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Mindfulness based feminist therapy: The intermingling edges of self-compassion and social justice

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ABSTRACT
Survivors of intimate partner violence (IPV) often have trouble regaining a lost sense of self, even after years of 'good' feminist therapy. Both postmodern feminism and Buddhist philosophy have common ideas about the constructed nature and fluidity of the self, and feminist and Buddhist ontologies can inform each other—the former on the nature of subjectivity under oppression, the latter on how to relate differently to the self by not identifying with our stories as who we are. Therefore, one might assume that mindfulness-based approaches might be helpful with this problem. However, social justice values that feminists and social workers prize seem absent in mindfulness approaches that appear to be individual-focused and politically passive. This article argues that feminism and mindfulness have points of congruence as well as much to offer each other where they diverge, and it presents exploratory research investigating the role of mindfulness and self-compassion on reconstructing a sense of self and agency in survivors of IPV by comparing outcomes of a community-based feminist group and a mindfulness-based group. The findings provide a glimpse into the strengths of each approach and suggest some benefit in weaving these into a mindfulness based feminist therapy for survivors of IPV.

Mindfulness-based therapeutic modalities to the various problems and private suffering that people experience have steadily increased in number over the recent past due in part to the volumes of medical and scientific research that support them as evidence-based interventions (Black, 2014; Hickey, 2010). Kabat-Zinn’s Mindfulness Based Stress Reduction (MBSR) program introduced mindfulness into hospital-based services at the UMass Medical School in 1979 (Kabat-Zinn, 2013). Kabat-Zinn removed direct references to Buddhist philosophies and values in the early program material emphasizing the health benefits, and therefore “medicalized” mindfulness in its secular adaption for Western patients. Research and practice in medicine and psychology has grown exponentially since the early 1990s, but is slower in finding its way into social work practice (Hick, 2009; Turner, 2009).
This slow integration into social work practice may be due to a hesitation by social workers to use approaches like mindfulness that stem from an ancient Buddhist meditation practice. Perceived as focused on the individual, passive, and nonpolitical (Hickey, 2010; Purser & Loy, 2013; Stanley, 2012), such an approach would be particularly problematic for critical (antioppressive, feminist, etc.) social work applications. Buddhist scholars also critique the medical model adaptation of mindfulness, because it removes it from its ethical roots (Loy, 2003) or “moral framework” (Hickey, 2010; Loy, 2003) and its tradition of social justice or “engaged Buddhism” (Hanh, 2004; Kotler, 1996; Queen, 2002). Stanley (2012) advocates adopting “a sceptical (sic) position towards this contemporary orientation” and for understanding mindfulness “as not only an inner state of mind, but also a public social practice” (p. 631).

This “sceptical position” toward integrating mindfulness into feminist practice was one I occupied before being introduced to mindfulness. From the early 1990s, I have focused on feminist social work practice with women who experience interpersonal, including intimate partner, violence (IPV). In 2006, I took professional training in MBSR (Kabat-Zinn, 2013) and Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2013), hoping to rekindle a long-time contemplative practice that had been idling for a while and was also attracted to the “stress reduction” aspect of mindfulness to help me better cope with concurrent obligations to my PhD candidacy, university teaching, professional practice, and personal relationships. Overall, I was impressed by its holistic approach to wellness, and more specifically, that compassion and self-compassion were integral to its philosophy. The loving-kindness mediation, a practice of imagining and holding oneself and then progressively including others in attentional awareness with great kindness and compassion (Salzberg, 2002), had a profound impact on me. To be taught and encouraged to consider myself as worthy of love and kindness as all other beings, and then experience holding myself in unconditional positive regard during the meditation practice enabled a paradigmatic and relational healing shift that years of personal trauma therapy had not accomplished.

It then occurred to me that by teaching mindfulness meditation to women who had experienced IPV, it might also help to address one of the stickier problems related to me by women I had worked with who felt that even after very good (including long-term) feminist therapy they also felt something was still missing for them. They expressed a lag between their head and their heart (Lee, 2006), a sense of self that was lost (Brison, 2002), disconnected or forever changed by their traumatic experiences. I begin to wonder if mindfulness, especially practices focusing on self-compassion, might be an avenue to recovering or reconnecting to the self that felt lost to them, and if Buddhist understandings of the self were potentially compatible with postmodern feminist epistemologies of a fluid, ever-changing self-in-relationship (Klein, 1995).
After my mindfulness training, I began teaching MBSR in the community all the while comparing it, and other mindfulness-based interventions (MBIs), to the feminist group modalities I knew. The MBIs’ emphasis on psychoeducation and personal meditation practice, and the absence of opportunities for participants to talk about the “context” of their experiences of violence and oppression suggested to me that feminist, constructivist, and other social justice oriented approaches had something important to offer MBIs.

In this article I argue that mindfulness and feminist approaches have commonalities as well as much to offer each other if interwoven into a group modality for survivors of IPV. Both postmodern feminism and Buddhist philosophy have common ideas about the constructed nature and fluidity of the self. Feminist and Buddhist ontologies can inform each other, the former on the nature of gendered subjectivity under oppression, the latter on how to reconstruct and relate differently to the self by cultivating self-compassion and not identifying with our constructed reality (our stories) as who we are. Exploratory research is presented comparing two separate interventions for survivors of interpersonal violence, a community-based feminist group and a mindfulness-based group, using the Self Compassion Scale (Neff, 2003a) that includes six subscales measuring self-kindness, common humanity, mindfulness, self-judgment, isolation, and overidentification. Results suggest that while both modalities increase self-compassion significantly, each group had a differential effect in measures of mindfulness, common humanity, overidentification and sense of isolation. If we were to weave these two approaches into one modality that I call Mindfulness Based Feminist Therapy, it may contain the best practices of both that benefit the personal and political: a safer container for mutual recognition of suffering under oppression, and the power of self-compassion and empathic listening for healing the sense of self.

Theoretical framework

Intersubjectivity, attachment theory, and empathic agency

“The person I was . . . was taken from me and my family. I will never be the same for the rest of my life” (Herman, 1997, p. 56). The crucial I and the me in this statement is a woman’s self who is changed forever by violence, abuse, and other forms of oppression and notably, the loss of her self to her intimate others. Feminist therapist, Judith Herman, notes in Trauma and Recovery (1997) that women who experience interpersonal trauma lose their basic sense of self through objectification. Feminist philosopher, Susan Brison (2002), understands the self to be “both autonomous and socially dependent, vulnerable enough to be undone by violence and yet resilient enough to be reconstructed with the help of empathic others” (p. 137). Because of the relational nature of the self, to be invisible, to be unacknowledged or not
recognized, is to not exist. In order for healing the autonomous aspect of the self to occur, a survivor must acknowledge her dependency on caring others as she learns to care for others and allows herself to be cared for by others.

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

Meyers’ (1994) theory of intersubjectivity and empathic agency helps us understand how we internalize early caregiving relationships and is congruent with attachment theory. Attachment theory underscores the symbolic significance of the comforting availability of the caregiver (Wallin, 2007)—so it’s not just about physical protection from danger, but also the availability of an “empathic other” (Meyers, 1994). Researcher Mary Ainsworth (Wallin, 2007) developed this idea of an emotionally available other, and the importance of the quality of early communication between infant and caregiver for secure attachment. Ainsworth developed the “strange situation” where she observed the interactions between children and parents when children under the age of six are in a strange environment, at times interacting with strangers when the caregiver is absent. She was responsible for the concept of the “secure base” that early caregivers represent for children, based on what a child’s expectation might be of their caregiver given their past experiences of the caregiver’s responses to their distress. This secure base allows a child to explore and expand her environment, because she has the secure knowledge that she has an accepting, reassuring, and comforting other to return to when needed. These experiences and expectations of the empathic caregiver eventually gel and become mental maps or representations called internal working models of the self.

Sarah Daniel (2006) concluded in her review of literature on adult attachment patterns and individual psychotherapy that adult attachment patterns “cannot be taken as a reliable measure of the person’s childhood relationship to parents” (p. 972), which means that attachment styles or patterns have the potential to change in adulthood. That suggests that women experiencing IPV may internalize their abusive relationship as a working model of self. Meyers (1994) also argues that the empathic self can be compromised as a result of any “oppressive social environment.” This is an important connection between the personal and the political—it elegantly points out, for example, what
happens to women under patriarchy. It would explain how oppression undermines the loving work of early caregivers, adult friends, and other “empathic others” and how oppression (systemic and personal) can separate us from our relationships with others, our ability to “recognize” our “self” and compromises our ability to respond as moral agents. However, the good news is that “empathic others”—therapists, peers, family—can also help reawaken or renovate a securely attached internal working model of self.

**Mindfulness in dialogue with feminist therapy**

Feminist therapy privileges the perspectives and experiences of marginalized and traumatized individuals and is driven by the therapist’s theoretical framework rather than any particular technique (Brown, 2004). The goal of feminist therapy is to help clients develop feminist consciousness or an awareness that their suffering is not because of personal deficits, but by the way she has been systematically excluded and silenced because of membership in a nondominant group in society. As such, feminist therapists use an integrative or eclectic approach to trauma treatment with a political underpinning. The collaboration between the therapist and the client is a space not only where personal healing transactions occur, but also a political space, a space that is potentially transformative for the client, the therapist, and society.

In her analysis of feminist trauma treatment models, Laura Brown (2004) found characteristics present in most approaches used by feminist therapists like Judith Herman (1997), Christine Courtois (Courtois & Ford, 2009), and others: it works contextually—socially and emotionally; is explicitly political; focuses on empowerment; strives to create an egalitarian, collaborative relationship; communicates deep empathy for the client; is strengths based; attempts to meet clients where they are; creates networks for political change; believes the woman—“assumes that the intersubjective ‘truth’ of survivor’s experience will emerge” (p. 468); is psychoeducational—sharing information “about trauma’s neurobiological, social and existential impacts so that the trauma survivor can feel less negatively unique and more able to cognitively appraise trauma response in a compassionate non-judging manner” (p. 470).

Arguably, mindfulness-based modalities share some of the same characteristics of feminist therapy, for example, communicating deep empathy and meeting people just as they are (Brown, 2004); finds expression in Kabat-Zinn’s (2013) statement “you are already perfect just as you are, in the sense of already being perfectly who you are, including all the imperfections” (p. 37). MBIs are emotionally and socially contextual (Brown, 2006), insofar as, recognizing how our worldview and sense of self arises from our conditioning (Kabat-Zinn, 2013; Segal et al., 2013), but are not explicitly political. Feminist therapy speaks of empowerment (Brown, 2004), mindfulness teaches “liberation” from suffering for all beings (Kornfield, 1993). Both create a sense of community: mindfulness,
especially in lovingkindness practice, expresses a notion of the interconnectedness of all beings (nonseparation) from which arises a sense of compassion toward all and an ethic of nonharm (Salzberg, 2002); feminist therapy values the benefits of breaking isolation to normalize experiences of trauma, and puts a great emphasis on networking for social change (Brown, 2004).

The last two points that Brown (2004) cites as characteristics of “good” feminist therapy, the “intersubjective truth of the survivor narratives,” and “psychoeducation” are rich ground for exploring the edges of overlap between feminist and mindfulness approaches. The potential benefits emerging from this interweaving of approaches to help women dislodge the internalized abuser and create a new working model of self are explored as follows.

**Intersubjective truth and mindfulness**

Many critical social workers endorse the notion of narrative therapy as potentially the modality “par excellence” for antioppressive practice because of its critical, deconstructive elements that have the possibility of interrupting the continued reproduction of social relations (Pozzuto, Angell, & Dezendorf, 2005). Narrative therapy is congruent with the feminist paradigm for simultaneously addressing the traumagenic environment, raising consciousness, and building resiliency and coping skills with clients. Feminist narrative therapy contains the characteristics of “good” feminist therapy; it is collaborative, political, and transformational. It recognizes the paradox of the client’s agency alongside her oppression and victimization. The therapist is not neutral, but takes sides with her client, but is still aware of the potential controlling, regulating, constraining, and normalizing effects of therapy itself. Feminist therapy historically grew as a resistance to androcentric constructions of women’s experiences and problems as pathology but in spite of major contributions, mainstream feminist therapy suffers from three major limitations, “essentialism, subjectivism and reification of dominant stories” (Brown, 2011, p. 99).

Congruent with postmodern feminists who critique radical feminist ideologies as essentialist, feminist therapists must challenge any essentialist notions we may have about “women’s experience.” Challenging essentialism prevents us from treating gendered traits as though they were natural and common instead of socially constructed, and calls us to emphasize difference and diversity. Feminist sociologists, Doucet and Mauthner (2008), considered the idea that it is possible to blend postmodernist and poststructuralist approaches with feminist critical theory “so that ‘a culturally constructed subject can also be a critical subject’” (Fraser, 1995, cited in Doucet & Mauthner, 2008) but in the end rejected this as epistemologically untenable as they feel it denies and reinstates agency at the same time.
From an Eastern epistemological perspective, one could argue that this is a tenable position. Dialectical theory, based in Buddhist psychology (Linehan, 1993) would posit that agency and nonagency can be held in tension. A neurobiological study on the distinct neural modes of self-reference demonstrated that we can separate the streams of narrative and nonnarrative awareness so that we can be present to both a constructed sense of self and the “not self” as well (Farb et al., 2007). This point of tension or dynamic is addressed in Buddhist philosophies of “not-self” or “selflessness” or “emptiness.” The self as we understand it in everyday life is the person or “I” that appears to our minds that seems permanent, unitary and under its own power, separate from, but in charge of, mind and body. The more we observe the more we come to see that self to be the sensations, thoughts, feelings we experience—this is the “self” that is created as a result of interdependent arising (Kornfield, 1993). Suffering results from the self that clings to and identifies with phenomena that are constantly changing and the illusion that we are separate and alone. Liberation and joy arises when we come to realize that we do not exist as separate beings (Klein, 1995; Kornfield, 1993), and that our thoughts—and the stories we tell about ourselves—are not who we are. This orthogonal rotation in consciousness, also known as cognitive defusion (Hayes, 2004) or decentering (Hayes-Skelton & Graham, 2013), accessible through mindfulness (meditative and nonmeditative) training, can give IPV survivors a liberatory distance from which to bear witness to their own, and other’s suffering. When we are not identified with our stories as we are, we can more easily unpack the oppression we may have internalized and reauthor our narratives toward a preferred future (Allen, 2011) and sense of self.

**Psychoeducation and mindfulness**

Sharing information “about trauma’s neurobiological, social and existential impacts so that the trauma survivor can feel less negatively unique and more able to cognitively appraise trauma response in a compassionate nonjudging manner” is a salient feature of feminist therapy (Brown, 2004, p. 470). Because of its Western roots in medicine and empirical research focused on the ameliorating effects of mindfulness on the brain for stress, depression, anxiety, and more, MBSR and MBCT are particularly strong in psychoeducation. There are also very effective mindfulness-informed behavioral (Hayes, 2004; Linehan, 1993) and sensorimotor (Ogden, Minton, & Pain, 2006) interventions that also involve educating trauma survivors on the latest brain science and affect regulation theories that provide the framework for teaching breathing and relaxation techniques for engaging the parasympathetic nervous system and down regulating the stress response (Hanson & Mendius, 2009). Affect regulation is an important issue in feminist groups where the sharing of stories, deemed
important for unpacking and reframing oppressive narratives (Brown, 2011), can result in emotional activation of the storyteller and vicarious traumatization of the listeners.

Psychoeducation on the stigma of being a survivor of IPV and consequences of shame is also important. Research conducted by Buchbinder and Eisikovits (2003) with 20 Jewish Israeli women showed that shame was prevalent in the narratives of these women, and suggest that shame becomes an obstacle in leaving the violent relationship. In another study on domestic violence (Sharhabani-Arzy, Amir, & Swisa, 2005), self-criticism significantly increased the risk of posttraumatic stress disorder. This is not to say that staying in an abusive relationship is a result of some sort of cognitive distortion or maladaptive schema. Gilbert and Proctor (2006) see this rather as a safety behavior, especially when pointing out abusive behaviors in one’s intimate partner is risky and may evoke further abuse or violence. Self-criticism, in their view as evolutionary psychologists, is about safety and protection, but paradoxically it can increase the sense of internal threat, and the individual is unable to regulate their own affect and be compassionate to self when threat, whether internal or external, occurs.

Several therapies are already focusing on this important aspect of helping people develop affect regulation skills and self-compassion in response to traumatic experiences. Though not necessarily taught explicitly, self-compassion is considered integral to the many mindfulness-based interventions such as MBSR (Kabat-Zinn, 2013), MBCT (Segal et al., 2013), Dialectical Behavioral Therapy (Fruzzetti & Levensky, 2000; Linehan, 1993; Marra, 2004), and Acceptance and Commitment Therapy (Hayes, 2004). The modalities that have “mindfulness based” in their titles are interventions that incorporate formal meditation practice done as homework, whereas, the others incorporate “informal” mindfulness or everyday wakeful attentional awareness, but not formal meditation practice. The importance of teaching self-compassion and skills for self (affect) regulation are central to Compassionate Mind Training (CMT) because they can help create feelings of safeness, and reduce the sense of threat (Gilbert & Proctor, 2006) for people with high levels of shame and self-criticism. CMT is one of the modalities that does not teach formal meditation practice, but uses psychoeducation to teach people about daily mindfulness and acceptance skills to help with containing difficult affect, safety behaviours, and journaling and imagery (Lee, 2006) to evoke thoughts and feelings of self-compassion, warmth, and self-caring.

Deborah Lee’s adapted CMT approach specifically addresses the lag “between what the person understands from a cognitive perspective and what they feel emotionally . . . between intellectual reasoning and emotional reasoning, or propositional and implicational cognitive systems” (p. 327) for people whose experience of cognitive-behavioral and other modalities has only helped them to a point. This sounded very much like the women that I
had worked with that said there was still “something missing” for them, and so selections of Lee’s “Perfect Nurturer” guided imagery and other exercises were incorporated into the mindfulness research modality. These self-compassion exercises are designed to help create an internal “emotionally available other” to unseat the abusive “other” that has been internalized as the working model of self. In traditional Buddhist meditation training, practices are taught that focus explicitly on compassion, so lovingkindness meditation was also incorporated. The teaching of lovingkindness meditation has a traditional trajectory that starts with guiding students to silently repeat four basic and adaptable phrases of kindness—for example, *May you be happy and free from suffering, May you be healthy and in touch with your wholeness, May you be safe from inner and outer harm, May you live your life with ease*—starting with the self (*May I be happy, etc.*) (Salzberg, 2002).

**Methodology**

**Research group modalities**

The *Mindfulness* group (MFN) was based on the 8-week MBSR program with an extra infusion of lovingkindness practice; and included psychoeducation and exercises from CMT (Gilbert & Proctor, 2006) and The Perfect Nurturer modality developed by Deborah Lee (2006). The final *Mindfulness* modality is outlined in the week-by-week chart that follows (Table 1). The “Theme” category describes the psychoeducational component for that week, the “Agenda” describes the mindfulness-based activities (e.g., guided meditation, yoga, art), and “Handouts and Homework” are the activities and reading that the participant engages in between group sessions. Even a cursory look at Table 1 reveals the emphasis on psychoeducation and personal meditation practice. What dialogue is present during group work is mainly focused on participants’ reflections on their personal practice.

In contrast, the community-based *Woman Abuse Group* (WAG) advertised their group for IPV survivors:

… a place for women to break isolation, to help develop support networks, to identify and explore options and to place abuse in a societal rather than an individual context. The Support Group offers a place for women to share experiences with other women who have been abused. The goal of support groups is education and support, to encourage self-confidence, and enhance decision-making capacity. Women who attend the group may have left an abusive relationship or can still be with their partner. The Support Groups are held once a week for 12 to 14 weeks. The following issues are covered: What is abuse; impact of abuse for women and children; personal safety and safety planning; warning signs for future relationships; developing a life plan. (personal communication, April 18, 2011)
Table 1. Mindfulness (MFN) group agenda.

<table>
<thead>
<tr>
<th>Week</th>
<th>Theme</th>
<th>Agenda</th>
<th>Handouts &amp; Homework</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Automatic Pilot</td>
<td>Raisin exercise</td>
<td>Body scan, mindful daily activity (CD1 Body Scan)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduction to mindfulness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yoga/Body scan</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Barriers to Practice</td>
<td>Yoga/Body scan</td>
<td>Body scan, pleasant event calendar (CD2 Sitting Meditations)</td>
</tr>
<tr>
<td></td>
<td>“Thoughts are not facts.”</td>
<td>Dealing with Barriers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Thoughts and Feelings” exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mindfulness of Breath Meditation</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mindfulness of Breath &amp; Body</td>
<td>Awareness of hearing—using focused awareness</td>
<td>Sitting, unpleasant events calendar</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sitting—breath &amp; body</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working with unpleasant body sensations</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Stress Reactivity &amp; Safety Seeking</td>
<td>Yoga/Walking Meditation</td>
<td>Sitting/Yoga/Walking (CD3 Yoga)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sitting Meditation—Mindscape</td>
<td>Reflection exercise on historical influences that trigger threat and self-criticism (threat conditioning)</td>
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<tr>
<td></td>
<td></td>
<td>Working with the “thought stream”</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Neurophysiology of Stress video</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>“Letting Be”</td>
<td>Yoga/Sitting—Mountain</td>
<td>Sitting guided &amp; unguided (CD4 silence with bells)</td>
</tr>
<tr>
<td></td>
<td>Staying with Difficult Emotions</td>
<td>Working with difficult emotions</td>
<td>Journal: Compassionate reframing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“The Guesthouse”</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Using Compassion to Change our Minds</td>
<td>Yoga/Lovingkindness meditation</td>
<td>Sitting (CD5 Metta &amp; Mountain)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building a compassionate image in the heart/mind</td>
<td>Journal: More compassionate reframing with the perfect nurturer</td>
</tr>
<tr>
<td>7</td>
<td>Building Self-Compassion</td>
<td>Yoga/Lovingkindness mediation</td>
<td>Create your own practice configuration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compassionate imagery—Art as meditation</td>
<td>Journal: Consequences of becoming a compassionate self</td>
</tr>
<tr>
<td>8</td>
<td>Living a Compassionate Life</td>
<td>Yoga/Body scan /Walking metta</td>
<td>The rest of your life: Stick with your intentions for practice!</td>
</tr>
</tbody>
</table>
Although the agency never refers to the group as “feminist” the characteristics of “good” feminist therapy (Brown, 2004) can be discerned.

Research design

An exploratory quasi-experimental, nonequivalent group research design (Mertens, 2005) was used to assess possible outcome difference in survivors of IPV using a mindfulness approach versus a community-based feminist approach. Approval for the study was granted by a university Research Ethics Board and the hosting agency. The community-based social service agency allowed me access to the Anti-Violence Program through which I recruited five volunteers from their long-standing feminist WAG for my comparison group, and seven women from their wait-list for the MFN treatment modality. Both groups ran in the same agency with two facilitators. One notable difference between the two groups was that the WAG modality was 12 weeks in length, whereas the MFN group was 8 weeks. Exclusion criteria included clinical levels of depression and dissociation using the Beck Depression Inventory (Beck & Steer, 1987) and the Dissociative Experiences Scale (Carlson et al., 1993) and previous meditation experience.

Because of the central role self-compassion plays in the reconstruction of the self, moral agency, and the amelioration of shame and self-blame (Gilbert, 2005; Gilbert & Proctor, 2006), and as an indicator of general psychological well-being (Neff, 2004) the Self Compassion Scale (Neff, 2003a) was administered pregroup and postgroup. The Self Compassion Scale is a 26-item scale that yields a single score for self-compassion; it contains within it six subscales, three which measure the positive attributes of self-compassion and three that measure the “mirror” negative attributes present in people with low self-compassion. Neff defines the three positive attributes as: self-kindness, the ability to extend kindness and understanding to oneself; common humanity, seeing one’s experience as part of the larger human experience rather than as isolating and separating; mindfulness, the ability to hold one’s thoughts and feelings in balance. The three “mirror” attributes (reverse scored) are self-judgment, evaluating oneself negatively; isolation, the feeling of separateness; and overidentification, or cognitive fusion with thoughts and emotions so that one becomes so immersed in current emotional reactions one cannot step back and adopt a more objective stance (Neff, 2003a, 2003b). Data from the prepsychometric and postpsychometric surveys conducted with the WAG (n = 5) and the MFN group (n = 7) were manually inputted into SPSS software for statistical analysis. An alpha level of .05 was used in all analyses.

Results

Pretreatment to posttreatment, the mean score for the Self-Compassion Scale (SCS) increased in the MFN modality (M = 3.93, SD = .61) significantly,
Calculation of paired samples T-tests for self-compassion scale (SCS) subscales.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Prepost</th>
<th>T-test</th>
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<tbody>
<tr>
<td></td>
<td>Mdiff</td>
<td>SD</td>
<td>t</td>
<td>Df</td>
</tr>
<tr>
<td>Woman Abuse Group (WAG) Posttreatment (n = 5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>.08</td>
<td>.335</td>
<td>.535</td>
<td>4</td>
</tr>
<tr>
<td>Common Humanity</td>
<td>.50</td>
<td>1.00</td>
<td>1.12</td>
<td>4</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>.50</td>
<td>.968</td>
<td>1.56</td>
<td>4</td>
</tr>
<tr>
<td>Self-Judgement</td>
<td>−.24</td>
<td>−.297</td>
<td>1.81</td>
<td>4</td>
</tr>
<tr>
<td>Isolation</td>
<td>−.75</td>
<td>−.685</td>
<td>2.45</td>
<td>4</td>
</tr>
<tr>
<td>Overidentification</td>
<td>−.05</td>
<td>−.570</td>
<td>.196</td>
<td>4</td>
</tr>
<tr>
<td>Mindfulness (MFN) Posttreatment (n = 7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>.71</td>
<td>1.04</td>
<td>1.82</td>
<td>6</td>
</tr>
<tr>
<td>Common Humanity</td>
<td>.64</td>
<td>.626</td>
<td>2.71</td>
<td>6</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>.71</td>
<td>.769</td>
<td>2.46</td>
<td>6</td>
</tr>
<tr>
<td>Self-Judgement</td>
<td>−.23</td>
<td>−.770</td>
<td>.786</td>
<td>6</td>
</tr>
<tr>
<td>Isolation</td>
<td>−.46</td>
<td>−.698</td>
<td>1.76</td>
<td>6</td>
</tr>
<tr>
<td>Overidentification</td>
<td>−.786</td>
<td>−.548</td>
<td>3.79</td>
<td>6</td>
</tr>
</tbody>
</table>

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

$t(6) = −2.694, p = .036$, one-tailed. The WAG modality mean score also increased ($M = 3.5, SD = .66$) significantly, $t(4) = 2.987, p = .02$, one-tailed.

Within the six SCS subscales, the WAG group mean showed a significant decrease in sense of isolation [$t(4) = −2.449, p = .04$, one-tailed]. The MNF group showed a significant increase in their sense of common humanity, $t(6) = 2.714, p = .02$, one-tailed; a significant increase in mindfulness, $t(6) = 2.456, p = .02$, one-tailed; and a significant decrease in over-identification, $t(6) = −3.792, p = .01$, one-tailed, (Table 2).

Discussion

Positive change shown by increased levels of self-compassion occurred with the women within each modality, suggesting that the mindfulness and the feminist modalities are both supportive environments for helping women regain an overall sense of well-being (Neff, 2004). It would also suggest that the three positive aspects of self-compassion would be more present: self-kindness, common humanity, and mindfulness (Neff, 2003a).

Those of us who have worked for decades in feminist-based agencies know intuitively and empirically that we do good work, and that our interventions are effective and help the women with whom we work. We also know that the “therapeutic relationship” is a key aspect of the collaborative, strengths-based approach we take with clients, and that this relationship in itself can be very healing. The therapeutic relationship in a group modality is also expressed within the relationship that the women build with each other through sharing stories with “empathic others” (Brison, 2002; Meyers, 1994) and normalizing each other’s experiences, perhaps even more so than with the formal “therapists” or group facilitators. Therefore, it makes sense that a change—using self-compassion
as a general indicator of well-being and “positive health outcomes” (Neff, 2003a) —would be measureable in the WAG modality.

The findings that emerged from the MFN group suggest that overall the mindfulness-based modality increased self-compassion significantly for these women. In the MFN modality, while there was not the same emphasis on narrative storytelling, my cofacilitator and I were, as Laura Brown (2004) suggested, “theory-driven” as “good” feminist therapists should be, that is, working from a critical framework and epistemology; and we also provided “empathic others” where women were recognized and relational healing could take place.

The additional emphasis on self-compassion in the MFN modality was an invitation to embrace a radical act of self-acceptance, and an examination of the SCS subscales suggests that this emphasis made a differential effect between the two modalities. The single significant change within the SCS subscales for the feminist WAG participants was a decrease in their sense of isolation (Table 2). This should come as no surprise, as one of the main benefits of sharing stories of abuse and survival is the normalizing and connecting effect this has for women, and for the majority of women in this first-stage group, this would have been the first time they would have told their stories. This again suggests that healing through the presence of “empathic others” (Brison, 2002; Meyers, 1994) arises from women attending to each other’s stories, questions, and thoughts. However along with the listening that builds empathy and compassion for others comes the arousal of affect that may exacerbate trauma-related symptoms.

In the MFN group, the SCS subscales showed a significant decrease in overidentification with afflictive emotions, and a significant increase in mindfulness, which Neff (2003a) describes as the mirror-opposite of overidentification. These findings suggest that the women in the Mindfulness modality learned to change their relationship to difficult thoughts and emotions through developing the skill of self-regulation as part of the mindfulness training and the increased sense of safety from self-compassion training process (Gilbert & Proctor, 2006). An increase in mindfulness, as defined by Neff (2003a) is the ability to take a more objective stance toward our emotional experiences. Retelling of narratives of oppression is deemed important for unpacking and reframing oppressive narratives (Brown, 2011), but can result in emotional activation of storytellers and listeners. This highlights the importance of introducing mindfulness and compassion training for self-regulation in feminist groups. When we are not identified with our stories as who we are, we can more easily unpack the oppression we may have internalized and reauthor our narratives toward a preferred future (Allen, 2011) and sense of self.

Women in the Mindfulness modality also gained significantly in their sense of common humanity—perceiving one’s experiences as part of the
larger human experience rather than seeing them as separating and isolating, that is, the ability to feel empathy for self and others. Increased common humanity may suggest a stronger sense of self-in-relationship, and perhaps points toward a stronger sense of “moral agency”—possible only when we can truly recognize ourselves and others as separate individuals and be present to our, and others’, suffering (Meyers, 1994). This relational subjectivity based in mutual empathy and recognition is important to nurture toward creating a new working model of self. Buddhist philosophy teaches that much suffering results from the illusion that we are separate and alone, and that compassion-focused mindfulness training helps us wake up to liberation and joy of realizing that to we do not exist as separate beings (Klein, 1995; Kornfield, 1993). Integrating lovingkindness meditation and other forms of compassionate mind training may well give IPV survivors a liberatory distance from which to bear witness to their own, and others’ suffering, and realize we—our common humanity and all beings—are all interconnected.

Limitations

The author had multiple roles as researcher, modality developer, and cofacilitator of the Mindfulness group, so a bias toward positive interpretation of outcomes is present. It is important to note that due to the small sample size in each modality, these statistics are tentative at best as there is insufficient n present for a statistical power analysis (Cohen, 1992). However, the data do point us toward information that is worth noting with respect to what happened in these two treatment groups.

Implications for social work practice

Intermingling the edges of mindfulness philosophy and feminist theory encourages social workers and other agents of change to look at beliefs we may have about the perceived incompatibility of the two value systems. Upon deeper examination, the two have similarities in ontologies and orientations to social justice and ethical ways of being. A conscious and critical reintegration of foundational Buddhist ethics into contemporary mindfulness approaches would make it more congruent with feminist and other social-justice-oriented social work.

Feminism and mindfulness also have much to offer each other’s signature modalities. Feminist therapies offer MBIs years of experience in the importance and power of sharing and unpacking stories to reveal systemic oppression and reauthor narratives toward a preferred future. MBIs offer feminist therapies compassion-based mindfulness skills for engaging with the world with a reconnected/reconstructed sense of self, the joy that arises from knowing
we are interconnected, and able to respond wisely and compassionately to the
great troubles and stress in our private and public worlds.

The modest exploratory study in this article provides a glimpse into the
strengths of a mindfulness-based, compassion-focused modality as well as a
feminist, community-based group for IPV survivors. Compassion increased
in both groups, but on finer examination findings suggest the greatest
strength of the feminist group was to decrease women’s sense of isolation,
and of the Mindfulness group to increase mindfulness and common
humanity, while decreasing overidentification with afflictive thoughts and
emotions. When we bring these two approaches into one modality, the
resulting Mindfulness Based Feminist Therapy (MBFT) may contain the
best practices and values of both: a safer container for mutual recognition
of suffering under oppression, and the power of self-compassion and
empathic listeners for healing the sense of self. Manualizing MBFT and
further research using a randomized control trial is required to provide
conclusive evidence of its effectiveness.

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