and email address is not preferred practice when working with incarcerated populations (Rosenfeld & Green, 2009).

Research participants in correctional facilities are not typically offered remuneration, as this is regarded as potentially coercive since wages offered within the correctional system are considerably lower than in the community. Therefore, participants in the study were not offered remuneration for their participation.

Participants' anonymity was protected through the use of a pseudonym in place of the participant's real name and removal of all potentially identifying

information from the transcript and the final document. Sound recordings were downloaded to a computer and removed from the recording device. Electronic files, sound recordings, and any other study documents are being stored on a password-protected computer and/or a locked filing cabinet at the University of Alberta. After defense of this research, the sound recordings were destroyed, although transcripts will be retained for five years for potential future research. All research data will remain at the University for five years following the completion of the research project, after which it will be destroyed.

# Chapter Four - Findings

The purpose of this study was to explore incarcerated women's understanding and experiences of self-compassion. Utilizing the methodology and methods of IPA, interviews were conducted with nine women residing in a Canadian provincial prison in Alberta. The following chapter consists of two main sections. The first section details vignettes of the nine participants, which provides a summary of the women's unique life experiences, including mental health challenges and understanding/experiences of self-compassion. This affords greater context in which to situate the findings and maintains fidelity to the idiographic practice of IPA. The second section details the results of the study.

## Brief Vignettes

**Amanda.** Amanda is a Caucasian woman in her 30's serving a sentence for fraud. This was her first sentence served and first time in conflict with the law. She shared many difficulties in her life, including distress from anxiety, and attention-deficit hyperactivity disorder (ADHD), the latter for which she took medication and attended individual therapy. Therapy helped her learn about the theory and practice of mindfulness. Mindfulness allowed Amanda to cultivate greater self-awareness into adaptively regulating her emotional state when in distress, rather than lashing out at others. She recently gave birth to a child prior to becoming incarcerated and spoke about how it was important to take care of herself first in order to be able to adequately take care of her child.

Amanda became very involved in prison programming in an attempt to learn new skills to be ready for release, such as attending group therapy for

trauma, and taking on a leadership position on her unit. She was an example to many women and other women spoke highly of her. She maintained a positive attitude towards her incarceration and worked hard to cultivate a life free from criminal behaviour upon release. Prison helped her practice self-compassionate behaviours, such as exercising, eating well, reading the bible, and journaling. Self-compassion primarily involved adopting a positive mindset about being in prison and accepting her feelings and thoughts for what they are. Self-compassion also involved taking advantage of opportunities for growth, and accepting difficult circumstances, such as being in prison.

**Angel.** Angel is a Caucasian woman in her 60's serving her sentence for Dangerous Driving Causing Death and Bodily Harm. This was her first sentence served in prison and first time in conflict with the law. Angel often questioned whether she had PTSD because of the traumatic nature of the outcome of the offence that resulted in her incarceration; the death of a family. Angel cried and often averted her gaze when discussing her incarceration. She lived with profound guilt and shame and struggled at times with whether she was worthy of self-compassion. Angel found it easier to put others first rather than herself, especially her daughter. She strived to live a life free of self-criticism and profound sadness. Angel held a job prior to incarceration and talked with pride that she had a strong work ethic, which was instrumental to how she approached life. She suffered from alcohol addiction, and became sober while in prison and intended to stay sober upon release. Angel tried to ensure her incarceration was a learning experience. She found that being incarcerated was not as bad as she

expected as long as she followed the rules. Despite struggling with self-pervasive self-criticism, she recognized that being hard on herself ultimately did not make her life easier and that practicing self-compassion involved primarily accepting herself and moving on with her life.

**Angie.** Angie is an Aboriginal woman (not identifying with a specific nation) in her 40's serving a sentence for theft. This was not her first sentence served, and she had never engaged in violent behaviour. Angie viewed herself as a mother figure since many other women in prison confided in her and sought her emotional support. She also held a leadership position on her unit.

Angie was a victim of numerous traumatic experiences throughout her life. She grew up in an abusive context on a reserve this created challenges for her practice of self-compassion. Historically, she had not disclosed to anyone about the trauma she experienced. She was afraid of the impact of the disclosure on her mental health and felt ashamed of the court system hearing her life history. During this current sentence, she pursued a legal option that required her to document her trauma before the court in an attempt to re-contextualize her offending behaviour with the goal of decreasing sentence length. She found this disclosure "triggering" and experienced uncomfortable emotions, like anxiety. Nevertheless, for Angie, it was self-compassionate to explore difficult emotions and endure despite discomfort. She maintained it was an important part of moving forward in her recovery to finally address the root of what has influenced her offending behaviour over the years. During this time, Angie reached out to a native elder and native counsellor for support.

**Britney.** Britney is a woman of Caucasian and Aboriginal descent (Cree nation) in her 20's serving a sentence for trafficking. This was not her first sentence. Britney faced many challenges in her life, such as ADHD, addiction to substances, and homelessness. While substances played a large role in her life, she did not consider using substances a self-compassionate act, since drugs ultimately harm the body and mind. Self-compassion involved activities and a mindset that are ultimately helpful, rather than destructive behaviours. Britney experienced abuse as a child and not only did this influence her beliefs of not being worthy of self-compassion, but it also shaped her belief that she never learned as a child how to treat herself with compassion. However, she remained hopeful that she could continue to learn about and practice self-compassion as an adult.

Britney liked to spend time reflecting on where her life has brought her and how to improve. She found it easier to take care of others and put others first, such as family, friends, and romantic partners. She felt that throughout her life people have taken advantage of her for her skills and resources because she liked to try and ensure others were taken care of. Britney found it challenging to find a way to continue to have compassion for others, but not at the expense of her own self-compassion. However, this had begun to shift after repeated incarcerations.

Britney expressed that being in prison helped make it easier to practice self-compassion, which included activities like exercising and journal writing. She was also involved in group and individual therapy in prison, where she was addressing trauma and learning skills for successful reintegration into society.

She enjoyed the trauma group therapy since it helped her explore the concept of self-compassion. Therapy also helped Britney realize she had difficulty looking forward to her future and that self-compassion involved being able to make choices to not engage in criminal activity.

**Jessica.** Jessica is an Aboriginal woman (not identifying with a specific nation) in her 30's serving a sentence for Assault with a Weapon. This was not her first sentence, as she described being in and out of prison for more than 10 years. Jessica struggled with substance addiction for many years. She described being involved in abusive dynamics within her family on the reserve where she grew up. Strained family relationships made it difficult for Jessica to set boundaries with her family in order to address her own needs. She was concerned about how to practice self-compassion while still entrenched in these difficult relationships. Ultimately, Jessica wanted to establish boundaries with dysfunctional family members and leave behind her "old life," which involved disengaging from criminal activities and substance use.

Jessica spent past sentences making friends in prison with people who kept her entrenched in criminal activities. During this sentence, she saw antisocial peers as an obstacle to self-compassion since these individuals spent time bragging about past criminal behaviour which made it difficult to try to be different. She described how "prison code" dictated that people view those who show compassion towards themselves or others as "weak." This time in prison, she recognized the importance of disconnecting with antisocial peers and engaging with other offenders who were interested in recovery. Jessica grew up

Catholic and based on how she was raised, she was not exposed to traditional Aboriginal way of life. She desired to become more connected with her Aboriginal culture, and reached out to the native counsellor at the prison to help support this interest. She wanted to be able pass on cultural knowledge and rituals to her children. Self-compassion also involved improving herself upon release, including pursuing education, engaging in therapy, and making different choices.

**Judy.** Judy is a Caucasian woman in her 20's serving a sentence for theft, which was not her first sentence. Judy described ongoing struggles with addiction to substances and criminal behaviour since a teenager, which resulted in running away from home and subsequent homelessness. She often engaged in criminal activity to support her addiction. Judy was distressed and often cried about why she continued to make bad choices that brought her back into prison. She desired to move on and live a normal life, free of criminal behaviour and substance use. She grew up in a well-adjusted family that continued to support her, yet she had taken this for granted. Judy had positive experiences connecting with correctional officers and she viewed some of these individuals as a stabilizing influence in her recovery. For Judy, making different choices, such as remaining sober, was an important self-compassionate act. She was scheduled to enter a substance rehabilitation program shortly after the first interview.

**Lainey.** Lainey is a Caucasian woman in her 30's serving a sentence for impaired driving. This was not her first sentence served for this particular offence. Lainey perceived that she had made numerous bad decisions in her life, particularly numerous incidents of driving under the influence. She struggled

with alcohol addiction and believed that historically she had blamed others for her circumstances. Lainey had challenging family relationships, particularly with people pressuring her to make specific decisions regarding her employment and how to raise her daughter. As she started to develop self-compassion, she realized she found it difficult to take time for self-compassion when she was taking care of her daughter. She recognized that she had taken advantage of family members and hurt others with her conduct.

Prison helped Lainey recognize the importance of taking the time to intentionally invest in her life, rather than wasting time. She recognized the importance of setting boundaries with others, including leaving an abusive relationship. She accepted that she had made her choices and prison was the consequence. Self-compassion required constant work and effort. She viewed prison as an intimidating environment for those who "are not strong."

**Levi.** Levi is an Aboriginal woman (not identifying with a specific nation) in her 30's serving a sentence for impaired driving. This was her first sentence served, but not her first time in conflict with the law. Levi felt profound sadness over incarceration separating her from her daughter. She was quite distressed that after her incarceration, she lost her housing in the community, which resulted in her daughter becoming homeless and engaging in substance use. Despite being angry over her daughter's choices, Levi practiced reframing her perspective and expressed empathy for her daughter, specifically, how she would not punish her once they reunited. Being a mother was an important part of her identity. Levi

attended individual therapy in prison, which helped her open and become connected with her emotions.

Prison involved numerous challenges. Levi experienced racism and spoke about the importance of remaining connected with other Aboriginal women for support. She described prison as intimidating for people unless they can find comfort and connection with a group of people. While prison was challenging since there was racial tension, Levi saw self-compassion as avoiding people who actively intimidate others in prison. She described wearing a mask in prison in order to be tough, and that this helped her survive. However, she stated she hated the inauthenticity of this façade and was concerned about how "hardened" she would be upon release.

Levi believed that she must first have self-compassion before she can give compassion to others. Prison helped her practice self-compassion and put herself first. Despite many challenges, turning to God was important to remain upbeat and focused. Self-compassion involved tolerating distress in an adaptive way, maintaining sobriety, and making different choices away from crime and substances. She believed it was self-compassionate to take part in the current research, despite other women on the unit making comments to her that it was a waste of time.

**Marie.** Marie is a woman of Caucasian and Aboriginal descent (no specific nation) in her 40's serving a sentence for Break and Enter, and Assault. This was not her first sentence. Marie expressed profound distress due to depression, trauma, ADHD, anxiety, and alcohol addiction. She was on numerous

medications. She cried frequently, especially when talking about how family members perpetrated abuse against her and that a particular abusive incident almost ended her life. She chose not to maintain eye contact when discussing how the family member who abused her was incarcerated for perpetrating such abuse, as she decided to report a particular incident to the police.

Marie described numerous obstacles to self-compassion. She felt she was not worthy of self-compassion since she experienced abuse and was actively coping with symptoms of trauma. She put her children first before herself and continued to experience abuse despite giving compassion to others. Giving abusers compassion, yet still experiencing abuse created profound distress and shame for this dynamic being the reality of her family life.

Marie described returning to prison as "re-traumatizing," since she did not feel safe within the intimidating environment. While prison brought a sense of familiarity, she did not want to continue living this way. Marie was concerned that if she left prison without the proper resources, she would not thrive, and would be labelled "a criminal and alcoholic."

Marie attended group therapy for trauma and this was her fourth time attempting the program. She felt she was not ready to address her problems before this point and was still not sure if she was ready. She found that engaging with clinical staff and attending chapel was comforting. Marie believed that the women attending chapel "take off their masks" and allow themselves to be vulnerable with each other. Self-compassion ultimately involved being able to live a life that did not include being assaulted or engaging in criminal behaviour.

**Themes**

The findings of this study are captured by six superordinate themes:(a) honouring oneself, (b) adopting a new mindset, (c) gaining self-awareness and insight, (d) accepting and letting go, (e) desiring self-improvement and enacting change, and (f) flow of self-compassion. Table 1 illustrates the number of women who endorsed each theme.

Table 1

*Number of Women Endorsing Main Themes*

| Names | Honouring Oneself | Adopting a New Mindset | Gaining Self-Awareness and Insight | Accepting and Letting Go | Desiring Self-Improvement and Enacting Change | Flow of Self-Compassion |
|---|---|---|---|---|---|---|
| Amanda | • | • | • | • | • | • |
| Angel | • | • | • | • | • | • |
| Angie | • | • | • | • | • | • |
| Britney | • | • | • | • | • | • |
| Jessica | • | • | • | • | • | • |
| Judy | • | • | • | | • | • |
| Lainey | • | • | • | • | • | • |
| Levi | • | • | • | • | • | • |
| Marie | | • | • | • | • | |

**Honouring oneself.** Participants in the study viewed self-compassion as beliefs and actions through which they honoured themselves. Self-compassion was a way of asserting to themselves and to others that their needs were important and valuable. This included engaging in activities to feel good and not allow others to treat them unfairly. Self-compassion as honouring oneself included giving oneself permission, trusting oneself, and setting boundaries with others.

***Giving oneself permission.*** Giving permission to take time for oneself, both emotionally and physically was an integral component of understanding and experiencing self-compassion. Phrases such as "allowing time for me," "doing for me," "allowing myself," were extensive throughout the participants' accounts. Britney, an Aboriginal woman serving a sentence for trafficking, described self-compassion as giving herself permission to pursue the things that would bring her happiness:

> [Self-compassion] means allowing yourself to have the things that'll make you happy. To let yourself go where you need to be…. It's like putting yourself on the line for your own happiness.

Some women experienced obstacles to practicing self-compassion as putting themselves first. Angel, a Caucasian woman serving a sentence for dangerous driving causing death and bodily harm, experienced guilt, as she felt she was not deserving of self-compassion:

> Why do I deserve self-compassion when I've taken two lives? So, I have a hard time. I think a lot about [the other family]. I know they don't give two hoots about me….And I would probably be in the same situation if I

> was in their shoes. Why should I feel compassionate toward myself when I've done this to a lot of people? I hurt a lot of people.

Despite these feelings of guilt, Angel was able to adopt self-compassion by giving herself permission to take time for herself while in prison:

> [Self-compassion is] allowing time for you….In [prison], I've never had so much time for rest, reading, and just thinking. I'm always busy doing stuff for me that does not matter. I got a lot of time for me in here right now.

A number of the women also understood self-compassion as giving oneself permission to take the time for self-care activities, such as inducing pleasure and "feeling good." This was also described across the interviews as "taking care of yourself." Britney understood self-compassion as caring about her physical appearance and also having this be for herself and not others:

> [Self-compassion] is showing yourself kindness. It's making yourself feel good. Making yourself feel like you deserve it. Putting your make-up on in the morning because you want to look good for yourself not for anybody else. Having a shower when you're not feeling good because you want to feel cleansed. The little things you can do for yourself to make you feel good.

Britney also described engaging in shopping as a self-compassionate act of making herself feel good and achieving a goal:

> Shopping is my compassion….It made me feel really good because I'd achieved whatever goal, like [being] able to pay all my bills and then have extra money. So, I felt good and it was treating myself with compassion.

***Trusting oneself.*** Participants viewed self-compassion as learning to trust in their own feelings and actions. Lainey, a Caucasian woman serving a sentence for impaired driving, described self-compassion as trusting her feelings and not being influenced by others' opinions:

> To be compassionate to myself [means] I'm really just valuing how I feel and if I get feelings, I'm going with them regardless of what anyone says. I'm using my intuition. That's what I'm really starting to listen to….[For example], I haven't gone to chapel in a long time. I've been trying to go and get some books from an Evangelist that's always on the TV, as I listened to her prior to coming in [to prison]. I put [in a request] the chaplain and he can't get her books. Then there was an announcement over the PA to go to church. For some reason, I get up; I'm going to church. I went and this [other inmate] told me she'd bring me those books from that [Evangelist]. I've maybe went [to chapel] twice the whole time I've been here. And that was like, okay, that's my intuition.

Some women understood self-compassion as the importance of relying on themselves rather than expecting others to meet their needs. Britney described how being in prison helped facilitate her self-compassion, particularly by enhancing her understanding of the importance of relying on herself:

> [Being in prison] makes me want to be more compassionate towards myself as opposed to when I'm out [in the community]. I'm helping everybody out there because I have what I need, right? But in [prison], I don't have anybody to help me on the flipside. I'm running around helping people, and it makes me feel good , but when I'm in [prison] and I'm low, I don't really have anywhere to turn. I think it just shows me that I need to help myself more.

Lainey shared a similar conceptualization of taking initiative for herself in prison:

> I matter, so why shouldn't I take care of myself? I need to treat myself the best way I possibly can. If I don't, nobody else will. Life is a cafeteria. You've got to figure out and go pick what you want because it's not going to just drop right here. Nobody else will bring it to you, no matter if you are hungry. A lot of times you might get the crust. Well I don't want the crust! I want the whole loaf!

***Setting boundaries with others.*** Self-compassion as honouring oneself was also explicitly tied to setting clear boundaries with others. The participants understood self-compassion as putting themselves first by identifying and articulating their needs to others, rather than perpetuating dysfunctional interpersonal dynamics. Setting themselves apart as an empowered, independent person, rather than enmeshed with others, was an important component of self-compassion. Putting themselves first was not from a place of selfishness, but rather, from a place of assertiveness that their needs were valuable and worthwhile. All the women felt they had done so much for other people that this

had left no emotional resources to invest in themselves. Therefore, the women viewed an important aspect of self-compassion as advocating for themselves. This included language such as "I matter" and "putting my needs first" throughout the interviews.

However, the participants considered the ability to put their needs before others was often a challenge. They reported that it was much easier to treat others with compassion than it was to extend this towards themselves. Marie described difficulty putting herself before her children:

> It's hard because I do have more compassion for other people than I do for myself sometimes. I'm figuring all this stuff out [and] I'm trying to help myself….I think of [my children] first and I'll do for them first….I'll take my shirt off and give it away before I'd do it for myself. That's how I am.

Britney struggled with the belief that spending time on herself was "wasting it" and that it was easier to give to others:

> If I'm just feeding into the hunger that I have, then I just feel guilty for wasting it on myself. My compassion for others, [now] that one helps pick me up….I'll see a friend of mine struggling with their stuff and I'll grab their baggage and I'll walk with them….Not just physically, [but] emotionally. I'll help carry whatever it is they're carrying until I forget what I'm carrying. [Soon I'm also] carrying [for] those other 10 people I met on the road. So my compassion, it's more for other people than it is for myself.

Despite often putting others first, Britney recognized that it was important to practice self-compassion by shifting to put her needs first.

> I help [people] all the time with what I can, but once it gets out of hand, it starts affecting me. I can only give as much as I can without going without myself. I'll never be poor enough to make someone else rich. You have to put your boundaries down…. I think I need to treat myself with more compassion. I think it would push me to do things not just for everyone else but for me.

Angie reported how she began to shift from a predominant focus on others back to herself and adopt a stance of self-compassion by no longer self-sacrificing for others:

> In the beginning, I used to worry about [other people] all the time and put myself second. But now, I have to worry about myself. That's where I'm at right now….I help them and it gets to the point where it can't go on because I take care of them so well that they don't want to on their own. But now it's definitely going to be different. I will help, but not to the point of sacrificing stuff I want to do for myself too….I have to because I have a heart and sometimes I must put it first before anything else. I just want to carry on for myself now.

Jessica indicated a similar conceptualization regarding prison context:

> [Other inmates] ask you for something and if you can't give it to them, they just get so 'well, why not?' Sometimes, you take away from yourself to help others. When you don't do that, everyone hates you. [I am]

> starting to learn that I just have to take care of myself first. Just take care of myself more, don't worry about pleasing others, and just worry about myself.

Jessica also described self-compassion as distancing from negative peers in prison and remaining focused on herself:

> Last time it was a lot harder [in prison]. You are thrown in with a bunch of people that, if anything, will make life easier on the streets. I'd try to make friends because you are here for a little bit, so you want to get along with other people. You know what they are going through and everybody's talking about the stories about what you've done in the past. Everyone tries to glorify their stories and it's always the same stories being told over and over. You see somebody on the street, and next thing you know, you are talking about what you've done like it's all fun and games, when it really wasn't. The last time, I involved myself in that. Actually learned some bad things [and] actually tried different drugs that I'd never ever seen on the streets. This time [in prison], I just distanced myself from those people. Just trying to put up that barrier. I don't want to push people away and I don't want to be rude, but I don't want to hear the stories. I've just spent more time to myself, thinking. Try to stay focused on me.

Self-compassion as setting boundaries with others was also demonstrated by not only behaving differently, but also vocally expressing this to others.

Jessica indicated self-compassion allowed her to speak her mind about how she was feeling to her family, despite her worries that this would not be well-received:

> I think I am going to speak out more and tell [my family] exactly how I feel. I know it will probably start a lot of arguments, but I have to speak my mind now.

Some women struggled with demonstrating self-compassion while in prison because the participants believed that others would perceive them as vulnerable or weak in the prison environment. For Marie, she was at times afraid to practice self-compassion in prison for fear that others would take advantage of her if she continually complied with everyone's requests:

> I'm trying to learn how to say no word. Because in the jail people will just take advantage of you for that….I never think of me. Why don't I ever think of myself?

Lainey articulated self-compassion as resisting pressure to conform to intimidating prison culture and relationship pressures:

> I do not tell [my family] how many hours they should work. I make my own money and there's no way I should be told or have punishments if I don't go with what they want me to do. Here [in prison] is a smaller version of it with the [other inmates]. So right now, I'd rather go without than conform. I'm sick of it. I don't force my shit onto you. Please don't do that to me. I guess in a way that's self-compassion as well.

Angie described self-compassion as not becoming overly involved in other inmates' affairs that do not concern her. She felt this was doing too much for others at the expense of herself:

> I've always been the kind of person that puts other people's needs first. I definitely will be more compassionate to myself in the future and not so much my surroundings unless it involves me.

Another important aspect of self-compassion as setting boundaries with others involved setting boundaries regarding intimate partner violence. For women like Marie, having an abusive partner created challenges for self-compassion:

> I don't think I'm that compassionate toward myself…. Probably because over the past 6 years [I've been] in and out of abusive relationships. [I was] getting beaten up all the time and twice I just about died.

Participants viewed self-compassion as leaving an abusive partnership and no longer tolerating such abuse because their needs and self are worthwhile. Lainey articulated:

> I need firm boundaries with a lot of my relationships that have been lacking. But who could have a relationship with an alcoholic?…I will never tolerate domestic abuse again, because I matter.

**Adopting a new mindset.** Self-compassion for several participants consisted of adopting a new way of thinking about themselves and their circumstances. This included thinking more positively and gaining greater appreciation for life.

***Maintaining a positive attitude.*** Participants understood self-compassion as positive thinking, as a way of reframing their world from a positive reference point rather than thinking negatively. This involved a continuous commitment to adopt such a stance, despite the adversity and difficult circumstances of incarceration. This was illustrated in the interviews as "being more positive," "positivity," "feeling more positive," and "thinking positive thoughts" throughout. Jessica reflected on how during the current sentence served she was going to be more self-compassionate by thinking more positively than during past sentences:

> My self-compassion is trying to be more positive this time [in prison].

Angie described self-compassion as a positive outlook on life:

> I think I look more positive now and less negative….I just try to be positive all the time now. I don't look so down on anything or at least I try not to. I don't judge. No matter what it's going to be bad, but it's just a matter of your outlook. I try to be positive now.

Amanda described self-compassion as positively reframing her situation in prison by telling herself that her life circumstances will get better and that being in prison was necessary given the circumstances:

> I just had a baby before I came in [prison]. I'm compassionate to myself knowing that I'm still a mother. I tell myself positive things. Just because I am a mother doesn't take my motherhood away. I'm here and I'm going to get better…. I am compassionate to myself….We can sit here and be negative and down on ourselves, but it doesn't change the fact or make you have less time [in prison]. You still get the same amount of time in

> the end…. Goes by fast when you are positive about it….I am a good mother and right now I'm just having a break. I made some bad choices, some wrong choices and these are the consequences and repercussions.

Judy described how her self-compassionate mindset was exemplified in how she thought about the activities she engaged in while in prison and the importance of how thinking negatively actually became her reality:

> [Self-compassion] is a mindset reframing everything you do…. Like doing the garbages on the unit and taking them out. It's helping keep the environment clean. Just [saying to yourself] 'ugh, I have to do this,' then everything drags and seems shitty. Then everything starts to be shitty. And you trip. And you hit your head. You're frustrated so you start picking up your feet and walking heavier.

***Appreciating life.*** For many women, self-compassion involved being more appreciative of life, as well as recognizing what was truly important in their lives. Britney described how self-compassion included paying attention to the things around her that are normally missed:

> [Self-compassion is] anything from if you're bored and you want to do something, just go for a walk and enjoy yourself. Enjoy life and its finest details. The little things that make the world go around, things you usually don't pay attention to, pay attention to them. Be in awe of them.

Angie described how self-compassion involved appreciating life:

> [Self-compassion is] better for me. Took a while. Life is too short now for me and I'm just appreciating it more.

Self-compassion as greater appreciation also included recognizing what was truly important and not taking people and circumstances for granted. This included the participants' recognition of the importance of family, friends, and their own health. Lainey reported it was self-compassionate to recognize she had a good life that she had previously taken for granted:

> I realize what I value now. I've had a blessed life and I've taken it for granted.

Judy recognized that living the life that she was raised in, away from criminal activity, is what was ultimately important:

> Why shouldn't I deserve [self-compassion]?…I have this great family and they are still behind me 150% and are still willing to drive out here for every court date to come see me and take me back home. Self-compassion will bring me back to that life.

**Gaining self-awareness and insight.** For all women, self-compassion as self-awareness and insight included a broad range of practices to gain insight into the thoughts, feelings, and behaviours of themselves and others. This included developing a greater understanding of self and others and processing difficult emotions.

***Greater understanding of self and others.*** Participants understood self-compassion as gaining insight by arriving at a greater understanding of themselves and others. An integral component of this understanding included engaging in reflection about one's past experiences and offending behaviour, and subsequently coming to a greater understanding of the factors that contributed to

incarceration. Greater understanding also included reflection on the difficulties one has developing self-compassion. When asked about self-compassion, Lainey indicated it was reflecting on her circumstances leading to incarceration and helping her understand the circumstances:

> Oh, [self-compassion is] to reflect. To help me realize what has caused all this to happen. Because it didn't happen overnight. This isn't my first impaired [driving sentence]. I've had many.

Britney described how self-compassion helped her develop a greater understanding of why she was in prison:

> I'd just drink, fight, [and take] drugs. I wouldn't sleep. I didn't eat. I wasn't taking care of myself. I would ride my bike all the time, but I would ride it in traffic. I didn't care. I was on a self-destructive path. Now, it seems like I can take the time to see all this stuff while I'm here, see everything I've done, and everywhere I've been. I can see where it led me.

Being in prison helped Lainey find self-compassion through understanding what led her there in the first place:

> I was in a fog. The things I've done are so out of character….[Prison] has changed my life, saved my life. This was very uncomfortable. It's not nice to say, but it was wonderful. It was a wonderful wakeup call for me. I was a bully before; I realize it now. I was a bully to my mom, my daughter, my brothers, and everybody who didn't go along with my stupid little plans. I would just go along and make their lives miserable if they

> got in my way and that's what I see happens [in prison]. I've got thrown everything I was dishing out in [prison] and talk about compassion now! Yes. I've got it.

Judy understood self-compassion as coming to an understanding about her substance addiction, which facilitated openness to new beliefs:

> When you stay in that state of mind where you want to get out and smoke crystal meth, everything you do is different. Before I was so angry and now [that I have self-compassion], I am so understanding. I now even believe in God now all of a sudden and I never did before. If anything, I believed in the devil.

Self-compassion was also viewed as a greater understanding of others, particularly recognizing that all women in prison share similar thoughts, feelings, and behaviors. Lainey described how self-compassion was recognizing that others share similar challenges:

> [Self-compassion] helps because for so long you think that your problems are just yours. But you are no different from me. We all have the same feelings. We were all made the same. Like we all got [a prison sentence]. And that's the funny thing is that sometimes in [prison], I don't understand why [other inmates] can't see that. We're all going through the same garbage, so why can't we all work together? You know what I pray for? Self-compassion! Because we all feel the same way at the end of the day and in [prison]. We are basically all together.

Lainey understood self-compassion as a greater understanding of how her problematic behaviour negatively impacted her mother, and was better able to see the situation from another's perspective:

> Self-compassion is clarity. I've pieced it together. I'm not blaming. I'm taking responsibility because I've played a huge role in it too. I've made bad choices….I don't blame [my mom] at all for being right ticked off with me. She has every right really. She's kept my whole world afloat really. So of course I can wrap my head around her life right now. She wants her life! She's getting into retirement years she doesn't need to be raising my [child] because I've dropped the ball. I can totally see.

***Processing difficult emotions.*** For a number of women, self-compassion was understood as processing difficult emotions. Self-compassion was described as awareness, confrontation, and the ability to tolerate difficult emotional states. Some women also referred to self-compassion as "being in touch with my feelings." Numerous women found it challenging to enact this aspect of self-compassion due the intimidating aspect of the prison environment reinforcing that one cannot appear vulnerable. This was demonstrated by participants having to hide their emotions and intentionally appear "hardened" while in prison in an attempt to fit in and protect from potential exploitation by other offenders. Lainey described how wearing such an emotional mask in prison is, ultimately, inauthentic:

> You're walking on eggshells all the time. It's not a good feeling….It makes you a hard person….and we're not even mean people. There's a lot

> of good people in [prison] but because of being in jail, everybody has to put on their hard hat. It's stupid. And [my friends and I] laugh about that. We wish we were outside [and] could sit together, laugh together.

Levi described a similar experience:

> [Prison] really changes you….The way I am in here is not the person I am outside [prison]. I have this big shield on me. I walk around with armour when I'm … in jail….You got to protect yourself. You got to stand up for yourself. Can't be a passive person, and can't be walked on. Nobody's gonna help you. Nobody's gonna pick you up. You gotta have that mean eye look all the time. [It] doesn't matter if it's just a worker walking by. You still gotta be on guard…. You gotta keep your eyes and ears open. You gotta hear what people are saying….I don't like the way it feels. It's an angry feeling. It actually hurts me because I'm not that type of person. I don't like to be on guard all the time. I don't always like to watch my back….Nobody is who they are when [they] leave [prison]. I'm back to myself. I can be the lady I want to be instead of sitting there acting all tough. That's not who I am.

Ultimately, despite Levi feeling the need to wear an emotional mask in prison, she experienced self-compassion through attending therapy, where she was able to explore her emotions and be vulnerable:

> When I talk to the psychologist, I'm able to cry. I'm able to release instead of bottling it up inside all the time….I can free myself. I can be

> myself. I can cry. I can feel. I can be who I want to be. I don't have to be this tough person putting on an act, like you're on stage.

Jessica also articulated how therapy with the prison native counsellor and connecting with elders were self-compassionate acts that helped her explore difficult emotions:

> I [want to] start working on going deeper into my feelings. I put in a request to see the native elder….[The prison has] a native counsellor who comes in as well. See if I [can] get some one-on-one time. I went once in the past and it scared me away. We just scratched the surface that I wasn't comfortable talking about at the time and backed off. That was a few years ago. I think I'm ready to go back and try to deal with stuff now.

For Angie, being self-compassionate was the ability to explore and confront her traumatic past while on trial. During this current sentence, Angie decided to pursue a legal option available to Aboriginal women called the Gladue Factor, which involved providing extensive firsthand documentation to the court recounting her traumatic experiences and how such experiences influenced her offending behaviour. While this process was frightening for her, the act of confronting rather than hiding from her past was self-compassionate:

> I used to keep a lot of things inside too, so now it's all coming out….Right now in court I'm being more self-compassionate by letting my feelings out and I'm not keeping my past buried….Normally I would take any offer they want to just to deal with it and get out. But I'm holding my breath and going through this Gladue factor it's called now. It's opening me up

> to making me deal with all my issues that I've had…. But I'm ready to deal with it in a positive and [self]-compassionate way.

Many women also described journal writing as a self-compassionate act, which helped them express difficult emotions adaptively. Angie described how this self-compassionate experience helped her prepare for recounting her traumatic experiences in court:

> I'm trying to think of being [self]-compassionate.…I just requested a journal from psychology. I started writing my past on paper. I decided to write my feelings instead of talking to someone and venting. I vent on paper. It helps me be [self]-compassionate.

Amanda discussed how writing letters was self-compassionate behaviour since it helped her to express, rather than suppress, her emotions:

> [I] write notes and letters on whatever is bugging [me]. [I write] whatever is on my mind because I like to think lots. I'll just go Dear God, dear whoever, dear my children, dear whoever it may be at the time [of] my issue, and I write. I put it away in a little envelope….Just the other day I was writing. [I] wrote to God. Why would you take away my child's dad? … I was just feeling sad and angry whatever and I just wrote and that was it. It was gone and it felt good. I don't bottle it up and it's not been back since.

Amanda also described self-compassion as being aware of her emotions and acting accordingly to ensure she did not make her situation worse for herself or others:

> [Self-compassion is] telling myself 'it's just a feeling; I'll get over it.' I take a deep breath and realize it's a feeling….When you take the time and say that 'I am feeling shitty today,' you can let people know that. Or say, 'I'm having a shitty day' and go into your [cell]. It's [also] the action that comes after the emotion. Once you are aware of how you feel, you act.

Jessica described self-compassion as being honest about her feelings regarding coming into prison for a third time:

> [Self-compassion is] being true to yourself. Being honest with your feelings. I have it when it comes to what I want to get out of my stay [in prison] this time. I'm getting focused and honest with myself about really trying hard this time.

Self-compassion was also viewed as tolerating distress. One woman referred to having self-compassion as "strength" to endure difficult emotions and circumstances. For Levi, self-compassion helped her tolerate the moment by moment experience in prison being away from her children:

> [Self-compassion] gives me strength [and] guidance. I just believe. I know things will be better. I can go on with my day. I can make it through this next hour. Not a day goes by that I don't cry. But I gotta be strong.

**Accepting and letting go.** Several participants understood self-compassion as acceptance of themselves and their circumstances. This included acceptance of perceived negative qualities of themselves, difficult life circumstances, and letting go of emotional pain and harsh self-judgment. Self-

compassion as acceptance of perceived inadequacies was reflected in the following statement from Angel:

> Self-compassion is the strength that allows me to realize that I'm not going to be a perfect person. I can always be a better person. I think that I have accepted to a point a lot of my imperfections.

While many participants experienced abuse as a child, Angie articulated self-compassion as no longer feeling ashamed of her past abuse history, which allowed her to disclose this to others:

> I'm not afraid to say how I was brought up. I'm not embarrassed anymore. I'm letting people know.

Some women described self-compassion as acceptance of difficult circumstances, such as being incarcerated, committing a crime, and making mistakes. When asked about what was a salient aspect of self-compassion, Amanda described acceptance of her first sentence:

> Today, I'm okay with being here. But I'm okay with it for now. It is what it is and you are here and that's it.

Angel understood an important aspect of self-compassion was finding forgiveness in herself and from others for having committed the offence:

> I think the biggest thing [about self-compassion] is to forgive myself. In order to contribute again in society, I have to forgive myself and accept what I have done and ask for forgiveness from God, forgiveness from my family, and forgiveness from the victim's family.

Britney described self-compassion was accepting past mistakes and no longer being afraid of making mistakes:

> It's okay for me to make mistakes. I accept every mistake I've made. There are lots of mistakes I wish I hadn't made, but I wouldn't know what I know now if I hadn't made mistakes. Failures - I'm not scared of them anymore.

For a number of participants, self-compassion was not only accepting past mistakes and circumstances, but also not remaining stuck in such mistakes. This included relieving themselves of emotional distress by not ruminating about past mistakes but rather, learning from them and letting go. Levi described how it was important not to dwell in the past and not let bad circumstances keep her from moving forward:

> I have to start all over again. It's going to be hard, but I will not let it get to me. I'm going to say, 'You know what? It happened. Let's just start all over again. Let's not dwell on it, let's not be angry. I'm not going to let that happen.' I've had enough time to think about that….I don't want to worry about all the stuff that's been gone. And I don't want to hear about stuff when I wasn't there; there's no point. If something went down, it happened.

Angel understood self-compassion as not only accepting that she committed the offence leading to incarceration, but also recognizing that this was a mistake:

> I made a mistake. Sometimes I wish I would have died. Then I wouldn't be going through all this now. On the other hand, I lived and am trying to

> make the best of it I can. Still doesn't make it really easy, but I am coping. I cry, but I am coping. If things fall off, let's adjust and make the best of the situation.

Several women discussed how self-compassion was letting go of harsh self-judgment of one's flaws. Marie, a woman of mixed Aboriginal and Caucasian ancestry serving a sentence for break and enter and assault, described self-compassion as being "not so down on yourself all the time." Jessica described a similar understanding of self-compassion:

> Compassionate to yourself [is] not putting yourself down or feeling negative about yourself every day….And not kicking myself when I'm down.

Amanda emphasized the importance of letting go of self-blame and guilt:

> There are a lot of mothers out there… When they come into jail, they are not always sober. You sober up…and blame yourself when reality sets in. But being compassion toward yourself [means] you don't put as much blame or heavy load on yourself….You can't beat yourself up….I just don't let the guilt and burden get me down.

While many women understood self-compassion as letting go of harsh self-criticism, the presence of intimidating individuals in prison, at times, created obstacles to this self-compassionate practice. Lainey described her perspective of how feeling intimidated by others can reinforce self-criticism and create fear:

> There's a lot of people [in prison] and a lot of intimidation and garbage like that that goes on in here. So, if they sit there and listen to what other

> people have said about them, then they're almost harder on themselves. Then they don't do things they enjoy because they may be frightened or scared [of others].

Finally, Angie understood self-compassion as letting go of anger towards others by no longer holding a grudge: "I have to be [self]-compassionate because I can't hold a grudge anymore. Let that go."

**Desiring self-improvement and enacting change.** Participants understood self-compassion as the desire to improve themselves, specifically, making changes in their lives in order to establish a better life. Self-compassion was viewed by participants as a practice that was always a work in progress involving continually striving to become more self-compassionate. This included making broad and specific changes in their lives; specifically, this was described as looking to the future and making different choices.

***Looking forward.*** For all women, looking forward in their lives and envisioning a prosocial, healthy future was a self-compassionate act. All women described self-compassion as a desire and intention to "move on" with life, rather than remain stuck in current destructive behaviours and circumstances. This envisioning and aspiring aspect of self-compassion was strongly influenced by the correctional context. Angel described self-compassion as including not only moving on past the offence that brought her into prison, but also reintegrating into society:

> If I don't [adopt self-compassion], I'm stuck in a rut and how do you stay a contributing member of society if you're going to be stuck in a rut?

> You're going to be sitting in a psychologist's or psychiatrist's office forever and I do recognize that's not where I want to be. I don't mind talking to counsellors about it. But I know myself what I have to do. I made up my mind…to get on the right path and move on.

Levi articulated self-compassion as moving on after release from prison. Looking forward was founded on an acceptance of the past, as articulated in the previous theme:

> I just want to move ahead. I don't want to worry about all the stuff that's been gone. And I don't want to hear about stuff when I wasn't there. There's no point. If something went down, it happened. Let's just move on.

Some women described self-compassion as a desire to live a normal life removed from criminal activity. Judy understood self-compassion as changing her behaviour, specifically criminal behaviour that brought her back to prison numerous times:

> [Self-compassion makes it] much easier to change. Now I'm changing myself for the better, there is nowhere to go but up. I've been there and done that already. There's not much but hurt that comes from [criminal behaviour].

For many women, self-compassion was taking the time to intentionally think about what they needed to do to equip themselves for successful reintegration into the community. Jessica understood self-compassion as taking care of herself and preventing relapse:

> I'm thinking about for when I get out, ways to better myself. Different things I can do with my lawyer and looking at ways that would actually help me. When I do get released, I would prefer to get released into something that would help me, like a program. Straight into that [rather] than being put out onto the street again. I'm trying to work on something with my [Aboriginal] band and see if they'll have something ready for me when I do get released, so I don't just fall down this time. I don't want to relapse.

Self-compassion was also understood as investing in oneself, such as taking on new learning endeavors and developing skills to better oneself. Jessica viewed self-compassion as the process of learning, specifically, a way to enhance herself and move forward in life:

> It's self-compassionate when you learn new things. Makes you feel like every time you read something different you've learned something different. You just have moved ahead than behind.

Angel understood self-compassion as learning from her experience in prison:

> Maybe that's compassion for me is that I can learn from this. I am using this whole situation [in prison] as a learning experience and trying to learn as much as I can.

One Aboriginal woman described self-compassion as taking on new learning endeavours by re-connecting with Aboriginal culture. Angie described self-compassion as gaining a greater understanding of her culture:

> I'm trying to get in touch with some of my spiritual side and my culture. I want to participate in more stuff, like sweats, sun dances, and stuff like that in my culture….I think it's time to involve myself in more; it just seems like its fading away, our culture. I want to gain more knowledge, be more grounded, more centered in my culture and myself.

***Making different choices.*** Self-compassion was conceptualized by participants as not only envisioning change, but also making different choices. This mainly included distancing from criminal activity and dysfunction in their lives and adopting prosocial pursuits and healthy relationships. Lainey viewed self-compassion as making better choices and not putting herself in harmful situations again:

> [Self-compassion] has great impact because you are going to make better choices. You're not going to put yourself in shady situations or anything because you value yourself.

Angel described self-compassion as making difficult choices, providing an example of ending her relationship with her husband and father of her children, a decision she knew was right even if it did not feel good:

> [An example of self-compassion is] when I was breaking up with my husband, the father of my kids. I was doing it for my kids and indirectly for me. So was that self-compassionate? Yes, to myself because it was something I had to do….And I will not repeat and will not let myself get into a situation [like that] again.

Self-compassion as enacting change was also experienced as being intentional about the choices one makes while in prison, especially taking the time to actually practice self-compassion. Amanda articulated:

> I think I treat myself more with compassion now than I used to before coming in. Jail is something that I needed….I think I have become a better person in a lot of areas where I needed to work on because I actually took the time to do it.

Lainey described self-compassion as an ongoing commitment to make the time to practice self-compassion and not giving in to obstacles competing for her time:

> You have a choice if you want to sleep your time, read your time, workout, or however you choose to be compassionate towards yourself. When you are on the outside, you're always doing something. You're always busy with laundry, work, lunches, school, schoolwork. I've never made the time. I'm going to choose different ways now.

For some women, like Lainey, self-compassion involved choosing to think through one's actions rather than acting impulsively:

> I'm choosing to pick my battles. Thinking it through. What I've noticed before with a lot of us [is] we want it instantly. We wanted it yesterday, and if we can't, then we blow up. Now I'm thinking it through and I don't need everything instantly. I'm ready to work for it again….I think about the consequences now and how it is going to affect everyone.

Numerous women also discussed making specific choices that they described as self-compassionate. Lainey viewed self-compassion as not reoffending:

> What will [self-compassion] look like? It will look like I am not going to reoffend. I'm not going to put myself in a situation to ever do anything like this again.

Participants reported that self-compassion also involved making the choice to take advantage of resources within prison to help better themselves and learn new skills. This was an important action component of self-compassion since it was seen as using one's time effectively rather than "wasting time." Amanda described how prison helped her get in touch with self-compassion, which was demonstrated by taking part in prison programming and being proactive in addressing her health concerns:

> [Prison] is probably the best thing that ever happened to me in my life…. I have lots of supports. I'm getting all the things I needed because my life was spiralling before I got in here….Now all of those issues seem to be addressed. When I leave here, I'm not just going back to the same thing. I have resources from being in [prison]….I got 6 or 7 certificates: first aid, parenting [course], and women's path [trauma group therapy]. I talk to the psychiatrist and psychologist, which I needed because I had been a person that suppressed and bottled up their feelings….I'm on pills for my hyperness. All the things I really didn't do and didn't take care and wasn't

> compassionate to myself on the outside. I'm going to take all the resources I can. I am compassionate to myself.

Jessica described self-compassion as getting sober and taking part in cultural programming:

> [Self-compassion is] getting clean. Trying to get my body clean and flush everything out. I also put in a request to see the native elder and about transitions. They have a native counsellor. See if I [can] get some one on one time.

A number of participants understood self-compassion as a choice regarding connectedness with others, such as distancing from dysfunctional individuals in their lives and engaging with prosocial individuals. This was a particularly challenging aspect of self-compassion since some participants viewed destructive relationships as an obstacle. For example, Jessica discussed challenges with how family members make it difficult to move forward:

> Certain people I see, like family members, make it hard to move forward. My family is a big thing that makes it hard to move forward because a lot of the issues involve them.

Judy described how it was self-compassionate to make the choice to delete phone contacts from maladaptive individuals to help distance herself from them.

> I think the biggest thing that is going to help me is losing all my numbers. Not phoning anyone anymore [from a criminal lifestyle] and making sure they are all right. I feel kind of bad about doing it, but I can't. I can't if I want to keep going.

Lainey described only allowing people in her life that make her feel good about herself and support her goals, cutting out people who do not do this, even if that was family:

> When people mistreat you, like even my father, our communication is done…. He cuts me down every chance he gets. So why would I want that? Even a friend that always has something derogatory says to you, 'oh but I'm your friend.' You know what? You're not. I'm compassionate to myself, therefore that's the only people I'm going to allow in my life as well and that's who I choose to surround myself with when I leave [prison].

**Flow of self-compassion.** An important aspect of the phenomenon of self-compassion was its interconnectedness with compassion. The participants' experiences of self-compassion seemed to flow outward toward others and inward from others.

***Flowing inward from others.*** Some women discussed that when others treated them with compassion, this normalized and encouraged them to extend the same compassion towards themselves. Britney discussed her ex-boyfriend as a person who made her feel like she was worthy of self-compassion. Subsequently, when she was treated poorly, this fed back into her self-concept of feeling she was not worthy of her own compassion:

> He made me feel I was worthy, like I was good enough to love. He made me feel like I was actually a person. He was always good to me….And that's what made me feel good. Since he left, the guys I've gone out with

> were assholes. They treated me like shit and that's what I felt I deserved. So my self-compassion wasn't really my own….I do rely on other people for my own self-compassion. How other people treat me affects how I treat myself.

Judy referred to becoming more compassionate towards herself as "seeing the light," which was facilitated by how correctional officers treated her:

> A couple of guards in here were what helped me see the light. Like this one [name], he was absolutely amazing. There were a lot of guards at the [other correctional facility] were very 'oh you are a piece of shit because you are an inmate.' Why shouldn't I treat myself like a piece of shit then?

***Flowing outwards towards others.*** For many of the women, an important aspect of self-compassion was that it facilitated compassion towards others. In order to treat others with compassion, many women believed that they first needed to treat themselves with compassion. This sentiment was articulated by most of the women, particularly Judy: "If you don't give a shit about yourself, then you can't give a shit about anything or anyone else?" and Amanda: "If you don't have compassion for yourself, you can't have that for anyone else." Jessica articulated how self-compassion helped her become more compassionate in her relationships with others:

> [Self-compassion] makes your relationships healthier,…more compassionate towards other people, more kind and respectful. You can give more to a relationship. [You can] have healthier, longer lasting

> relationships where you can help each other out. Not always about competitiveness and more trusting.

Levi conceptualized self-compassion as first needing to treat herself with compassion before she could meaningfully treat her children with compassion without it being emotionally draining:

> You can't love others unless you love yourself first….And [self-compassion] helps me because I think about my kids. I think about [being] healthy for my kids, mentally, physically….When I first came into incarceration I had a hard time dealing. I thought I was going to go crazy and I realized you know what? I might be here for a while and in order to be strong and continue to do my time here, I have to take care of myself. So, I started exercising. I started eating right. I started praying. I have to take care of myself in order to take care of my kids when I get out….I have to reach out and try to comfort my feelings before I can comfort my children.

Angel articulated that being self-compassionate is connected to feeling compassion towards others:

> I feel I am self-compassionate [because] I feel I am compassionate towards others. I listen [and] I relate well to others. I try to put myself in that situation as to how I would feel and how would they feel. Actually, I probably am a little more compassionate toward myself than I give myself credit for….But, I guess I feel that if you have to feel some self-compassion in order to be compassionate to others, you need to be able to

> feel that compassion yourself to be that way towards others….If I wasn't caring and self-compassionate, I wouldn't be able to understand how I think people would think in feel in their given situation.

Lainey indicated self-compassion helped her not over-identify with her own experience, but rather, be more open to the needs of others:

> You can put yourself in their shoes. You're not so wrapped up in your own selfishness. You can take your own mind off your own garbage and think about other people.

# Chapter Five - Discussion

The purpose of this study was to explore how incarcerated women understand and experience self-compassion. The intent was to develop a rich, in-depth understanding of the phenomenon of self-compassion as experienced by women in a provincial correctional context and to locate this understanding in the literature on self-compassion and female offenders. Women in prison understood and experienced self-compassion as a multifaceted emotion regulation strategy expressed in six superordinate themes: (a) honouring oneself, (b) adopting a new mindset, (c) gaining self-awareness and insight, (d) accepting and letting go, (e) desiring self-improvement and enacting change, and (f) flow of self-compassion.

## Discussion of Key Findings

A brief profile of the participant's pathways to crime and mental health challenges is necessary since it affords greater understanding of the context that has influenced the specific participants. Such experiences help to contextualize some of the integral factors that contributed to the participant's understanding and experiences of self-compassion.

**Pathways to crime and mental health context.** The participants described varied pathways to crime consistent with the literature. Some women explained their initial and ongoing involvement with the criminal justice system was due to addiction, which led to sentences for possession of a substance or trafficking. This is consistent with drug-connected pathways, as described by Chesney-Lind (2006) and social and human capital pathways, where crimes are economically motivated (Giordiano, Cernkovich & Rudolph 2002). Most of the

women in this study described histories of trauma that were interconnected with substance use, which further entrenched the women in the criminal justice system. This pathway is congruent with Daly's (1994) batterer pathway and Brennan and colleagues (2012) victimized/battered path to criminal behavior.

Participants in the study endorsed a significant number of experiences and struggles with trauma, mental illness, substance abuse, and dysfunctional relationships. The participants demonstrated mental health challenges prior to and during incarceration, which is consistent with previous literature (Crisanti & Frueh, 2011; Kimonis et al., 2010; Sarteschi & Vaughn, 2010; Veysey, 2010). The majority of women experienced trauma throughout their lives (physical abuse, sexual abuse, intimate partner violence). Such types of abuse were consistent with other samples of incarcerated women (Milligan & Andrews, 2005; Bradley & Davino, 2002; Zust, 2009; Flemke, 2009). The high prevalence of trauma in the current sample of women is consistent with previous research (Clements-Noelle et al., 2009; Cook et al., 2005; McDaniels-Wilson & Belknap, 2008). Most of the women in the sample reported positive histories of past criminal activity, history, and/or mental health problems, which is in line with the research (Derkzen et al., 2013). The women in this study offer additional evidence of the long-standing and complex mental health challenges characteristic of women in prison. The intersection of mental health challenges and offending behaviour also provided a unique context to the themes of self-compassion, as demonstrated in the next section.

**Themes of self-compassion.** As women began to allow self-compassion into their lives, they began to relate to themselves in a more adaptive way. Self-compassion involved a multitude of ways to honour oneself, such as giving oneself permission to consider one's own needs as primary. This was not at the expense of others' needs, but rather, was an understanding that one's own needs are of value and worthwhile of one's investment of time and energy. Since incarcerated women are plagued with mental health challenges, such as depression and addictions that are frequently associated with shame, it is not surprising that the participants struggled with believing they are of value. The core of shame is that one is inherently not of value (Gilbert, 2003; Tangney & Dearing, 2002). Incarcerated women who experienced a bolstering of their self-perceptions were engaged in a process of rebuilding, in which the shattered sense of self is repaired after a shame-eliciting event (Van Vliet, 2009). Some participants may have experienced a shift in their self-perceptions back to a prior positive sense of self. Others experienced a shift in self-perception through therapy, which helped the participants realize they have never embodied a positive self-concept. Overall, all participants gradually began to realize that allowing themselves permission to prioritize their own needs was integral to building (or rebuilding) a compassionate self.

On the journey towards self-compassion, the participants experienced a number of challenges. Women in the study experienced challenges trying to prioritize their needs, and they found it easier to be compassionate towards others than toward themselves. This is in line with Gilbert's (2009) theory that some

people find it easier to demonstrate compassion towards others, and display greater difficulty directing compassion inward, often due to fear that self-compassion is a form of self-indulgence or weakness. Being perceived as weak in the prison context was a considerable obstacle to self-compassion. This is not surprising since being perceived as weak is believed by offenders to increase vulnerability to exploitation by others in prison (McCorkle, 1992). Despite this struggle, the women strived to embrace self-compassion not as weakness, but as strength of acknowledging one's value.

The challenge of putting oneself first may also be influenced by gender role socialization. Western culture idealizes sex-role stereotypes of women as caring, nurturing, dutiful, and self-sacrificing with others (Badinter, 2012; Ridgeway, 2011). Engaging in selfless acts of caring for others, even at the expense of oneself, is positively reinforced for women in Western society. This is a type of gender performativity, a concept articulated by Judith Butler (1990), where gender is conceptualized not as expression of what one is, but rather as an expression of one's behavior. Gender performativity is also the idea that one's behaviour is scripted by hegemonic social conventions and ideologies that are reinforced through repetition in one's culture (Butler, 1993). The participants' experiences of self-compassion as putting oneself first may be regarded as a rejection of this oppressive status quo of gender performativity and may be seen a radical re-conceptualization of how they, as women, should relate to themselves.

For the participants, self-compassion was not only about giving oneself permission to value one's own needs, but also involved setting clear boundaries

with others about such needs. Setting boundaries involved standing up for oneself by making changes to usual relationship dynamics, and not feeling pressured to appease the other person. Research is this area of self-compassion is nascent. One quantitative study to date specifically examines self-compassion and appeasement. Barnard and Curry (2012) found that clergy members who were higher in self-compassion have lesser desire to please members of their congregation and a greater ability to say no to requests ($r = .21$, $p < .05$). While the women in this study also desired to protect their own desires in social interactions, the unique aspect elucidated in this study demonstrates self-compassion as explicitly setting boundaries by verbally and behaviourally articulating to others that their needs matter. It is not surprising that boundaries have particular significance for women in this study, since boundaries are a fundamental component of the correctional context. Correctional institutions require offenders to adopt very clear and stringent external boundaries and limits. Violating such boundaries can often result in severe punishment, which renders some offenders so dependent on external boundaries that they gradually lose their ability to rely on self-imposed personal limits to guide their behaviour and relationships (Haney, 2002). Ultimately, self-compassion may help women in prison be better able to impose healthy personal boundary limits in their relationships with others.

Self-compassion as setting boundaries with others was also strongly influenced by the women's relational contexts of perceiving that they have been perpetually treated unfairly by others. Setting boundaries was an attempt to try

and redefine relationships in the women's lives in the hopes that circumstances will be more functional in the future. For example, some women ended their abusive romantic relationships. This is consistent with research demonstrating that people with higher levels of self-compassion not only demonstrate more positive relationship behavior (Neff & Beretvas, 2013) but also are less likely to self-subordinate needs in interpersonal relationships (Yarnell & Neff, 2012).

The participants further described self-compassion as engaging in pleasurable activities to take care of the self. With some activities, there was a specific focus on experiencing pleasure, such as eating something that tasted good, listening to music, or massaging scented lotion into the skin. Other activities were more utilitarian such as exercising, tending to one's hygiene, and making healthy food choices. Attempts to elicit pleasure by engaging the senses are akin to distress tolerance skills as articulated in Dialectical Behavior Therapy (Dimeff & Linehan, 2001). The ability to tolerate one's distress involves calmly recognizing the impact of negative situations and engaging in behaviours to help mitigate the distress in a non-destructive way (Linehan, 1993). Focusing on activating the five senses (taste, hearing, touch, smell, sight) is a core distress tolerance skill to ground oneself and activate a feeling that is different than a distressing feeling (Linehan, 1993). Exercising and eating well are healthy habits that make one less vulnerable to distress; healthy body lends to healthy mind (Linehan, 1993). For the women in the study, self-compassion functioned as a self-soothing strategy to nurture the body and the mind.

Some women talked about adopting a new, positive mindset as another example of self-compassion. This involved appraising one's circumstances, thoughts, feelings, and behaviours and re-framing through a positive valence and aiming for balanced thinking. The participants intentionally noticed how positive thought processes helped to dissipate perpetual negativity about their circumstances, particularly incarceration. Such an understanding of self-compassion has similarities with one of the goals of Cognitive Behavioural Therapy (CBT), which is to ameliorate maladaptive cognitive processes and dysfunctional emotions and change behaviour (Beck, 1997). CBT helps individuals replace negative thoughts with more positive or neutral thoughts, self-statements, and beliefs (Craske, 2009; Sanders & Wills, 2012). This includes fostering a shift from all-or-nothing ways of thinking (e.g., participants stating, I always fail, or I will never get out of prison) to more balanced ways of thinking (e.g., participants stating, sometimes I do well at things I try and sometimes I do not, or I will get out of prison in 4 months). Shifting maladaptive thinking patterns contributes to a decrease in emotional distress and self-defeating behaviour (Craske, 2009).

As the participants began to shift their thinking styles, they became better able to adopt positive thoughts and move away from overpowering negativity. Shifting maladaptive thinking styles has also been described as psychological flexibility. Kashdan and Rotterburg (2010) define psychological flexibility as the measure of how an individual: (a) adapts to fluctuating situational demands, (b) reconfigures cognitive resources, (c) shifts perspective, and (d) balances

competing desires and needs based on one's environment. Psychological flexibility is a goal of Acceptance and Commitment Therapy (ACT), which attempts to change the way one interacts with or relates to thoughts by creating contexts in which a person's unhelpful functions are diminished (Hayes & Smith, 2005). The women in this study actively shifted their perspectives in order to better cope not only with incarceration but also with difficult past and present circumstances, such as trauma or offending behaviour. For example, Amanda began to shift viewing incarceration as unbearable to bearable. This was described by some as no longer sitting around and being non-constructive, but embarking on learning opportunities, such as enrolling in programming. The context of prison shifted to a place of learning and betterment than a place of despair. Negative thinking is therefore no longer helpful in this context, but rather, the participants' thoughts shifted to being happy that one was learning new skills and preparing for successful reintegration into society. For many women in the study, self-compassion was a form of psychological flexibility, enabling them to shift from maladaptive thinking to more balanced thought processes. This lends further support to how self-compassion is an adaptive strategy for coping with difficult circumstances.

Another aspect of self-compassion participants identified involved gaining self-awareness and insight. Participants discussed reflecting on their circumstances and decisions, which helped the women arrive at a new perspective of themselves and their circumstances. For example, rather than sleeping all day, some women spent their time questioning why they had engaged in offending

behaviour, why they used substances, or why they caused harm to other people. This type of self-awareness can be conceptualized as a form of burgeoning insight. Insight is a term frequently used in mental health settings to characterize a person's level of awareness into one's thoughts, feelings, behaviours, mental health challenges, or level of functioning (Surguladze & David, 1999). It is a complex concept that is not viewed as an all-or-nothing phenomenon, but rather as dimensional since individuals can have different levels of awareness into parts of the self simultaneously. While there is no agreement on a single definition of insight, David (1990) proposed a multi-dimensional model for conceptualizing insight in the context of mental health challenges. In this framework, insight refers to: (a) awareness that one is suffering, due to some form of mental illness, (b) more specific awareness that certain experiences, beliefs, and perceptions may not be accurate and could be explained by a mental health problem, and (c) acknowledgment of the medical implications of the above, which is demonstrated by acceptance of treatment. For the participants, taking the time to reflect contributed to greater understanding and insight into their offending behaviour, substance use, and why they remained in abusive relationships.

Through the process of gaining greater self-awareness, the women in the study attempted to make sense of their experiences as a coping method to alleviate suffering. This process of developing insight can also be paralleled with the concept of meaning-making, in which people attempt to represent their world symbolically and through reason to ultimately create meaning in their lives, which can ultimately assist with self-growth (Baumeister, 1991; Bonanno, 2013). It is

common for people to attempt to make meaning out of life circumstances, especially for stressful life events (Park, 2010). Angel made meaning by understanding her incarceration as a *learning experience* where she could reflect on how to ensure the circumstances that resulted in the offence resulting in incarceration were not repeated. She saw incarceration as necessary at the present moment in her life based on her actions. Amanda made meaning of being absent from her children as being on a *necessary break* to learn how to properly take care of herself in order to be better able to take care of her daughter. Judy made meaning of her incarceration as a *second chance* to reconnect with family and enter substance abuse treatment. For women in this study, self-compassion may have the transformative potential to help women reframe their experiences and make meaning out of challenging life events.

Self-compassion for the study participants also involved processing difficult emotions, primarily by approaching rather than avoiding these emotions. This is an adaptive approach to emotion regulation known as response-focused emotion regulation, in which coping is a response to ameliorate an active state of distress , such as deep breathing or exercising to decrease levels of anger or anxiety (Gross & John, 2003). Participants described the importance of expressing their emotions, which was facilitated primarily through attending therapy, documenting trauma history in a court of law, and journaling. This provides further evidence that self-compassion is a more adaptive emotion regulation strategy than maladaptive externalizing approaches, such as aggression and violence (Krakowski, 2003; Roberton et al., 2012).

While the participants found these aforementioned strategies helpful for addressing difficult emotions in an adaptive way, they were not without obstacles. Prison as an intimidating environment where the women were afraid to become vulnerable was once again described by participants as a salient obstacle to the adaptive expression of emotion. Expression of emotions is a vulnerable act. The intimidating nature of prison contributes to offenders developing a "prison mask," which includes actively controlling and suppressing emotions in order to appear strong with the intended effect of avoiding being taken advantage of (Haney, 2002). In the words of a prison administrator: "prison is a barely controlled jungle where the aggressive and the strong will exploit the weak, and the weak are dreadfully aware of it" (Keve, 1974). Despite participants actively recognizing the potential for exploitation in prison, the women in the study demonstrated vulnerability by embracing self-compassion.

Self-compassion led to increased insight and understanding of others' behaviour and circumstances. The participants began to recognize that other women in prison were coping with similar circumstances and that they all may share similar feelings and thoughts. This is consistent with how empathy is described in the literature, in which one is able to imagine another's perspective (Davis, 1994; Lazarus; 1991). Realizing others share similar thoughts, feelings, and experiences is also in line with Neff's (2003a) understanding of self-compassion as enhancing compassion towards others. Through a greater understanding of others, the women began to recognize that other women in prison were coping with similar painful circumstances (i.e., being in prison, being

away from their children) and expressed compassion towards these other women. This outward flow of compassion helped anchor the participants to the greater human experience and thus, their interpretation of the situation became less isolative. This has direct connection to Neff's (2003a) conceptualization of self-compassion as embodying a sense of common humanity, recognition of shared suffering.

While self-compassion as gaining insight included acknowledging and processing of thoughts, feelings, and behaviors, self-compassion also involved becoming accepting of such and letting go of harsh self-criticism. This connects to literature on acceptance, for example, within ACT, where thoughts and emotions are encouraged to be observed to ebb and flow (Hayes & Smith, 2005). Acceptance, rather than denial or resistance, helped the participants cope with the reality of being in prison and recognize they cannot change their current living situation. This practice was also reminiscent of radical acceptance as articulated within DBT; the participants embodied a stance of willingness to accept difficult thoughts and emotions, rather than willfully resisting them (Kabat-Zinn, 2003; Linehan, 1993; Neff, 2003a).

The participants described self-compassion as no longer engaging in perpetual self-attacking dialogue regarding past offences and difficult life circumstances. However, this aspect of self-compassion was also met with obstacles. Given the extent of trauma experienced, it was not surprising to learn that the women interviewed endorsed high levels of shame and self-criticism. While one woman specifically discussed guilt for her actions, it was observed that

the majority of women potentially experienced internal shame. This was described through harsh self-judgments about perceived lack of worth and profound negative self-appraisal, which is congruent with the literature (Gilbert, 2003 & Gruenewald et al., 2007). It is possible that the participants' experiences of internal shame were the result of perceived socioevaluative threat when in my presence. This was demonstrated by diverting one's gaze when discussing: (a) a crime that was an accident and resulted in others' deaths, (b) physical anomalies on one's body, (c) that a mother does not know where her daughter is, (d) that one continues to reside in an abusive relationship, and (e) how one was responsible for a family member's incarceration. Shame is a powerful obstacle to self-compassion, which is corroborated by previous research (Gilbert, 2009).

The participants shifted to being more kind and gentle in how they related to themselves. This is reminiscent of self-kindness, which is as an integral component of Neff's (2003a) conceptualization of self-compassion, where harsh judgment and self-criticism is replaced by gentleness and kindness towards the self. Further empirical evidence demonstrates that nurturing self-compassion decreases self-criticism and feelings of inferiority (Gilbert & Procter, 2006; Neff, Rude & Kirkpatrick, 2007). Seen through the lens of Gilbert's (2009) theory on the affect regulation system, extending kindness and gentleness towards one's thoughts may help to deactivate the participant's threat and protection system, and activate their soothing and contentment system which results in less critical self-talk (Gilbert, 2009).

Self-compassion as desiring self-improvement and enacting change was a new and unique finding; the literature appears to be void on any mention of these as concepts of self-compassion. Participants envisioned a prosocial future and determined concrete ways to improve their circumstances and well-being. Looking forward to potential life changes is likely very important to women in prison since restriction of liberty inherently limits one's choices and opportunities. The process of institutionalization also contributes to a decrease in a person's ability and expectation to be able to control one's life choices (Haney, 2002). The longer one is institutionalized, a greater dependence occurs on institutional structure and contingencies (Haney, 2002). While some offenders tend to adjust to prison by diminishing self-initiative and independence, the participants' journeys towards self-compassion appeared to be a form of resistance to this process of institutionalization. Self-compassion appeared to function as a mechanism to regain control over one's future choices and life trajectory.

Part of self-compassion as looking forward to the future was participants' constant striving to improve themselves to their full potential. This is in essence akin to self-actualization, where humans experience an inherent drive to strive to achieve their full potential (Maslow, 1970; Rogers, 1961). As the women viewed themselves as constantly striving for self-improvement while still in prison, self-compassion was also understood as something that is not finality, but rather, a work in progress. Being self-compassionate was also an ongoing commitment to practicing and improving one's ability to be self-compassionate. This constant drive for self-improvement is an example of Gilbert's (2009) incentive and

resource seeking affective system, which guides people towards the achievement of important life goals, and is associated with feelings of excitement, curiosity, and pleasure. Rather than giving into apathy, self-compassion helped the participants engage more meaningfully and autonomously in crafting their futures.

When enacting change, the participants were very clear that certain specific changes were an embodiment of self-compassion. All women discussed not re-offending as a key goal when envisioning their future and planned to enact such a change once released. Numerous targets of change that the women identified were criminogenic needs targets that are conceptualized by Andrews and Bonta's (1998) as the "central eight." These include decreasing contact with antisocial peers, returning to school, finding employment, not reoffending, using one's time effectively by engaging in therapeutic programming, not having endless idle time, and limiting substance use. Specific self-compassionate behaviours, as identified by the women in this study, appear to be congruent with factors shown in the offending literature to be predictive of decreasing recidivism. Therefore, treating oneself with compassion helped the participants be better able to make adaptive, prosocial choices. Self-compassionate behavior may be antithetical of offending behaviour.

Self-compassion was also articulated by the women in the study as having interconnectivity with compassion. If people in the women's lives treated them poorly, the women internalized this and began to treat themselves as such. This is not surprising since many participants endorsed struggling with feelings of insecurity and inadequacy influenced by experiencing abuse. Thus, the opposite

was also true; receiving compassion from others encouraged them to treat themselves with compassion. Such behaviour is akin to Gilbert's (2009) psychoevolutionary model of affect, namely that receiving warmth, kindness, and compassion externally (i.e., from others) activates the soothing and contentment system. This allows the individual to feel peacefulness, affection, kindness, and contentment, reducing the threat system response. Gilbert (2009) articulated that self-compassion is a skill that can be learned. In the case of the current sample, self-compassion can be learned from others by others treating them with compassion. This may be increasingly important for women in prison since many are plagued by trauma and chronic dysfunction, and may not have learned how to treat themselves with compassion. Treating women in prison with compassion may be a precursor to assist some female offenders with cultivating self-compassion.

Self-compassion also flowed outwards towards others; the participants articulated how treating themselves with compassion cultivated their ability to treat others with compassion. This was frequently described as taking care of themselves before they can appropriately tend to the needs of others. While popularized in health care provider literature, this concept of being able to better care for others translates to anyone who is caregiver of any kind, such as a mother, spouse, or elder. This flow of self-compassion is articulated in the literature, as those individuals high in self-compassion tend to demonstrate greater helping intentions toward others (Welp & Brown, 2014). This understanding of self-compassion provides support for Neff's conceptualization of self-compassion

as integrally interconnected with other-focused concerns (Neff, 2003a; Neff & Pommier, 2013). Self-compassion is thus becoming of increasing importance in helping some female offenders learn to treat others with compassion.

**Implications for Clinical Practice**

This study's findings have implications for clinical practice with incarcerated women. Mental health professionals and allied professionals (i.e., correctional officers) may benefit from a comprehensive understanding of the nature and potential benefits of self-compassion, especially with this particular population. Two of the most salient psychological challenges experienced by the participants included emotion dysregulation and shame. These are epiphenomena of mental health challenges, such as trauma and substance abuse, which not only cause distress, but also contribute to the perpetuation of offending behaviour. These approaches may be transferable to other contexts in which women experience restriction of liberty and conflict with the law.

Participants described difficulties being able to value themselves and their needs over others. It is not surprising that the participants struggled with putting themselves first, since women who are incarcerated experience significant stigma and oppression that can contribute to decreased self-worth and disempowerment (Jenkins, 2004). It is therefore important to help women in prison recognize and reclaim their value not only within themselves, but also in relation to others and larger society. This is often achieved in therapy through fostering empowerment. Empowerment is a primary goal of feminist therapy, in which the therapist helps women cultivate economic, political, social, and educational self-awareness and

strength by recognizing, claiming, and embracing their own personal power (Brown, 2007). Empowerment is the attempt to shift the way in which women view themselves in the world and in relation to others (Worrell & Remer, 2003). A feminist therapy framework places emphasis on the negative influences of sexist and oppressive societal beliefs, gender socialization, and sex-role stereotypes, including gender performative notions that women should value caring for others more than themselves. These oppressions are examined from a sociocultural environment perspective to ascertain its influence on behaviour and its effects on the whole person (Brown, 2007).

In practice, the therapist can integrate compassion-focused approaches within the aforementioned feminist framework. For example, it may be helpful to model new compassionate language to the client, demonstrating a different way of relating to the self. For example, this may include intentionally emphasizing acceptance, self-kindness, tenderness, and being worthy of relating to oneself in kind and compassionate ways. This would help to normalize a more adaptive way of thinking, feeling, and relating to oneself, and as the client moves through therapy, it is intended that a shift in relating to the self in a self-compassionate way would be maintained in day-to-day life. Helping women reframe the language in which they relate to themselves by emphasizing worthiness of self-compassion may be a helpful supplement when empowering women in prison to value themselves and their needs.

There is potential for the integration of self-compassion into gender-responsive treatments, such as targeting trauma. The women in this study who

suffered from trauma described coping with painful emotions by chronically avoiding or denying, often facilitated through substance use. A standardized approach for treating emotional avoidance in trauma is Cognitive Processing Therapy (CPT), which is a 12 session evidence-based therapy that has shown to be effective in the treatment of PTSD (Resick & Schnicke, 1993). It initially began with victims of sexual assault, although CPT has been applied with numerous other populations, such as combat veterans. Its theoretical underpinnings conceptualize PTSD as a disorder of "non-recovery," in which one's beliefs about the causes and consequences of traumatic experiences produce strong negative emotions. As a result, this prevents accurate processing of the traumatic memory, and avoidance becomes the predominant coping strategy. Avoidance functions to help the person avoid situations and trigger reactions; however, it does not allow the individual the ability to gain greater understanding of one's experiences. This is typical with incarcerated women, who often use substances as a form of avoidance. Therapy is structured and one approach is for participants to formally process a traumatic event by writing and re-writing about it. This can include writing an impact statement to identify how the individual understood the event and the impact the event has had on the person's beliefs about oneself, others, and the world (Resick & Schnicke, 1993).

The participants described that being able to approach their emotions, process and not avoid them, was indicative of self-compassion. The women specifically identified expressive letter/journal writing, in which they label and express their emotions and distress, as a self-compassionate strategy. While

expressive letter writing has been demonstrated to improve overall health and well-being in a young adult population experiencing trauma (Pennebaker, 1997; Resick & Schnicke, 1993), this strategy can be improved upon to cultivate experiences of self-compassion within CPT. Compassionate letter writing (CLW; Gilbert, 2009) helps clients refocus their thoughts and feelings on being supportive, helpful, and caring towards themselves. The letter may be written in first person or from a caring and compassionate friend/image viewpoint. After writing about the distress experienced, clients can shift to validate their own feelings. The purpose is to intentionally focus on compassion as a different way of thinking, rather than telling oneself what one should not have felt or should not have done. CLW has been shown to improve mood and increase self-compassion in young adult females (Odou & Brinker, 2014). This approach may be strengthened by integrating CLW with CPT for incarcerated women. While writing about the traumatic event, the therapist could encourage the client to intentionally focus on and include self-compassionate language throughout the narrative account. When writing the impact statement, including a section on how one would like to nurture and take care of oneself since after the event may help cultivate self-soothing and self-compassion.

Participants described how attending therapy was integral for learning not only how to cope with difficult emotions and circumstances, such as trauma, substance abuse, and incarceration, but also to develop a greater understanding of themselves. Since the participants identified gaining self-awareness and insight as a component of self-compassion, attending therapy should be encouraged. While

not a primary focus within the data, one woman described the importance of how self-compassion was developing a greater understanding of her Aboriginal culture. This could be encouraged by connecting Aboriginal clients with culturally-responsive programming within prison, such as meeting with the First Nations therapist if available. Exploration could take place, in collaboration with a member of the Aboriginal community, to determine whether specific programming is of interest, such as participating in sun dances, sweat lodges, smudging, and healing ceremonies. Options available will be inherently restricted by the availability of such programming within the correctional institution. Staff can also help connect Aboriginal women with prosocial members of their community or band to assist with engagement in cultural rituals after release from prison. Ultimately, greater insight into one's mental health challenges and circumstances has been shown to be related to improved treatment outcomes (Schwartz, 1998). Thus, self-compassion is an adaptive way to cope with difficult emotions and circumstances, develop insight into one's life experiences and culture, and adhere to treatment.

The participants discussed how letting go of harmful shame-based self-attacking was difficult. Compassion-focused therapy was designed to specifically ameliorate the deleterious impact of shame and self-criticism (Gilbert & Irons, 2005). Rather than simply focusing on shifting cognitions, CFT helps individuals learn to emotionally nurture and self-soothe through activating the safeness and contentment system. Specific compassion-focused therapy techniques can help ameliorate the effect of shame. Firstly, the therapist can model compassion

through a stance of unconditional positive regard, openness, acceptance, and non-judgment. This includes exposing women in prison to new language of how to relate to the self; not using terms like "don't" or "shouldn't" but rather, an emphasis on language such as warmth, acceptance, and patience. It is also quite important that the therapist normalizes the pervasiveness of shame and self-attacking since it is a hard-wired response based on how our brains have developed (Gilbert, 2009). This can help to unburden the person as to why she is experiencing shame and helps contextualize why shame is such a pervasive, yet normal, cognitive and affective response to a multitude of challenges, such as the trauma of incarceration. Through normalization and unconditional positive regard, it is possible that building a compassionate self can begin.

Second, a Two-chair approach may help clients experience the profound impact of the inner critic (Gilbert, 2009; Gilbert, 2010a). This is an adaptation of the two chair technique established in emotion-focused therapy (Greenberg, 2002). In one chair, the client is encouraged to voice her thoughts from her usual self-critical stance, often grounded within a particular concern, such as incarceration. Shortly after, the individual is asked to change seats, take slow deep breaths, and adopt a compassionate posture. This includes shifting of tone of voice and taking the position of the compassionate self. The compassionate self recognizes the inner critic and speaks from a compassionate place of acceptance and warmth, and not telling the critical self "should or should not" type of statements. This approach may help activate two of the three affective systems in the brain: the threat-based self-attacking system and the self-soothing affective

system, which works to soften the impact of shame (Gilbert, 2011; Neff et al., 2007).

Self-compassion can also be integrated into reintegrative shaming/shame transformation approaches utilized in prison. Self-compassion can be conceptualized as a shame transformation approach that attempts to buffer the individual against the potential impact of disintegrative shaming. Along with teaching clients the differences between guilt and shame, psychoeducation of the psychoevolutionary model of affect (Gilbert, 2010a) would be fruitful to help clients understand why they have an over-regulated threat-based system that contributes to feelings and thoughts of shame. Furthermore, helping clients through guided imagery to develop an image of a "perfect nurturer" may be helpful for instilling feelings of warmth (Lee, 2005). The person determines the qualities of the image that would meet the person's emotional needs unwaveringly with help from the therapist. These compassion-focused approaches for cultivating affiliative emotions may provide additional effectiveness for ameliorating the deleterious impact of shame.

Prior to adopting self-compassion, women described a perpetual negative and hostile mindset about the world. CBT is a typical approach for addressing maladaptive thought patterns in an attempt to teach clients about unhelpful thinking patterns (Beck, 1997). The most extreme form of unhelpful thinking patterns manifest as criminal attitudes. One way of addressing criminal attitudes and hostile misattribution with correctional populations is through a comprehensive three phase therapeutic modality called the Violence Reduction

Program, which attempts to decrease the frequency and intensity of aggressive behaviours and decrease or eliminate antisocial attitudes and beliefs (Wong & Gordon, 2013). Many women endorsed self-compassion as adopting a new mindset of thinking positively. Providing psychoeducation on the psychoevolutionary model of affect (Gilbert, 2010a) would further help clients understand why their brain interprets information as hostile and keeps them in a perpetual threat-base state. This could include teaching on the importance of affiliative emotions and their role in soothing and contentment. Such an understanding could be applied to each client's personal trauma history, substance abuse history, and offending history. This integration provides a compassionate reframe of dysfunctional and hostile thinking patterns within the traditional cognitive behavioural therapy framework.

The women who participated in this study identified an aspect of self-compassion as looking forward and achieving goals. CBT approaches are utilized to help clients with goal setting, such as collaborating with clients to determine SMART goals. SMART is an acronym for Specific, Measurable, Achievable, Realistic, and Time Limited (Dobson & Dobson, 2009). Such structure helps clients learn to set goals that have increased likelihood to succeed. The participants also described difficulties at times with goal setting, particularly being able to make a plan for the future and follow through, such as abstaining from substance use. While CBT approaches like SMART goals target goal setting, gender responsive programs in prison, such as Seeking Safety, address comorbid substance abuse and PTSD, which helps women develop relapse

prevention plans (Najavits, 2002). Not only can self-compassion help women visualize goals for the future, but other compassion-focused approaches can be integrated as well. Women in prison can be introduced to compassionate imagery, where the client builds a compassionate image that imbues wisdom, strength, warmth, and non-judgment (Gilbert, 2009). Clients should be encouraged to identify what kind of sensory qualities this image would have and how it would relate to the person. This can be tailored to encourage incarcerated women to build a compassionate *future* image of themselves, which would be the client when she has achieved a specific goal (e.g., after achieving one month of sobriety, after completing group therapy). The therapist may direct the client to focus on specific sensory qualities that she would like to embody at the time of achieving a specific goal (e.g., when you achieve this goal, what would the image (a) say to you, (b) say to others, (c) look like, (d) feel like, (e) where would the image be?) This may also include crafting what the compassionate image may say, or how the image would act if the client experienced a lapse or obstacle to achieving the goal. This latter aspect would be important since some incarcerated women experience challenges even looking forward to what their life would look like even months from the present. Cultivating a compassionate image, which looks forward to a future successful self, may help incarcerated women be more efficacious in achieving goals.

Integrating self-compassion into offender rehabilitation could be a fruitful supplement to standardized gender-neutral approaches. For example, when processed within the correctional system, treatment is framed through the Risk

Need Responsivity model, which involves matching level of service to level of risk, assessing for criminogenic needs, and personalizing intervention given specific factors, such as learning style, motivation, abilities, gender, race, and strengths (Andrews, Bonta, & Hoge, 1990). Criminogenic needs are evaluated through empirical measures, such as the Level of Service/Case Management Inventory (Andrews, Bonta, & Wormith, 2004). Since the participants understood self-compassion to include the desire and specific actions to not re-offend, it may be clinically indicated to evaluate for levels of self-compassion in addition to criminogenic needs. Assessing levels of self-compassion in offenders may provide additional helpful information to better tailor responsive treatment, such as how female offenders tend to treat themselves and others when in difficult situations (e.g. getting carried away with one's feelings, over-identifying with emotional pain etc). This may help inform decisions of what treatment factors are relevant to address, such as prioritizing emotion dysregulation.

Levels of self-compassion can be empirically assessed at any time in treatment using the Self-Compassion Scale (Neff, 2003b). This measure is grounded in Neff's (2003a) conceptualization, which measures the degree to which people display self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Not only can this measure be utilized at the beginning of treatment to establish a baseline, but it can be re-administered periodically throughout treatment to determine progress. Since the participants also conceptualized self-compassion as a work in progress requiring a constant commitment, periodic measurements can provide the client

empirical evidence to help track self-compassion over time. This can help clients formalize the self-compassionate activity of striving towards self-compassion in their daily lives. While this study supported aspects of self-compassion that are consistent with Neff's (2003a) definition of self-compassion, this study also revealed aspects that go beyond her definition, such as setting boundaries with others, and desiring improvement and enacting change in one's life. Therefore, while utilizing Neff's (2003a) measure can provide some important context about one's level of self-compassion, it will only formally evaluate some, but not all, aspects of self-compassion that are relevant for incarcerated women.

All the above interventions are recommended to always be implemented from a culturally informed lens. While both Aboriginal and Caucasian women described consistent themes of self-compassion, there is still much to explore about how culture is embedded within understanding and experiencing of self-compassion. It is noted that how self-compassion is understood and experienced between different cultures and ethnicities was not the main focus of the research question; however, this is an area in dire need of future research. It is fundamentally important for practitioners within prison to operate from an anti-oppressive framework when working with Aboriginal clients, since this population is over-represented in the Canadian correctional system.

**Recidivism.** A number of the conceptualizations of how the women in this study understood and experienced self-compassion have implications for reducing recidivism. Many participants described a long history of breaking the law and never questioned why this was so, until they started to develop self-

compassion. Since the participants understood self-compassion as reflecting on their behaviour and arriving at a greater understanding of themselves, nurturing self-compassion may help women in prison develop a greater understanding of their offending behaviour. In addition, a key component of self-compassion in this research was making different choices, specifically involving abstaining from criminal activity and dysfunction (e.g., not reoffending, abstaining from substance use, disconnecting from antisocial peers). Therefore, an aspect of helping to foster self-compassion through therapy might be helping women in prison better understand their behaviour and make better choices.

Results from this study indicate that when a sub-group of offenders are treated with compassion by others, this group may be more likely to extend compassion towards themselves. This informs the final recommendation, which involves shifting the focus of the women's immediate prison environment to include more aspects of an affiliative-focused therapeutic community. Prison can be viewed as a community in which people live. The social dynamics of one's community are fundamental to the evolution of a number of human abilities, such as self-awareness, cooperation, social sharing, empathy, and emotion regulation (Baumeister & Leary, 1995). While prison's systemic punishment philosophy is an attempt to rehabilitate behavior, the execution of such a community's values may result in the perpetuation of fear, shame, and blame for this specific group of female offenders. Such an environment also contributes to entrench some female offenders in a cycle of self-criticism, shame, and emotion dysregulation. This does not instill in women feelings of safety or connectedness to others (Veale,

Gilbert, Wheatley, & Naismith, 2014). Rather, it may contribute to threat-derived strategies, such as aggression and violence; the very behavior prison is attempting to attenuate (Cooper, Flanagan, Talley, & Michaes, 2006; Krakowski, 2003; Roberton et al., 2012). While offenders may behave according to the rules of the community, for some, this may be due to learned helplessness and cynical compliance rather than having internalized values of the community (Veale et al., 2014). Thankfully, humans have the ability to adapt their behavior and relationships with self and others according to the social context in which they reside (Cacioppo & Patrick, 2008). Some female offenders have shown they may benefit from residing in an environment that focuses on the promotion of affiliative emotions and social safeness. Therefore, redefining the prison environment, for some offenders, may significantly shift not only the management of these individuals, but also promote their well-being. In practice, a compassion-focused therapeutic community may require changes to current policies, procedures, and programming in prison. Such changes may entail openness to the conceptualization of prison as a compassion-focused therapeutic community that simultaneously maintains the paramount importance of safety and security. It would be important to identify which sub-groups of offenders would potentially benefit from a compassion-focused approach. This could potentially involve piloting an affiliative approach on specific units in prison which house offenders who have been selected to potentially benefit from this approach, based on the current research. Keeping an entire unit's environment and staff focused on the

promotion and implementation of this approach would help establish a sense of community.

It is noteworthy to revisit the important point that this research has identified the potential positive application of affiliative compassion-focused approaches with a sub-group of female offenders. It would be remiss not to clarify that this approach may not necessarily be best for some offenders, such as treatment-refractory sub-populations, namely, psychopaths or high risk offenders. In any prison system, there will always be offenders who require a different approach to rehabilitation and management due to their level of acuity and risk to others.

All prison staff, and not just clinical staff, can play a vital role in encouraging offenders' exploration and regulation of difficult emotions. In addition to integral training on safety and security, such as self-defence and manual restraint protocols, supplemental training of staff could include education on: psychoevolutionary model of affect, interconnectedness of violence and emotion dysregulation, how shame can be inadvertently reinforced in prison by how women are treated by others, the differences between shame and guilt, and self-compassion. Correctional officers are in a unique front line role to model the values of a compassion-focused therapeutic community by treating the women with compassion, which instills openness for some women to treat themselves with compassion and may reduce the likeliness of aggression.

Correctional officers may benefit from additional training in how to intervene in a compassion-focused way during de-escalation (when appropriate),

through caring interest and empathic engagement with the individual's distress. This may potentially result in successful de-escalation for some offenders without the use of manual restraint or segregation. This would be an example of how one can embody a philosophy of compassion, while simultaneously maintaining the safety and security of others. The incorporation of such recommendations may allow prison to maximize its therapeutic potential as a rehabilitative community for this sub-group of offenders, helping women cultivate safety, comfort, empathy, and connectedness with others.

**Methodological Considerations**

As with all studies, this study is not without its limitations. As a qualitative research method, IPA advocates subjective interpretation of the data. The foundational component of the double hermeneutic (Smith et al., 2009), or hermeneutic circle as described by Heidegger (Heidegger, 1962), is that the researcher is attempting to simultaneously make sense of the participant making sense of her phenomenological world. While reflexivity, peer review and member-checking helped provide trustworthiness of the analysis, it is understandable that my biases and assumptions cannot be completely removed from interpretation.

While the small sample size of this study does not allow for generalization of results, it is important to recognize that the first and foremost purpose of this study was to develop rich descriptions of phenomena. Therefore, the group of women interviewed are not intended to represent an objective reality shared by all women in prison. Furthermore, while the women who participated were only

from two cultural groups (Aboriginal and Caucasian), this did allow adequate representation of these two groups within the IPA framework.

The sampling procedures also have limitations. Collecting data at one provincial prison location only allowed recruitment of individuals residing within that particular correctional institution. There were also limits on the specific days the author could come and collect data, due to correctional institutional staff availability and protocols (i.e., needing to accommodate and coordinate multiple research projects simultaneously). Purposeful sampling, while specifically targeting the population of interest, rests on the premise of individuals self-selecting to participate. Therefore, those who chose to participate were intrinsically interested in contributing to the study. Those who chose to participate could possibly be higher in self-compassion, more psychologically-minded, more affiliative, and more willing to be open to disclosure than non-participants. There were also limitations within the research protocols of the facility, since those women who would have lost privileges or were in segregation would not be able to participate, even if such women desired to.

There may also be limitations based on the women's mental status, at the time of the interviews, for what was chosen to be shared. Some women had difficulties articulating and describing their experiences, which required me to use prompts to help elicit details. This was further a challenge since the women did not have access to the interview questions until the same day as consent documentation was signed, which is also when the first interview took place. Hence, they were not able to think about the questions prior to the interview.

**Future Directions**

Based on the themes and implications elucidated from this study, there are many avenues to expand upon in future research. While numerous aspects of the phenomenon have been described in this study, such an understanding creates new research questions to further understand self-compassion with women in prison. For example, women described self-compassion as an ongoing process that included struggles along the way to some anticipated end point. Many women spoke of prison helping and hindering self-compassion and used imagery of being a work in progress. It could be illuminating for a grounded theory study to take place proposing a theory of how women in conflict with the law develop self-compassion. Implications from this current study create a rationale for grounded theory work to take place in order to better understand how women develop self-compassion.

A mixed method and/or longitudinal approach would be helpful to explore women's experiences of self-compassion as they progress through the criminal justice system (i.e., from remanded status, sentenced status, probation/parole status), to understand how the criminal justice system further impacts self-compassion. This could also include a quantitative component examining whether measures of self-compassion change or stay the same at different stages. This would help with an understanding of whether women in conflict with the law experience different challenges regarding self-compassion throughout the legal process.

While this study has transferability to similar populations and settings, it is important to expand upon this research and examine self-compassion with other correctional populations. This could include women within the federal correctional system (serving lengthier sentences for offences, such as murder), women on probation or parole, or female offenders under 17 years of age. A study could also include examining differences among these settings, including additional provincial sites, and possible similarities and differences among women convicted of different kinds of crimes (e.g., violent vs. non-violent). Women and girls in such contexts may provide unique perspectives to further expand upon the phenomenon of self-compassion.

Understanding self-compassion with incarcerated women would be more holistically understood by utilizing quantitative approaches. For example, Neff's (2003b) Self-Compassion Scale could be used to empirically measure self-compassion as a correlate with other measures, such as barriers to release, mental health problems (such as trauma, substance abuse, and shame), criminal attitudes, and criminogenic needs. Since a theme of self-compassion involved enacting change, one specific area for examination could be measuring levels of self-compassion with stages of change, such as with the University of Rhode Island Change Assessment Scale (DiClemente & Hughes, 1990). This would help to gain a greater understanding of how self-compassion is related to a person's specific stage of change regarding a problematic behaviour, such as criminality.

Another future area of research could involve self-compassion and culture, specifically, how one's culture influences understanding and practice of self-

compassion. Interestingly, culture and self-compassion were only mentioned by one person, who stated self-compassion involved re-connecting with rituals within her Aboriginal culture. There is limited qualitative literature on self-compassion and culture, specifically a dearth of literature on self-compassion and Aboriginal culture. It may be fruitful to have a specific research question to explore this connection further in order to better understand how the phenomena of culture and self-compassion are interconnected. This could be further enhanced by investigating self-compassion with non-dominant cultures in Canada. This may be accomplished by conducting studies where the sample includes only members of a particular cultural group (e.g., Aboriginal women), rather than a mixed sample. This may help elucidate context that is relevant for only the culture of interest.

While the focus of this research was with women in prison, questions are raised as to gender differences in self-compassion. Specifically, how would the phenomenon of self-compassion be understood and experienced by men? Differences or similarities would be important to understand if intending to utilize self-compassion therapeutically with men, and more specifically, incarcerated men. There is very little research specifically on gender differences in self-compassion and no literature examining gender differences between men and women in prison. A more holistic understanding of how to utilize self-compassion in prison would be gained when understanding similarities and differences with men. Such information would help a more targeted development

and implementation of gender-responsive treatment approaches with prison populations.

## Conclusion

The current study is the first of its kind to investigate incarcerated women's understanding and experiences of self-compassion utilizing the methodology of IPA. Self-compassion was a transformative way for the women of this study to relate not only to themselves, but also to others. Overall, results of this research provide further support for the proposition that the construct of self-compassion is inexorably related to positive psychological health and well-being. Remarkably, despite the correctional environment and mental health challenges creating obstacles to self-compassion, the participants were still able to pursue their journey towards self-compassion.

Results of this study contribute meaningfully to the growing body of literature examining self-compassion by revealing new aspects of self-compassion, such as setting boundaries with others, looking towards the future, and making different choices, such as not re-offending. Such results hold considerable promise for compassion-focused interventions with women in prison, particularly aimed at promoting non-violent ways of coping with distress, encouraging healthy relationships, and cultivating a prosocial life. While this study has attempted to fill a gap by providing much needed knowledge at the nexus of self-compassion and female offending, it is hoped this work inspires future research to expand on this area. Self-compassion may indeed play an important role in the rehabilitation of women in prison.

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## Appendix A – Participant Information Letter

### UNIVERSITY OF ALBERTA - Department of Educational Psychology

**Title of Project:** Understanding Incarcerated Women's Experiences of Self-Compassion

**Principal Researcher:** Lara Hiseler, ME.d, Doctoral Student
**Research Supervisor:** K. Jessica Van Vliet, Ph.D., R. Psych – Associate Professor, University of Alberta

**What is this study about?**

- The aim of this study is to explore how women at the [correctional institution] treat themselves with compassion or kindness.
- This study could help women who have difficulties coping with their feelings, as well as other helping staff who work with these women.
- I am doing this research as part of my Ph.D. degree in counselling psychology at the University of Alberta.

**Who Can Take Part?**

You can take part in this study if you are:

- A woman 18 years old or older
- Currently serving a sentence at [correctional institution]
- Can speak English

**What Will I Have To Do?**

- Take part in two interviews with the researcher that will total 1.5 to 2 hours of your time. The interviews will be about your experiences of self-compassion.
- The first interview will take 1 to 1.5 hours interview where you will be asked to talk about your experiences with treating yourself with compassion. This first interview will be audio recorded and typed out onto a computer.
- If possible, a second interview (30 minutes to 1 hour) where you will be asked to read over the transcript of the first interview and check if it is true to what was said. You will also be able to comment on the beginning part of the analysis. This interview is also audio-recorded.
- The interviews will all be held at [correctional institution] in a private room with yourself and the researcher.

**Possible Risks**

- There is a potential risk that thinking about experiences of self-compassion may cause you to become upset if it is related to a difficult time in your life.

- If this occurs, the researcher will offer you support and assist you to get additional help at [correctional institution] if you need it.

**Possible Benefits**

- Talking about times when you treat yourself with compassion in a safe and supportive environment can be a positive experience.
- Some women may also feel good about being part of a study that is trying to improve women's care.

**What About Privacy?**

- The principal researcher and her supervisor are the only two people who will have contact with your data.
- All information you provide will be kept confidential, meaning stays between you and the researchers, unless the law requires us to report it in the following situations:
    - If you tell the researcher that a child (under the age of 18) is being hurt or at risk of being hurt
    - If you tell the researcher you intend to commit suicide or hurt someone else
    - If research records are requested by a court of law

- All information that is collected will be labeled with a fake name so that your name is not connected with the documents.
- Computer files and audio recordings will be stored on a password-protected computer at the University of Alberta and any other documents from the study will be locked in a filing cabinet at the university for five years following the end of the research project. After this time, they will be destroyed.
- None of the study information will be shared with staff at [correctional institution]. Staff at [correctional institution] will be made aware if you tell the researcher that a child under the age of 18 is being hurt or is at risk of being hurt, if you intend to commit suicide or harm someone else, or if research records are requested by a court of law.
- The information gathered from all who take part may be presented at academic events and published in journals. None of your identifying information will be used.

**Voluntary Participation**

- *Taking part or not taking part in this research will not in any way increase your access to privileges or give you preferred treatment at [correctional institution]. You are not required to participate.*
- You can stop being part of the study at any time or not answer any questions without penalty.
- If you choose to end your participation in this study, any data gathered up to that point will be kept unless you let the researcher know you would like to have it removed. If you wish to have your data removed, you will need to let the researcher known within four weeks after you have had gone over the interview transcript with the researcher. After this time, your data cannot be removed from the study because it may have already become a part of data analysis.
- You can ask for your own copy of a summary of the report once the study is done.
- Questions about your rights as a research participant may be directed to the University of Alberta Research Ethics Office at (780) - 492 - 2615.

**If you choose to take part in this study, you can let [name of staff liaison and position] know, who will let Lara Hiseler know you are interested.** If you have any questions or would like more information, please let [name of staff liaison] know so he may contact Lara Hiseler on your behalf.

Thank you for your interest in this study.

**Principal Researcher:**
Lara Hiseler, ME.d, Doctoral Student
University of Alberta
Department of Educational Psychology

**Supervising Researcher:**
K. Jessica Van Vliet, Ph.D
University of Alberta
Dept of Educational Psychology

## Appendix B – Consent Form

**Study Title:** Understanding Incarcerated Women's Experiences of Self-Compassion

Do you understand that you have been asked to be in a research study to examine how you treat yourself with compassion or kindness and that by doing so you will participate in two separate interviews?

Yes No

Have you received and read a copy of the attached *Participant Information Letter*?

Yes No

Do you understand it will take approximately 1.5 to 2 hours of your time?

Yes No

Do you understand the benefits and risks involved in taking part in this study?

Yes No

Have you had a chance to ask questions and discuss this study?

Yes No

Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your future care?

Yes No

Has the issue of confidentiality been explained to you?

Yes No

Do you understand who will have access to information you provide?

Yes No

Are you aware that you will not gain any privileges, or receive preferred treatment as a result of your participation in this study?

Yes No

Who explained this study to you? _____

I agree to take part in this study
Yes No

Printed name of participant: _____

Signature of participant: _____ Date: _____

Signature of investigator: _____

Two copies of this consent form will be provided. One is to be kept by you for your records, and the other is to be returned to the researcher.

If you have any questions or concerns about this research, please contact [staff liaison] who will contact Lara Hiseler on your behalf.

**Principal Researcher:**
Lara Hiseler, ME.d, Doctoral Student
University of Alberta
Department of Educational Psychology

**Supervising Researcher:**
K. Jessica Van Vliet, Ph.D,
University of Alberta
Dept of Educational Psychology

**Appendix C – Recruitment Flyer**

**Department of Educational Psychology**

**University of Alberta**

# PARTICIPANTS NEEDED FOR RESEARCH IN KINDNESS & COMPASSION

**I am looking for female volunteers over 18 years of age serving a sentence at [name of institution] to take part in a study of how you treat yourself with compassion and kindness.**

**You will be asked to attend a 1-1.5 hour interview with a researcher and one follow-up 30 minute interview if appropriate.**

**For more information about this study, or to volunteer, please contact [name of staff liaison] who will contact the researcher, Lara Hiseler, on your behalf**

**Thank you!**

**Lara Hiseler**
**Doctoral Student**

## Appendix D - Participant Demographic Form

Today's Date _____ / _____ / _____
Month Day Year

Age _____

Participant Pseudonym _____

Relationship Status (please check ✓ one)

- □ Single
- □ Married/Common-Law
- □ Separated/Divorced
- □ Widowed
- □ Other _____

Living Situation prior to incarceration (please check ✓ one)

- □ Alone
- □ With a partner/spouse and/or children
- □ With my parent(s)
- □ With a roommate
- □ No Fixed Address
- □ Other _____

Highest Level of Education (please check ✓ one)

- □ Partial elementary school
- □ Elementary School
- □ Partial high school
- □ High School
- □ Partial college/university
- □ College diploma
- □ Undergraduate degree
- □ Partial graduate school
- □ Graduate degree
- □ Other _____

Employment Status Prior to Incarceration (please check ✓ one):

- □ Not employed
- □ Part-time employment
- □ Full-time employment
- □ Part-time student
- □ Full-time student
- □ Other

Occupation (prior to incarceration) _____

Crime currently incarcerated for _____

Length of time for current incarceration _____

Ethnic/Cultural Background _____

Religion _____

## Appendix E - Interview Guide

1) What does the word compassion mean to you?

   Prompts may include:
   - What does the word kindness mean to you?
   - Please tell me specific examples.
   - What else?

2) What does being compassionate towards yourself mean to you?

   Prompts may include:
   - Please tell me specific examples.
   - What else?

3) In as much detail as possible, please tell me about specific times when you have been compassionate toward yourself.

   Prompts may include:
   - What, specifically, were you thinking/feeling/doing at the time?
   - Could you tell a story about a time you were kind to yourself?
   - What does treating yourself with kindness look like?

4) In what way, if at all, has being in jail affected/influenced your ability to be compassionate towards yourself? Has anything changed?

   Prompts may include:
   - Please tell me specific examples.
   - What, specifically, were you thinking/feeling/doing at the time?
   - Could you tell a story to help me understand what you mean?

5) What, if anything, gets in the way of being compassionate towards yourself? Anything else? Sometimes when are things more difficult?

   Prompts may include:
   - Please tell me specific examples.
   - What, specifically, were you were thinking/feeling/doing at the time?
   - Could you tell a story to help me understand what you mean?

6) What, if anything, helps you be compassionate towards yourself? Kind to yourself? Are there times that are easier than others?

   Prompts may include:
   - Please tell me specific examples.
   - What, specifically, were you were thinking/feeling/doing at the time?
   - Could you tell a story to help me understand what you mean?
   - What else?

7) In what way, if at all, does treating yourself with compassion affected/influenced how you feel and think about yourself?

   Prompts may include:
   - Please tell me specific examples.
   - What, specifically, were you were thinking/feeling/doing at the time?
   - Could you tell a story to help me understand what you mean?

8) In what way, if at all, does treating yourself with compassion influence how you view or relate to other people?
   Prompts may include:
   - Please tell me specific examples.
   - What, specifically, were you were thinking/feeling/doing at the time?
   - Could you tell a story to help me understand what you mean?

9) What impact does being compassionate towards yourself have on your day to day life?

   Prompts may include:
   - Please tell me specific examples.
   - What, specifically, were you were thinking/feeling/doing at the time?
   - Could you tell a story to help me understand what you mean?