

"If you're kind to me, I'll be kind to you." Compassion to self and others
as a dynamic and relational process among young people who have
engaged in harmful sexual behaviour: A Grounded Theory.

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Abstract

The past decade has seen increasing research interest in compassion to self and others, both as a construct and a likely precipitant of psychological wellbeing. A growing literature base suggests that psychotherapeutic interventions aimed at increasing self-compassion can help to alleviate negative effects often associated with shame and self-criticism. Compassion-focused interventions have subsequently been proposed for populations likely to experience heightened shame. Despite the interest in this area, only limited research has attempted to explore how compassion is understood and experienced among varying populations. Research that has been undertaken has tended to adopt quantitative approaches, utilising self-report measures validated with well-educated, often academic, populations. There is clearly a need for the construct of compassion to be explored with other populations, particularly those who may be disadvantaged and/or at risk of heightened levels of shame. One such population is young people who have come to the attention of services for engaging in harmful sexual behaviour (HSB). This research therefore intended to fill this gap and extend the existing literature base on compassion by employing a qualitative approach. Nine young people (8 males, 1 female) aged 14-18, who were receiving input from youth offending services for HSB, were recruited for this research. Each participant took part in a one-off interview where they were asked about their understanding and experiences of compassion to and from self and others. Adopting a Constructivist Grounded Theory methodology, data were analysed through an iterative process of constant comparison, leading to the construction of a substantive theoretical model grounded in the data. The resultant model explicates the dynamic and relational process of compassion to self and others experienced by young people who have engaged in HSB. The model is considered in relation to existing literature and implications for clinical practice are discussed, along with directions for future research.

Chapter One: Introduction

1.1 Overview of Chapter

This chapter begins by exploring the current literature-base surrounding compassion, including the developing argument for the role of self-compassion in mediating the negative effects of shame and self-criticism. The focus then turns more specifically to those who commit sexual offences and, in particular, young people who engage in harmful sexual behaviour. After considering the role of shame in this population, it is argued that compassion is also likely to be an important construct warranting exploration. In the absence of pre-existing research in this specific area, the case is made for a need to first understand the meaning and experience of compassion to self and others for this group. The rationale and aims for the current study are outlined, before concluding with a chapter summary.

1.2 Brief background and Rationale

The last decade has seen increasing academic and clinical interest in compassion to self and others, as well as its relationship to various factors including mental health and wellbeing, psychopathology, and behaviour. Posited by some as an effective moderator of more problematic states such as shame and self-criticism (Gilbert, 2000a, 2005, 2010a, 2010b), self-compassion has become the focus of a cluster of therapeutic interventions that seek to alleviate the negative effects of shame through developing a self-compassionate stance (Gilbert, 2009a, 2009b, 2010b; Gilbert & Procter, 2006). Despite having their roots in evolutionary theory and Ancient Eastern philosophy (Gilbert, 2009a, 2009b), compassion-focused interventions within the psychotherapeutic fields are in their relative infancy. Throughout this chapter it shall be argued that establishing a sound understanding of compassion as a construct, as well as the meaning and experience of compassion to self and others for populations of clinical interest, should be the first port of call for researchers wishing to understand the value of self-compassion for those at risk of heightened shame. Whilst this is an expanding field, it is noted that most of

the current self-compassion literature has employed quantitative, psychometric-based approaches to research, implicit in which is the assumption that compassion can be self-reported and is relatively stable across time – at least in the short-term – and context, to the degree that it can be accurately measured. Currently, there is far less available research into the meaning, understanding, and experience of compassion to self and others among differing – and especially more disadvantaged – populations. One such population, for whom experiences of shame are likely to be problematic and therefore the exploration of compassion to self and others is particularly warranted, are young people who engage in harmful sexual behaviour. To the researcher’s knowledge, there is currently no published research on self-compassion among this population; it is therefore vital to begin by exploring the meaning, understanding, and experience of compassion for this group.

1.3 Compassion to Self and Others

To consider the role of self-compassion in human experience, it is first necessary to clearly establish what is meant by the term *self-compassion*. In addressing this question, it is helpful to begin by defining the broader concept of *compassion*.

1.3.1 Defining compassion. The Oxford Dictionary defines compassion as a “sympathetic pity and concern for the sufferings or misfortunes of others” (2017). Literally translating as to “suffer with” (Neff & Davidson, 2016, p.40), the word compassion appears to imply an acknowledgement that another is suffering in some way, coupled with a relatable response in affect, either through sympathy or concern, to this suffering. It is however stressed that compassion does not equate to empathy, with the key difference being that whilst both reflect an ability to take the perspective and feel the emotions of another, compassion involves an additional desire to help (Strauss et al., 2016). Indeed, the Buddhist tradition – from which many compassion-focused interventions draw their ethos and approach – defines compassion as the wish for another to be free from suffering (Dalai Lama, 2012). Numerous definitions offered

within the psychological and academic literature appear to corroborate this understanding: “compassion involves sensitivity to the experience of suffering, coupled with a deep desire to alleviate that suffering” (Goetz, Keltner, & Simon-Thomas, 2010, p.351); “[compassion is] a deep awareness of the suffering of another coupled with the wish to relieve it” (Gilbert, 2010a, p.13). It appears then that the most widely adopted definition of compassion involves two components (Halifax, 2012):

- i. A sensitivity to the experience of another’s suffering
- and
- ii. A desire or motivation to relieve that suffering

Notably, from this understanding compassion does not require one to act on the desire to relieve suffering, and any additional selfless or helping behaviour enacted as a result of feelings of compassion may more readily be defined as altruism (Weng et al., 2013).

To complicate matters, compassion is not consistently defined by these components throughout the literature and is sometimes conceptualised more broadly, for example, as “a quality that aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging” (Gilbert, 2010a, p.217). A review by Strauss et al. (2016) attempted to synthesise various conceptualisations of compassion adopted within the psychological literature. They proposed that compassion involves five elements: recognising suffering, understanding its universality, experiencing an emotional resonance (e.g. through feeling sympathy, empathy, or concern for those who are suffering), tolerating distress associated with witnessing suffering, and a motivation to act or acting to alleviate the suffering. This more recent conceptualisation both includes and extends the dual-component definition offered above. It is important to note the variations, however subtle, between what might be considered more common-place definitions of compassion and those adopted by professionals and academics, as these may highlight potential discrepancies between the understanding and meaning of

compassion among varying populations. Furthermore, the absence of a clear, universal definition reflects a likely ambiguity and subjectivity around compassion as a construct, and it has been noted that the distinction of compassion from other relatable constructs, such as kindness, caring, and altruistic behaviour is not clear-cut (Goetz, Keltner, & Simon-Thomas, 2010).

1.3.2 Defining self-compassion. In essence, having compassion for oneself can be viewed as similar to having compassion for another (Neff, 2003a, 2003b). “Self-compassion is simply compassion directed inward, relating to ourselves as the object of care and concern when faced with the experience of suffering” (Neff & Dahm, 2015, p.121). To build on the earlier deconstruction of compassion then, self-compassion can be understood as:

- i. A sensitivity to our own experience of suffering
- and
- ii. A desire or motivation to relieve that suffering

Again, this definition would imply there being no requirement to act to relieve suffering, just a motivation to do so. In adopting the definition of compassion to explain self-compassion, it necessarily renders the latter open to the same criticism as the former – that there is likely to be ambiguity and subjectivity to self-compassion as a construct, which may be understood and experienced differently among varying populations. Nevertheless, there appears to also be a good deal of commonality among the various definitions of compassion and therefore self-compassion. Having established an idea of what is meant by (self-)compassion, we can now turn to current theoretical perspectives on its development and function.

1.3.3 A theoretical basis for compassion to self and others. Since the turn of the century, there has been a growing interest in Western society in compassion as a construct and its link to wellbeing. The promotion of compassion to self and others is not a new concept; in fact, it is well embedded within Eastern philosophy and the Buddhist tradition (Neff, 2003b). But

recent years have seen exponential growth, particularly within the fields of psychology and psychotherapy, in the development of therapeutic interventions seeking to cultivate these qualities, with the aim of promoting psychological wellbeing. Naturally, this has demanded the construction of coherent theoretical frameworks from which to understand the development and function of compassion, the key proponents of which are outlined below.

1.3.3.1 Buddhist tradition. In Buddhism, compassion – or “Karuna” – is usually understood to mean an active sympathy or willingness to bear the pain of others. For Buddhists, this is a means to realising Enlightenment, but also a manifestation of Enlightenment itself (O’Brien, 2017). The Dalai Lama described compassion as “an aspiration, a state of mind” requiring “both wisdom and lovingkindness,” where wisdom refers to an understanding of the suffering we wish to relieve, and lovingkindness to the experience of empathy and intimacy with other sentient beings (cited by O’Brien, 2017). In Buddhist teaching, “in order to have compassion for others, we have to have compassion for ourselves” (Chodron, 2010) and specific meditative practices, such as the tonglen in Tibetan Buddhism (Chodron, 2010; O’Brien, 2017), promote a connection to one’s own suffering along with the suffering of others.

1.3.3.2 Neff’s model of self-compassion. Neff (2003a; 2003b) first attempted to conceptualise and measure self-compassion within the academic literature through drawing together the key principles from Buddhist tradition pertaining to compassion. She operationalised self-compassion as consisting of three main components: self-kindness, common humanity, and mindfulness. She argued that kindness to the self was a necessary facet of self-compassion, but that Western culture – although in favour of kindness to others – was far less encouraging of self-kindness. She reflected that it is not uncommon to “encounter extremely kind and compassionate people who continually beat themselves up” (Neff & Dahm, 2015, p.122), which seems at odds with the Buddhist position that self-compassion must be practised before compassion to others can be achieved. But being able to acknowledge that we are doing

the best we can and to show ourselves the support and understanding we would show a friend in need was a fundamental aspect of directing kindness towards oneself, allowing oneself to be moved by our own distress, which, Neff postulated, would enable the motivation to alleviate one's own suffering to emerge (2003a). Neff referred to common humanity as the sense that difficulties, flaws, and failings are all part of the human condition, and that in suffering we are not alone. She believed that adopting this stance would facilitate a connected mindset in response to suffering, allowing individuals to feel less isolated when in pain. Finally, Neff (2003a) identified the ability to approach our negative thoughts and emotions mindfully, with balance and equanimity, and without judgement, avoidance, or repression, as key to fostering a self-compassionate stance. Fundamentally, Neff viewed self-compassion as an inherent trait developed in childhood, although did qualify this with an assertion that this trait can be built on and grown later in life, given the right guidance or conditions (Neff, 2003a; Neff & Dahm, 2015).

1.3.3.2.1 What self-compassion is not. Having conceptualised what self-compassion *is*, Neff (2003a, 2003b) made important assertions about what self-compassion *is not*. She distinguished self-compassion from self-esteem, arguing that the latter involves an evaluation of the self in comparison to others, potentially resulting in self-absorbed or narcissistic behaviour, or even requiring us to put others down in order to feel good about ourselves. Self-compassion, she stated, is different because it does not rely on self-evaluation, promoting instead a stance of non-judgemental acceptance. Neff goes on to separate self-compassion from self-indulgence, highlighting that to be truly self-compassionate would mean to avoid unhealthy indulgence for the sake of instant gratification (e.g., by smoking, taking recreational drugs) as this may ultimately harm longer-term wellbeing. Finally, she distinguished self-compassion from self-pity, asserting that self-pity emphasizes personal suffering and egocentric feelings of isolation,

whereas self-compassion, by her definition, would promote social connectedness and frame suffering in the context of a shared human experience (2003a).

1.3.3.3 *The compassionate mind: an evolutionary perspective.* Whilst Neff's work offers a relatively comprehensive model for understanding what it means to be self-compassionate, Gilbert's (2010a) work on the Compassionate Mind provides a theoretical basis for the evolutionary social function of compassion, as well as its role in promoting psychological wellbeing. Gilbert (2010a) described the evolutionary origins of the compassionate mind, whereby the ability to give and receive compassion develops from basic social motivational and functional emotional systems, enabling us to achieve a number of social goals necessary for survival – such as caring for kin or seeking out sexual partners. Gilbert's conceptualisation of compassion centres on two key evolutionary theories: social rank theory and social mentality theory. Social rank theory (Gilbert, 2000b) drew on existing ideas about the function of hypercompetitive social attitudes (Burkle, Ryckman, Gold, Thornton, & Audesse, 1999) and posited that humans are driven to maintain social acceptance and approval in order to maximise one's social rank and therefore be in a more desirable position to compete for social advantages. From this perspective, experiences of compassion serve an evolutionary function: to promote social acceptance and belonging; for a loss of social connectedness would represent a social threat (Gilbert, 2000b) and has been linked to psychological distress (Lee, Draper, & Lee, 2001).

Social mentality theory (Gilbert, 2000a) posits that humans possess internal systems that generate patterns of cognition, affect, and behaviour, which evolved to facilitate interpersonal relating through the interpretation and enactment of social roles. These systems – or 'social mentalities' – serve specific functions and enable individuals to solve various social challenges essential to human survival, such as care-seeking or competing for resources. As such, humans have access to a plurality of social roles, meaning we can feel different things and play different parts, according to the state of mind we are in. The roles that individuals adopt at any given time

are informed by the detection and decoding of social signals, as well as an individual's interpretation of the emotions evoked within them as a result of the response in others to their role enactment. The evocation of positive affect is usually indicative of role success, whereas negative affect will signal failure. In the roles enacted by mother and infant, for example, effective proximity and attunement will likely evoke positive affect, but separation may evoke feelings of a negative disposition. The appropriateness of the adopted role relies on the accurate and competent evaluation of social signals. It is however common for aversive role mismatches to occur; for example, between the individual who anticipates a sexual encounter with another, and the other who perceives their relationship to be one of friendship. In his explication of social mentalities, Gilbert (2000a) goes further to suggest that as a result of the higher-order thinking abilities – and thus self-consciousness – evolved in humans, such as the ability to self-reflect, social mentalities can be activated on an intrapersonal level (through a process of self-to-self relating), as well as for their original function in interpersonal (self-to-other) relating.

On the basis of these theories, Gilbert (2005, 2010a) identifies a tripartite model comprising three main emotional systems inherent in human experience: the 'drive (for resources) system' helps motivate us towards a desired goal; the 'threat-system' enables us to safety-seek and protect ourselves from danger; and the 'soothing system' allows us to foster safety from within, evoking warmth and compassion in a non-judgemental and mindful way (Gilbert, 2010a). Within the three-systems model, compassion is understood as relating to the soothe-system and is connected to care-seeking and caregiving behaviours on an interpersonal level, but can also be internalised through a process of self-relating (self-compassion). Compassion, in this sense, can be played out in three directions: from oneself to another, from others to the self, and from self to self (Gilbert & Choden, 2013). These systems and the social mentalities they subsume develop or mature to varying degrees as a direct result of our

environment and significant interpersonal experiences (with key attachment figures for example) to ensure our survival.

1.3.3.3.1 The role of attachment. Attachment theory was first proposed by Bowlby (1969, 1973, 1980), who highlighted the importance of the early relationship between an infant and their primary caregiver(s) in shaping their social, emotional, and cognitive development. Infants have an innate urge to seek-care from their available attachment figures, without whom they would not survive (Bowlby, 1969). The specific relational patterns experienced within these early interactions lay the blueprint for more established patterns of relating to significant others, such as peers and romantic partners, later in life (Allen & Land, 1999); such blueprints are commonly referred to as attachment styles, or strategies (Ainsworth, Blehar, Waters, & Wall, 1978; Bartholomew & Horowitz, 1991; Bowlby, 1969). In essence, the function of an attachment relationship is to provide a safe-base from which to explore the world (Bowlby, 1969). When attachment figures provide ‘good enough’ care (Winnicott, 1960), it is likely that a secure attachment style will be developed (Ainsworth, Blehar, Waters, & Wall, 1978). In the face of an absent, inconsistent, or threatening attachment figure however, infants are forced to adopt safety-strategies to ensure their survival, usually resulting in one of the insecure attachment styles (Ainsworth, Blehar, Waters, & Wall, 1978). Adolescence has been recognised as a transitional period when greater autonomy is sought so as to no longer rely as much on the support of parental figures; it is however recognised that a backdrop of secure attachment relationships can greatly enhance this process (Allen & Land, 1999).

Both Gilbert and Neff put forward the idea that our ability to foster (self-)compassion develops in childhood through our interaction with the environment and significant others within it. Gilbert (2010a) was perhaps more specific in directly linking our ability to foster a compassionate stance to self and others via the soothe-system and its associated social mentalities, to our relational experiences with our key attachment figures. For the child whose

primary caregiver models compassion through warmth, acceptance, and soothing containment/safety, the soothe-system is likely to develop accordingly, allowing them to internalise such qualities and draw on them when the need arises to offer similar feelings of compassion for themselves or others. For those who have been repeatedly exposed to threatening environments – for example interpersonal trauma – the threat-system may become over-developed, thus increasing the likelihood that this system will be regularly activated, triggering associated emotional responses such as anxiety – linked to hypervigilance for danger, and shame – as a maladaptive coping strategy intended to trigger self-criticism and ensure self-monitoring to promote positive relationships with others (Goss & Allan, 2009). Similarly to Neff's position that self-compassion can be cultivated through practice, Gilbert (2010a & 2010b) argues that the attachment motivational system can be reactivated by the compassion of a therapist, or through a compassionate exercise, presenting a further opportunity to develop the soothing system. In Gilbert's (2010a) three-systems model, development of the soothe-system is important as its activation can have a moderating effect on the threat-system, subsequently reducing the experience of threat-associated emotions such as shame.

1.3.3.3.2 Fears of compassion. An interesting facet of Gilbert's theory on compassion is the role that the fear of compassion, or indeed self-compassion, plays. Gilbert, McEwan, Matos, and Ravis (2011) postulated that individuals who have experienced threat from others, for example through the perpetration of sexual abuse, may come to perceive expressions of compassion as posing a threat to one's safety. In such circumstances, a fear of compassion may serve to protect the individual as a function of the threat-system; however, this can ultimately result in the converse effect of preventing the individual from developing the capacity to self-soothe, therefore limiting their ability to regulate an over-active threat-system. Following social mentality theory (Gilbert, 2000a), it was suggested that an established fear of compassion from others in this sense may translate to a general fear of affiliative emotion directed to the self,

including when this originates from the self – as in self-compassion (Gilbert et al., 2011). A study by Hermanto and Zuroff (2016) found further evidence for a link between low levels of compassion from others, or care-seeking, and low levels of self-compassion. Interestingly, their results suggested that the lowest levels of self-compassion among participants were in fact predicted by low care-seeking, but high caregiving. They proposed that this may relate to a compulsive caregiving attachment style (Bowlby, 1977, cited in Hermanto & Zuroff, 2016), thought to be predicted by early experiences of the subjugation of their own needs and forced care of an attachment figure.

Gilbert et al. (2011) argued that a fear of expressing compassion towards others was also evident in some individuals. They linked this phenomenon to the wider attachment literature, reasoning that a fear of compassion to others could be explained by an insecure attachment style (Ainsworth, Blehar, Waters, & Wall, 1978), where expressions of compassion from and to a primary caregiver were either non-existent or enacted inconsistently. The fact that Neff (2003a, 2003b) felt it necessary to distinguish self-compassion from self-pity and self-indulgence implies a likelihood that these constructs may be conflated. As pity and indulgence are often construed as undesirable (Neff, 2003a), it seems feasible that a fear around the promotion of such traits could act as a barrier to self-compassion. Studies relating to criminal behaviour have also indicated that compassion can be viewed as placing the self in a position of weakness where advantage can be taken, or as letting people ‘off the hook’ (McLaughlin, Hughes, Fergusson, & Westmarland, 2003). Fears of compassion arising from interpersonal experiences are important to understand as they are likely to influence self-compassion, given social mentality theory’s proposition that the same internal systems activated in interpersonal relating are used in self-relating (Gilbert, 2000a). Understanding what might get in the way of compassion and how to overcome this is also necessary in developing clinical interventions that aim to encourage

individuals to foster a compassionate stance – particularly when this in itself may activate a threat-response.

1.3.3.4 *The developmental trajectory of compassion.* Gilbert's (2010a) theory of the Compassionate Mind emphasises the important link between early attachment relationships and the development of compassion. But compassion, as defined earlier in the chapter, appears also to involve a number of affectual and cognitive capacities, without which the ability to experience compassion would seemingly be impeded. Indeed, well-established neurodevelopmental and social psychological research into constructs associated with compassion have identified that numerous processes are involved. By way of example, empathy – thought to be closely linked to compassion (Batson, 1991) – has been broken-down into key components including affective arousal, emotion understanding, and emotion regulation; each associated with specific regions of brain activity and with their own developmental trajectory (Decety, 2010). The importance of perspective-taking has also been highlighted within the morality literature (Gibbs, 2010; Gibbs, Basinger, Grime & Snarey, 2007). Perspective-taking alone is underpinned by specific cognitive capacities – such as perspectival coordination and working memory – but also involves social processes and is thought to be enhanced by exposure to more diverse social perspective-taking opportunities (Gibbs et al., 2007). The ability to cognitively understand states of mind in self and others is often referred to as 'theory of mind' (ToM; Wimmer & Perner, 1983); in other words, the capacity to understand that individuals possess their own minds and as such can differ in their thoughts and intentions. Whilst ToM and empathy are both likely to be important in compassion, they reflect distinct processes. Empathy, for example, involves an emotional resonance and therefore utilises emotion processing at both a cognitive and affectual level (Eisenberg & Eggum, 2009), whereas ToM is underpinned by cognitive processes which do not necessarily involve an affectual response. The development of compassion is therefore unlikely to be predicted solely by the quality of early attachment relationships; whilst these clearly play

an important role, consideration must also be paid to the specific capacities involved in experiencing compassion, and the degree to which such capacities have developed within individuals.

Research suggests that humans demonstrate some tendencies towards helping behaviours from a young age. Between 14 and 18 months, infants can begin to comfort others in distress and display some spontaneous helping behaviours (Warneken & Tomasello, 2009). In what is often termed ‘neurotypical’ development, cognitive and affectual capacities increase with age in a relatively linear and predictable fashion. Whilst some early-years research has suggested that babies are born with the capacity to experience some aspects of emotional resonance and expression (Dondi, Simion & Caltran, 1999), it is widely recognised that the cognitive abilities required to achieve mature empathic understanding develop later in life (Decety, 2010). Key proponents of child development theory have emphasised the role of social interaction, including modelling, scaffolding, and exposure to diverse social experiences, in the ongoing development and maturation of such abilities, as well as others (e.g., Piaget, 1936; Vygotsky, 1978). Given the importance of socialisation and interaction to the developmental process, it follows that children who have been deprived of effective social scaffolding – perhaps through interpersonal abuse and neglect, or as a result of the limited capacities of their caregivers – may experience developmental delay in key areas of functioning, including some of those central to compassion. As with Gilbert’s (2010a) model, this perspective would highlight the importance of early relationships. However, it is widely recognised that developmental delay can occur in some individuals for various other reasons, seemingly independent of the quality of caregiving and attachment. Key examples of this include the areas of intellectual disability (ID) and social and communication difficulties, such as those experienced in Autism Spectrum Disorders (ASD). Whilst there remains speculation around the aetiology of such presentations, there is clear evidence to suggest that individuals diagnosed with an ID and/or ASD can experience significant

difficulties in social skills (Smith & Matson, 2010), ToM (Ashcroft, Jervis, & Roberts, 1999; Baron-Cohen, Leslie & Frith, 1985), and executive functioning capacities (Danielsson, Henry, Messer & Rönnerberg, 2012; Ozonoff, Pennington & Rogers, 1991). Difficulties in empathy have also been acknowledged for individuals with ASD (Baron-Cohen & Wheelwright, 2004), although it has been proposed that these are more closely linked to difficulties in the cognitive imagining of another's pain and/or perspective taking – particularly when social cues are complex or subtle – as opposed to there being an innate inability to experience empathy on an affectual level. Other developmental disorders, such as conduct disorder, are thought to be characterised by deficits in the affectual capacity to empathise (de Wied et al., 2006), despite an often in-tact – although skewed – capacity to understand mental states (Happé & Frith, 1996). This has clear implications for the current research, particularly given the high prevalence of ID and ASD in the population of young people who engage in harmful sexual behaviour (see below; Hackett, Phillips, Masson, & Balfe, 2013) and the association between offending behaviour and conduct disorder (Murray & Farrington, 2010). Furthermore, it raises a question around whether young people with delayed or disrupted cognitive and/or affectual development will possess the relevant capacities to enable them to experience compassion and/or to cognitively understand these processes and reflect on them through conversation – such as within an interview context. One related area of the literature which has attempted to delineate the developmental trajectory of processes linked to morality, including the moral emotions, is that of moral reasoning.

1.3.3.4.1 Moral reasoning. Moral reasoning, also referred to as moral development, can be understood as the evolution of specific beliefs, emotions, attitudes, and behaviours that contribute to moral understanding and decision making. As with other domains of the developmental psychology literature, research in this area has sought to understand how and why moral reasoning develops in individuals, as well as the specific factors that impact this. Piaget (1932) – thought to be one of the first theorists to apply a psychological framework to moral

reasoning – outlined three key stages of moral development in children: the *pre-moral* period (0-5 years) where children have little awareness of socially defined rules, *heteronomous* morality (5-10 years) where rules of authority figures are viewed as unalterable, and *autonomous* morality (10 years – adolescence) where rules are understood as negotiable and actions or decisions are viewed with the propensity to affect everyone. Piaget viewed his stages as forming an invariant sequence, and emphasised peer-interaction in an individual's progression through them (1932). Kohlberg (1976) built on Piaget's initial theory, expanding this into a six-stage cognitive-developmental model which extended beyond childhood to adolescence and adulthood. In addition to peer-interaction, Kohlberg highlighted the importance of wider social engagement in the development of moral values and social perspective-taking processes (1976). Kohlberg (1971) argued for the universality of his moral development theory, but has been criticised from several angles, including cultural and socioeconomic bias (Snarey, 1985), negation of the role of emotion (Sullivan, 1977), and the fact that moral reasoning may not be consistent across all contexts (Krebs & Denton, 2005).

Since Kohlberg, moral development has been studied across the life span and several other perspectives have been proposed; some of these highlighting the role of 'instinct' in our sense of morality (Haidt, 2001), some emphasising social factors including opportunities for social perspective-taking (Comunian & Gielen, 2006), and others focusing largely on the role of emotion (Eisenberg, 2000). Hoffman (2000) argued for the centrality of empathy to moral reasoning. Whilst Gibbs (2010) agreed that empathy is key, he argued that Hoffman's perspective was one of 'affective primacy' and what was instead needed was a theory of 'co-primacy' which highlights the importance of both empathy and the cognitive integration of moral principles. Thus, this position emphasises the role of both cognitive and affectual processes underpinning morality. Despite the differences between perspectives, there appears to be some agreement that moral reasoning develops in individuals to a particular stage and in a relatively

linear fashion dependent on a multitude of variables, including those highlighted above. Palmer (2003) integrated this thinking into a developmental theory, whereby the trajectory of moral reasoning development is shaped not just by parental and peer influence, but also by information processing capacities, and social and environmental factors. Perhaps unsurprisingly then, empirical research in this area has pointed to a correlational link between moral development and factors such as age, education, socioeconomic status, and community participation (Colby, Kohlberg, Gibbs & Lieberman, 1983; Comunian & Gielen, 2006). Of particular interest is the suggestion that these patterns might be in-part explained by the likelihood that such variables would expose individuals to more diverse social opportunities and subsequently influence the development of increasing psychological understandings of others and their perspectives – or a multitude of ‘theories’ of mind (Gibbs et al., 2007) – thus providing further support for the role of empathy and ToM in the maturation of moral reasoning abilities. As previously noted in the context of compassion, it would therefore appear that for individuals whose affective and/or cognitive development is delayed or disrupted, we may expect to observe less mature moral reasoning. This is supported by the fact that comparatively less mature moral reasoning has been observed in populations with ID; although interestingly, within an ID population, individuals who engage in offending have been found to have marginally more mature moral reasoning than those with ID who do not offend (Langdon, Clare & Murphy, 2011). Furthermore, such developmental delays may in some cases be contributed to by limited social opportunity and/or the quality of parental and peer relationships (Comunian & Gielen, 2006; Palmer, 2003) – returning us to the salience of attachment theory (Bowlby, 1969). Research revealing moral reasoning at the lower stages in populations of youth who offend (Stams, Brugman, Deković, & van Rosmalen, 2006) may go some way to supporting this notion, particularly because of the elevated risk of interpersonal trauma and lack of social opportunity often observed in this group (Ward, McCormack & Hudson, 2002). Indeed, Gibbs (2010) argued that a developmental delay

in moral judgement, coupled with social skills deficits and distorted cognitions/cognitive schemas serving to justify or minimise criminal behaviour are common in groups of offenders.

Given its association with other ‘moral’ constructs such as kindness, altruism, guilt and shame, compassion is likely to be closely linked, if not intrinsic to moral reasoning. It seems plausible, for example, to conclude that experiencing compassion for somebody who transgresses may impact one’s reasoning about their guilt and the subsequent action that should be taken. As such, compassion may be a salient component of the stages of moral reasoning which demand empathy, ToM, and a motivation to consider the explicit needs of individuals, but may be less important at less mature stages which centre on the avoidance of punishment and rigid adherence to a global authority. The definitions of compassion discussed earlier in the chapter allude to the importance of both cognitive and affectual processes involved in the experiencing of compassion; much like Gibbs’ (2010) emphasis on the co-primacy of empathy and moral principles in driving moral reasoning. It therefore might be predicted that, like moral reasoning, compassion will be affected by factors like age, intellect, education, social-interaction and exposure to varied social opportunities. Clearly there is much to be learned from the existing literature on moral reasoning and its likely cross-over with compassion; and such research may provide a useful framework from which to consider the results of the current study.

1.3.3.5 *The importance of context.* The preceding sections have outlined an evolutionary argument, drawing largely on Gilbert’s work (2000a, 2000b, 2005, 2010a), for compassion as a functional emotion associated with caregiving and care-seeking social mentalities. Despite a growing interest in this domain, there remains some discrepancy within the literature as to how compassion is experienced from moment to moment, and it has remained largely absent from any taxonomy of emotion (Goetz, Keltner, & Simon-Thomas, 2010). Whilst some assert that compassion develops as a trait-like feature, whereby some individuals will generally be more compassionate across contexts and timeframes than others (e.g., Neff, 2003a;

Neff & Dahm, 2015), in other areas of the literature it is viewed as more of a brief emotional state (Goetz, Keltner, & Simon-Thomas, 2010). It might be argued that evolutionary theories assume a little of both perspectives. On the one hand, compassion is understood as a trait-like feature cultivated through early attachment relationships and, for example, the development of the soothe-system (Gilbert, 2010a); on the other, it can be triggered temporarily in social contexts as a result of the activation of a specific social mentality (Gilbert, 2000a) serving to motivate the enactment of a related social role (such as caregiving). Clearly, there is much to learn about the nature of compassion and how it is enacted across various situations.

Goetz, Keltner, and Simon-Thomas (2010) did go some way to delineating contextual precipitants to compassion. Following their review of the existing evolutionary compassion literature, they highlighted both the importance of specific antecedents and an appraisal process involved in experiences of compassion. With regard to antecedents, they found that, in-line with the definitions offered earlier, compassion arises in response to suffering or harm. Specific antecedents in the literature related to pain, illness, sadness, disability, homelessness/poverty, victims of catastrophe, and children or babies in need. They also proposed an appraisal model, whereby compassion was preceded by a distinct chain of appraisals. They posited that individuals assessed costs and gains to the self in four key areas:

1. Self-relevance: how important the other (object of compassion) was perceived to be in relation to self-wellbeing. For example, how close the relationship was (parent, friend, etc.).
2. Goal-congruence: the extent to which another's suffering violates the wider goals upheld by the self (e.g., that humans should have equal rights).
3. Blame: the extent to which the other can be blamed for their suffering. This therefore involved an appraisal of the deservingness of compassion.

4. Coping ability: a judgement on the individual's self-ability to cope with the suffering of the other and/or resources to offer help.

The proposal of an appraisal model involved in compassion is interesting in its implication that there is a degree of agency involved in the decision to enact compassion. Human agency has been understood to involve intentionality, forethought, self-reactiveness, and self-reflectiveness, and also involves a moral element observed in an individual's developed capacity to refrain from actions that violate, but engage in actions that promote, internalised moral standards (Bandura, 2006). Bandura's (1991, 2006) work on human and moral agency may prove an important concept in the current research area, as it may provide some insight into why people who enact compassion in some areas of their lives, can – through a process of moral disengagement – carry out harmful behaviours in another.

1.3.4 Assessing compassion. Being able to appropriately assess compassion is key to understanding how compassion is experienced and influenced among varying populations. The ability to effectively assess (self-)compassion is important for both research and clinical practice, as it facilitates an evaluation of the effectiveness of compassion-focused interventions (i.e., whether they do improve levels of (self-)compassion) and allows for the exploration of specific compassion experiences for the individual, from which to direct clinical intervention. To-date, the compassion literature-base has adopted a predominantly quantitative approach to the exploration of compassion, with a focus on the development of scales to measure an individual's 'level' of compassion to self and/or others. The Self-Compassion Scale (SCS; Neff, 2003b), a 26-item self-report measure, was the first designed and currently most frequently used scale for this purpose. Asking respondents to answer questions spanning six factors based on Neff's (2003a) model (self-kindness/self-judgement, common humanity/isolation, and mindfulness/over-identification), the SCS calculates a self-compassion score, where higher scores represent greater self-compassion. Other commonly used scales include the Fears of

Compassion Scale (Gilbert et al., 2011) and the Compassion Scale (Pommier, 2011) that seek to measure aspects of compassion in a similar way.

Strauss et al. (2016) systematically reviewed nine measures purported to measure compassion to self and/or others. They looked at the SCS, SCS: short form (Raes, Pommier, Neff, & Van Gucht, 2011), Compassionate Love Scale (Sprecher & Fehr, 2005), Santa Clara Brief Compassion Scale (Hwang, Plante, & Lackey, 2008), Compassion Scale (Martins, Nicholas, Shaheen, Jones, & Norris, 2013), the Compassion Scale (Pommier, 2011), Relational Compassion Scale (Hacker, 2008, cited in Strauss et al., 2016), Compassionate Care Assessment Tool (Burnell & Agan, 2013), and the Schwartz Center Compassionate Care Scale (Lown, Muncer, & Chadwick, 2015). They concluded that due to low quality ratings linked to poor internal consistency and insufficient evidence presented for the factor structure, and in the absence of any examination of floor/ceiling effects, test–retest reliability, or discriminant validity for most measures, there currently exists no self- or observer-rated scale of compassion that is psychometrically robust. Strauss et al. (2016) highlighted that the development of a measure of compassion in the absence of a clear definition of compassion is problematic.

1.3.4.1 Critique of the quantitative approach to assessing (self-)compassion. Whilst the development of quantitative scales has facilitated the progression of (self-)compassion research, there are a number of potential limitations to this approach that should be borne in mind. In addition to the poor psychometric properties of current scales highlighted above, most available scales appear to imply the existence of compassion, including self-compassion, as an objective construct, distinct from other constructs with which it consistently proves to be highly correlated (e.g., kindness, altruism, empathy; Goetz, Keltner, & Simon-Thomas, 2010). Despite some acknowledgement across the literature that environment, state of mind, and interpersonal relating all play a role in compassion experiences (e.g., Gilbert, 2000a, 2010a), implicit in these measures is the assumption that an assessment of an individual’s ‘level’ of compassion can be accurately

obtained through self-report questionnaires that fail to take into account current contextual factors. Furthermore, most research in this area to-date has been correlational, and in so is limited in its ability to explain the potentially complex relationship or interplay between various affiliative and/or negative emotions. An argument could therefore be made for the enrichment of the current literature base through further qualitative research. Indeed, a study by Reddy and others (2013), which assessed a cognitive-based compassion training intervention with adolescents in care, suggested that qualitative methods of data collection were able to detect possible clinical change that the SCS did not. This may also speak to the complex nature of the affiliative emotions, including compassion, pointing to the need for more qualitative research to explore compassion as a construct. This could be particularly pertinent research among disadvantaged populations, for whom there is little work published in relation to their understanding and experience of compassion to self or others. A study by Pauley and McPherson (2010) used Interpretative Phenomenological Analysis to explore the experience of self-compassion among a clinical sample of adults with depression and anxiety. Whilst their results offered important insight into the experience of self-compassion for this group and in many ways appeared to corroborate the existing quantitative literature, much further work is required and particularly among other populations of clinical interest.

1.3.5 Compassion-focused interventions. Gilbert's theoretical framework formed the basis for a compassion-focused approach to mental health intervention; namely that of compassion-focused therapy (CFT; Gilbert, 2009a, 2009b, 2010b). Whilst it is beyond the scope of this chapter to offer a comprehensive overview of all current compassion-focused interventions and their efficacy, it is important to draw attention here to some of the key findings from evaluations of CFT for clinical populations that may bear similar features and experiences to the current population of interest. This helps to build the rationale for the present research focus, demonstrating that, as will be argued later, (self-)compassion is likely to be an important

treatment target for young people who engage in harmful sexual behaviour, and therefore needs to be understood in terms of how this group relate to and experience it as a construct and process.

Central to Gilbert's three-system model is the idea that each system interacts with the other two, and can therefore influence the degree to which the other systems are activated. CFT therefore seeks to develop an individual's capacity to foster a self-compassionate stance, activating and developing the soothe-system and subsequently helping to alleviate the socially isolating effects of shame and other emotions associated with the threat-system (e.g., anger and anxiety). Indeed, research has indicated that both improved levels of compassion and a reduction in shame can be achieved through CFT (Gilbert, 2010b; Gilbert & Procter, 2006). Further support for the efficacy of CFT has accumulated in the recent literature, with the model demonstrating positive treatment outcomes for a variety of populations, including adults with a psychosis (Braehler, Gumley, Harper, Wallace, Norrie & Gilbert, 2012) or other severe and enduring mental health problem (Gilbert & Procter, 2006). CFT also helps clients to identify and address any fears of compassion that may act as a barrier to the development of the soothe-system. In the context of the current research, it is worth noting that compassion-focused interventions have been found to be helpful for both adult forensic populations (e.g., Laithwaite et al., 2009) and adolescents exposed to adversity in early life (Reddy et al., 2013).

1.3.6 Self-compassion and shame. Gilbert's (2010a) three-system model (discussed above) provides a theoretical explanation for a link between self-compassion and shame, whereby self-compassion (associated with the soothe-system) can moderate adverse effects associated with heightened shame (a feature of the threat-system). Given that the current study intends to explore compassion to self and others, which based on evolutionary theory is likely to be closely linked to experiences of shame, it is important to examine what we know about shame as a construct, and to further explore its proposed link with self-compassion through the consideration of current relevant research. First though, it is necessary to define shame.

1.3.6.1 Defining shame. Shame is as a self-conscious, other-focused, emotion, driven by an evaluation that certain personal attributes or behaviours will be seen as undesirable or unattractive by others, thus resulting in rejection and a subsequent perceived threat to the self (Tangney, Stuewig, & Hafez, 2011). As humans are driven to maintain social connectedness (Gilbert, 2000b; Lee, Draper, & Lee, 2001), it could be conceived that experiences of shame serve to motivate an individual to engage in reparative action as an attempt to rectify the threat of rejection and instead promote social acceptance (Braithwaite, 1989). Some research, however, indicates that experiences of shame have the opposite effect, in that they increase the chances of further undesirable behaviour (Cohen, Wolf, Panter, & Insko, 2011), thus making it more likely that social rejection will be the outcome. Clearly there is conflicting explanatory theory underpinning the current understanding of shame. This dichotomy has been understood by some as a conflation of two differing emotions: namely shame and guilt.

1.3.6.1.1 Shame versus guilt. The psychology literature makes an important distinction between shame and guilt, in that whilst guilt involves “a focus on a specific behaviour – a sense that ‘I did a bad thing’, ... shame [involves a more] ... painful focus on the self – a sense that ‘I am a bad person’” (Tangney, Stuewig & Martinez, 2014, p.800). Whilst guilt therefore may incite a motivation to take reparative action to correct a wrongdoing, shame is seen as the more devastating emotion, in that it involves a condemning of one’s own core identity or self-concept (Van Vugt et al., 2011). Juxtaposing shame and guilt, Gilligan (2003) argued that in order to experience guilt, one must experience love – both for others and the self. Shame on the other hand, is underpinned by humiliation and a deep sense of personal worthlessness (Gilbert & Miles, 2002) – a self-hatred so intolerable that it is often projected outwards through anger and violence. Interestingly, Gilligan posited that shame is closely connected to innocence and guilt to pride (2003). He reasoned that whilst feelings of guilt can connect the individual with humility, love, and regret, and thus motivate them to diminish their pride, shame instead leads

people to diminish this painful feeling through arrogance and boastfulness, and in doing so diminishing their innocence, such as through the commission of violence. Gilligan (2003) also acknowledged the significance of gender here, in that men who have been socialised into the male gender role may feel that violence is necessary in a number of contexts to protect ideations of ‘masculinity’, whereas social norms often prohibit the use of female violence, resulting in feelings of shame for women who aggress.

This distinction between shame and guilt can also be roughly mapped onto Braithwaite’s (1989) ‘Reintegrative Shaming Theory’ from the criminology field, which framed societal responses to criminality as having the effect of either ‘disintegrative shaming’ – involving practices or policies that focus on punishing the individual, leading to social isolation and humiliation (linked to the psychological definition of shame), or ‘reintegrative shaming’ – where the behaviour is condemned but the person respected and accepted back into society with a chance to make reparations (linked to the psychological definition of guilt) (Tangney, Stuewig, & Hafez, 2011), such as through restorative justice (McLaughlin, Hughes, & Westmarland, 2003). Shame has then been further conceptualised as comprising of two facets (Gilbert, 1998): *external shame* – characterised by the belief that others will view oneself as defective in some way and *internal shame* – when the emotion is internalised through the negative appraisals of one’s own behaviour or attributes, or views the self as globally bad (Goss & Allan, 2009). Harris and Maruna (2006) also identify a third classification of shame, which suggests that it can arise from the belief that an abstract ethical other would think badly of us following a serious transgression. This recognises the influence of wider social ethical contexts and can be said to also fit with Gilbert’s definition of external shame. Gilbert (2010c) framed shame-based critical dialogue as a response to perceived threats to the self, arising from either internal or external stimuli. External threats represent a threat from outside the self, such as the actions of others, whereas internal threats are generated internally through our judgements or beliefs about our

thoughts, imagination, and emotions; for example, we can feel ashamed of a thought or fantasy. Gilbert (2000a) argued that humans are particularly susceptible to internal threats as a result of our capacity for self-awareness, which in turn gives rise to the concept of self-identity and facilitates self-evaluation.

1.3.6.2 Adverse effects of shame. Shame has been associated with a number of other difficult experiences such as self-criticism, social isolation, and anger (e.g., Gilbert, 2010a; Gilbert & Irons, 2009; Gilligan, 2003; Kolts, 2011). A variety of mental health difficulties have also been linked to heightened levels of shame, including depression and anxiety (Gilbert, 2000b). It has been suggested that shame may play a role in precipitating and maintaining various dangerous behaviours, such as bingeing and purging in eating disorders (Goss & Allen, 2009), self-harming behaviours (Gilbert et al., 2010), and violent (Gilligan, 2003) and sexual offending (McAlinden, 2005). Furthermore, shame has been found to act as a barrier to treatment in some cases by inhibiting disclosure of behaviours (e.g., Swan & Andrews, 2003). This is important because barriers to disclosure may prevent individuals from fully engaging with interventions, thereby potentially reducing their effectiveness. It could therefore be argued that shame may be an appropriate treatment target both prior to and during the delivery of interventions for a variety of populations.

In their evolutionary and biopsychosocial model of shame, Gilbert and Irons (2009) explicated how experiences of a hostile or critical parenting style and/or bullying by peers created an unsafe and socially rejecting environment. They posited that this can then lead to the internalisation of shame, whereby the self is 'put-down' through processes of self-criticism and self-denigration, particularly when the externalisation of the anger evoked through the rejection by key attachment figures was not permitted or possible. This theory supports findings from other studies which have observed a link between restrictive and rejecting parenting styles and increased self-criticism in later childhood and adolescence (Koestner, Zuroff, & Powers, 1991).

An interesting gender difference has also been noted, whereby for girls, the link between maternal style and attitudes towards the self seems more robust and patterns of self-criticism are more stable across adolescence and early adulthood (Koestner, Zuroff, & Powers, 1991; Shahar, Blatt, Zuroff, Kupermine, & Leadbeater, 2004).

1.3.6.3 *Self-compassion as a moderator of shame.* Gilligan (2003) suggested that shame equates to a deficiency of self-love. The evolutionary theory of compassion (Gilbert, 2010a) provides further rationale for the relationship between these constructs in its conceptualisation of self-compassion as a moderator of shame via the ability of a developed soothe-system to bring into balance an over-active threat-system. In further support of this relationship, there is a growing body of evidence to suggest that compassion-focused interventions can lead to reductions in shame. Research into compassion-focused interventions has observed a number of positive treatment outcomes, including reductions in shame or perceived social marginalisation (Braehler et al., 2012; Gilbert & Procter, 2006). Numerous other studies have also repeatedly found an inverse correlational relationship between shame and self-compassion (e.g., Gale, Gilbert, Read, & Goss, 2014; Lucre & Corten, 2012). There has also been some evidence for a further mediating effect of ‘fear of compassion’ on the existing relationship between shame and self-compassion (Kelly, Carter, Zuroff and Borairi, 2013).

1.4 Young People Who Engage in Harmful Sexual Behaviour

Since the 1990s there has been increasing recognition that sexual abuse can be, and often is, perpetrated by children and young people (Home Office, 2002). Widespread media coverage of cases such as the murder and suspected sexual abuse of two-year-old James Bulger in 1993 by two ten-year-old boys shocked the nation and precipitated discussions around the criminal culpability of children, resulting in the lowering of the age of criminal responsibility in England, Wales, and Northern Ireland from 12 to 10. For reasons outlined below, sexual abuse – when perpetrated by children and young people – is now commonly referred to as harmful sexual

behaviour (HSB). Whilst professional interest in the domain continues to grow, HSB remains a vastly under-researched area. The following sections will summarise the current thinking around HSB and those affected by it.

1.4.1 Defining harmful sexual behaviour. Numerous organisations, including the National Society for the Prevention of Cruelty to Children (NSPCC), Department of Health, and Department of Education, have adopted their own, varying, definitions of HSB. In the absence of a globally accepted definition of the term, a recent enquiry into HSB by the charitable organisation Barnardo's (2016) used the following: "Harmful sexual behaviour is when children and young people (under 18) engage in sexual discussions or activities that are inappropriate for their age or stage of development, often with other individuals who they have power over by virtue of age, emotional maturity, gender, physical strength, or intellect and where the victim in this relationship has suffered a betrayal of trust. These activities can range from using sexually explicit words or phrases to full penetrative sex with other children or adults" (p.10). This definition extends other frequently used definitions (e.g., Rich, 2011) to include the role of power differentials in HSB (Calder, 1999).

The conceptualisation of HSB came in response to criticisms of previous labels such as 'adolescent sexual offenders' and 'sexually abusive behaviours by young people' for stigmatising the young person who subsequently became viewed as an 'abuser' or 'sexual offender' (Bernardo's, 2016). Furthermore, these earlier terms were deemed too narrow and prescriptive; for example, 'adolescent' precludes the consideration of behaviour by children younger than adolescence, and use of the word 'offender' implies commission of a criminal act and subsequent conviction, whereas in reality a large proportion of HSB is dealt with outside of the Criminal Justice System through welfare agencies such as social care (Bernardo's, 2016). 'Abuse' and its connotation with 'abuser' suggests an awareness for the individual that their actions are wrong, which is not always true in cases of HSB. 'HSB' therefore emphasises the

behaviour over the individual, both reducing stigma and allowing for the consideration of potential developmental issues, as well as the propensity for the young person to change (Hackett, 2014). Additionally, HSB provides a much broader definition that can encompass the wide spectrum of inappropriate sexual behaviours likely to result in harm and those who engage in them. It has also been proposed that the term ‘HSB’ allows for the acknowledgment of harm caused to the individual who engages in such behaviour, as well as any additional victims, by including both sexually abusive behaviour involving coercive victimisation (Burton, Miller, & Shill, 1998) *and* sexually concerning or problematic behaviour where there is no victimisation of another (Bernardo’s, 2016; Hackett, 2004).

1.4.2 Prevalence. The exact prevalence of HSB is difficult to assess for a variety of reasons. Perhaps most significantly, the number of HSB cases brought to the attention of services, and therefore included in official statistics, may not reflect the true number of incidents of HSB within society. As evidenced by an increase in referrals for HSB, particularly among younger children, between 1992 and 2000 (Hackett et al., 2013), the increasing recognition and understanding of HSB among professionals over time has facilitated the detection of a larger number of cases for support and intervention. Whilst the identification of cases therefore appears to have improved, there are still likely to be cases who remain undetected and therefore current figures could potentially be under-representative. Hackett et al.’s (2013) finding that in many cases of HSB the behaviour had been occurring for several years prior to the referral to services is again likely to suggest an underestimation of prevalence when figures are determined by service involvement. Societal stigma, fear, and taboo surrounding sexual offences and HSB (Bernardo’s, 2016) may also deter families and individuals from reporting and/or seeking help, which again could lead to statistics being misrepresentative.

Research suggests that between a quarter and a third of all reported sexual offences in the UK are carried out by young people under the age of 18 (Hackett, 2014). Erooga and Masson

(2006) reported that children and young people were responsible for between 30 and 50 per cent of all sexual abuse coming to the attention of professional systems within the UK. When the potential underestimation of national statistics highlighted above is taken into consideration, it is clear that the prevalence of HSB is widespread and worthy of professional attention. The National Children's Home Report (NCH, 1992) was one of the first publications to raise HSB as a national concern in the UK, sparking research attention to the field. Since then, attempts have been made to identify risk factors associated with HSB, as well as inform treatment and intervention for individuals and families affected by HSB. This remains, however, a relatively under-researched area warranting further investigation.

1.4.3 Risk factors associated with HSB. Studies that have been conducted to establish the likely characteristics of and risk factors associated with those who engage in HSB have revealed remarkably similar findings across various samples in the UK and North America and are summarised here.

1.4.3.1 Age. The largest study of HSB undertaken in the UK to-date (Hackett et al., 2013) analysed data for 700 young people referred to nine services across England and Wales over a nine-year period (1992-2000) to investigate individual, familial and victim characteristics, developmental histories, and the nature of the HSB. They found that referrals for HSB spanned a wide age range from children as young as five, up to the cut-off age for services of 18. They also reported that one per cent of their sample included referrals for young people between 18 and 28, often with an intellectual disability, for whom professionals felt support and intervention from HSB services skilled in work with young people would be more appropriate than services for adult sexual offenders. Hackett et al. (2013) reported that half of their sample were aged 14 to 16 and a third under 13.

A large study of 1,616 adolescent sexual offenders across 30 North American States (Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996) reported that the most frequent referral age

for HSB was 14. Hackett et al. (2013) do however note that the age at referral was not necessarily synonymous with the age of onset of HSB, which was likely to have been earlier. These data seem to suggest that children can engage in HSB from a very young age, but that this is more likely to result in a referral to services during adolescence. Possible explanations for this include referrals occurring at an age when the young person becomes more autonomous and adults therefore feel less able to manage any concerning behaviour, or when the sense of risk elevates due to increased power differentials (e.g., the young person becoming bigger and stronger, their intellect or emotional intelligence developing beyond some others) or opportunity for HSB behaviour to occur (e.g., due to increased independence). Indeed, a multi-site study in North America indicated that the average age of onset for a range of problematic sexual behaviours was between 10 and 12 (Zolondek, Abel, Northey, & Jordan, 2001).

Potentially, concerning sexual behaviour may also be more readily recognised in adolescence than in younger children due to preconceptions around the onset age of sexual interest, as well as a societal reluctance to acknowledge the prevalence of sexual abuse against young children (Bernardo's, 2016). The fact that the frequency of referrals for younger children has increased alongside society's understanding of HSB (Hackett et al., 2013) may support this proposition.

1.4.3.2 Sex. All available research considering the sex of those who engage in HSB reports that the overwhelming majority of cases that come to the attention of services are male. UK studies appear to have consistently found there to be over 90 per cent males among their samples (e.g., 92%; Taylor, 2003; 97%; Hackett et al., 2013) with similar proportions being identified in the USA (97.4%; Ryan et al., 1996). It is difficult to gauge the extent to which underreporting may impact these percentages, or whether a bias for reporting HSB in relation to males may exist. Such a bias may be perpetuated by gender stereotyping around sexual behaviour, including sexual aggression, or even the fact that there are far more services available

to males who engage in HSB than females, meaning that referrals for males may be easier to make and/or include in national figures. Nevertheless, these figures do seem to strongly support the view that HSB is more likely to be perpetrated by males.

1.4.3.3 Ethnicity. Hackett et al. (2013) reported that the vast majority of their UK sample were white (93%) with far fewer numbers of young people described as black (1%), mixed race (3%), or Asian (3%). They did note that for around a third of their sample information on ethnicity was not available, which they attributed to the fact that during the earlier years of their study (from 1992) it was not common place for ethnicity to be recorded by services in Britain. These percentages are fairly reflective of the estimated proportions of ethnic populations across the UK at the time (Schuman, 1999); however, as a number of services were located in metropolitan areas with higher concentrations of people from black or minority ethnic groups, it is possible that young people from these groups are underrepresented in services working with HSB. Whether this is because young people from these groups do not engage in HSB, or whether there are barriers to these young people being identified and/or engaging with services is unclear. This could also reflect cultural differences in the conceptualisation of HSB and which behaviours are subsequently viewed as a cause for concern.

1.4.3.4 Intellectual disability. Also commonly referred to as a learning disability or cognitive impairment, the reported prevalence of intellectual disabilities (ID) among young people involved with services because of HSB is quite striking. Around two per cent of the general UK population are reported as having an ID (Holland, 2011). The proportion of young people with an ID reported to be engaging in HSB in the UK, however, is much higher, with previous research suggesting figures as high as 25 per cent (Masson & Hackett, 2003) and 38 per cent (Hackett et al., 2013), and in a specialist adolescent forensic service, 45 per cent (Dolan, Holloway, Bailey, & Kroll, 1996) of service users. It is however important to bear in mind that individuals with an ID are likely to be overrepresented in samples of young people engaging in

HSB due to their increased visibility within professional systems (O’Callaghan, 1998), and it should not therefore be assumed that young people with an ID pose a much greater risk of HSB than those without (Thompson & Brown, 1997).

1.4.3.5 Living circumstances. Hackett et al. (2013) reported that of their UK sample, 42 per cent were living at home with their families at the time of their referral to services for HSB, 12 per cent were living with other relatives, 18 per cent were in ‘voluntary care’ (i.e., under s.20 of the Children Act, 1989), and 14 per cent were looked after under a Care Order. They reported that just six per cent had been transferred to secure accommodation. Given that we think a significant proportion of HSBs are perpetrated against a family member (see below 1.4.3.9), it is important to consider the impact this may have on key attachment relationships (including how family members respond to the young person) and how this may influence whether or not the young person remains at home or with the family. Likely disruptions to attachment relationships, impacted, for example, by anger and shame (Gilbert, 2010a), may therefore be a central focus for interventions in this area (see also 1.4.4).

1.4.3.6 Trauma history. It has been suggested that around half of young people referred to services because of HSB have a trauma history of non-sexual abuse, including physical violence, domestic abuse, emotional abuse, severe neglect, parental rejection, family breakdown and conflict, and parental drug and alcohol use (Hackett et al., 2013). Rates of prior sexual abuse vary substantially across the literature, with some reporting around a quarter of their sample as having been victimised sexually (Dolan et al., 1996) and others reporting rates as high as 75 per cent (Worling, 1995). Gender differences have also been observed, with reports that a higher percentage of females who engage in HSB having been the victims of sexual abuse than males (Hackett et al., 2013). Whilst these findings may suggest that females are more likely to have been the victims of sexual abuse, recent events, such as the ‘English football sexual abuse scandal’ (2016) where hundreds of adult males have come forward to disclose historic childhood

sexual abuse by their football coaches, may indicate that sexual abuse against young males is much more prevalent than currently believed, but that there have clearly previously been barriers – perhaps linked to societal stigma – to victims disclosing.

1.4.3.6.1 Exposure to pornography. There are a number of sources that highlight exposure to pornography, and in particular violent pornography, as a risk factor for HSB (e.g., Flood, 2009). Whilst it has been argued that explicit content falls along a continuum of extremity and that the degree to which this material can impact behaviour depends very much on the level of exposure coupled with where the content falls on the continuum (Hackett, quoted in Bernardo's, 2016), there is also some concern that advances in technology have led to an increase in the amount of pornography and explicit material that can potentially easily be accessed by young people (Vizard, quoted in Bernardo's, 2016). Exposure to pornography is not, however, a sole contributor to engagement in HSB, and individual resilience to exposure, thought to be influenced by factors such as 'good parenting', may play a role in mediating the link between the two (Bernardo's, 2016).

1.4.3.7 Convictions. Findings from UK research suggest that many young people referred to services for HSB do not have a history of convictions (58%; Hackett et al., 2013). Similarly, many cases of HSB themselves do not result in a criminal conviction (Masson & Hackett, 2003). This may, in part, be due to the fact that the age of criminal responsibility across most of the UK is 10, with the exception of Scotland where it is 8, although a child can only be prosecuted from age 12 (NSPCC, n.d.). This means that children under 10 cannot be tried and convicted of any criminal act and would therefore not have a conviction history. In many cases where the young person is of an age of criminal responsibility, there is a lack of evidence or motivation from those involved to pursue a conviction, and it is increasingly common for HSB within the UK to be dealt with via a child protection route (i.e., through Social Care) instead of through the Criminal Justice System (Bernardo's, 2016). As highlighted earlier, the term HSB is

relatively broad and can also therefore include problematic sexualised behaviour where there is no victimisation of another, and therefore is unlikely to constitute a criminal offence. For those young people who do have existing convictions, these have been found to range from a number of sexual offences (contact and non-contact) including indecent assault and rape, to non-sexual offences including burglary, arson, and drug/alcohol use (Hackett et al., 2013).

1.4.3.8 Nature of the HSB. There is a broad consensus across the literature that HSB covers a wide range of behaviour from non-contact sexualised behaviour through to attempted or actual penetration. The categories of HSB do not appear to be mutually exclusive and it is reported that many young people display multiple types of behaviour (Hackett et al., 2013). Hackett and others (2013) warned that whilst it is often assumed that HSB among young people is experimental in nature, their findings revealed that just over half of their sample had penetrated or attempted to penetrate another individual. They also reported that almost a fifth had used, often expressive, violence. This is important as there is some, albeit limited, research to suggest that adolescents who commit sexual offences involving physical violence are at a greater risk of recidivism (Butz & Spaccarelli, 1999; Prentky, Harris, Frizzell, & Righthand, 2000; Sipe, Jensen, & Everett, 1998).

1.4.3.9 Victim characteristics. Hackett et al. (2013) found that in most cases young people had victimised children under 11 years of age. Just under half of their sample had victimised young people aged 11-17, and around 17 per cent had victimised adults (over 18). Varying frequencies for victim gender have been reported in the literature, but Hackett et al.'s (2013) research suggested that most frequently (in 51% of cases) young people victimised females only, with 19 per cent of cases victimising males only, and 30 per cent offending against both males and females. This finding was surprising given that previous studies had revealed much lower rates of multi-gender victimisation (e.g., Dolan et al., 1996), but is significant as this has been proposed as a risk factor for recidivism for both adolescent and adult sexual offenders

(Worling, 2002). In a UK sample, Yates, Allardyce and McQueen (2011) reported that in 33% – 50% of cases, HSB occurred within the family home and victim and perpetrator were related.

1.4.4 Interventions for young people who engage in HSB. In recognition of the fact that the approach to HSB in the UK was previously incoherent and ill-managed, with over a quarter of young people charged with HSB not being subjected to any form of assessment, the Assessment, Intervention, Moving on project (AIM Project, n.d.) was established in 1999 to provide a coherent and consistent strategy and protocol for the strategic assessment and intervention with this group (Henniker, Print, & Morrison, 2002). A core principle of AIM is that interventions for this diverse population of young people need to range in intensity across various levels of concern. The National Institute for Health and Care Excellence has developed guidelines for services and professionals working with young people who engage in HSB (NICE, 2016). These state that interventions should be multi-modal and flexible, and include, where appropriate, both individual and systemic therapeutic work. Individual work might include cognitive-behavioural (CBT) approaches that may, for example, help young people identify and address cognitive distortions that serve to justify their harmful behaviour (e.g., Apsche, Evile, & Murphy).

Systemic work including the wider family network is also advocated, and in many cases involves a multisystemic therapeutic (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) approach. MST is an intensive family- and community-based intervention that views the young person as embedded within several interconnected systems, such as their family, peer group, school, and community. Intervention is aimed at the various system levels and adopts a strengths-based approach, focusing on what strengths and resources are available and how these can be developed. Another important strengths-based approach, initially developed for adult forensic populations (Ward, 2002) but also employed more recently for adolescents who engage in HSB (e.g., Wylie & Griffin, 2013), is the Good Lives Model (GLM).

The GLM recognises that all humans possess a set of fundamental needs, known as ‘primary goods’, that they will try to meet or access using the resources available to them. Ten primary goods are identified: relatedness (desire to belong and have relationships); community (being part of a cultural or social group); life (healthy physical functioning); agency (desire for control and autonomy); knowledge (desire for wisdom and information); excellence in work and play (striving for mastery and desire for fun); inner peace (emotional self-regulation and safety); spirituality (seeking a sense of purpose and meaning in life); happiness (overall satisfaction including sexual pleasure); and creativity (novel and creative experiences) (Ward & Gannon, 2006). In this context, HSB can be understood as an inappropriate means to meeting core personal and social needs (Wylie & Griffin, 2013). The focus of interventions following the GLM, like MST, is therefore on maximising the young person’s ability to obtain their primary goods through appropriate and prosocial means. Further argument for strengths-based approaches such as these is gleaned from research such as Borowsky, Hogan, and Ireland’s (1997) study, which indicated that the most significant protective factors against HSB were academic achievement in adolescent females and emotional health and community connectedness in adolescent males.

Although not explicitly identified in the literature, it is possible to draw conceptual links between these strengths-based approaches to intervention and the evolutionary theory of compassion outlined earlier in this chapter. The identification of an ‘inner peace’ primary good, associated with emotional self-regulation and safety (Ward & Gannon, 2006), may be related to the systems of emotional regulation and connected social mentalities posited by Gilbert (2000a), developed through the experience of attachment to a caregiver, which can act as a safe-base from which to encounter the world. Such assertions would predict that in the absence of a secure attachment relationship, experiences of safety and emotional self-regulation may be compromised, thus leading to a deficit in the domain of inner peace and therefore potentially

compassion. This idea would also present an argument for concentrating interventions on the wider systems surrounding the individual, such as in MST, in order that secure and appropriate attachment relationships with family and peers can be promoted. The focus of these interventions on enhancing strengths and promoting social engagement also serves to avoid stigmatising individuals, and therefore potentially reducing shame and increasing motivation to engage (Wylie & Griffin, 2013). Following the increasing evidence that compassion-focused interventions can also reduce shame through enhanced self-compassion, it is worth noting a potential rationale for the integration of compassion-focused approaches for young people who engage in HSB, particularly in relation to the promotion of social connectedness and reduction of shame to maximise the chance of the individual achieving meaningful social (re)integration.

1.5 Shame and Self-Compassion in Young People Who Engage in HSB

A current dearth of research exists in the area of HSB alone, even more so in relation to the role of the self-conscious and affiliative emotions in HSB. It shall, however, be argued in the following sections that what can be gleaned from the wider literature on shame, compassion, and offending behaviour, points to the likely importance of compassion to self and others for this group of young people.

1.5.1 The role of shame in HSB. As outlined in section 1.3.6.1.1, shame is conceived by many as a painful emotion, underpinned by beliefs about the worthlessness of the self (Gilligan, 2003). Shame can be triggered by the perception that others will view the self as defective in some way (Gilbert & Miles, 2002) and can therefore be linked to the concept of stigmatisation. Goffman (1968) conceptualised stigma as arising from the judgement that another person is distinguishable from the self as a result of significant negative attributes, such as that they are bad, dangerous, or weak. Stigmatisation is therefore underpinned by strong social prescriptions about what it is to be 'normal', and recruited by members of society to distinguish between those who conform to social norms and those negative others who do not. In this sense, the experience

of being stigmatised by another can be said to evoke feelings of shame (Lewis, 1998). This link is important because of the highly stigmatised nature of sexual offending (McAlinden, 2005). It therefore follows that young people who have engaged in sexual behaviours that are so vehemently denounced by society, are likely to experience heightened levels of shame as a result, as has been observed for adult sexual offenders (Marshall, Marshall, Serran & O'Brien, 2009). Young people who engage in HSB are arguably even more susceptible shame, when considering that adolescence is “a time of particular psychological vulnerability to the risks associated with feelings of social isolation” (Hall-Lande, Eisenberg, Christenson & Nuemark-Sztainer, 2007, p.265).

This issue is further compounded by the significant prevalence of previous interpersonal trauma and negative early interpersonal experiences among this population (e.g., Ward, McCormack & Hudson, 2002). Early interpersonal trauma is often associated with high levels of internalised shame (Gilbert & Irons, 2009), which may amplify the effects of stigma and subsequent shame experienced as a result of engagement in HSB. In relation to Gilbert's three-systems model (2010a), this would likely lead to an over-developed threat-system and difficulties activating processes associated with the soothe-system, such as adopting a compassionate stance. Furthermore, the punitive measures endorsed by criminal justice agencies to address serious transgressions, such as sexual offending, have been criticised for stigmatising and shaming individuals to such a degree that it may increase the likelihood of further offending (McAlinden, 2005).

1.5.1.1 Shame and recidivism. Importantly, there is evidence within the literature on offending behaviour to suggest that shame may predict recidivism. In relation to ‘white-collar’ tax offence crimes, Murphy and Harris (2007) found that feelings of stigmatisation experienced during an enforcement event were positively correlated with re-offending rates. In a ten-year follow-up study of 130 incarcerated male property offenders, LeBel, Burnett, Maruna, and

Bushway (2008) found that feelings of being stigmatised (or ‘doomed’) predicted the likelihood of both reconviction and re-imprisonment, even after controlling for the number of social problems an individual experienced after release. Tangney, Stuewig, Mashek, and Hastings (2011) assessed 550 jail inmates’ shame-proneness and guilt-proneness. Whereas guilt appeared to be a protective factor in relation to severity of crime, involvement with the Criminal Justice System, and known predictors of recidivism, shame-proneness was positively related to violence and antisocial subscale scores. Shame-proneness was inversely related to measures of self-control and was not found to be a protective factor in any domain.

Van Vugt et al. (2011) carried out a meta-analysis of 19 studies to investigate the link between moral development (including the development of moral emotions such as shame) and recidivism. They found that a more mature moral development was associated with lower rates of recidivism. Whilst this might suggest that shame could reduce the likelihood of re-offending, the relationship between moral cognition (e.g., empathy) and recidivism was clearer than that of moral emotion (e.g., guilt and shame) and recidivism. This might be explained by their conflation of guilt and shame into one category, whereas (as highlighted above) these two emotions may have very different relationships with re-offending. Tangney, Stuewig and Martinez (2014) assessed shame-proneness, guilt-proneness, and externalization of blame in a longitudinal study of prison inmates. They found that guilt-proneness negatively, and directly, predicted recidivism in the first-year post-release; shame-proneness did not.

In a study of 1,243 incarcerated young offenders, Hosser, Windzio and Greve (2008) found that shame and guilt ratings predicted post-release recidivism. Specifically, shame ratings at the outset of incarceration predicted higher recidivism rates, whereas guilt ratings predicted lower re-offending. It is, however, necessary to highlight that, similarly to the existing study of compassion, much of this research has been conducted using quantitative, self-report measures, which assume shame as a valid and distinguishable construct from other self-conscious

emotions. That is not to say that there is no substance to the findings from these studies, but rather that much more research utilising alternative approaches is required.

These findings point to the likely importance of targeting and reducing shame in interventions for groups who offend, but also highlight the possible risk that punitive – and therefore potentially shaming – interventions may be counterintuitive and actually serve to increase recidivism rates. This follows evolutionary theories of shame, which suggest that shame is a threat-based emotion, responded to with self-preservation strategies such as externalisation of blame and outwardly-directed anger, and could therefore conceivably lead to further harmful behaviour (Gilbert & Miles, 2002). The work of Gilligan (2003) provides further argument for the link between shame and recidivism. Based on his thirty-years working with men convicted of murder and other violent crimes, he observed that virtually all acts of serious violence followed feelings of shame and humiliation – a sense that they had been disrespected in some way. Given then the level of stigmatisation and shame following acts of sexual violence, such as HSB, it is hardly surprising that heightened levels of shame have been linked to an increased likelihood of re-offending for those convicted of sexual offences (McAlinden, 2005). Further evidence for this can be gleaned from the recidivism literature (albeit limited), which suggests that adolescents who employ physical violence in their HSB may pose a higher risk of sexual re-offending (Butz and Spaccarelli, 1999; Hackett, 2004; Prentky et al., 2000; Sipe, Jensen, & Everett, 1998).

1.5.2 Compassion to self and others among young people who engage in HSB. To the researcher's knowledge, there is currently no published literature directly exploring the understanding and experience of compassion to self or others in young people who engage in HSB, although a handful of studies point to self-compassion as a relevant treatment target for adolescents (e.g., Neff & McGehee, 2010) and groups of offenders (Laithwaite et al., 2009). What can be ascertained from the literature points to the likelihood that young people who have

engaged in HSB will experience heightened levels of shame as a result of the highly stigmatised nature of their harmful behaviour, along with their experience of being engaged with punitive systems, like the Criminal Justice System (McAlinden, 2005). Furthermore, adolescence is a time when young people are likely to be particularly susceptible to the perceived judgements of others and the adverse effects of social isolation (Gilbert & Irons, 2009; Hall-Lande, Eisenberg, Christenson & Nuemark-Sztainer, 2007). This is further compounded by the significant prevalence of previous negative early interpersonal experiences among this group (e.g., Ward, McCormack & Hudson, 2002), which, as we have seen above, may lead to an over-developed threat-system and under-developed ability to self-soothe (Gilbert, 2010a). Additionally, levels of internalised shame may be heightened within this group, as a result of previous exposure to interpersonal abuse (Gilbert & Irons, 2009), which is beyond their control to change.

Whilst it might be argued that a degree of shame for individuals who engage in harmful behaviour may be functional in motivating desistance and reparative action (Braithwaite, 1989), research in fact suggests that guilt would be a more successful precipitant of this, and that heightened and prolonged shame may even increase the risk of recidivism (see 1.5.1.1). Shame may therefore be an important treatment target for this population, and as we have seen in other areas of the literature, interventions aimed at fostering a self-compassionate stance may be a helpful way of achieving this (Braehler et al., 2012; Gilbert, 2009a, 2009b, 2010b; Gilbert & Procter, 2006). As has been highlighted above, however, there are some significant weaknesses in the current body of literature on (self-)compassion, not least that the meaning and experience of (self-)compassion as a construct has rarely been explored among clinical or disadvantaged populations.

1.6 Aims of the Current Research

Whilst there may well be a rationale for the development of compassion-focused interventions for young people who engage in HSB based on their potential proclivity for shame,

it is difficult to begin to know how and why, if at all, these interventions might be of benefit, without first knowing how compassion is understood and experienced by them, or if it even represents a construct to which they can relate. The current research therefore intended to provide an initial platform from which to direct future research in this area, as well as to contribute to and extend the current literature base on (self-)compassion by adopting a qualitative approach to exploring this concept among a disadvantaged and under-researched population. The initial focus of this research was therefore:

To explore compassion towards self and others among young people who have engaged in harmful sexual behaviour

Adopting a Constructivist Grounded Theory methodology (Charmaz, 2006, 2014), participant data were explored in response to this question through an iterative process of constant comparative analysis – to be described in the next chapter – leading to a substantive theory of compassion to self and others among young people who have engaged in HSB.

1.7 Chapter Summary

This initial chapter provided an overview of current literature in the domain of compassion to self and others. Drawing on existing research, the argument for a theoretical link between (self-)compassion and shame was outlined, whereby the ability to foster self-compassion may have a moderating impact on the adverse effects of shame. The chapter then turned to the topic of harmful sexual behaviour, outlining the likely relevance of exploring compassion within a population of young people who have engaged in HSB, given the heightened risk of stigmatisation and shame likely to be experienced in this group. It was argued that the existing literature-base on compassion is limited in its predominantly quantitative nature and would be greatly enriched by further qualitative exploration of the understanding and

experience of compassion amongst populations of clinical interest, such as young people who engage in HSB. Having built the case for the current research question, the next chapter shall outline factors pertaining to the methodological approach and offer a detailed overview of how the research was conducted.

Chapter Two: Methodology

2.1 Overview of Chapter

This chapter outlines the methodological approach and procedures adopted for this research. Beginning with a discussion of the philosophical position taken-up by the researcher, a rationale is then provided for the use of a Constructivist Grounded Theory methodology. The approach to data collection and method of analysis is outlined, with consideration paid to ethical issues and plans for dissemination of the research.

2.2 Philosophical Assumptions and Positioning of the Research

This research drew on a constructivist paradigm and subsequently employed a Constructivist Grounded Theory methodology in addressing its aim: *to explore the understanding and experiences of compassion to self and others among young people who have engaged in HSB*. In explicating the rationale for this approach to the research, it is first necessary to acknowledge the researcher's position in relation to two core philosophical concepts: ontology and epistemology. An ontological stance reflects a belief about the nature of social reality (Klakegg, 2015) and falls somewhere along a continuum between two juxtaposed positions: realism – the belief in an objective external reality, independent of the human mind (Fletcher, 1996), and (extreme) relativism – the belief that an external world, and therefore 'reality' or truth, exists only to the extent of our thoughts about it, and not therefore beyond one's own subjective experience of it (Blaikie, 2007). Epistemology is essentially the theory of knowledge, or knowing, and is primarily concerned with the "origin, nature, limits, methods, and justification of human knowledge" about the world we live in (Hofer, 2002, p.4). A belief about the nature of reality will necessarily inform a belief about how knowledge of that reality can be acquired. Ontology has therefore been framed as the starting point of all research (Blaikie, 2007), from which an epistemological position will be taken and a subsequent methodology selected, resulting in the overall paradigm (Denzin & Lincoln, 2008).

The current researcher's ontological stance reflects a belief in equally valid multiple realities, or multiple subjective 'truths', and does not assume that reality can ever be fully known. The epistemological position recognises knowledge as value-laden and subjective, and holds that knowledge is best gleaned through detailed exploration of people's lived experience. Furthermore, it is assumed that knowledge is co-constructed through social interaction and dialogue, and therefore the researcher's role in co-constructing knowledge through their conversations with participants must be acknowledged. Such assumptions lend themselves to a constructivist paradigm, which holds that "the mental world – or the experienced reality – is actively constructed or "brought forward," and that the observer plays a major role in any theory" (Riegler, 2012, p.237).

2.2.1 The rationale for a qualitative approach. Research methods can be broadly categorised into one of three approaches: qualitative, quantitative, or mixed-methods – a combination of the former two (Klakegg, 2015). Historically, researchers in the social sciences have tended to employ quantitative methods, reflecting the positivist paradigm that has largely prevailed over alternative philosophical positions in this domain (Tuli, 2010). Positivism asserts that the truth pertaining to an existent external reality can be accessed via rigorous experimental research methods involving hypothesis-testing; thus, quantitative methods are associated with large participant groups, quantification, and seeking valid and reliable data that is free from bias and generalisable across population and context (Charmaz, 2014). Conversely, qualitative approaches facilitate the exploration and understanding of personal experiences and the meaning ascribed to them. They can produce rich descriptive data (Barker, Pistrang, & Elliott, 2015) and seek to understand multiple subjective realities, positioning participants as the experts of their own lived experience (Charmaz, 2014). As such, qualitative research is more commonly associated with in-depth interviewing procedures with smaller participant groups, and seeks to understand the meaning of an experience in a given context (Barker, Pistrang, & Elliott, 2015).

Qualitative methods have gained increasing credibility in social scientific research over the last decade (Willig & Stainton-Rogers, 2008) and it is becoming widely acknowledged that they have much to offer in contribution to the existing knowledge-base built on predominantly quantitative research.

The decision to employ a qualitative approach in the current research was an obvious one given the ontological and epistemological position of the researcher outlined above. The focus of this research is concerned with understanding the meaning and experience of compassion to young people who have engaged in HSB, and as such, it was felt that an interview-based qualitative study with the population of interest would be the most appropriate method to explore the personal meaning of this phenomenon to this group. Furthermore, given that this is a relatively novel research area, it is argued that qualitative methods would be better suited to making initial explorations. As was highlighted in the previous chapter, the existing literature in the area of compassion to self and others has generally employed quantitative methods that seem to assume compassion as an objective construct that can be accurately measured. Whilst the existing research in this area has no doubt offered important contributions to the field, it is proposed here that a qualitative approach would greatly enrich the literature-base, by facilitating the exploration of compassion as a construct and seeking to understand the subjective meaning of compassionate experiences for a population of clinical interest. Having made the case for a qualitative approach to the current research, the argument for the specific application of a Constructivist Grounded Theory methodology shall now be outlined.

2.3 Grounded Theory

Grounded Theory (GT; Charmaz, 2000, 2006, 2014; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990) is a systematic general methodological approach to research, which places emphasis on an inductive process of constant-comparative analysis and data-led theory development, in order to construct a theory about issues of importance to people's lives

(Mills, Bonner, & Francis, 2006). Although often employed in qualitative research (Charmaz, 2014), GT can in fact be utilised for quantitative, qualitative, or mixed-methods designs (Glaser, 1978). GT differs from many other methodologies in the importance it places on approaching participant research under as little influence as possible from existing theories and ideas. It is proposed that by not developing hypotheses or predictions about the outcome of research before it has begun, the researcher will remain open to new ideas emergent from the data as it is gathered and analysed (Glaser & Strauss, 1967). The aim of GT is to, through the coding and memo-writing procedures associated with its application (Charmaz, 2014), identify concepts and categories arising from the data, and ultimately to construct a substantive theory that is grounded in the relevant data (Charmaz, 2000, 2006, 2014; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Whilst there are a number of defining features associated with any application of GT methods (see 2.3.1), there are also several ways in which GT is conceptualised and applied. Whilst it is beyond the scope of this research to provide a full overview of the history of GT, the evolution of the methodology through three of the central approaches will be briefly outlined.

GT was first delineated in the late sixties by Glaser and Strauss (1967). Developed at a time when the positivist paradigm dominated the world of social research (Fletcher, 1996), Glaser and Strauss sought to bring some rigour and precision to the application of qualitative methods, which have been heavily criticised for being biased and ungeneralisable (Denzin & Lincoln, 2008). In their seminal text *The Discovery of Grounded Theory* (1967), they outlined their initial approach to undertaking GT research. The distinguishing feature of this ‘classic’ approach to GT, is its assumption that an objective theory about the process of interest was observed to ‘emerge’ from the data. As such, the researcher in classical GT is viewed as an objective party who ‘discovers’ theory, or truth, through the process of constant comparison inherent in GT (Glaser, 1978). Sometime after their original GT text, Glaser and Strauss parted

ways, and Strauss ultimately went on to develop, along with his colleague Corbin, what has since been termed an 'evolved' GT (Mills, Bonner, & Francis, 2006). This evolved GT (Strauss and Corbin, 1990) diverged from the original methodology in terms of a paradigm shift towards a relativist pragmatist position, acknowledging the subjectivity and contextual and temporal relevance of the theory constructed (Mills, Bonner, & Francis, 2006). Whilst this approach accounted for multiple realities experienced between participants, the implication that knowledge about these realities can be gleaned by an impartial observer still existed (Charmaz, 2014). The final GT approach outlined here has been proposed by Kathy Charmaz (2006, 2014) as a Constructivist Grounded Theory (CGT). Whilst preserving many of the defining features of classic and evolved GT, Charmaz extends these principles to include the recognition that the researcher will bring their own subjective experience to the research context, and will play an active role in co-constructing meaning with participants throughout the process of data collection and analysis (2006, 2014).

2.3.1 Defining features of Grounded Theory. As suggested above, despite some major shifts in the philosophical assumptions underpinning various versions of GT, virtually all approaches retain a set of defining features that are central to the approach. These were identified by Charmaz (2014, p.7) as:

- Simultaneous involvement in data collection and analysis
- Constructing analytic codes and categories inductively from data
- Using the constant comparison method
- Advancing theory development during each step of data collection and analysis
- Memo-writing
- Theoretical sampling
- Conducting the literature review after developing independent analysis

Furthermore, all GT approaches place participants' voice and experience at the centre of theory development. This is particularly important when exploring novel areas as the researcher is encouraged to remain open to new perspectives and restrictions arising from theoretical dogma may be limited.

2.3.2 The rationale for a Constructivist Grounded Theory methodology. Given the researcher's ontological and epistemological position, and following the argument made at the start of the chapter for a constructivist paradigm, the decision was taken to adopt CGT for the current research. Furthermore, a qualitative CGT design was selected because of its focus on data-led theory development and the systematic approach it brings to qualitative research, which ultimately enhances rigour and trustworthiness (Glaser & Strauss, 1967; Charmaz, 2014). It was considered that this approach would not only facilitate the construction of novel theory from fresh perspectives in this under-researched domain, but would also further enrich the current literature on compassion which has thus far been pursued from a largely positivist position, employing quantitative methods to quantify 'levels' of compassion among individuals (see Chapter One). Furthermore, CGT acknowledged the researcher's own subjectivity and involvement in the co-construction and interpretation of data (Charmaz, 2014). This was considered particularly relevant in the current context as the researcher had some prior knowledge in the domain of compassion, and it was therefore important that this could be taken into account throughout the research process through the self-reflexive processes encouraged in this approach (Charmaz, 2014). As is common for many CGT studies, data were derived from qualitative interviews with participants (Charmaz, 2014).

2.4 Procedure

2.4.1 Participants and recruitment. Nine young people who were receiving input from the Youth Offending Service (YOS) in relation to HSB were recruited for this research. A further two young people were approached by their YOS workers, but declined for their

information to be passed to the researcher as they did not wish to participate. The emphasis on theoretical saturation (described in 2.4.3.2) prescribed by CGT supersedes the need to pre-determine the number of participants to recruit. That is, the aim of CGT is to keep recruiting until the categories identified through the analysis are saturated (Charmaz, 2014). It has however been noted that situational factors, such as running out of time or money, can mean that recruitment is forced to stop before saturation is reached (Wiener, 2007, cited in Charmaz, 2014). In the current research, barriers to recruitment (to be addressed in Chapter Four) meant that nine was the total feasible participant number that could be recruited within the relevant time constraints.

In the build-up to recruitment, links were established with three YOSs covering three counties in the UK. YOSs fall under the umbrella of local council services (rather than the police or courts) and are responsible for working with young people who are convicted of a criminal offence, for the purposes of addressing their risk factors and supporting them to avoid further offending (Crime, justice and the law, n.d.). The researcher spent time attending YOS meetings and developing relationships with the teams, liaising with staff to ascertain the likely numbers of potential participants and to discuss the logistics of recruitment. Following conversations with YOS staff around the demographics of young people on their caseloads for whom there was a concern over HSB, and taking into consideration staff concerns about the ability of young people of a certain age and intellectual capacity to engage with the research, the following inclusion and exclusion criteria were established:

Inclusion criteria:

- Males or Females
- Aged between 12 and 18 (inclusive)
- Currently receiving input from the YOS in relation to HSB

Exclusion criteria:

- Young people who were unable to give informed consent due to an intellectual or communication disability/difficulty
- Young people for whom a mental health difficulty (e.g., psychosis) was likely to compromise their ability to give informed consent or to engage in the research
- Young people for whom staff from the relevant service felt it would be inappropriate or harmful to include in the research (e.g., likely to become distressed by the interview content or process)

The decision to define the age bracket for inclusion as 12-18 stemmed from conversations with YOS staff who felt that the young people on their caseloads under the age of 12 would have difficulty engaging in discussions around compassion. Although considered an adult at 18 and therefore no longer a 'young offender', YOS staff advised that sometimes young people who receive a Youth Offending Order at 17 and turn 18 before completing this may continue to be managed by the YOS for the final few months of their order. The upper age bracket was therefore extended to 18 to account for these cases.

Having been provided with information about the research (see Appendix A), YOS staff were asked to identify young people from their caseloads who met the inclusion criteria and to approach them to discuss taking part, using guidance provided by the researcher to facilitate these discussions (see Appendix B). In this sense, recruitment was purposive (Teddlie & Yu, 2007). CGT prescribes the use of initial purposive sampling, followed in the later stages by theoretical sampling, which enables the researcher to identify the credentials of further participants who are likely to be of particular interest in relation to the emerging theory (Charmaz, 2014). Due to the relatively small number of young people receiving input from these YOSs for HSB, coupled with the presence of several obstacles to the recruitment process (see Chapter Four), options to be selective in recruitment were limited. Theoretical sampling was

pursued, however, in the active recruitment of a female participant following the discussion by some male participants of potential gender differences in compassion. Furthermore, theoretical sampling can be said to have been achieved through the adaptation of the interview schedule throughout the research process to facilitate further exploration of emerging categories from different participant perspectives (see 2.4.2.1).

Once potential participants had been approached by their YOS caseworkers with some brief information about the research, they were asked for their verbal consent to be contacted by the researcher if they were interested in taking part. If verbal consent was gained, caseworkers passed the relevant contact details to the researcher who then contacted potential participants and their carers to provide further detailed information about the research (see Appendix C) and gain their consent to participate. All participants and their carers were asked to sign a written consent form (see Appendices D & E) – provided over email or via their YOS caseworker – prior to arranging an interview date. Participants and carers were also asked to provide additional participant information, such as participant demographics and details of their involvement with the YOS, including the nature of their HSB (see Appendix F), and asked for their consent for this information to be checked with the YOS they were recruited through. In anticipation of the fact that this population may have been difficult to engage, an incentive in the form of a £10 high street voucher was offered to each participant

2.4.1.1 Setting. Interviews took place in a setting where the young people were used to meeting their YOS workers. For five of the young people, this was in the interview rooms at their local YOS office. Two young people were interviewed in a quiet room at their school, and the final two were seen at their homes with care workers or family members also present at the address, but not present in the room during the interview. Each interview involved careful liaison with young people and their carers, YOS workers, and staff at the relevant interview

location to ensure interviews could be carried out adhering to local risk protocols, and ensuring the safety of participants and researcher (see 2.5).

2.4.2 Data collection. The data for this research comprised interviews with the nine participants, along with the additional participant information generated through the corresponding form completed by participants and their carers (Appendix F). Interviews were chosen as the method for data collection as it was felt that this approach would best facilitate the detailed exploration of participants' subjective experiences of compassion. All participants were interviewed on a one-off basis over a period of six months, with interviews lasting between 22 and 68 minutes ($M = 42.22$ minutes). Interviews followed a semi-structured interview protocol (see 2.4.2.1) and were recorded using a Dictaphone, enabling subsequent verbatim transcription by the researcher. Participants were informed that they could stop the interview at any time and were offered an opportunity at the end of the interview to comment on the research process, raise any concerns, or ask any questions they had for the researcher.

2.4.2.1 Materials. In addition to the information and consent forms mentioned above (see Appendices A to F), an interview schedule was developed to guide the semi-structured interviews with participants (see Appendix G). The interview schedule was semi-structured in that it outlined the general themes to be covered in interview, along with some suggested questions that could be used flexibly should participants require prompting. The decision to use a semi-structured interview protocol was influenced by the CGT approach to data-led research (Glaser & Strauss, 1967; Charmaz, 2006, 2014). It was felt that a structured interview would be too directive and undermine the initial inductive nature of CGT (Charmaz, 2014) and the intention was for the interviews to also be guided by participants and the themes that were important to them.

The interview schedule, developed specifically for the present research, was adapted from one used by Pauley and McPherson (2010) in their exploration of the experiences of

compassion in a clinical sample who were experiencing depression and anxiety. However, whilst Pauley and McPherson drew on Neff's (2003a) three-facet conceptualisation of compassion to structure their interview questions, the present schedule followed Gilbert's evolutionary model, within which compassion is expressed and experienced in three directions: from others, towards others, and towards the self (Gilbert & Choden, 2013). The schedule was therefore structured to facilitate the exploration of participants' understanding and experience of compassion within these three contexts. At the start of the interview, participants were asked for their definition of compassion, before being presented with two alternative definitions: *noticing when someone's going through a difficult time and wanting to do something to help* and *compassion is a quality that aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging*. The first definition represents the dual-component definition of compassion widely adopted within the literature (Halifax, 2012) but was adapted by the researcher to include simpler language that might be better understood by the participant group. This definition was tested in a pilot interview with a 14-year-old male with learning difficulties and feedback indicated that it was understandable. The second was the definition Gilbert offered in *The Compassionate Mind* (2010a, p.217) and selected by the participant in the pilot interview for providing a broader definition of compassion. Presenting these definitions facilitated the establishment of a shared definition of compassion before proceeding with questions about participants' experiences of compassion to/from self and others.

The proposed interview schedule was tested in the pilot interview and suggested that the majority of the questions were accessible to this age group and ability. The exception to this was there being some difficulty understanding the question: *Can you think of any positives to being able to be compassionate towards yourself?* – which was subsequently re-worded to: *What's good about being able to be compassionate towards yourself?* The young person who took part in the pilot interview was also presented with six varying definitions of compassion and asked

for his feedback on which were the easiest to understand. This discussion informed the selection of the two definitions subsequently used in the participant interviews.

Following the process of constant comparative analysis prescribed by CGT (Charmaz, 2014), data analysis began soon after the initial interviews took place. As initial conceptual categories were identified in the data through this process, additional questions were added to the interview schedule in order to access alternative participant perspectives in future interviews, facilitating the exploration of the parameters of such categories through the process of theoretical sampling (Glaser & Strauss, 1967; Charmaz, 2014). Additional questions were added to explore the following categories as they emerged:

- The reciprocal relationship between self and other
- Individual factors influencing experiences of and expressions of compassion (e.g., gender)
- Experiences and understanding of different compassionate acts (e.g., emotional support vs. provision of physical necessities)

2.4.3 Analysis. Interviews were transcribed verbatim and, along with the additional participant information, formed the complete data set. As is conventional for a CGT approach, data analysis began following the first two interviews and continued throughout data collection via an iterative process of constant comparative analysis (Glaser & Strauss, 1967; Charmaz, 2014). Data were subjected to the coding and memo-writing procedures described below and the conceptual categories identified in early interviews informed future recruitment, where possible, as well as the adaptation of the interview schedule as described above.

2.4.3.1 Coding and memo-writing. Familiarisation with the data was promoted by interview transcription being conducted by the researcher (Henwood & Pidgeon, 1992). Once transcribed, each interview was subjected to initial coding procedures (Appendix J), consisting mostly of line-by-line or paragraph-by-paragraph coding, in which each segment of the dialogue

was labelled with a code to summarise its meaning (Charmaz, 2014). Initial codes were kept brief and the use of gerunds as codes wherever possible ensured that coding remained close to the data with an emphasis on action (Charmaz, 2014). The process of grouping similar codes together then began and the most frequent or salient of these became focused codes. Focused coding (Appendix K) facilitated the identification of broader concepts within the data that were relevant to the topic of study. As well as the abstraction of initial codes into broader concepts, focused coding began the process of explicating the parameters of categories and how they related or interacted with one another. The final stage of coding – theoretical coding (Appendix L) – allowed for the abstraction of focused codes, or categories, into higher order conceptual categories. As noted previously, this process was not undertaken in a linear fashion, rather, coding happened in an iterative process of constant comparison, whereby data were returned to following the identification of new levels of codes, which were then applied and re-applied to data until the resulting set of core conceptual categories accounted for all available data (Charmaz, 2014). The process of coding and explicating the parameters of categories was further aided by the use of conceptual and analytical memo-writing, whereby memos (Appendix M) helped the researcher to organise their thoughts and trace the evolution of quotes, to codes, to concepts.

2.4.3.2 Theory development. The fundamental task of GT research is to arrive at a substantive theory, or model, grounded in the data (Glaser & Strauss, 1967). In the current study, and as shall be described in more detail in the next chapter, major and minor conceptual categories identified through the coding and memo-writing procedures were drawn together into a theoretical model explicating the interactional relationship between the categories identified. As noted earlier in the chapter, the concept of theoretical saturation is usually employed to identify when to stop collecting data. Theoretical saturation refers to the assumption that the categories, or themes, identified in the data are fully explicated and account for all available data.

It also suggests that the recruitment of further participants and data would not result in any further categories being identified (Charmaz, 2014). Whilst adopted by many qualitative researchers, theoretical saturation as a concept is vague and subjective, and there exists a dearth of guidelines as to how saturation can be achieved (Guest, Bunce, & Johnson, 2006). Charmaz (2006) notes that as an interpretive approach, CGT can be flexible in acknowledging both the importance and limitations of this subjectivity. Theoretical saturation was therefore employed in the current research, but as will be addressed in the next chapter, there were limitations to adopting this approach here.

2.4.4 Trustworthiness. In order that judgements can be made about the credibility of research, it is necessary for those undertaking it to consider matters of rigour and how the application of their chosen methodology promotes these. Positivist principles such as validity, reliability, and generalisability, however, become problematic in naturalistic research (Shenton, 2004). The philosophical assumptions underpinning qualitative approaches render assertions of rigour from a positivist position inappropriate, and so a different set of guidelines is required. Guba (1981) has proposed four main criteria to be considered in the assessment of rigour, or trustworthiness, for qualitative research: credibility, transferability, dependability, and confirmability. Credibility – in preference to the positivist internal validity – refers to the degree to which we can be confident that the findings reflect the participants’ ‘truth’ (Lincoln & Guba, 1985). Transferability – proposed in place of external validity or generalisability – means considering how the findings might apply in other contexts. Dependability – instead of reliability – seeks to show that the findings are consistent and could be repeated. And finally, confirmability, following the recognition that removing all researcher bias would be impossible, refers to the researcher’s “comparable concern to objectivity” (Shenton, 2004, p.72). Several steps were taken to enhance trustworthiness in the current research and these shall be outlined and discussed later in Chapter Four.

2.5 Ethical Considerations

The British Psychological Society (2010) have produced a code of conduct for human research ethics. Within this document they specify that research should obtain ‘valid consent’ – which requires participants to consent freely to the research having been provided with adequate information; that risks to participants/researchers or others should be avoided, or that minimal risks are assessed and managed accordingly; and that any information obtained from or about participants should remain confidential (unless otherwise agreed in advance) in that participant data should not be identifiably linked to them. The following sections will address these key principles in relation to the current research.

2.5.1 Informed consent. Due to participants being under 18 (with the exception of one young person who had recently turned 18 but remained under the YOS), carer consent was sought in all cases. Participants and carers were fully informed about the nature of the research and what would be required of them prior to taking part. The fact that interviews were recorded may have been unsettling for some participants – particularly given that they were likely to have had previous experience of being recorded for police interview – but the reason for doing so (i.e., to ensure that the whole interview could be transcribed verbatim and thus effectively analysed) was explained to them at the consent stage. They were then able to make a decision on whether or not they were happy to agree to this. Whilst efforts were taken to promote participants’ autonomy in their decision to take part, there was a possibility some participants may have felt an element of coercion to engage, given that they were recruited through a service under which their appointments were usually enforceable. The fact that two potential participants decided not to take part, however, indicated that at least some young people felt they had the freedom to choose.

2.5.1.1 Data collection and storage. Participants were informed that they could choose to stop the interview at any time. They, and their carers, were informed that they were able to withdraw their data at any time before, during, or after the interview, up until April 2017, when it was anticipated that data analyses would be finalised and submitted as part of the researcher's Doctoral thesis. Withdrawal from the study was possible by contacting the researcher directly, or by requesting that staff from the relevant YOS contacted the researcher on their behalf. In line with the Data Protection Act (1998), data that was not withdrawn was stored securely for the duration of the research and will continue to be stored for three years following the completion of the study, in case any unforeseen amendments or corrections are required in the write-up or analysis.

2.5.2 Confidentiality. Participants were informed that their data would remain confidential, in that their names (or any names of other people, locations, etc., they mentioned in interview) would be changed to prevent them from being identified. Participants were allocated a participant number so that their data could be traced should they wish to withdraw from the study. The specific locations of the YOSs where the research took place have been omitted from the write-up of the research in order to further protect participant confidentiality, and this was fully explained to participants when gaining their consent. It was made clear to participants that whilst confidentiality would be upheld wherever possible, any disclosure they made during their participation in the research that raised concerns over their safety or the safety of someone else, or any disclosure of details of a past serious offence or abuse, would need to be passed on to the relevant person or authority in the interests of safeguarding. They were also informed that should that need arise, they would, wherever possible, be notified about what information would be passed on and to whom.

2.5.3 Risk of harm to participants. There was deemed to be a small risk of participants becoming distressed by the interview topic, particularly in relation to participants potentially

finding it difficult to think of examples of times where they have experienced compassion and feeling upset by this, or by becoming distressed by emotions such as shame or guilt. To minimise the risk to participants in this way, young people who were deemed by either the researcher or YOS staff to have been experiencing levels of psychological distress too great to be able to complete the study, or where it was thought that the nature of the questions were likely to evoke significant distress, were not asked to participate. Participants were also not required to discuss any aspect of their previous offending during their participation and were explicitly informed that their involvement in this research would not impact on the input they were receiving from the relevant YOS in any way. Furthermore, the researcher drew on her skills and experience in clinical interviewing to facilitate participants' engagement and alleviate any minor discomfort during interview. It was agreed that in the event of a participant becoming significantly distressed, however, the interview would be terminated and staff and carers made aware so that they could provide any necessary follow-up support.

2.5.4 Risk of harm to researcher. Interviews were conducted by a single researcher, alone with young people who had a history of HSB and in some cases other types of offending, including violence. There was subsequently a potential risk of the researcher being harmed by a participant. This risk was effectively managed by adhering to the relevant YOSs safety and lone worker policies, speaking to staff involved with the young person to ensure that any known risks were accounted for prior to the interview, and notifying staff and carers of when and where the interviews were taking place and when they had been completed. It was also assumed that because the interview material was not intended to be provocative in any way, the risk of conflict occurring within the interview itself was very minimal. The researcher further employed her clinical experience in dynamic risk assessment and remained alert to any potential arousal or agitation on the part of the young people being interviewed.

2.5.5 Ethical approval. Prior to the recruitment stage, research governance and ethical approval was sought and granted from each of the three local authorities where the participating YOSs were based (see Appendix H). Ethical approval was also granted by the University of Essex (see Appendix I).

2.6 Dissemination

It is intended that a summary of the findings of the current research will be provided to the services through which participants were recruited. Participants and carers who indicated that they would like to receive a summary of the findings of this research will also be sent a summary via their preferred contact method (as indicated on their consent form; see Appendices D & E). The current research was undertaken as part of the Doctorate in Clinical Psychology and submitted as a Doctoral thesis. As such, the final draft will be available at the University of Essex for future trainees, students and staff to read and make use of. It is also planned for the results from this study to be submitted for publication by a peer reviewed journal that has published research in similar areas, such as *Psychology and Psychotherapy: Theory, Research and Practice* or *Clinical Psychology and Psychotherapy*.

2.7 Chapter Summary

This chapter provided an overview of the methodological approach and procedures utilised for this research. Accounting for the researcher's ontological and epistemological position, the case was made for a constructivist paradigm and therefore the use of CGT. It was further argued that a qualitative CGT approach was expected to enrich the existing literature in the area. Procedures for recruitment, data collection, and analysis were outlined and ethical considerations were made. The following chapter provides further details of the analytic process data were subjected to and presents the results from this.

Chapter Three: Results

3.1 Overview of Chapter

This chapter begins with an overview of key characteristics of the final participant group recruited for this research. What follows is a summary of the analytical interpretation of participant interviews through the coding and memo-writing procedures detailed in the previous chapter. Data were synthesised into a substantive theoretical model to explain the dynamic and relational experience of compassion to self and others among young people who have engaged in HSB. The model is first presented in its entirety before the explication of each major conceptual category in turn. Minor and sub-categories are also delineated and the relationships between categories are outlined. Participant quotes help to demonstrate how the model is grounded in the data and the process of member checking the model for its reliability and fit is described.

3.2 Participant Demographics

A total of nine young people – eight males and one female – were recruited for this research. Participant ages ranged from 14 to 18 ($M=15.44$ years) and the sample were almost exclusively White British ($N=8$), with just one participant of Black British origin. Participants were recruited across three YOSs spanning three counties in the UK. Two participants disclosed previous mental health difficulties relating to low mood and anxiety, one of whom was currently under Child and Adolescent Mental Health Services (CAMHS) and the other had been seen by CAMHS previously. Three participants were diagnosed with an intellectual disability, one of whom was also diagnosed with a social and communication disorder. A further one participant had a diagnosis of Autism Spectrum Disorder. The education level of participants ranged from Key Stage Three to AS Level. One participant attended special education and another had left full-time education to pursue employment. The remaining participants attended mainstream educational establishments.

One young person's family declined consent for the researcher to access information relating to their offending or engagement with the YOS. The remaining eight participants were receiving input from the YOS in relation to HSB ranging from inappropriate sexualised comments and sending indecent images, to forced penetrative sex with a child. Seven of the eight participants who consented for their information to be shared with the researcher had received a criminal conviction for offences relating to HSB. One participant had been convicted of other violent offences, but concerns around HSB had emerged during their work with the YOS.

Regarding living arrangements, four participants lived with immediate family, one with other relatives, and the remaining four participants were in care. Participants varied in the length of time they had been working with the YOS, ranging from 10 months to three years. All participants had engaged in some level of individual work with YOS staff, with most having completed some work on victim empathy and self-esteem. At the time they were interviewed for this research, five of the nine participants were approaching the end of their sentence and therefore their involvement with the YOS. Whilst the challenge of recruitment (see discussion of limitations in 4.4) reduced the researcher's ability to sample selectively, the final participant group did appear to be representative of the general population of young people known to services for HSB, given that the group were predominantly White British males, a third of whom had a diagnosed intellectual disability, and who between them had engaged in a wide spectrum of concerning behaviours classed under the umbrella term HSB (Bernardo's, 2016).

3.3 Analysis and Introduction to the Model

As detailed in the previous chapter, data included in the analysis comprised written transcriptions from the nine participant interviews undertaken. Transcribing was carried out by the researcher, promoting familiarity and closeness to the data (Henwood & Pidgeon, 1992), thus beginning the process of constant comparative analysis prescribed by CGT (Charmaz, 2014).

Data were collected in four waves, with interviews being transcribed and subjected to coding procedures following interviews with participants two, five, seven, and nine. Initial coding (Appendix J) enabled all incidents within the data to be coded, resulting in over 400 initial codes for the entire data set. Further focused coding (Appendix K) allowed for the abstraction of open codes into emerging higher-level categories, resulting in the identification of twenty-five categories, which for ease of reference shall be referred to as minor categories. Engaging in focused coding alongside data collection meant that the parameters of emerging categories could be further explored with future participants through theoretical sampling (Charmaz, 2014). The final stage of coding – theoretical coding (Appendix L) – led to the identification and integration of eight major conceptual categories.

Frequent memo-writing (see Appendix M) throughout the process of constant comparative analysis facilitated the recording and elaboration of conceptual and analytical ideas occurring to the researcher at different stages of the research (Charmaz, 2014). This process was fundamental in developing an understanding of the parameters of conceptual categories and the variances both within and between participants in their experience of them. Furthermore, memo-writing helped to explicate the relationship and interaction between major categories.

Once satisfied that the emergent categories and their subsequent dimensions accounted for the available data, it was possible to amalgamate these abstractions into a substantive theoretical model that sought to explain the range and meaning of experiences of compassion for the young people who participated. The model, in its nascent form, was presented to participants eight and nine at the end of their interviews to facilitate member-checks (see 3.5). Following the analysis of the final two participant interviews, it was apparent that no new codes had been generated and the model accounted for all available data. Whilst this may be grounds to argue that theoretical saturation had been reached (Charmaz, 2014), it is acknowledged that due to a lack of depth to some participant interviews (as a result of participants giving very short

answers), it is difficult to know whether further categories would be identified through further in-depth interviews, and this should be borne in mind when interpreting the results. A diagrammatic representation of the resultant model is presented in Figure 3.1 and each aspect of the model shall each be discussed in detail below.

3.4 Explication of the Model

The theoretical model illustrated in Figure 3.1 not only draws together the various levels of conceptual categories identified through the systematic analysis described above, but also indicates the apparent relationships between these. It is intended that this visual representation be taken alongside the following narrative discussion of conceptual categories in elucidating the experience of compassion to self and others among young people who have engaged in HSB.

3.4.1 Defining compassion. Participants varied in their familiarity with and ability to define the word compassion. In defining it, participants engaged in a process of relating to compassion as a concept, distinguishing it from other concepts, and defining what was meant specifically by self-compassion within the wider construct of compassion (see below). Whilst defining compassion was distinct from enacting compassion (see 3.4.5) – in that some participants struggled to elaborate on the provided definitions of compassion with their own interpretations, despite clearly having had experiences of it, and others conceptualised various enactments of compassion that they felt they had not experienced first-hand – the two categories also interacted with each other. This interaction was observed in how their experiences of enacting compassion shaped their understanding of it as a concept, and vice versa.

3.4.1.1 Relating to the concept. Two participants extended the two definitions presented during the interview with their own conceptualisations of compassion. These young people both acknowledged the central aspect of recognising that someone was in a difficult position and being moved in some way by this, relating this to feelings of sympathy and

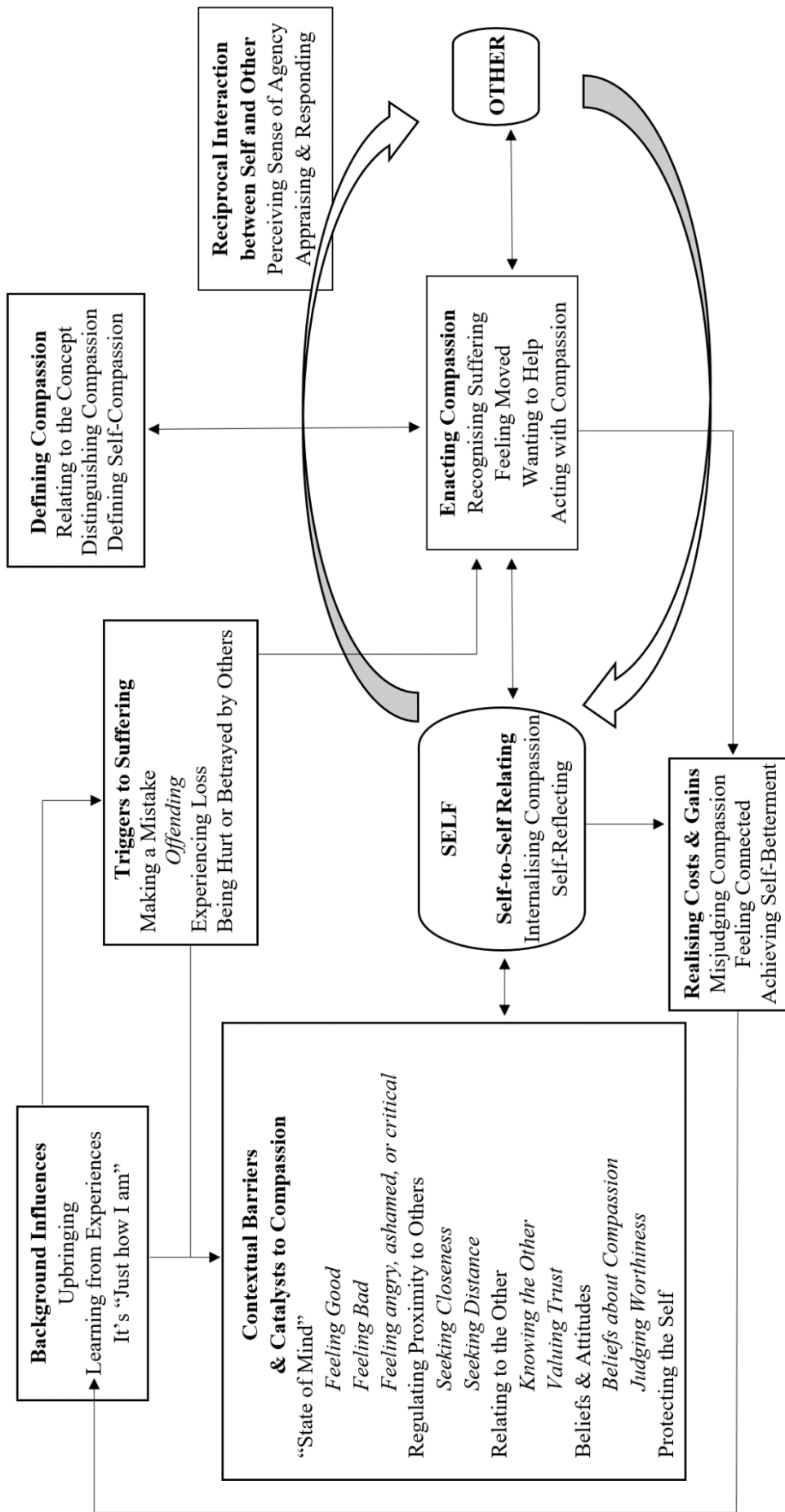


Figure 3.1 Diagrammatic representation of the substantive theoretical model of compassion to self and others amongst young people

who have engaged in HSB, where arrows represent a directional relationship between categories.

empathy. One of these participants also recognised a desire to act and the need to act in the best interests of the other:

“Doesn’t it relate to, like, your conscience in a sense? So, if you feel, like, sorry for someone, then, like, you can tell that that’s your compassion towards them” [P1; 10-11]

“I think it means showing someone respect and empathy towards the, if they’re like down, or something. Or showing you care about them and not making a joke of it. Caring for them, helping them, and, just being positive and not trying to make them feel worse, I guess”

[P4; 10-12]

One participant initially misunderstood compassion as an accumulation of personal characteristics (height, weight, looks), but after being presented with the two definitions, was able to demonstrate his understanding of the concept:

“...you can look after a person, you can teach them different skills, um, you can guide them on the right path, you can mentor them in their favourite hobby, you can try to soothe them with kind words and, and, and try cheer them up with poems or paragraphs, you can protect them in school, or out of school, you can keep an eye on them” [P2; 33-36]

The remaining six young people expressed that they had either not heard the word compassion before, or that it was an unfamiliar concept to them:

“I dunno to be honest. Um, I just come ‘round it and don’t even think about it, so... But just cos I, I don’t normally use that word, or just don’t even think about...Just don’t even think about this” [P3; 12-37]

Emphasis was placed on reaching a shared definition of compassion before proceeding with the interview. Through discussing the two definitions presented by the researcher, participants identified related constructs that were meaningful to them; namely kindness, care, and support. Throughout the course of the interview, participants also connected to other important aspects of compassion:

“...helping people through difficult times of isolation and just coming together” [P1; 95-97]

“I guess it’s more like a pep talk and pat on the back, I guess, like comforting someone” [P4; 154]

“...my mum supports me through everything, you know, she tells me if something’s wrong, or if something’s right...” [P9; 100-101]

3.4.1.2 Distinguishing compassion. Participants who were able to extend the definitions of compassion, also specified what it is not. Compassion was distinguished from other emotions as involving an act between parties –

“I find compassion more of a, a giving thing. I find my emotions are privately mine... and I don’t like sharing my feelings” [P4; 691-692]

- perhaps indicating a fear of exposure or vulnerability, but also the relevance of social connectedness, associated with compassion. Participants noted that compassion in the context of some close relationships did not really feel like compassion at all:

[Showing friends compassion] feels good but I don’t, like, I just know that it’s one of them ones that’s just like, it’s normal to me now... I’m not like a, like, so evil person that if I do something nice or something to keep a record...” [P1; 368-373]

“...when it’s, like, your close friends, it doesn’t feel like it’s compassion, it’s just like banter and talking to each other” [P4; 317-318]

This may suggest that compassion involves a response to suffering in a way that feels ‘out of the ordinary’ – or alternatively this could represent a difficulty distinguishing compassion from related constructs like kindness, which may feel more commonplace to some. This point also raises the importance of distinguishing between *wanting* to help (see 3.4.5.3) and help being an expectation within the context of a specific relationship:

“...it’s your mum, so you gotta express that [compassion]” [P1; 328]

“...cos you’re sticking up for your mates to be honest. If you didn’t, they’d think that you didn’t, don’t like ‘em anymore to be honest, so you have to try and keep your friends” [P6; 594-595]

“...if you’re not nice to them [friends] and that, you can sometimes lose a friend” [P7; 183]

3.4.1.3 Defining self-compassion. Most participants reported being unfamiliar with self-compassion as a concept. Drawing on earlier discussions around compassion however, all could understand self-compassion as a similar process, only directed inwards. Again, participants’ ability to comprehend the complexity of self-compassion varied. For some, enacting self-compassion involved prioritising and treating oneself over others:

“Do things I enjoy...Umm, playing games, watching tv...” [P5; 380-382]

“Say if you was caring for yourself, you could, um, buy yourself some clothes and not buy anyone else any...” [P6; 492-493]

“...when you’ve, like, had a good day and, like, and you just wanna go out and get yourself something nice, like, for the weekend or something” [P7; 290-291]

Whereas others recognised the relevance of acting in one’s best interests, rather than simply fulfilling any personal desire:

“...say...you’re on a diet or something, you need to buy something healthy, but then you know there’s like sweets and you’re really tempted, yeah that that type of thing, so you know you need to like think what’s better for you in that way” [P9; 286-288]

“You wouldn’t really be showing yourself love if you’re just always getting in trouble. Always in handcuffs or something” [P1; 488-489]

3.4.2 Triggers to suffering. Participants spoke about specific events that led to some degree of suffering for themselves or others. Triggers to suffering were important to the experience of compassion in that they precipitated suffering which could then be recognised, thus beginning the process of enacting compassion (see 3.4.5). Previous suffering also influenced future suffering via participants’ ability to learn from experiences (see 3.4.3.2). Participants talked about suffering in the aftermath of making a mistake – including for some their offending, suffering a loss, and being hurt or betrayed by others.

3.4.2.1 Making a mistake. Four participants referred to their own mistakes as potential triggers to themselves or others suffering. A significant feature of the nature of these mistakes was that they either threatened a valued relationship or attracted some undesired judgement by an important other:

“...if I got something wrong, say the teacher says I got something wrong, I’ll go back and do it. Like, the correct way...[to] please the teacher” [P6; 473-478]

“...if you done something wrong to your mates as well, you would try and put it right”

[P6; 480]

“So, because now she’s [ex-girlfriend] going out with someone else, I’m a bit sad about it. So, like, that’s my big mistake. I won’t forgive myself for a long while for that” [P8; 481-483]

This points not only to the potential role of perceived criticism, or even rejection by others – perhaps associated with feelings of guilt (Tangney, Stuewig & Martinez, 2014) or externalised shame (Gilbert, 2002) – in personal suffering, but also its possible potential for motivating reparative action.

3.4.2.1.1 Offending. Interestingly, only three participants referred to the offences that led to their involvement with the YOS. Two young people framed these as mistakes that had led to personal distress:

“...if it’s like major mistakes, like, let’s say I got into trouble...Like when I got arrested. I’ll just be like ‘Woah! What is happening here, like, chill! What did I do? How am I here?’”

[P1; 423-428]

“...I’ve been through hard times as well, from my past, like, cos years ago I done something stupid and that’s why [YOS worker]’s involved...” [P8; 60-61]

Another participant reflected on the harm that had been caused to others by his offences, despite him not having intended it:

“I may have hurt people through the situation I’m in now, but, that wasn’t always intentional. And, you know, yeah, it’s not great...” [P4; 463-465]

Importantly, this young person linked the lack of compassion he had received from others in his life to his later engagement in HSB:

“...they weren’t showing compassion towards me for my hurt point of view, by just saying yeah ok, all they had to do was put me in a different form and I’d have been completely happier. I probably wouldn’t be in any of the situation I’m in now. But, just from me being put in that one class. I’d have shown more people compassion, cos I knew I could trust the people I was with. I wouldn’t be in this situation. No offence, but I wouldn’t even know this building, I probably wouldn’t have to do this...” [P4; 480-485]

3.4.2.2 Suffering a loss. Five young people spoke of suffering a loss. Personal losses were framed in terms of losing a significant other – either through the end of a relationship or a bereavement. The death of a valued other was linked to feelings of sadness, but the response of others at this time of sadness played an important role in alleviating or exacerbating distress:

“[Teacher] just blurted out in assembly ‘oh yeah, [participant]’s grandad died, give him space’ and everything. They didn’t give me space at all, I was crowded, not by people showing me compassion, by people taking the piss cos I was crying about it” [P4; 368-370]

“...when my dad told me my nan passed away, I like was really upset and that, cos that was really hard for me...a couple of my mates, family as well helped me...They, it stopped me thinking about my nan at the time, just think about school and all that...” [P8; 74-86]

The end of a relationship resulting from rejection by another appeared to trigger not only sadness but also anger and blame –

“...when I was younger I didn’t control my anger, cos I come back in Year 8 cos I lived with my mum for about 2 months – it didn’t work out” [P8; 286-287]

“She [girlfriend] dumped me last night [87] ... And she didn’t even give me a reason why...so me and my mates ain’t speaking to her today, at all. She wants to speak to us but we ain’t. We’re just blocking her” [P6; 122-125]

- and similarly, this could also be the case for the individual's own rejection of another which was later regretted:

"I've made loads of mistakes in my life, but, the one that always, big mistake, I don't wanna forget myself on that one, and that was leaving my ex-girlfriend" [P8; 479-480]

When considering losses that might precede suffering for another, participants tended to exemplify physical losses, such as homelessness, or temporary losses of wellbeing, as a result of illness or injury for example:

"...recently my nan has gone into hospital, cos, like, she had a fall...and she was a bit upset"
[P5; 43-45]

"...if it's a homeless person, well I'm, if I had change I'd give it to them cos they're homeless and they might need it for food or home" [P8; 427-428]

"...but when there is something definitely happened like, um, say someone hurt themselves or something like that, then I'd be like, 'ah, are you alright?'" [P3; 117-118]

This may suggest participants had more difficulty recognising interpersonal loss for others than in themselves, particularly perhaps in the absence of physical indicators of distress, which points to the significance of suffering needing first to be recognised for compassion to be felt.

3.4.2.3 Being hurt or betrayed by others. Seven participants described suffering as a result of harm caused by others through criticism or physical attacks:

"...if I'm not upset, then I know that I'll have like 3 to 4 people targeting me at once.

And, and, they say horrible things to me, and I take offence to it, and, and then I try to, I try to keep it out my head, but it keeps coming in” [P2; 125-128]

“...being beaten up, nearly hospitalised, pushed down the stairs, having chairs thrown at me, being stabbed by screwdrivers and pencils, and everything. And then trying to help people and then them throwing it back at me. Just adds all of that together, and I just felt it all again, every time” [P4; 268-271]

Furthermore, experiences of feeling that their trust in another had been betrayed not only led to personal suffering, but could also influence an individual’s willingness to accept or offer compassion in the future:

“Like what happened with me, you can say like ‘ah, yeah, I care’ and then the next thing you know you can turn ‘round and they’re, like, being a complete nasty, spiteful, backstabber, and you’ve told them everything that was wrong, and people are just gonna use that” [P4; 344-347]

“...when I tell someone something it goes to the next person and moves on. I lost my trust with certain people in the school” [P8; 102-103]

Recognising when valued others were at risk of being hurt was also important, and several young people characterised themselves in a protective role in response to this:

“I stick up for my mates and everything...inside of school...If they’re being bullied [P6; 43-48]

“...if they’re [friend] in trouble, like, if there’s a fight or something, I’m just there, like, they are. Like the beef, you feel me? But yeah, that’s, that’s bad, I’m not encouraging it. Just in case this gets sent out, I wouldn’t encourage it for anyone else. But, yeah man, you wouldn’t really see your friend get beat up, would you?” [P1; 275-278]

3.4.3 Background influences. Participants referred to factors in their personal backgrounds that they felt have shaped their experiences of compassion. These were expressed as relating to the way they were brought up, to what they had learned about compassion from previous interpersonal experiences, and to individual factors inherent in themselves as a person. These background factors influenced how compassion was enacted and received, mediated by a range of contextual factors that served to inhibit or enhance compassion in different ways (see 3.4.4).

3.4.3.1 Upbringing. Five participants referred to their upbringing, or highlighted the role of upbringing, in shaping how they or individuals communicate their suffering or ask for help:

“I would find it harder, or maybe it was just the way I was brought up but, it’s harder for, if I’m not like, tight with you, or close with you, I wouldn’t go around asking people for, for certain stuff” [P1; 181-182]

“I suppose because there was more of us [growing up]. So, like, mum and dad just paid attention to the older lot...And then me, so that’s when, like, I just started to, just hold it all in, and just now, it’s just stuck with me, so I just couldn’t go out there and just shout, like, ‘I’m really sad’ or anything like that” [P3; 273-278]

“Most probably the way they’re brought up. Say if you’re, like, brought up with a really posh family, you’re most probably gonna be like, say if someone pokes you, you’re like ‘oww!’ and then say if you’re like brought up, like say, in a normal house with strict parents, you’re most probably gonna be like that, kind of, tough son or whatever that don’t care about anything to be honest” [P6; 530-533]

Upbringing was thus seen as a contributory factor in shaping beliefs around how pain should be dealt with and communicated to others, as well as whom it would be acceptable to approach for

help. Of particular note was participant three's reference to hiding difficult emotions as a self-protection strategy (see 3.4.4.5), because in his past caregivers were seemingly unavailable to provide appropriate care or containment.

One participant spoke of the potential relevance of cultural expectations on beliefs about compassion, using India as an example:

“But the Indians would be like nah, we don't wanna receive it, cos like, it's shameful. So yeah. Like, some people would feel, like, nah ... they don't wanna receive compassion cos they're like, ah it's them accepting that they're below someone else that's giving it to them” [P1; 124-128]

This points to the role of an individual's cultural upbringing in shaping their attitude to giving and receiving compassion, and whilst culture was not referred to explicitly by other participants, cultural prescriptions were alluded to by some participants in their consideration of gender differences in compassion (see 3.4.3.3).

3.4.3.2 Learning from experiences. Seven participants felt that previous experiences of compassion had shaped their current outlook on giving and receiving it. In terms of identifying compassionate others, most participants spoke about compassion in the context of peer relationships. A few mentioned family members and, perhaps unsurprisingly, these tended to be the young people who remained in the care of their family. Only three young people mentioned other significant figures of compassion for them, namely teachers, a therapist, and staff from the clubs they attended. Some young people recounted how they had been helped in the past, and it later became apparent that these experiences had influenced the ways in which they had learnt to express compassion (see 3.4.5.4):

“...people looking out for me when I was in a low place. Um, people were taking me out for meals, spending more time with me, calling me up some days, um, people texting me to check if

I'm ok, people sending me poems, paragraphs, um painting, pictures, um, um, I had people buying me, like, tops, t-shirts, trousers, things like that" [P2; 76-80]

"...if someone has depression and they have like a therapist, like I had, then they help you get through, like, if you're having a really hard time, and it really does help" [P9; 71-72]

"My dad. He's just like, the best guy on earth. Like me and him gets on like really well. We've got the same hobbies and stuff like that. So yeah, he's just those, that kind of person that's just like compassion, to be looking after you, with kindness, and just step beside you through thick and thin I suppose" [P3; 157-166]

One participant highlighted how familiarity with experiences of compassion could ease the process in future:

"Cos if you've never done it [shown compassion] before, so yeah, it's gonna be like hard...But if someone's done it before, they'd just be like, it'd just be really easy, to, to just chuck it all out there and just, yeah, and just don't care about it, but if you've never done it before" [P3; 524-527]

However, another young person explained that receiving a negative response to an act of compassion deterred him from being too quick to show compassion in future:

"I can remember I made a really bad mistake when I was bullied at school. One of the guys was really down who actually bullied me a lot, and I went up to him and said 'what's wrong?' and then he bullied me more for asking him what was wrong, and I don't really know why...he started pushing me over, all sorts, and I just think 'wow.' That, that that was, yeah. That's the, why I'm now very cautious" [P4; 122-128]

Participants contrasted experiences of compassion with examples of times they have felt hurt or rejected by others. Importantly, in the same way that their compassionate encounters seemed to have shaped their approach to care and kindness, encounters that might be deemed ‘uncompassionate’ impacted negatively on participants’ ‘state of mind’ and influenced self-protection strategies such as self-reliance to avoid being let-down, or avoiding compassionate acts in order to limit the possibility that this will invite further harm to the self:

“When people are not kind to me, it feels like, I have, I have, I have like 10 kilos on my back, and I’m tryna, like, trying to pick it up, and I’m tryna move away from it, but it keeps me in the same spot, and it, and it keeps, keeps going on and on” [P2; 139-141]

“...if you’re so reliant on other people, then you’re just gonna be disappointed every single time. I remember when I was a kid and my best friend, well, ex-best friend, he’s cool now but I don’t really chat to him that much, but um, his dad, obviously I liked chilling with them, and his Dad’s just like yeah yeah yeah like, we’ll go out, we’ll go out, we’ll go out. I waited for this guy, like, he was meant to take us all to the cinema, but obviously he’s got a family of his own, so, he’s like oh yeah [name] I’ll come and pick you up. He sold me dreams, and I was just chilling at home, I was waiting for this guy who never came ... Yeah it was just sad, like yeah ... I don’t wanna rely on anyone too much” [P1; 539-551]

“After everything that’s happened to me before: being beaten up, nearly hospitalised, pushed down the stairs, having chairs thrown at me, being stabbed by screwdrivers and pencils, and everything. And then trying to help people and then them throwing it back at me. Just adds all of that together, and I just felt it all again, every time. And I was just like, I can’t keep doing this. Cos I’m trying to get over that stuff that’s happened before, and every time something bad happens to me I just see it again and again” [P4; 267-273]

An accumulation of past uncompassionate episodes was also felt by some to outweigh many of their more compassionate encounters:

“...more negatives have happened than positives, and, more people are negative towards me than positive things, so, one outweighs, like ... one negative thing you said, then two positives, then another negative, and the negative will just blow the two positives out” [P4; 778-780]

3.4.3.3 It’s “just how I am.” Four participants spoke about compassion (or difficulties with compassion) as an inherent personal quality:

“People who have goodwill will have, like, compassion in them, as in, as a sense of their personality. Because if you’re not, if you don’t go out to do nice stuff then I don’t think you’d ever feel very compassionate about anyone” [P1; 38-42]

“I can’t do that [be self-compassionate], no, but I think other people can... don’t know [why] really...It’s something that some people can’t do” [P6; 422-430]

“[For those who are self-compassionate it’s] mostly the kind of people they are” [P6; 434]

In a similar vein, some participants noted that for them it was easier to offer compassion to others than to accept it from others or themselves, and felt the most fitting explanation was that this was just the kind of person they were:

“I’m the caring person, but when someone tries and cares for me I don’t want them to be caring, like, for me. Cos, that’s just how I am” [P8; 183-184]

Another possible influential individual factor was gender. Some participants reflected on how gender roles could affect how men and women communicate their emotions and enact compassion. Most however agreed that whilst this could influence compassion, it was not a defining factor:

“Yeah, like, men don’t show their emotions as much as females, which is obviously [pause]. I definitely don’t show them for one” [P3; 106-107]

“Well, girls are more like, kind of, you know, like, soft kind of thing. Like, and then boys are just, like, don’t really care to be honest” [P6; 523-524]

“If I get compassion from female colleagues, it doesn’t really feel any different, but they’re more touchy feely and like ‘ah, give us a hug’ and everything. Male colleagues are more like ‘do you just wanna go out for a drink or a coffee or anything?’ ... Yeah I think they do sort of, but, it depends how the person is anyway cos you get some tough girls, you get some cuddly guys. I don’t really think gender makes any difference” [P4; 861-868]

3.4.4 Contextual barriers and catalysts to compassion. Participants spoke about the importance of context in any given moment where compassion could be experienced. The factors they felt were relevant could be understood in terms of the emotional ‘state of mind’ of either party, the individual’s attempts to regulate their proximity to others, how they related to the other or object of compassion, particular beliefs and attitudes held about compassion and the other, and their attempts to ensure self-protection. These factors were talked about in different ways amongst participants, but were conceptualised by all in terms of how these factors could increase or decrease the likelihood that compassion would be enacted. Contextual factors are therefore framed here as barriers and catalysts to compassion, and directly influenced the process of enacting compassion and relating reciprocally to the other via the individual (or self).

3.4.4.1 “State of mind.” Described by participant one as “state of mind” [240], the emotional experience or sense of ‘how I am’ in a given moment was felt by participants to have the potential to inhibit or enhance an act of compassion. Participants spoke of the potential impact of ‘feeling good’ vs. ‘feeling bad’ as well as more specifically about feeling angry or ashamed.

3.4.4.1.1 *Feeling good.* Seven participants concurred that they found it easier to acknowledge the suffering of others and respond with compassion when they themselves were in a positive state of mind:

“Oh yeah, I’m a nice guy, but, it just depends on my state of mind. Um, if I’m feeling generous then yeah, I’ll help you out” [P1; 240-244]

“If I’m, if I’m feeling happy, like, it would be easier to show compassion... Yeah, it probably does just depend on your emotion...It depends what emotion they’re feeling as well. If I’m feeling particularly happy and I can see that they’re sad or something, then I’ll just be like, yeah, like, let me just lighten your mood” [P1; 341-357]

“I guess when I’m in a really good mood and someone’s in a really bad mood then I would like, you know, sit them down and tell them everything’s gonna be ok and I’ll help them through it” [P9; 201-202]

One participant also reflected that they would find it easier to accept compassion when feeling in a better frame of mind. This assertion is interesting given that the process of enacting compassion was conceptualised as being necessarily preceded by some degree of suffering (see 3.4.2), which would suggest that being in a positive state of mind might negate the need for compassion in the first place.

3.4.4.1.2 *Feeling bad.* Whilst eight participants talked about the impact of ‘feeling bad’ on compassion, they varied in their thoughts about whether this would be a barrier or catalyst. Most, however, agreed that a negative state of mind was a potential barrier to acting compassionately towards others, regardless of whether feeling bad was specifically related to that particular other or not:

“...if I’m like angry in myself, or, like, I’m just, like, not willing to give it, I’m just not gonna give it to you to be honest” [P1; 244-245]

“Suppose if you’re not, not really in a, in a nice mood, you might not feel like doing it [being compassionate] as much” [P5; 461-462]

“Well it depends on the mood I’m in...When I’m really, like, not happy. And when I’m tired. Um, I’m not really nice” [P7; 143-153]

Some participants felt that feeling bad would make it easier to accept compassion –

“...when I’m not in the best place, and I have someone who supports me to get, get, to get through it, or when I’m finding it hard...because then no one’s actually targeting me...So like, if I’m upset, then I know that I’ve like, 4,5 to 10 people who keep an eye on me...” [P2; 117-123]

“[It’s easier to accept compassion when I’m] quite sad I suppose” [P5; 183]

- whereas others felt this would in fact be a barrier:

“...when I’m in a bad mood she tries to talk me out of it. But I don’t let anyone talk to me, cos when I’m in a bad mood I don’t like anyone talking to me cos it just makes me worse” [P8; 185-186]

“...if I’m having a bad day, I’d probably, like, not really talk to many people” [P9; 142]

“[It’s harder to be self-compassionate] when you’re not that happy and err, um, like, when something’s, like, sort of on your chest and that” [P7; 272-273]

This discrepancy might be explained by some participants’ conflation of all negative affect into ‘feeling bad’, whereas different negative emotions may have very different influences on compassion. Indeed, some participants were specific in their reference to anger, shame, and

criticism, which can perhaps act as a barrier in terms of their link to social isolation, whereas feelings of sadness may more readily evoke sympathy in others and therefore promote compassionate encounters.

3.4.4.1.3 Feeling angry, ashamed, or critical. Eight young people talked about shame, anger, and criticism. Anger and shame were associated with seeking distance from others (see 3.4.4.2.2) and in this sense acted as a barrier to compassion, which would instead necessitate feelings of empathy and connection. Being critical of the self and/or other was felt to inhibit compassion to the self or other respectively through its association with the belief that the object of criticism was not worthy of compassion (see 3.4.4.4.2). For some participants, however, there was an acknowledgement that feelings of shame or self-criticism could precede an experience of self-compassion:

“I guess, if I put myself down or something then, you know, I just think, like, you know, nobody’s perfect, and, you know, just next time I’ll just, you know, you know, if someone’s bullying me or saying something then I just ignore them because no one’s perfect” [P9; 342-344]

One explanation for this difference could be the degree to which feelings such as anger or shame impede compassion. Participant one, for example, reflected on how it was easier to feel self-compassion and get past personal mistakes when they were minor:

“[It’s easier to be self-compassionate] if it’s not, um, major, like, yeah. If it’s just a lickle ting” [P1; 522-524]

The apparent discrepancies both within and between participants’ accounts of the contextual impact of state of mind on the likelihood compassion will be experienced or enacted points to the potential complexity in the relationship between the self-conscious and affiliative emotions.

3.4.4.2 Regulating proximity to others. Participants described how their desire to adjust their proximity to others in a given context could affect their experience of compassion. As suggested above, whether participants sought increased closeness to or distance from others was influenced by their current state of mind.

3.4.4.2.1 Seeking closeness. Seven participants acknowledged that when in a positive state of mind, they were motivated to approach and spend time with others, and therefore found it easier to offer warmth and compassion. Compassion was also viewed by some as a potential means of establishing closeness with others:

“...it’s nice to them, when you’re being nice to them...Plus you can make friends as well” [P7; 115-117]

In several cases, the topic of romantic relationships arose, through which it was made clear that participants valued the sense of connection experienced with a partner:

“...she [ex-girlfriend] was like my, my, part of my life kind of thing, but when someone like take it out, it’s like you’re just by yourself and you don’t know what to do” [P8; 487-488]

For other young people, the desire for a romantic relationship but lack of opportunity to establish one evoked feelings of sadness and even resentment:

“...until you see people, like on the train, you know like, boyfriend and girlfriend together, on the train, leaning on one another, kissing each other, cuddling each other, and you’re sat there by yourself thinking...I want that, but I’m just gonna get really depressed if I think about it” [P4; 730-734]

3.4.4.2.2 *Seeking distance.* Seven young people reflected on their need to seek distance from others when feeling angry. This appeared to facilitate headspace and time to calm down, but was also framed by some as necessary to protect the other from harm, as in some instances being compassionately approached by another when distance was sought only served to fuel anger:

“I just say ‘please leave me alone, and then let me calm down and I’ll talk to you after’...I might go outside and just sit down to just try and like forget what happened and just, relax”
[P8; 198-203]

Say if you’re in a really, like, annoyed mood, and you don’t want anyone to talk to you, if they could try talk to you. Say you’re that angry that you really wanna punch someone, you might turn round and hurt them” [P6; 298-300]

When participant six talked of his upset following a recent relationship break-up, he described how he used distance to communicate his anger and punish the person he perceived to have caused his suffering:

“So, me and my mates ain’t speaking to her today, at all. She wants to speak to us but we ain’t. We’re just blocking her. We’re just, she wal-, comes up to us we just walk away” [P6; 124-125]

But distance was not always framed as beneficial. In fact, some young people directly linked experiences of social isolation with a lack of compassionate experiences:

“But no one’s openly compassionate towards me. I don’t... I’ve never been popular to get that. I’ve always been sort of on my Larry, and, through school, after school...” [P4; 630-634]

“...if you’re isolated like you keep away from everyone else then, like, you wouldn’t know anyone else’s view apart from your own. Because you’re just, like, in a box in a sense. Like, you

wouldn't know, or you'd be strange to the compassion, the whole thing about compassion and everything, good for other people" [P1; 50-53]

It is possible that there may be a distinction to be made here between 'distance' and 'isolation', in which the individual who seeks distance from others does so through their own volition to promote functional processes highlighted above, such as 'head-space', whereas social isolation may not be explicitly chosen by the individual but imposed on them as a result of experiences of social rejection.

3.4.4.3 Relating to the other. The relationship between self and other was significant in predicting compassionate enactments between parties. Eight of the nine participants identified that the likelihood of compassion was influenced by the nature of a pre-existing relationship between self and other, and by whether they felt the other could be trusted. Relating to the other appeared to set the back-drop for the reciprocal interaction that occurred between parties as compassion was enacted (see 3.4.6), via the impact this had on the self.

3.4.4.3.1 Knowing the other. Whilst participants acknowledged that it was possible to feel compassion for anyone, eight young people felt that they were more likely to offer and accept compassion for people they valued and who they knew well. Knowing the other facilitated an ability to help, through knowing what would be helpful specifically for that person:

"...I know with that particular person, doughnuts is a way in. But, like I said, knowing people helps" [P4; 107-108]

"...but you'd have to get to know each other first...Cos you don't kn-, you don't know what he's like, you don't know what he likes and... Well, you don't know him" [P7; 337-342]

Although one participant acknowledged that receiving compassion from someone less well-known to them could feel more special:

“...it’d be more special I guess, or more of a novelty, it’d make you feel better, if someone else has noticed rather than people you see, what, everyday, or talk to everyday” [P4; 321-323]

Having received compassion from somebody in the past also made it more likely that compassion would be reciprocated:

“...if someone comes to me, I’ll be like, you know what, if you’re kind to me, I’ll be kind to you” [P2; 191]

“...if someone has done it [shown compassion] to you then you can understand what it feels like for the other person” [P3; 480-481]

I’m always nice and polite to people. It don’t, don’t matter if I like them or not, I just try and still be nice and then just see if they’ll be nice back. But if they don’t I’m just like ‘yeah, just leave it there’ [P3; 445-449]

“I try and help people more, and they help me back in return, and it’s just a cycle” [P4; 157-158]

For one young person in particular, being helped by a therapist who they did not know personally was helpful for that reason. What remained important within this relationship though was trust:

“...talking to someone that I didn’t really know very well, but I could trust them. Cos it was like really personal. But they really helped because, you know, I couldn’t really tell many people about it” [P9; 84-86]

3.4.4.3.2 *Valuing trust.* Five young people highlighted the importance of feeling able to trust the other in a situation with the potential to evoke compassion. This related to knowing the other, as knowing somebody well potentially led to trust:

“I suppose cos if you just know each other it should be, like, easier. Cos you’ve got that good bond. But if someone else from, like, outside the family comes in, there’s not like such a good bond cos you couldn’t trust that person” [P3; 196-198]

When it came to accepting compassion, young people needed to trust the other to feel safe in revealing the extent of their suffering:

“I guess the closest people in my family, I can trust them more than, say, my friends, I mean I can trust my friends quite a lot with things but it’s kind of, um, like maybe personal like type of things I don’t want them to know” [P9; 128-130]

“So, it’s a trusting as well, cos if I trust them with the things that’s upset me, they trust me back. So, if I don’t trust someone, I’m not gonna tell them what’s wrong” [P4; 160-161]

Previous experiences of feeling betrayed (see 3.4.2.3) appeared to play a significant role in this. Trust also extended to perceiving the genuineness of the other’s desire to help and subsequently how effective this was in helping the individual or enabling them to internalise a compassionate experience (see 3.4.7.1). This was exemplified in participant four’s reflection that help from professionals was potentially less genuine because they are paid to help:

“I think it’s cos they’re professionals though, it’s their job to try and make people feel better. Isn’t it? It’s not your friends doing it” [P4; 815-816]

This point presents an interesting contrast with participant nine's observation above that speaking to an unknown professional facilitated their seeking and acceptance of compassion. Whilst this may speak to a difference between individuals, perhaps influenced by their perception of trust and genuineness as noted above, this may also conceivably relate to the perceived role and agenda of the professional, as participant nine spoke of her encounter with a therapist – often framed as 'helping professionals' – whereas participant four spoke in reference to professionals within the YOS who may be associated with punitive action.

3.4.4.4 Beliefs and attitudes. Five young people spoke about specific beliefs and attitudes that served as barriers or catalysts to compassion. The degree to which particular attitudes or beliefs held by participants became more or less salient in terms of their influence on compassion was very much context-dependent, in that they became more or less significant depending on how the individual related to the other and how compassion was enacted.

3.4.4.4.1 Beliefs about compassion. Some participants framed compassion as a weakness, in that it renders one open to being taken advantage of and potentially undermines self-reliance:

“You can get taken advantage of...People assume that you're such a nice person they'll just... feel like it's easier to push you or to sway you, in a sense...Like, people will just, like, take advantage of you” [P1; 557-565]

“...if you're so reliant on other people, then you're just gonna be disappointed every single time” [P1; 539]

This related to self-protection strategies such as hiding feelings or “trying to be the hard guy” [P3; 136]. Participant one raised an interesting point about the need for compassion indicating that one party is worse off than the other, and reflected on how accepting help could be experienced as shaming for this reason:

“But the Indians would be like nah, we don’t wanna receive it, cos like, it’s shameful. So yeah. Like, some people would feel, like, nah ... they don’t wanna receive compassion cos they’re like, ah it’s them accepting that they’re below someone else that’s giving it to them” [P1; 124-128]

Beliefs about self-compassion specifically could also act as a barrier:

“I don’t [show myself compassion] ...No. I, if, something’s wrong I just get on with it. I think stop feeling so sorry for yourself and just, you know, get on with it” [P4; 723-726]

“...some people might think, if you’re you know being like too kind to yourself, people might think that’s a bit boasting, or like you know, your life is great and you know, that type of thing” [P9; 377-378]

3.4.4.4.2 *Judging worthiness.* Five young people spoke about judging the worthiness of the object of compassion. Judgements about the other’s worthiness of compassion were felt to influence compassionate acts, and these could be shaped by an individual’s attitude or belief about the other based on their characteristics or behaviour, or the previous interpersonal encounters they have had with each other:

“I suppose if you were in, like, a sort of group, and you got, saw someone being picked on or something, you’d probably, sort of, not be as nice to...the person...that’s picking on someone” [P5; 571-574]

“...if, some people are a bit, er, racist, or sexist...they might not, might not wanna help, or be kind to that, kind of...colour...[and] probably religion, I suppose...well if you, you think that their beliefs are different to yours you might not wanna help them [P5; 478-494]

“...if people show hatred towards me, I’m not gonna show any sort of compassion to them. No way. I wouldn’t spit on any of them if they was on fire” [P4; 472-473]

“...why am I gonna show, in a sense, love, to someone I don’t like. That doesn’t really make sense” [P1; 260]

Similarly, participants who spoke of feeling highly self-critical were also less likely to relate to having had experiences of self-compassion, perhaps linked to a personal judgement that they are undeserving, and reported finding it more difficult to accept compassion from others:

“After they say something, and you just walk off like ‘that hurt so much from taking that in.’ But, yeah...Cos I can’t take compliments or like applause, or achievements, or anything...I find it hard so I’m like ‘yeah, thanks’ and then I just walk off, like, that hurt a lot, from taking that in” [P3; 360-365]

“[It might be harder to be self-compassionate] ...if you think you’re not good enough” [P5; 454]

3.4.4.5 Protecting the self. For six of the young people, the emphasis placed on self-protection was evident throughout their interview. Participants appeared to have developed strategies following past experiences of hurt and rejection, that served to protect the self in limiting the opportunity to be hurt again. This was observed in young people avoiding compassion in some situations through fear of getting it wrong –

“...but if you don’t know them, like, if I see someone in the street and they’re just, like, grumpy...you don’t really know how they’re gonna react to you anyway. So, I find it easier just to ask the people I know, otherwise you’re just gonna get a punch in the face, and I don’t need anymore of those” [P4; 67-74]

- or, as was detailed in 3.4.3.2, through the promotion of self-reliance to avoid being let-down by others. Some participants also spoke of their tendency to hide their emotions as a means of self-protection:

“Umm... Emoti... You know what, I, ah, I don’t, I don’t really feel like I’m the type of person to show too much emotion so...If people are giving emotional compassion I wouldn’t really notice, I’d just be like, mmm” [P1; 214-217]

“I’ve never showed full emotion, but when people have been bad to me it just...proves that I shouldn’t anyway” [P4; 681-682]

“I don’t say like show my feelings, I keep everything inside. So, everyone knows I do not like talking about how I feel and that. And like a lot of people say ‘you need to get help, you need to talk about how you feel’ but I’m the guy who just wants to keep all my feelings inside...I’ve always been that, always” [P8; 94-98]

“...mum and dad just paid attention to the older lot...so that’s when, like, I just started to, just hold it all in, and just now, it’s just stuck with me, so I just couldn’t go out there and just shout, like, ‘I’m really sad’” [P3; 275-278]

Of course, the difficulty with hiding one’s emotions in the context of compassion, is that without the ability to communicate suffering, the process of enacting compassion (discussed below) is unlikely to happen.

3.4.5 Enacting compassion. Through the analysis it was identified that the process of enacting compassion – whether between two people or to the self – involved four key stages: recognising suffering, feeling moved, wanting to help, and acting with compassion. All participants spoke in some way about recognising suffering and acting with compassion. Six young people referred to feeling moved in some way by suffering, and seven talked of wanting to help as a precursor to acting with compassion, which linked to a perceived sense of agency (see 3.4.6.1).

3.4.5.1 Recognising suffering. In order that an experience of compassion be triggered, it was first necessary to recognise that someone – be it the self or another – is suffering. Suffering could be recognised through a change in body language or someone’s ‘usual self’ –

“I get really emotional and they know. So, they try and, like, be really car-, like caring for me and that...it’s how my body language goes” [P8; 334-336]

“...most of my friends are bubbly, so if they’re not normal, if they’re not bubbly then you know there’s something wrong” [P4; 38-39]

- which appears to explain some of the importance placed on having pre-existing knowledge of the other. Being attuned to suffering also allowed individuals to recognise signs of emotional states that would potentially discourage them from approaching the other person, such as anger:

“Say if I see ‘em not, like, going red and clenching their fists I’ll go up to them, but if they’re clenching their fists I’ll just, like, leave it” [P6; 308-309]

3.4.5.2 Feeling moved. Recognising suffering led to feeling moved on some emotional level. Recognising suffering in another evoked an emotional response through the process of empathising and/or sympathising –

“...if you see the adverts, like of the little kids suffering or something, like, it could go to your conscience and you could feel, you could react in a certain way, for the benefit of the children” [P1; 18-19]

- whereas one’s own suffering could also be associated with the evocation of guilt or shame:

“I probably react [to mistakes] like, kind of, I dunno, ashamed of myself in a way” [P9; 296]

3.4.5.3 Wanting to help. Feeling an emotional response to suffering led to a desire to alleviate the suffering. However, wanting to help was influenced by how worthy of compassion

the individual deemed the potential object of compassion to be (see 3.4.4.4.2). Furthermore, the desire to help and subsequent decision to help could be affected by the perceived costs and gains likely to occur through helping (see 3.4.8).

3.4.5.4 Acting with compassion. Participants had different ideas about what, for them, would constitute an act of compassion. For some, compassion in the form of providing physical necessities, such as money, felt more familiar –

“Friends show compassion, in school. Like, if I, if I had no school money, or something” [P1; 157]

“[Aunt] does quite a lot for me...makes me dinner...cleaning” [P5; 131-133]

“I’ve got a cousin that gives me quite a lot...get quite a lot of clothes from him” [P5; 140-141]

“Do something for me...Like, do my work or something” [P7; 75]

- whereas for others, compassion was related to in the sense of providing emotional support:

“...you can try to soothe them with kind words and, and, and try cheer them up with poems or paragraphs, you can protect them in school, or out of school, you can keep an eye on them, you can keep going over to their house, see if they’re alright, check on their family, check on them” [P2; 34-37]

“...say if my mate’s going through a hard time, I’ll tell ‘em what happens and everything” [P6; 148-149]

“...if I’m having problems he’ll, like, tell me, you know, you know, you should stick up for yourself ... my mum supports me through everything” [P9; 95-100]

This suggested that participants' previous experiences of compassion from others (see 3.4.3.2) influenced which acts of compassion they were likely to offer others. Alternatively, the examples of compassionate acts offered by participants may have reflected their own understanding and definition of compassion, which may then explain why similar examples were talked about in relation to compassion to and from others. In this case, it could be argued that the way participants spoke about specific acts of compassion gave clearer insight into their understanding of compassion as a construct than by asking them to define the word. Relating to the other (see 3.4.4.3) also had an important link with this category, as participants described how they drew on their knowledge of the other to determine which compassionate act would be most appropriate.

3.4.6 Reciprocal interaction between self and other. Through the process of constant comparison employed in this analysis, the reciprocal interaction between self and other emerged as the core category. As is often the case with a core category, the researcher is prone to seeing it across many aspects of the data (Glaser, 1978). In the present study, the concept of a reciprocal interaction between self and other was not only evident in the immediate interaction occurring at the time of a compassionate act, but also occurred across earlier relational experiences through which participants learnt from and responded to, and could be internalised as a process of self-relating (see 3.4.7). Other types of reciprocal interaction – such as between various processes conceptualised in the categories and subcategories identified within this chapter – also appeared to play an important role in shaping participants' experiences of compassion to self and others, which by and large constituted a dynamic and relational process. The reciprocal interaction occurring at the point of a compassionate act between self and other represented a dynamic whereby a perceived sense of agency and a process of appraising and responding to the changing relationship between the self and other, influenced by patterns of self-relating (see 3.4.7) and characteristics of the compassionate enactment (see 3.4.5), were key.

3.4.6.1 Perceiving a sense of agency. Six participants identified a perceived sense of agency within the reciprocal interaction involved in an act of compassion as a key influential factor to how compassion was experienced. Perceiving that another had *chosen* to help them was important in marking the genuineness of compassion received from another:

“...if I was tight with someone then I, I would accept it [compassion]. Like, I would feel, like, more comfortable to ask...Because, in a sense, like, you, you would know what the person’s thinking, like. Or you’d, like, feel more comfortable to say ‘ah yeah, they’re giving, giving it to me out of their free will’” [P1; 199-203]

Similarly, some young people reflected on how in enacting compassion themselves, it was important that they had decided to offer compassion, as being told by another to act compassionately ran the risk of triggering a negative emotional response such as anger:

“Say if my mates, like, forced me to go over and speak to them [someone upset] cos they don’t wanna go speak to them, and they annoy me from doing that. It’s like basically, I won’t go speak to them, no one will go speak to them, so. So, they’ve just made another person angry, by making them go over to them” [P6; 350-352]

Agency was also talked about in terms of people’s desire to help themselves; infringements of personal agency were framed as potential barriers to accepting compassion:

“...sometimes they might not want help or, um, wanna do it themselves” [P5; 162-166]

“I’m always that sort of guy who just wants to sort my own self out...I just like wanting to vent my own things” [P8; 206-210]

3.4.6.2 Appraising and responding. This category reflected the nuances of reciprocal interaction that participants recognised within a compassionate encounter, and all participants spoke about this process in some way. Enacting compassion was not as straightforward as the stages outlined in 3.4.5, as during and following an expression of compassion, individuals remained sensitive to responses in the self and other, appraising these and responding accordingly:

“[When] I’m with a person and they want to have a go at me, then I feel like there’s no point of being kind to them...or trying to keep myself happy” [P2; 132-133]

“I try and talk to them, and sometimes they don’t want me to help, so like ‘I’ll let you clam down, and then I’ll come back later.’ I come back later and they’re still in a bad mood, I thought fine. I wait for a while and then come back, and just like, they calm down and then they try and talk to me” [P8; 363-365]

Responding negatively to compassion, such as with anger or ridicule, served to stop a compassionate act and promote distance between parties. The specific act of compassion and the way it was presented was also important in influencing the reciprocal interaction between self and other:

“Maybe it’s just the way it’s presented...cos if no one is actually saying “yeah, I’m above you, that’s why I’m gonna show it,” not that they say, “I’m above you,” but they’re in a sense implying it. So, if no one’s like really showing that they’re above you, they’re just, like it’s just a step for you for you to just get higher, then, you would take it” [P1; 140-154]

The dynamic process of appraisal and response appeared to serve the function of maximising the efficacy of a compassionate enactment where possible, but at least promoting the ability to

protect the self in an instance where a mismatch between parties – with regard to the willingness to accept compassion – occurred.

3.4.7 Self-to-self relating. The process of relating to oneself was identified through the analysis as an important concept. Self-to-self relating became particularly relevant in the context of self-compassion, and whilst the process of relating to oneself with compassion was similar in many ways to the process of enacting compassion between the self and other, self-to-self relating was identified as a distinct concept that was heavily influenced by previous relational experiences with others. Participants talked about self-to-self relating in terms of their ability to internalise previous compassionate experiences with others, as well as the importance of self-reflection and its role in self-compassion.

3.4.7.1 Internalising compassion. The ability to be self-compassionate was seen, by those who could engage in discussion about the concept, as influenced by previous experiences of compassion from others. In this way, previous compassionate experiences could be internalised and replicated from self-to-self:

“I got support first, and then when I got that support I kind of helped myself cos then I was taking in what people were saying” [P9; 312-313]

However, previous experiences of rejection and criticism from others could equally be internalised and presented a barrier to self-compassion via the relationship with the self:

“I don’t like myself, I have no self-confidence whatsoever. I’ve had 18 years of people telling me I’m not worth it, I should die, I should be dead, I sh- not worth it, I’m not intelligent enough, I’m ugly, I’m stupid, I’m not worth it, all sorts, everything like that, and, you know what, after a while you just get so bored of hearing it you start to believe it” [P4; 762-765]

Exposure to compassionate experiences over time was also important in influencing how easy or hard participants found it to internalise compassion:

“Cos if you’ve never done it [shown compassion] before, so yeah, it’s gonna be like hard...But if someone’s done it before, they’d just be like, it’d just be really easy” [P3; 524-526]

Two participants who struggled in particular with self-compassion, noted that they instead focused their attention on providing support to others:

“I don’t show myself compassion, I help other people to make me feel better” [P4; 755-756]

“[Those who don’t show themselves compassion] focus on other people more than themselves to be honest... Like, put your friends first, before yourself” [P6; 434-437]

3.4.7.2 Self-reflecting. The ability to reflect on one’s own mistakes was viewed by three young people as an important step to be able to learn from these and to consider how things might be done differently in future (see 3.4.8.3):

“I need to, you know, think what I did [wrong] before and then, you know, become a better person” [P9; 326-327]

One young person related this to his experience of being arrested:

“...what did I do wrong? And, you just feel like ‘ah ok cool, now I know I have to do this again’ [be in a police cell] so it’s just a time for self-meditation” [P1; 429-430]

Self-reflecting required space, and therefore, in some cases was associated with seeking distance in order for reflection and learning to occur.

3.4.8 Realising costs and gains. Following an act of compassion and the subsequent responses from the parties involved through the reciprocal interaction outlined in 3.4.6, participants acknowledged that there ensued a realisation of the resulting costs and gains. Recognising costs and gains to a compassionate enactment was a further type of appraisal that fed back directly to learning from experiences, in order that this information be integrated and therefore drawn on in judging future acts of compassion. Overall, participants viewed the concept of compassion to/from self and others as positive, but recognised that undesired costs can arise when there is a mismatch between parties, due to some kind of misjudgement. Participants identified the potential gains to enacting compassion in terms of feeling connected to others or through achieving self-betterment.

3.4.8.1 Misjudging compassion. Three participants recounted specific experiences where compassion had been ‘misjudged’ by themselves or others, in the sense that there had been a mismatch between the intended impact and the response:

“...I just got to the point where I stopped helping so many people, cos they kept making jokes of me, fools of me...” [P4; 241-242]

“...sometimes, like, people could upset, upset you, like, doing something...they could do something that you didn’t want doing” [P7; 203-205]

The costs associated with encounters such as this were integrated through learning and subsequently shaped how compassion was approached in future (see 3.4.3.2). This learning could occur in the immediate aftermath of a compassionate encounter, but it was also possible for perceptions of a compassionate encounter to change over time, as can be seen in participant

four's recount of how his perception of another's use of compassion changed following new information:

“I thought I could trust that girlfriend but then she went out with a guy who hurt me quite badly last year, and, she said beforehand, like, she tried to comfort me about it and say ‘no everything’s fine’ and everything, and then she goes out with him. That’s compassion and being stabbed in the back afterwards, which didn’t help the compassion in the first-place cos that weren’t showing compassion” [P4; 175-179]

3.4.8.2 Feeling connected. Seven participants spoke in some way about feeling connected following an act of compassion. Acting with compassion was viewed by some as an opportunity to gain friends and/or promote positive relationships with others:

“[Through compassion] like, you could earn another friend” [P7; 260]

“Well say if I didn’t like them as much, I’d like them a bit more [after they showed me compassion]” [P6; 289]

“I risked my own life to save, to save a little kid’s life, cos I knew that if that kid got killed, their parents would be upset and they wouldn’t forgive themselves. But I knew that, I knew that if I saved that kid’s life, his parents would be happy and say, and say thank you, and that’s all I needed” [P2; 166-169]

“I suppose if you were being compassionate, er, it might be quite a nice feeling to be helpful. You get praised” [P5; 214-215]

Receiving compassion from others could also enhance feelings of social connection through demonstrating that somebody cares:

“...it’s, like, kind of them to actually see what could be the problem and stuff like that”
[P3; 300-301]

In a similar vein, self-compassion was seen to promote connection on a level of common humanity (Neff, 2003a) through the understanding that everybody suffers:

“I mean everyone makes mistakes, I don’t feel, like, terrible” [P9; 296-297]

3.4.8.3 Achieving self-betterment. One significant gain that five participants identified as attainable through acting with compassion was the opportunity to better the self. This was understood as a process that could occur within the individual through internalising compassion and self-reflecting (see 3.4.7) –

“...and then you just start thinking, and then, that’s when you start evaluating, like, ‘ok, maybe I got lost’, in a sense, just after. And then that’s when you just start thinking about steps on how to improve...the betterment of the, of yourself...” [P1; 463-467]

- but could also be enhanced with the compassionate support of another:

“...it’d make them a better person if, like, say like they, they did something wrong and they needed help, so I would give them advice what to do. Then they’d probably, hopefully, they’d take the advice and then, you know, probably think about what they did wrong and then become a better person” [P9; 245-248]

3.5 Member Checking

An important feature of any substantive theory generated through CGT methods is its relatability and relevance to the lived experience of the population to whom it pertains to apply (Henwood & Pidgeon, 1992). One way of assessing a theory’s relevance is to seek feedback

from members of the relevant population (Guba & Lincoln, 1989). Member checking was undertaken with two of the nine participants in the current study. As data analysis began following the first interview and continued as an iterative process throughout data collection, a nascent theoretical model was constructed by the time data for seven participants had been collected and analysed. The opportunity was therefore taken at the end of the final two participant interviews to introduce the emergent model and invite feedback on its feel and fit with each of their experience.

Both participants reported that all aspects of the model made sense to them when explained and felt relevant to their understanding and experience of compassion to self and others. When invited to give feedback on the wording or asked if they would make any changes, both participants maintained that they felt the model fit with their experience and did not recommend changes:

“I can’t, um, see changes really. It’s good [pause] yeah, that’s it really” [P8; 1012-1013]

“Yeah. I think, I think it all makes sense really... Yeah. Yeah, cos like the background, and everything yeah, yeah it does make sense” [P9; 520-522]

It is of course necessary to consider how effectively participants’ thoughts about the model were accessed via this process, and this is something which will be discussed in more detail in the final chapter.

3.6 Chapter Summary

This chapter began with an overview of key characteristics of the final participant sample included in the study. A summary of the analytical process the data were subjected to was provided, following which the resultant theoretical model was introduced and discussed in detail with reference to the dimensions of and interactions between the major, minor, and sub-

categories subsumed within the model. The inclusion of participant quotes demonstrated how the model is grounded in the data, and helped to evidence the model's utility in explaining the experiences of compassion to self and others among participants. The outcome of member checking procedures was described. The following and final chapter will build on the research results outlined here through the consideration of the substantive model in the context of extant literature, before discussing the strengths and limitations of the current research, along with the implications for research and clinical practice.

Chapter Four: Discussion

4.1 Overview of Chapter

The final chapter begins with an initial overview of the research findings detailed in Chapter 3. The theoretical model of compassion to self and others among young people who have engaged in harmful sexual behaviour (HSB), which emerged from the data analysis, will then be discussed in relation to extant literature in the areas of compassion and HSB. A case will be made for the value of the present research and substantive model in terms of extending the current literature base and highlighting an important area of clinical interest for future research. Strengths and limitations of the study are discussed, leading to a consideration of the implications of the findings and directions for future research. The chapter closes with a self-reflexive account from the researcher.

4.2 Summary of Findings

The analysis resulted in a substantive theoretical model that sought to explain the range and meaning of experiences of compassion for the young people who participated (see Figure 3.1). The model subsumed eight major conceptual categories: defining compassion, triggers to suffering, enacting compassion, background influences, contextual barriers and catalysts to compassion, the reciprocal interaction between self and other, self-to-self relating, and realising costs and gains. Compassion was experienced as a dynamic and relational process influenced by a complex interaction between these conceptual categories. The following section intends to explicate key aspects of the model within the context of the existing literature base.

4.3 Discussion of the Model in Relation to Extant Literature

4.3.1 Compassion as a meaningful construct. Participants varied in their familiarity with compassion as an abstract construct. Whilst efforts were taken to establish a shared understanding of compassion at the start of each interview, aided by the presentation of two definitions, it was of note that only two participants were confident in extending these definitions

with their own interpretations. Furthermore, some participants explicitly stated that they were not familiar with the word compassion, or that it was just not part of their everyday language. In these cases, constructs such as kindness and caring – which have been viewed as facets of compassion (e.g., Neff, 2003a) – were more relatable for them. Despite this, participants were all able to engage in some discussion around personal experiences of compassion. This suggests that experiences of compassion did not necessarily demand an ability to discuss, at length, compassion as an abstract concept. Rather, compassion could be experienced in the absence of familiarity with the construct, and similarly, the concept of compassion could be discussed on a hypothetical basis by some, without the presence of specific corresponding personal experiences.

It was notable that participants who were better able to engage with discussions around compassion as a construct were at the upper end of the demographic age bracket (16-18) and also educated to a higher degree – although these two trends naturally correspond. This may reflect the fact that compassion is a relatively abstract concept and, as suggested by some participants, uncommon in many people's everyday language. It is perhaps therefore less familiar to those of a younger age who are less likely to have been exposed to thinking around complex constructs, for example through higher education, and be less mature in their abstract reasoning (Hatcher, Hatcher, Berlin, Okla, & Richards, 1990).

The natural advancement of cognitive abilities observed in normal adolescent development (Hatcher, Hatcher, Berlin, Okla, & Richards, 1990) could in-part explain why older participants found it easier to engage with the topic. Again, this would lend itself to the suggestion that compassion is a complex construct requiring a particular level of abstract thinking to be fully articulated. Further support for this idea was gleaned through the observation that participants with an ID and/or ASD appeared to find it harder to engage in detailed discussions around the nuances of compassion. This finding lends itself to the conclusions of previous research that moral reasoning abilities and the development of cognitive

and affectual capacities central to compassion are positively correlated with factors such as age, education, and social opportunity (Colby, Kohlberg, Gibbs & Lieberman, 1983; Comunian & Gielen, 2006), and that deficits or delays in the development of such abilities would be expected in cases of ‘atypical’ development – such as in the case of ID and ASD (Ashcroft, Jervis, & Roberts, 1999; Baron-Cohen, Leslie & Frith, 1985; Baron-Cohen & Wheelwright, 2004; Danielsson, Henry, Messer & Rönnerberg, 2012; Langdon, Clare & Murphy, 2011; Ozonoff, Pennington & Rogers, 1991; Smith & Matson, 2010).

It is however important to note the potential relevance of context in relation to individual factors; it is possible that being older, having engaged with higher levels of education, and possessing more developed cognitive abilities may each contribute to feeling more confident in the interview context, and perhaps therefore feeling better able to engage in discussions around compassion with an unfamiliar researcher. Furthermore, it should not be assumed that difficulties in discussing compassion in abstract terms reflect a lack of understanding on the participants’ part. More so, it feels important to recognise that difficulties in discussing the topic at an interpersonal level may act as a barrier to the development of a shared understanding of compassion and to accessing a reflection of participants’ compassionate experiences through dialogue.

4.3.2 Enacting compassion. The results indicated that four key stages were involved in enacting compassion: recognising suffering, feeling moved [on an emotional level by the suffering], wanting to help [the person suffering], and acting with compassion. These stages corroborate and extend the dual-component definition of compassion outlined in the introduction chapter (Halifax, 2012) and can also be said to correspond with three of the five aspects proposed by Strauss et al. (2016): namely ‘recognition of suffering’, ‘emotional resonance’, and ‘alleviating suffering’ (which subsumes the current categories of wanting to help and acting with compassion). It should however be noted that Strauss and her colleagues drew on much of

Gilbert's work, amongst others, in developing their definition, and so it is perhaps unsurprising that the current model revealed a similar process considering the interview schedule was based on Gilbert's conceptualisation of compassion. The two additional aspects of compassion identified by Strauss et al. were 'tolerating uncomfortable feelings' and 'understanding the universality of suffering' (Neff, 2003a; Gilbert, 2009; Strauss et al., 2016). Whilst a category akin to tolerating difficult feelings did not appear in the present model, participants did speak about difficult feelings, such as anger, shame, and sadness, as contextual barriers or catalysts to compassion. This finding could potentially be understood in relation to previous assertions that compassion involves a tolerance of uncomfortable feelings (Gilbert, 2009; Strauss et al., 2016), in that the degree to which a difficult emotion can be tolerated in the moment, may dictate whether compassion is enacted or not – and thus whether the emotion serves as a catalyst or barrier. 'Understanding the universality of suffering', however, appears to directly correspond to the current model's category 'feeling connected', as one way of feeling connected to others in the face of shame was through an understanding that "everyone makes mistakes" [P9; 296]. Whilst it can therefore be argued that both the additional aspects of compassion identified in the earlier literature are indeed represented in the current model, it is of note that neither were conceptualised by participants as necessary elements to an act of compassion, without which compassion would be unachievable; rather, both the ability to tolerate uncomfortable feelings in a given moment and understand the universality of suffering, would be more readily understood as contextual catalysts to compassion, either facilitating the stages involved in enacting compassion or increasing the gains to be made through feeling connected.

The four stages outlined above were necessarily preceded by either the self or another's suffering; the triggers to which participants spoke of in terms of making a mistake, suffering a loss, or being hurt or betrayed by others. This provided partial support for Goetz, Keltner and Simon-Thomas's (2010) review of the compassion literature, which identified that the most

common antecedents to compassion included pain, sadness and homelessness (raised by participants in suffering a loss). The main focus with regard to the current participants' own suffering was largely on interpersonal loss, which can perhaps be understood in terms of the evolutionary function of compassion in facilitating human social connection (Gilbert, 2010a) and caregiving/seeking (Bowlby, 1969), which may be sought following an interpersonal loss which signals rejection and a subsequent threat of isolation (Gilbert, 2000b). Participants' examples of other people's suffering, however, often centred on observable losses, such as those arising from physical health problems or deprivation of physical necessities. Where another's distress did result from interpersonal difficulties, it tended to involve a transgression with a clearly identifiable social script, such as bullying. This indicated that past interpersonal conflicts or losses held significance for participants with regard to their own distress, but implied that similar events were potentially less recognisable to them in others. This finding could perhaps reflect immature or under-developed capacities central to recognising suffering – such as interpreting social cues, information processing, ToM and empathy – amongst some participants. Such a pattern may be explainable by the 'neurotypical' developmental trajectory of such abilities, which would predict that participants who are younger may be less advanced in these domains (Colby, Kohlberg, Gibbs & Lieberman, 1983; Comunian & Gielen, 2006); but also by the fact that 4 participants had either an identified ID or ASD, both of which have been associated with difficulties or delays in ToM, empathy, and the interpretation of social cues (Ashcroft, Jervis, & Roberts, 1999; Baron-Cohen, Leslie & Frith, 1985; Baron-Cohen & Wheelwright, 2004; Smith & Matson, 2010). This could have implications in the context of HSB – particularly given the prevalence of ID and ASD in this group (Hackett, Phillips, Masson, & Balfe, 2013) – whereby suffering may not be readily noticed in the absence of clear physical indicators of distress; such as with a passive victim. Whilst this is merely an implication and not an explicit finding of the current research, it may be a point for future exploration in this group.

Participants additionally framed ‘making a mistake’ in terms of interpersonal loss, as mistakes led to suffering when they resulted in the breakdown of a relationship or involved the threat of negative judgement by a valued other. Within this context, participants spoke of acting to repair relational damage or correct mistakes that invited criticism from others. This finding points to the important role interpersonal criticism and perceived social loss play in personal suffering, but also in motivating reparative action. This process is perhaps facilitated through the activation of moral emotions such as guilt (Tangney, Stuewig & Martinez, 2014) or [externalised] shame (Gilbert & Miles, 2002), and would thus fit with evolutionary theories that humans are motivated to maintain affiliative social bonds to ensure access to resources through enhanced social rank (Gilbert, 2000b), therefore adopting strategies such as heightened self-monitoring or self-criticism in the face of perceived criticism from others, in order to meet other people’s expectations of the self and avoid social rejection (Goss & Allen, 2009). An interesting distinction within this category, however, was the response of participants in the face of ongoing repeated negative interpersonal experiences with specific others, such as in the context of bullying. In these cases, distance was sought in favour of reparation, and feelings of anger and criticism were evoked. This finding provides much support for the literature on shame and its socially isolating effects (e.g., Gilbert & Irons, 2009; Gilbert & Miles, 2002). It is plausible that the difference observed in these two responses were underpinned by two separate emotional experiences, namely shame and guilt (Tangney, Stuewig & Martinez, 2014). This can also be understood in terms of attachment theory (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969), in that participants are motivated to respond to ruptures in their significant attachment relationships, such as with family or friends, but for those with whom an attachment bond did not exist, there was perhaps less need to maintain ties in order to promote personal safety and survival.

4.3.3 Compassion as a dynamic and relational process. Whilst compassionate enactments were talked about in terms of the four key stages discussed above, the present model in fact indicated that compassion involved much more than this, suggesting that compassion was experienced by participants as a dynamic and relational process influenced by a broader interaction involving background and contextual factors. Whilst the participant who proclaimed, “if you’re kind to me, I’ll be kind to you” [P2; 191] was referring to the relationship between himself and an object of compassion – insinuating that previous acts of compassion from another would enhance the likelihood of him ‘returning the favour’, this phrase also effectively encapsulates the significance of past experiences of compassion from others and how these shape future compassionate enactments. In a transactional-like process, participants felt that the more compassionate interpersonal experiences one has, the more likely they will be to act with compassion both to themselves and others. Conversely, an accumulation of negative interpersonal experiences damaged the relationship with the self and others via feelings of criticism, anger, and shame, and subsequently made it harder for individuals to accept compassion or internalise it for themselves. This pattern of previous interpersonal experiences impacting on compassion would lend support to Gilbert’s (2010a) three-systems model, whereby increased negative interpersonal experiences would lead to an under-developed soothe-system and over-developed threat-system.

Interestingly, even when participants spoke of difficulties accepting compassion from others and showing themselves compassion, they usually characterised themselves as compassionate to others. This finding supported that found by Hermanto and Zuroff (2016), who proposed that this may reflect a compulsive caregiving attachment style (Bowlby, 1977, cited by Hermanto & Zuroff, 2016). This may therefore highlight an interaction between caregiving and care-seeking mentalities involved in self-compassion (Gilbert, 2000a), in that if previous care-seeking, or ‘care-receiving’ has resulted in harm, individuals would be motivated

to avoid this mentality in future as a self-protection strategy. Attempts to provide self-care through internalisation of the caregiving mentality may prove futile if the internalised care-seeking/receiving mentality cannot be accessed, or is experienced as threatening, for this reason.

Some participants saw compassion as a means of developing relationships, such as friendships. In this sense, it could be understood as functioning to promote favourability, social connectedness and rank, and therefore fits with the ideas underpinning social rank theory (Gilbert, 2000b). This finding also supports the notion of an appraisal process involved in assessing the costs and gains associated with engaging in an act of compassion, but brings an additional perspective to the one offered by Goetz, Keltner and Simon-Thomas's (2010) appraisal model. They suggested that individuals would be more likely to enact compassion when the other was assessed as 'self-relevant', which they explained usually meant the individual had a pre-existing relationship with or felt close to the other, such that they would benefit from their wellbeing. Whilst appraising the other as a potential friend would not be too dissimilar from this idea, in that it frames the act of compassion in terms of social self-benefit, it does suggest the potential role of *imagined* future relationships, not just ones that already exist in some form.

Further support was found for Goetz, Keltner and Simon-Thomas's (2010) model in the current data. Participants placed importance on knowing the other, and all agreed that a pre-existing positive relationship would enhance the likelihood of a compassionate act. Whereas Goetz and her colleagues framed their self-relevance appraisal in terms of maximising self-wellbeing however, current participants spoke more of the importance of trust. Although Goetz's model only addressed compassion directed towards others, current participants placed weight on trust across each directional possibility. The current category 'judging worthiness' appeared to correspond to Goetz's 'blame' appraisal, in that judgements that the other was undeserving of compassion would prevent compassion being enacted. Their 'coping ability'

appraisal is reflected in the current category ‘protecting the self’, in which appraisals that determine an act of compassion as posing a risk of threat to the self will lead to compassion being avoided. However, the current research extends Goetz’s notion of coping ability from assessments about self-coping, to include appraisals about the other’s ability to cope. For example, if it was decided that the other would not be able to tolerate receipt of compassion (based usually on appraisals of the other’s body language and signs of emotional dysregulation, such as aggression), then compassion would not be enacted. This could also be said to link back to the emphasis on protecting the self. It can be argued that these findings again provide support for social mentality theory (Gilbert, 2010a), which posits that individuals are engaged in a constant process of detecting and decoding social signals, as well interpreting the emotions evoked within them as a result of the response in others to their role enactment. The appraisal process identified in this research can be understood from this perspective, in that individuals are sensitive to social cues between themselves and others in order to assess which mentalities and roles they need to enact.

Whilst there was clear support for the appraisal process previously outlined by Goetz, Keltner and Simon-Thomas (2010), the current model can be said to extend and develop this. Whilst their model delineated factors involved in the appraisal process preceding an act of compassion, the current model highlights a continued, dynamic appraisal process occurring throughout and following compassionate acts. Whilst enacting compassion, participants spoke of the reciprocal interaction between themselves and the object of compassion, and how they adjusted their approach depending on their appraisals of the others’ responses, and in turn, their own responses to these. Again, this would fit with social mentality theory for the reasons outlined just above. Following the compassionate act, participants identified how a further appraisal process occurred, enabling them to realise the actual costs and gains involved. These were then processed and integrated as learning points, which would then be drawn on in future

compassionate experiences as a function of ‘learning from experiences.’ This appraisal process demonstrates the complexity of the reciprocal interaction between self, other, and contextual factors – including the act of compassion itself – that occurs in a single ‘compassionate moment’ and suggests that the process of enacting compassion may be much harder to define and predict than other models have previously attempted.

The identification of an appraisal process suggests a degree of autonomy and agency in enacting compassion. This is important as ‘purist’ evolutionary theories have been criticised for assuming that emotional (and the resulting behavioural) processes result from innate, unconscious systems ‘hard-wired’ in our brains, thus negating human agency (Bandura, 2006). The findings here suggested that participants were able to appraise and decide whether or not to enact compassion. Furthermore, perceived agency in itself was fundamental to enacting compassion. Participants felt they would be less likely to act with compassion if they did not feel it was their autonomous decision to do so. Compassion from others was also more acceptable when it was perceived to have been an act of the other’s free will. This supports previous assertions around the importance of human agency in experience (Bandura, 1991, 2006) and may reflect some participants’ promotion of self-reliance as a self-protection strategy, as well as reiterating the significance of trust and perceived genuineness in an act of compassion. Of interest is the fact that participants could still notice and experience an emotional response to suffering, regardless of the agency they exercised in acting on this, perhaps suggesting that some processes involved in compassion – such as processing social cues, affectual empathy, and emotional arousal – are more automatic, or develop earlier, than others which are more consciously processed or complex. This may further relate to the observation by some moral theorists that moral reasoning is underpinned by both affectual and cognitive processes (e.g., Gibbs, 2010), and may subsequently point to a relevant distinction between the internal emotional experience of compassion and the cognitive processes underpinning the understanding

of and appraising of compassion, both of which warrant further exploration through future research. If indeed compassion calls for a similar ‘co-primacy’ model (Gibbs, 2010), it would be reasonable to assume, on the basis of previous developmental research (Decety, 2010), that various cognitive and affectual capacities would be involved; each with their own developmental trajectory. This raises an interesting point for discussion; namely whether individuals who have not fully developed the cognitive and/or affectual capacities implicit in the experience of compassion – such as in the area of ToM and empathy, as is frequently seen in populations with ID and ASD (Ashcroft, Jervis, & Roberts, 1999; Baron-Cohen, Leslie & Frith, 1985; Baron-Cohen & Wheelwright, 2004) – can truly experience compassion as it has been defined here. Moreover, can individuals who have developed some but not all of these capacities still experience aspects of compassion? Whilst the findings from the current research indicated that some participants – particularly those who were younger and/or presented with developmental difficulties associated with ID or ASD – appeared to struggle to cognitively understand compassion as an abstract concept, all participants could reflect to some degree on personal experiences of compassion. Previous developmental research indicates that humans can detect distress in another, and subsequently become distressed themselves, from birth (Dondi, Simion & Caltran, 1999). This would suggest that there may be an innate human capacity to experience at least some of the affectual processes involved in compassion. In this sense, there may well be an argument for an experiential continuum, whereby compassion is experienced to varying degrees dependent on the level to which central capacities have developed in the individual (i.e., the inherent ability of the individual to experience compassion), as well as the contextual barriers and catalysts to compassion present in a given context (i.e., the momentary likelihood that compassion will be experienced). Further research would be needed to explore the utility of this idea, although it would first be crucial to determine exactly what is meant by ‘compassion’ and decide whether this does in fact differ from related constructs such as empathy and kindness.

4.3.3.1 The importance of background influences. Participants reflected on how learning from past interpersonal encounters had affected their perception and experience of compassion and how they reported enacting compassion. This included specific compassionate (or uncompassionate) acts from others, but also their ‘upbringing’ in terms of the general interpersonal dynamics within the familial (or care) system participants were raised in. This finding provides support for much of the existing literature on compassion, which highlights the importance of early interpersonal experiences, particularly in the context of key attachment relationships, in shaping caregiving and care-seeking behaviours (Bowlby, 1969; Gilbert, 2010a; Gilbert & Irons, 2009). The fact that participants associated previous negative experiences with others – usually resulting in some form of social rejection – with difficulties in expressing or receiving compassion, appears to fit with Gilbert and Irons’ (2009) model of shame, whereby experiences of shaming, for example through criticism or bullying, lead to feelings of devaluation by others. Such feelings can then be attributed to external threats and lead to devaluation of others, or may be internalised and attributed to the self, leading to self-devaluation. Devaluation of others and/or the self may then inhibit compassion through judging the self or other to be unworthy of receiving it. This may be further confounded by difficulties enacting compassion, experienced by individuals who have had a lack of compassionate or ‘soothing’ experiences from key attachment figures from which to securely develop and internalise functional caregiving and care-seeking behaviours, such as compassion (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Gilbert, 2010a; Gilbert & Irons, 2009;). This finding therefore provides further support for the argument of a close link between shame and compassion (Gilbert, 2010a).

The people who participants associated with compassionate acts were generally attachment figures such as parents, peers, teachers, or club leaders, again highlighting the likely significance of attachment relationships in modelling compassion (Bowlby, 1969; Gilbert,

2010a). Participants' examples of their own compassionate acts tended to reflect the types of compassionate experiences they reported from others. Whilst this may provide further evidence for the development of caregiving/seeking through the attachment system (Bowlby, 1969; Gilbert, 2010a), this may also reflect participants' own definitions of compassion. For example, if participants' understood compassion as giving advice, it would follow that their examples of both compassion to and from others and the self may centre on giving or receiving advice.

Possible gender differences observed by some participants suggested that compassion may be expressed differently by men and women. Whilst most agreed that gender alone did not determine the ability to be compassionate, there were suggestions that men may find it harder to openly provide emotional support, which seemed to link to social prescriptions around how men and women ought to behave, such as males needing to be "the hard guy" [P3; 136]. This finding relates to the influence of gender roles on experiences of shame and anger that have been noted in the existing literature (e.g., Gilbert & Irons, 2009; Gilligan, 2003), whereby influences associated with social and cultural norms and group ecologies mean that hostile social environments tend to evoke gender identities such as the 'fearless' male. For young people who have been repeatedly exposed to hostile environments this may be particularly pertinent and linked to the development of self-protection strategies such as concealing negative affect or promoting self-reliance, as was observed for several participants in the present study. Such social identities may present a barrier to compassion, and it may be fruitful for future research to consider the association, if any, between various gendered social identities and expressions of compassion, as this may go some way to explaining why some gender differences have been observed for related experiences such as shame and self-criticism (Koestner, Zuroff, & Powers, 1991; Shahar, Blatt, Zuroff, Kupermine, & Leadbeater).

Some participants reflected on compassion being a quality that some people 'just had'. In this sense, compassion was framed as a trait-like feature, supporting Neff's (2003a, 2003b) view

that it is something which develops in early childhood and remains relatively stable. However, all participants spoke about specific background and contextual factors which they felt would inhibit or enhance compassion in a given moment, supporting much of the evolutionary theory, which assumes compassion as both trait- and state-like in different respects (Goetz, Keltner, & Simon-Thomas, 2010). The fact that some participants felt their ability (or inability) to be compassionate was simply a function of 'who they are', may suggest that the apparent complex interaction of factors influencing compassion evident through the analysis may not be consciously processed by some young people. Alternatively, this may reflect a pattern of 'learned helplessness' whereby young people have come to learn that they cannot exert control over their environment, often as a result of negative interpersonal experiences where they have been unable to exercise personal agency, such as being victimised through abuse (Kelley, 2009) or controlled under the CJS (van der Helm, Klapwijk, Stams, & van der Laan, 2009). Experiences such as this may also go some way to explaining why participants placed such an emphasis on perceiving a sense of agency in compassion.

4.3.3.2 Contextual barriers and catalysts to compassion. Several contextual factors served as barriers or catalysts to compassion, all of which could be influenced by the background factors discussed above. This was a key finding of the current research, as it suggested that compassion is a dynamic and context-dependent experience, not simply an inherent individual characteristic. Moments where there was the potential for compassion appeared to be influenced heavily by both the state of mind of the individual and of the object of compassion. Compassion appeared to be most likely when the individual was in a positive state of mind and the other was upset (but not angry). This finding related to the reciprocal interaction between self and other, during which an ongoing process of appraising and responding occurred, including appraising contextual factors such as state of mind, and therefore can be understood in the context of social mentality theory (Gilbert, 2000a), which, as discussed earlier, notes the ongoing process of

detecting and decoding social signals in social encounters, and facilitates access to various social roles dependent on state of mind.

Specific beliefs and attitudes about compassion, such as compassion being weak or rendering the self vulnerable, or self-compassion being boastful, were framed as barriers to compassion. This finding fits with the existing literature on fears of compassion (Gilbert, McEwan, Matos, & Rivis, 2011), which suggests that there exist social and cultural scripts that may serve to inhibit compassion in order to promote a positive social image (i.e., not appear self-indulgent or selfish and subsequently invite social criticism or rejection). From this perspective, a belief about compassion being weak may have resulted from an accumulation of past negative interpersonal experiences, which now serves to protect the individual by inhibiting social connection, which could render them vulnerable to further social attacks. Promoting self-protection was a fundamental aspect of the current model and several contextual factors influencing compassion could also be said to relate to protecting-the-self. Knowing the other was important in terms of knowing how to help – and therefore minimising the threat to the self through misjudging a compassionate act – but also in terms of being able to trust the other. Again, trust promoted self-protection by minimising the risk of betrayal or humiliation. The importance of trust extended to relationships with professionals and the importance of perceived genuineness of compassion, which in turn links to the perception that the other has exerted agency in deciding to help. Each of these findings suggest that participants were sensitive to signals that the other had their best interests at heart, or that an act of compassion involving them would not present a major social threat to the self. Again, this provides support for Gilbert's (2010a) work on the compassionate mind, whereby a threat response (including safety seeking) will always be prioritised in the first instance, and is likely to be over-developed and therefore over-stimulated for individuals who have been exposed to multiple adverse interpersonal

encounters, such as those common in a population of young people who go on to engage in HSB (Ward, McCormack & Hudson, 2002).

4.3.3.2.1 The role of anger, shame, and self-criticism. The findings highlighted a potential discrepancy regarding the link between anger, shame, self-criticism, and self-compassion. In some cases, participants spoke of seeking distance from others when angry or shamed, whereas one participant described how self-compassion could be helpful following incidents of criticism or shame. The fact that in some cases participants did not use the language ‘shame’ and ‘criticism’ and it was instead inferred by the researcher, may mean that subjective misinterpretations were made. This may, however, also point to the complex nature of the self-conscious and affiliative emotions, in which case this would provide support for the need to further investigate these through research. Nevertheless, these findings can be understood within the existing literature. Shame has been associated with impulses to hide and self-isolate (Gilligan, 2003) in order to ‘save face’ and avoid further social rejection/condemnation (Gilbert & Miles, 2002). It is also thought that shame can lead to anger and violence, as intolerable internal judgements about self-worthlessness are defended against through externalisation (Gilligan, 2003). The example of employing self-compassion in the face of shame or self-criticism to get through a difficult experience is supported by the existing literature that underpins CFT, of which this is the central tenet. It is of note that this particular young person framed her ability to use self-compassion at these times as a result of internalising the compassion she had received from others, again highlighting the significance of previous interpersonal relationships, including attachment relationships, and experiences of having felt ‘safe’ and ‘soothed’ by a trusted other (Bowlby, 1969; Gilbert, 2010a), as well as the link between inter- and intra-personal experiences of compassion – as suggested by social mentality theory (Gilbert, 2000a).

Feeling critical of the self or other inhibited compassion through its association with judging the worthiness of the object of compassion. This can be understood in terms of the close fusion between criticism and shame, whereby criticism of others may serve to degrade their social status and in turn boost the status or rank of the self as in social rank theory (Gilbert, 2000b), or where self-criticism acts as a mechanism through which internalised shaming occurs (Gilbert & Irons, 2009), both of which may be underpinned by appraisals of the object of compassion as undeserving (Goetz, Keltner and Simon-Thomas, 2010).

4.3.3.3 Self-compassion. Participants framed self-compassion as an internalisation of compassion. This provides support for social mentality theory (Gilbert, 2000a) and the evolutionary and attachment models underpinning Gilbert's three-systems theory (2010a), in that relational experiences of compassion to/from others were enacted to the self. This suggests that the systems involved in relating to others in this way can be co-opted for the self, and that their function will be influenced by earlier relational experiences with others (such as key attachment figures). It should, however, be highlighted that in the current study, self-compassion was defined for participants as compassion directed to the self, and this may therefore have influenced the fact that self-compassion was conceptualised in this way.

Some participants described how previous critical and shaming interpersonal experiences were also internalised through self-to-self relating. This pattern may be akin to the concept of internalised shame (Gilbert & Miles, 2002), whereby external threats (being criticised, rejected by others) become internal threats (thinking self-critically, self-shaming), and result in powerful feelings of shame (Gilbert & Irons, 2009). Several participants expressed their view that self-compassion, for them, felt too hard because of their negative self-view. In this study, participants generally seemed to frame self-criticism and shame as clear barriers to compassion. The importance of self-reflection, however, was viewed by participants as an aspect of being kind to the self, facilitating the ability to make appraisals and learn from the experience of

making a mistake. Interestingly, self-reflection was often facilitated by ‘space’ and thus distance from others, which appeared to contradict the emphasis placed in self-compassion definitions on social connectedness in preference to isolation (Neff, 2003a). This may, however, reflect a distinction between ‘distance’ and ‘isolation’ whereby the difference comes down to the individual’s degree of agency in making the choice to be close to or distant from others.

Whilst the current research did not reveal explicit data to further unpick what is likely to be a complex relationship between shame and self-compassion, the findings did appear to support existing theories of a theoretical relationship between the two (Gilbert, 2010a; Gilligan, 2003). It will be important for future research to continue to explore the directionality of this relationship in more detail.

4.3.4 Compassion and Harmful Sexual Behaviour. Only three participants referred to their HSB in interview, and in each case only passing reference was made. The fact that it was not raised in detail by anyone, despite the topic area and the fact that participants were aware of the researcher’s interest in HSB, may speak to the degree of shame experienced by participants as a result of their harmful behaviour and the societal stigma attached to it (McAlinden, 2005). Those who did refer to their offences, generally framed them as a mistake which led to their personal suffering. Although one participant acknowledged the potential impact of his actions on his victims, he did so in a way that absolved himself from intentionality. The same participant spoke evocatively of his personal experiences of interpersonal trauma, including being subjected to ongoing taunting, humiliation, and violence, by peers. Without wishing to make too great a leap, it is conceivable that shame may play a role here in limiting victim-empathy, given that shame is associated with powerful feelings of worthlessness, defended against by bolstering the self and externalising blame (Gilligan, 2003). This could be an interesting point for future research. Alternatively, the apparent lack of victim-empathy and focus on self-suffering could reflect an under-developed ToM and capacity to empathise, perhaps

associated with a more organic aetiology such as ID or ASD (Ashcroft, Jervis, & Roberts, 1999; Baron-Cohen, Leslie & Frith, 1985; Baron-Cohen & Wheelwright, 2004), or linked to immature development due to age (Colby, Kohlberg, Gibbs & Lieberman, 1983; Comunian & Gielen, 2006). Interestingly, however, two of the three participants who spoke of their HSB were the two eldest of the group, neither of whom had known developmental difficulties, such as might be associated with ID or ASD. Although tentative, this may instead suggest an alternative explanation for delayed development of specific empathic capacities in this group; for example, changes or impairments in psychosocial- and neuro-development that can result from early interpersonal trauma (Creeden, 2004). Such a link would support Gilbert's (2010a) assertion of the importance of secure early attachment relationships in developing compassion – and perhaps also the fundamental cognitive and affectual processes that underpin compassionate experiences.

Another possible point for future studies to explore would be the role of care- and compassion-seeking in HSB. It was clear from some participants that the desire to feel love and connection with another was significant for them, and it may therefore be plausible that they attempted to seek closeness through inappropriate means – such as might be formulated within the Good Lives Model (Ward, 2002). Alternatively, feelings of hurt and rejection experienced as a result of previous interpersonal trauma and exacerbated by the void of a romantic relationship, may lead to intolerable feelings of shame, which are then projected onto subsequent victims. Clearly, not enough data in explicit relation to HSB was gleaned in this research to make assertions about the role of shame and compassion in HSB, but the findings do suggest that these relationships may exist and certainly warrant further investigation.

4.4 Strengths and Limitations

This study was the first – to the researcher's knowledge – to explore compassion among young people who have engaged in HSB. Despite increasing recognition that many sexual offences are committed by children and young people, HSB is an under-researched and under-

resourced area (Bernardo's, 2016). It is therefore a strength of the current study that it may provide a platform from which to direct further interest and research in a clinically important domain. Furthermore, the existing literature base surrounding compassion has adopted predominantly quantitative approaches, utilising questionnaire-based studies to quantify the 'level' of compassion self-reported by an individual over a specified time-period. The present study not only enriches extant literature through the acquisition of qualitative data that explores the meaning and lived experience of compassion to the population of interest, but the results also highlight some potential flaws with a quantitative approach to compassion research that ought to be paid due consideration (see 4.5.1).

Several steps have been taken in the current research to enhance trustworthiness. Credibility (Guba, 1981) was evidenced through the use of a semi-structured interview tool that was piloted prior to the research. 'Negative case sampling' (Lincoln & Guba, 1985) was also employed in the sense that conflicting and contradicting incidences within the data were considered and categories formed and reformed until the resultant model accounted for all the available data. Member checks (Guba & Lincoln, 1989) were undertaken and peer scrutiny was achieved through the supervision of two qualified clinical psychologists with substantial research experience. Furthermore, a reflexive journal (Appendix N) was kept by the researcher throughout the research process in order to maintain a reflective commentary for the purposes of tracing their progressive subjectivity through data collection and analysis (Guba & Lincoln, 1989). It is difficult for researchers to make assertions about transferability, given that they can only comment on their experience of the 'sending' context and not the receiving (Shenton, 2004). It is therefore suggested that the researcher make the context of their research explicit, in order for readers to make their own judgements about transferability (Guba, 1981). Contextual details of the current research are outlined in Chapter Two and discussed in two sections below (4.4.1 & 4.6). It should, however, be noted that the intention of the current research was not to

develop a model that is transferable to other populations and/or contexts. What was sought in this case was a model to explain the idiosyncratic experiences of compassion as described by participants at the time of interview, and that is what has been offered. It may however prove fruitful for future researchers to compare new data to the findings from this research to gain further insight into the nuances and intricacies between multiple perspectives of compassion.

The inclusion of a detailed overview of the research design and implementation, data collection methods, and reflexive discussion of the research process (see below) go some way to illustrating the dependability of the research (Shenton, 2004). Furthermore, it has been argued that steps taken to ensure credibility can also promote dependability due to the close nature of these two criteria (Lincoln & Guba, 1985). Again, the reflective commentary provided below helps to satisfy confirmability (Shenton, 2004). In addition to the criteria addressed above, other guidelines for qualitative research (Critical Appraisal Skills Programme, 2017; Twining, Heller, Nussbaum, & Tsai, 2017) have highlighted the need to be clear about the researcher's epistemological position, and offer a reasoned argument for the selected methodology and why it is appropriate in addressing the research question. Furthermore, full details of the data collection and analysis process should be offered in order to contribute to "a chain of evidence" (Baskarada, 2014, p.10), all of which have been provided within the current study.

It is worthy of note that much of the existing literature in the area of compassion has recruited university students, or other non-clinical populations to assess and measure compassion – including studies on which assessment tools are based. If we are to fully understand the potential clinical utility of compassion-focused interventions and their impact on shame and compassion, or to develop appropriate approaches to the assessment of these emotions, it is important to understand the meaning and relevance of these constructs for the clinical populations for whom they are intended. The current study explored compassion with a socially disadvantaged population of clinical interest. The results indicated that although this group

experience compassion to self and others, the word ‘compassion’ can be an unfamiliar and problematic term. Difficulties in developing a shared language around compassion may act as a barrier to accessing credible information in research, and may also present issues for interventions that rely on the discussion of abstract concepts such as compassion and shame – such as CFT (Gilbert, 2009a, 2009b, 2010b).

It is, however, necessary to acknowledge some potential limitations to the current research. In defining compassion, some conceptualisation difficulties were evident. Most participants were unable to expand on the definitions of compassion offered by the researcher, reflecting their unfamiliarity with the term compassion. However, participants were still able to offer personal examples of experiences of compassion to and from self and others. This may suggest that a familiarity with and ability to define compassion as an abstract term is not a prerequisite for first-hand experiences of compassion, which would also be supported by the idea that compassionate experiences develop in early infancy through the attachment relationship with a caregiver (Gilbert, 2010a), before the ability to articulate experience is possible. What this does highlight is the potential difficulty in researching experiences of compassion through an interview process. Being able to reflect on and talk about compassion seems to involve a different capacity than that required to enact compassion to self and others. It may therefore be beneficial to consider alternative research methods for exploring this domain.

Linked to some participants’ unfamiliarity with the word compassion, in some cases alternative language was agreed and adopted in interviews. In these cases, terms such as kindness and caring represented more meaningful constructs for participants. It could therefore be argued that these interviews subsequently explored the constructs of kindness and caring, rather than compassion. It must however be noted that despite this, the current model revealed processes involved in the enactment of compassion and definitional elements of compassion that corroborated much of the current literature in the area. It is also worth highlighting the

difficulties in distinguishing discretely between the affiliative emotions such as kindness, love, compassion, altruism, and caring, that have already been observed by others (Goetz, Keltner and Simon-Thomas, 2010).

The final participant number of nine was a reasonable one given the qualitative nature of the research and the subsequent collection of a rich data set (Barker, Pistrang, & Elliott, 2015). The difficulty proclaiming theoretical saturation of categories (highlighted in the previous chapter), however, presents a challenge in assessing whether nine was an adequate number to conclude that the resultant theoretical model was fully saturated in this case. This is perhaps not unusual given that the concept of saturation is in itself subjective (Charmaz, 2014; Guest, Bunce, & Johnson, 2006). Difficulties with recruitment meant that nine was the largest feasible participant size within the relative time constraints. Developing links with services and encouraging staff to review their caseloads for potential participants was time consuming. Furthermore, it was noted that a number of staff appeared to make their own judgement on whether a young person would want to engage with the research, and in some cases, this prevented them from approaching young people. This is a potential barrier that would be worth considering in future studies with this population and/or service.

As was highlighted earlier, the fact that many of the findings corroborated Gilbert's work on the compassionate mind (2010a) is perhaps unsurprising given that the interview schedule was built on his tri-directional social mentality theory of compassion. It must also be noted that although a full literature review was conducted following data analysis to promote the independence and openness of the analysis (Charmaz, 2006, 2014), the researcher did have some existing knowledge of the evolutionary theory of compassion. This is likely to have influenced the analysis in terms of the sensitising concepts (Charmaz, 2014) adopted by the researcher. However, attempts were made to limit this through self-reflexive practices such as memo and journal writing, and transparency of reporting within this text. Given the level of corroboration

the current study provides for the existing literature-base, it is of great importance that the findings here also point beyond these, to the complex interaction between a number of background and contextual factors in any experience of compassion. It is particularly worthy of note that the reciprocal interaction between self and the object of compassion (self or other) is a dynamic process, which continues to shape compassionate enactments throughout and after they happen.

4.4.1 Impact of the interview context. In-line with the constructivist paradigm of the present study, it is important to consider contextual factors that may have contributed to or shaped the results (Charmaz, 2006, 2014). Participants were each invited to comment on the interview process for them, but interestingly none chose to offer much feedback. It was however the researcher's sense that several participants were conscious of wanting to give the 'right' answers, with some needing considerable encouragement to be able to contribute to the interview, which may also explain the lack of feedback offered in relation to the interview process. This is perhaps unsurprising when considering that interviews were undertaken through the YOS – a service through which young people were usually accustomed to conversations around right and wrong. Additionally, adolescents are of an age where they frequently find themselves in situational contexts where there is a clear power imbalance and the figure in authority holds the 'correct answers', such as in educational establishments. Participants may have held back in their responses as a submissive self-protection strategy (i.e., to say nothing would be better than to say the wrong thing and invite criticism), which research suggests may be particularly likely in contexts where the other – in this case the researcher – is perceived as more powerful (Gilbert & Irons, 2009). This may therefore have limited the extent to which the resultant model reflects the full array of social realities and multiple truths experienced by participants.

Feedback from YOS workers also suggested that some young people had been worried that the interview would focus directly on their HSB. This concern could be understood in relation to the wider literature around stigmatisation (Goffman, 1968) and the proposed nature of shame in social functioning (Gilbert & Irons, 2009; Gilbert & Miles, 2002; Gilligan, 2003). If shame is such a powerful emotion, associated with rejection, humiliation, and social condemnation, participants may have been motivated to avoid discussions around behaviours that were likely to be socially denounced by others. To promote engagement and avoid breaching ethical conduct, the decision was taken not to question participants directly about their HSB. Most participants did not volunteer information about their offences and those who did refer to them, did so briefly. It would be beneficial for future research in this domain to consider how a more direct exploration of the role of compassion and shame in HSB might be facilitated whilst maintaining ethical values. Some suggestions are offered in section 4.5.2.

Efforts were taken to avoid the possible contextual factors highlighted above impacting on the results and subsequent trustworthiness of the study. Ethical and procedural considerations, such as reminding participants that there are no right or wrong answers and building rapport to help them feel more comfortable in the interview process, were employed in an attempt to limit threat-based responses, such as shame or anxiety, from interfering with participants' ability and motivation to engage with the interview process. Nevertheless, it remains likely that the interview context will have played a role in how data were accessed and analysed, and should therefore be held in mind as a likely influential factor – and potential barrier – in obtaining a detailed reflection of participants' understanding and experiences of compassion in this setting.

4.5 Implications of the Study

Important implications in the context of both clinical and research applications can be drawn from this research. These shall be addressed in turn below before some suggestions for future research are offered.

4.5.1 Clinical implications. The results suggested that for participants, trust was an important precursor to compassion. A lack of trust, or the perceived disingenuousness of another, acted as a contextual barrier to a potential compassionate experience, perhaps through the activation of threat-based self-protection strategies, which in some cases evoked anger, possibly underpinned by internalised shame. This finding has important implications for clinicians who wish to work with this population. It is likely that the development of trust is fundamental to working with this group, who are likely to have learnt from past experiences that others are untrustworthy and will cause them harm. Particular focus should be drawn to the relationship between young person and practitioner and how trust issues might be overcome, such as by being consistent, transparent, and dependable, and remaining sensitive to the likelihood that shame-reactions may be easily triggered. Involving trusted others, such as family, friends, teachers, etc., in the process of intervention may also be a way of addressing this issue. This notion would lend further support to the multi-systemic and multi-level approaches to interventions currently recommended for this group.

The findings support previous research suggesting that this population of young people have often had negative early interpersonal experiences involving rejection and criticism. This is important from a clinical perspective as it speaks to the likelihood that young people will be significantly impacted by internalised shame, as a result of the devastating impact of external threats to the self, experienced through rejection by significant others – including key attachment relationships – which will have ultimately affected the relationship with the self and the ability to form trusting relationships with authoritative others in future. Clinicians should be aware that

this group of young people are likely to be very high in shame and self-criticism, and this may play out through anger directed towards potential attachment figures (including clinicians) as a self-protection strategy. Whilst further research into the complex relationship between compassion and shame amongst this group will be needed in order to fully direct interventions, it is worth noting that developing self-compassion is likely to be difficult for those young people high in shame. Hermanto and Zuroff (2016) suggested that in such cases, concentration be focused on the other-directed caregiving and care-seeking behaviours which may be more tolerable for the individual, because, they reasoned, social mentality theory suggests that self-caring behaviour should follow on as a bi-product of this.

It may be important to also consider developmental perspectives when determining appropriate interventions. In particular, young people may not have developed the specific cognitive and affectual capacities demanded for a sophisticated understanding and experiencing of compassion to self and others. This may be for a number of reasons, including organic factors such as age or the presence of neurodevelopmental disorders like ID and ASD, or the young person's neurodevelopment may have been affected by social and environmental factors such as interpersonal abuse or neglect. Consideration should be paid to the likelihood that young people can further develop capacities such as ToM, empathy, and emotion regulation. In cases where such capacities can be developed, interventions would benefit from sequencing to allow this to happen prior to specific compassion-focussed interventions being implemented. In cases where these capacities are likely to remain delayed or immature, compassion-focused interventions may be misplaced and unrealistic. Instead, efforts may be more helpfully focused on interventions which capitalise on the factors associated with less mature moral reasoning; such as clarification of 'right and wrong' as determined by unilateral authority (Gibbs, 2010). There may however remain some argument for the implementation of experiential compassion-focused exercises, such as self-soothing practices. It could be argued that even in the absence of the cognitive

capacity to fully understand compassion or effectively perspective take, developing the soothe-system through experiential means may still enhance the affectual aspects of compassion, in turn moderating threat-based negative emotions such as anger and shame (Gilbert, 2010a).

4.5.2 Research implications and future directions. This study highlighted some potential methodological flaws to the quantitative approach currently adopted by much of the existing research on compassion. Firstly, the results of this study suggest that compassion is experienced by this group as a dynamic and relational process influenced by contextual factors. This would seem to suggest that compassionate experiences are context-dependent and changeable from moment to moment, raising clear limitations with any approach that seeks to measure a stable ‘level’ of compassion experienced over time and independent of context. Furthermore, this finding may present a challenge to some of the existing literature, which frames compassion, both to self and others, as a trait-like emotion and something to be cultivated (e.g. Neff, 2003a).

Additionally, the findings suggested that whilst participants could each relay personal experiences of compassion, there were apparent differences between them in their ability to discuss in detail compassion as an abstract concept. These differences appeared to reflect participants’ varying cognitive abilities associated with their age, level of education, and the presence or absence of an intellectual disability. This raises important implications for the use of self-report measures to explore compassion in this group, and people of varying cognitive abilities in general; if participants have difficulty in comprehending compassion as an abstract concept, or struggle with any of the language surrounding compassion, it may compromise their ability to accurately self-report their experience of compassion through a forced-choice questionnaire. It is suggested that there would be great benefit in conducting further research with the aim of developing a shared language for compassion, that is meaningful across a wide span of populations and not just to the academic field.

It was noted that the use of interviews in this context may have presented a barrier to data collection in that some participants may have struggled to fully articulate their experiences of compassion due to a lack of familiarity with the term compassion as an abstract concept. It may therefore be fruitful for future research to consider additional, creative ways that may enable participants to better share their compassionate experiences, or to also include interviews with others who know the young person – such as families and professionals. It has been acknowledged that factors associated with interview context, such as the presence of power differentials, may have led to some participants withholding or editing their contributions through fear of ‘getting it wrong.’ Future research with this population may seek to limit this by conducting interviews over several meetings – and thereby prolonging the time in which the young person can become familiar with and develop trust with the researcher (Lincoln & Guba, 1985; Shenton, 2004). They may also choose to recruit outside of criminal justice agencies to avoid association with punitive systems. A further alternative would be for interviews to be conducted by professionals who are already working with the young people, such as their YOS caseworkers.

Whilst the current findings appear to suggest a link between shame, self-criticism, anger, and compassion, as has been highlighted in much of the previous literature (Gilbert, 2005; Gilbert, 2010a; Gilbert & Irons, 2009; Gilbert & Miles, 2002; Gilligan, 2003), the complex relationship between these emotions, or constructs, remains little known. This research raised the question of whether self-compassion does in fact moderate shame, or whether shame instead becomes a contextual barrier to the enactment of (self-)compassion. There is currently little evidence to suggest whether this relationship is uni- or bi-directional, or involves the kind of reciprocal interaction that has been observed by so many of the factors contributing to compassion in this research. The challenge of how to further investigate this matter remains for future researchers. As a final point here, whilst the substantive model constructed through the

analysis is not intended to be ‘generalisable’ – in the positivist sense – to other populations or contexts, the categories observed may provide a useful basis from which to structure further research aiming to explore the meaning and experiences of compassion to self and others among young people who have engaged in HSB, across alternative contexts, as well as for other populations

4.6 Researcher Reflexivity

My decision to conduct research in this area stems from a longstanding interest in the nature of harmful behaviour and my experience of working with forensic populations around risk. I have always been intrigued by the apparent dichotomy between punishment and rehabilitation that exists within the ethos of services in the Criminal Justice System (CJS), and curious about the role of shame within this process. When I began my clinical training in 2014, I first came across the work of Gilbert (2010a) and the compassionate mind. Drawing on aspects of CFT in my clinical work at the time, I became curious about the clinical utility of compassion-focused interventions for forensic populations, and wondered about the feasibility of undertaking such work with individuals who were actively involved with the CJS and therefore caught within a system arguably designed to evoke shame in the name of desistance (McAlinden, 2005). A seed was planted. Over the coming months I familiarised myself with some of the literature on compassion, paying specific attention to the application of such theory to forensic groups, and was surprised to find there was relatively little published, aside from the odd study reporting on the efficacy of compassion-focused interventions for populations who had offended. I was even more surprised to find little published research exploring compassion as a construct. Most of the literature I came across seemed to frame compassion – both to self and others – as a relatively objective and stable concept, which could therefore be meaningfully measured through the administration of a standardised self-report questionnaire. From this stemmed my idea for the current research.

It seemed to me that the literature base on compassion would not only be greatly enhanced by a qualitative exploration of the meaning of compassion to a population of clinical interest, but this would also present an opportunity to explore compassion within a group for whom shame, and therefore compassion, were likely to be important constructs. Undertaking research in this area could pave the way for further research and interest, perhaps even eventually leading to enhanced knowledge and direction on which to develop clinical interventions. I therefore entered this research with some grounding in the existing literature, and could not be said to have conducted participant interviews from a complete blank slate. As I have mentioned previously, I adopted CGT for several reasons, but a significant one was its acknowledgment that I would be bringing my own subjectivity to the construction of knowledge. In addition to my previous reading of the compassion literature, I of course have my own personal experiences and understanding of (self-)compassion. Partly, these experiences informed my decision to explore this area. I, for example, have experienced difficulty when trying to complete a self-report measure of compassion myself; I have found it both a challenge to condense my experience across time to a single numerical value, and have also experienced a strong internal urge to moderate my answers in-line with my own beliefs around modesty and self-indulgence. Whilst it is unlikely that I will have eradicated all influence of my subjective experience from my interpretation of participant data, it was important for me to reflect on this potential throughout the research and try to avoid it where possible. The use of memos and reflective journaling were fundamental to this process.

Conducting the interviews with young people was a rewarding experience. After the time and effort expended in developing links in the corresponding YOSs and having many conversations with staff there about the potential barriers to interviewing participants, I had almost begun to lose hope that this research was even possible. Once the ball was rolling, however, I think both myself and YOS staff were surprised at the degree to which most

participants engaged. There is a lesson here, I think, in the danger of our presumptions about the abilities or motivations of others getting in the way of just asking a question. It is easy to see how this can prevent research from being undertaken with hard-to-reach groups, and may even contribute to why HSB is such an under-researched area currently.

Of course, there were some young people who expressed they did not wish to engage, as was their prerogative, but most who were asked did want to take part, and were able to offer some great insight into their experiences. It must be acknowledged that some interviews felt easier than others. For some young people, short, few-word responses meant that I prompted a lot more in my questioning, and I did wonder at times whether this led to more of a directive approach, rather than the open one aimed for in CGT (Charmaz, 2014). Whilst I tried to remain aware of this and limit it to the best of my ability, I certainly felt a pull in some interviews to take on more of an encouraging and reassuring role, perhaps in the process becoming slightly leading in my questioning. It is also important to note the challenge it was during some interviews to remain in the ‘researcher’ role, and not instead slip into my ‘Trainee Psychologist’ clinical role, whereby interviewing takes an entirely different shape. Trying to hold this in mind was particularly relevant when participants spoke about incredibly difficult interpersonal experiences and the impact these had for them. Again, remaining self-reflexive and providing an honest account of these issues here is important in the promotion of trustworthiness.

4.7 Conclusion

This study was the first – to the researcher’s knowledge – to explore the meaning and experience of compassion to self and others among young people who have engaged in HSB. The results indicated that whilst all participants could identify personal experiences of compassion, some were unfamiliar with the word ‘compassion’ and its definition in abstract terms. Compassionate enactments were influenced by a complex interaction between background and contextual factors. Whilst the specific stages in enacting compassion and many

of the factors influencing this supported much of the current literature in this area, the present results suggested that compassion may in fact be a much more dynamic, reciprocal, and context-dependent process than previously thought. In particular, factors associated with the relationship between the self and the object of compassion, such as trust and perceived agency, were important for participants. Previous experiences of social rejection (associated with shame and criticism) also played a key role. Whilst few participants spoke explicitly about compassion in the context of their HSB, some tentative links were made and will provide a useful platform for future research. It is hoped that this study will enrich the existing compassion literature-base, but also that further research interest will follow in the area of young people and HSB, who, despite accounting for over a quarter of sexual offences in the UK (Hackett, 2014), remain a relatively under-researched and under-resourced population.

4.8 Chapter Summary

This chapter provided an overview of the findings from the research, with a discussion of the key aspects of the resultant theoretical model in relation to extant literature. Strengths of the study were acknowledged, as well as potential limitations that should be borne in mind when considering the findings. Theoretical, clinical, and research implications were outlined, and suggestions for future research were made. Finally, the chapter closed with a reflexive account from the researcher, highlighting their positioning and learning throughout the research process.

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Appendix A

Information for staff



Information for staff

Compassion towards self and others among young people involved with youth offending services because of sexually harmful behaviour

There is a growing body of research which suggests that helping individuals to develop their ability to be compassionate with themselves can moderate negative effects associated with shame. For those at risk of sexual offending this is of particular relevance as the literature suggests that this population are particularly susceptible to high levels of shame, and shame has been linked to recidivism in this group. This is arguably even more relevant for young people who might sexually offend, as young people and adolescents are at an age where they are likely to be particularly vulnerable to the impact of negative judgements from others and feelings of social isolation, and therefore may be at further risk of heightened levels of shame.

Whilst support for the efficacy of compassion-focused interventions for other populations is growing, there has been limited research to suggest whether such interventions would be helpful for a forensic population, and particularly young offenders. Any research that has been carried out has tended to be questionnaire based in nature and has neglected to explore how these groups actually *understand* the concept of compassion. I feel it is crucial to gain some insight into the meaning of compassion towards oneself and others for this group, in the hope that this might inform further research in this area, and the potential development of compassion-focused interventions for this target population.

I am hoping to interview a minimum of 12 young people for up to an hour each. I will use a semi-structured interview to explore their understanding of and thoughts about compassion towards themselves and others, compassion from others, and will also be able to explore any concepts they raise themselves in relation to this topic.

It is not necessarily a problem if the young person is unfamiliar with the concept of compassion, as this research finding would be useful in itself.

To ensure the confidentiality of those who do not wish to participate, I would like to ask for your help in identifying young people you are working with who you think might be suitable for this study. I would be grateful if you could approach them with brief details of the research (please see 'guidance for staff discussing research with potential participants') and ask if they are happy for me to approach them with further information. I will then do this and seek to gain informed consent if they want to take part.

If you have any questions or concerns about this research, please feel free to contact me on the following details:

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Appendix B

Guidance for staff discussing research



Guidance for staff discussing research with potential participants

Compassion towards self and others among young people involved with youth offending services because of sexually harmful behaviour

I am interested in talking to young people about their understanding and experiences of compassion.

Potential participants must be:

- Males or Females
- Aged between 12 and 18 inclusive
- Currently involved with youth offending services because of sexually harmful behaviour

They must not be:

- Young people who are unable to give informed consent due to a learning or communication difficulty
- Young people for whom a mental health difficulty (e.g., psychosis) is likely to compromise their ability to give informed consent or to engage in the research
- Young people for whom you feel it would be inappropriate or harmful to include in the research (e.g., likely to become distressed by the interview process)

If you are currently working with someone who meets the criteria and you think may be interested, I would be grateful if you could approach them and their carers to see if they would be happy for me to contact them/their carers with more information about the research. They do not need to give their full consent at this stage, they are just expressing an interest and consenting for me to contact them with more information.

Please let them know that:

- The research will involve participants speaking to a researcher for up to an hour about their thoughts on compassion.
- The discussion will be recorded on a Dictaphone so that the researcher is able to remember everything and transcribe the discussion.
- The research will take place on Youth Offending Service premises. If the young person would like to take part but is unable to travel in to the relevant service, we may be able to consider alternative locations.

The research will not affect the service they receive from the YOS in any way.

Appendix C

Information for potential participants and carers



Information for potential participants and their carers

Research project: Compassion towards self and others among young people involved with youth offending services because of sexually harmful behaviour

What is the research about?

I am interested in talking to young people who are being seen by youth offending services because of sexually harmful behaviour, about their understanding and ideas on 'compassion' towards themselves and others.

Why is this important?

Compassion is an important area to research because previous studies have told us that helping people to become more compassionate with themselves can help them to overcome shame and self-criticism.

This is important for young people who are involved with services because of their sexual behaviour as people in this situation can sometimes experience high levels of shame and self-criticism.

High levels of shame and self-criticism have been linked to a number of negative experiences (like low mood), and may also increase the risk that somebody will commit an offence in the future.

Finding out what young people have to say about compassion might help us to develop interventions that will help people become more compassionate with themselves and reduce feelings of shame and self-criticism.

What will I need to do?

If you would like to take part in this study, I will arrange to meet with you to talk with you about your ideas on compassion. You can meet with me for up to an hour, depending on how much you want to say.

If you are not too sure what compassion is, it doesn't matter as we can look at some definitions together when we meet.

I am just interested in your ideas and there are no right or wrong answers!

Other things you need to know:

- I will record our discussions so that I can remember everything you say. The record of what you say in the discussion will be saved securely for three years and then deleted.
- If you are not happy to be recorded, we can talk about other ways of helping me to remember what you say.

- Everything you tell me during the research will be kept confidential (no one else will know you said it) and I will change any names or places you mention. The only exception to this is that if you say something that suggests that you or somebody else are at risk of harm, I will need to pass this information on to the appropriate person or service.
- I will also need to let the service know if you tell me about any offences you or anyone else have committed that aren't already known.
- If I do need to let anyone else know about anything you have told me, I will try my best to tell you before I do this.
- If you agree to meet with me, you can choose to stop our discussion at any time you want to.
- You can also choose to withdraw from the research by contacting the Youth Offending Service or me (details below) and letting us know. You can do this at any time up until the research is finalised, which is expected to be in April 2017.
- You will be able to see a summary of the findings from this research in approximately May 2017.
- Taking part in this research will not affect the service you receive from the Youth Offending Service in any way.
- If you agree to take part, you will receive a £10 gift voucher that can be redeemed in a selection of shops.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact the University of Essex Complaints department on 01206 874370 or studentconduct@essex.ac.uk

Thank you for taking time to find out more about this research. Please feel free to contact me to ask any further questions you may have.

Researcher details:

Sian Williams, Trainee Clinical Psychologist
 C/O School of Health and Human Sciences (D.ClinPsy)
 University of Essex
 Wivenhoe Park
 Colchester

Email: smwill@essex.ac.uk

Appendix D

Participant informed consent form



Participant Informed Consent Form

Please circle yes or no to indicate your consent:

- I have read or discussed and understood the information about this study and agree to take part:

Yes / No

- I understand that I will take part in an interview lasting for about an hour (or a number of short interviews that add up to about an hour), where I will be asked about my thoughts on 'compassion':

Yes / No

- I am happy for the interview to be recorded on a Dictaphone:

Yes / No

- I understand that I can stop the interview at any time if I want to:

Yes / No

- I understand that I can contact the Youth Offending Service or the researcher after the interview (up until April 2017) if I decide I want to withdraw from the study:

Yes / No

- I understand that what I say will be kept anonymous, unless I say something that suggests there may be a risk of harm to myself or others:

Yes / No

- I understand that if I do say something that suggests a risk of harm to myself or others, the researcher will need to pass this information on to the people who work with me from the Youth Offending Service, and maybe other professionals:

Yes / No

- I understand that taking part in this research will not affect my involvement with the Youth Offending Service, or the work they do with me, in any way:

Yes / No

- I have had a chance to ask any questions I have about the research before taking part:

Yes / No

- A summary of the findings from this research will be made available around May 2017. If you would like to receive this summary, please indicate here how you would like to receive it:

- Post Address: _____
- Email Email address: _____
- Phone Tel number: _____
- Via the Youth Offending Service – please note if you select this option a reminder will be sent to the relevant service to contact you with the summary once it is made available.
- I do not wish to receive a summary of the research findings

Signed: _____

Name: _____

Date: _____

Participant number: _____

Appendix E

Carer informed consent form

**Carer Informed Consent Form**

Please circle yes or no to indicate your consent:

- I have read and understood the information about this study and am happy for _____ [name of young person] to take part:
Yes / No
- I understand that they will take part in an interview lasting for up to an hour, or a number of short interviews adding up to about an hour, where they will be asked about their thoughts on 'compassion':
Yes / No
- I am happy for the interview with _____ [name] to be recorded on a dictaphone.
Yes / No
- I understand that _____ [name] can stop the interview at any time if they want to:
Yes / No
- I understand that _____ [name] or I can contact the Youth Offending Service or the researcher after the interview (up until April 2017) if either of us decide we don't want _____ [name]'s interview to be used in the research:
Yes / No
- I understand that what _____ [name] says will remain confidential, unless they say something that suggests there may be a risk of harm to themselves or others, or disclose an offence, in which case this will need to be passed on to the appropriate people:
Yes / No
- I understand that taking part in this research will not affect the input _____ [name] receives from the Youth Offending Service in any way.
Yes / No
- I have had a chance to ask any questions I have about the research before giving permission for _____ [name] to take part:
Yes / No

- A summary of the findings from this research will be made available around May 2017. If you would like to receive this summary, please indicate here how you would like to receive it:

- Post Address: _____
- Email Email address: _____
- Via the Youth Offending Service – please note if you select this option a reminder will be sent to the relevant service to contact you with the summary once it is made available.
- I do not wish to receive a summary of the research findings

Signed: _____

Name: _____

Relationship to participant: _____

Date: _____

Participant number: _____

Appendix F
Additional participant information form

Additional Participant Information Form



Participant number: _____

Age: _____

Gender: _____

Ethnicity: _____

Religion: _____

Education level: _____

Mental health diagnoses: _____

Drug or alcohol use: _____

Nature of harmful behaviour: _____

Resulted in conviction?: Yes / No Number of previous offences (if any): _____

Nature of other offences: _____

How long have you been receiving input from YOS?: _____

Details of interventions already received from YOS:

Other services involved: _____

Do you give consent for the researcher to contact the Youth Offending Service and check the above information?:

Yes / No

Signed (participant): _____

Signed (carer): _____

Date: _____

Appendix G

Interview schedule

"I wanted to ask your thoughts on a particular topic today. Please remember that there are no right or wrong answers and that I am looking for your ideas on the different things we cover. It is your experiences and thoughts that I am most interested in. I will probably ask you at different times to explain to me in more detail or in a different way what you have said because I am interested in what you have to say and want to understand it better."

Establish what is understood by compassion:

Have you heard the word 'compassion' before? I am interested in what 'compassion' means to you? *[Focus on the various aspects that the individual suggests in their definitions and go into these in more detail].*

- What comes to mind when you think about compassion? Why do you think this comes to mind?
- What particular people/objects/things would you associate with being compassionate? *[Focus on any examples the individual suggests and explore the significance of these].*

I have some definitions of compassion here and I wondered if we can have a look at them and see what you think:

[Present interviewee with some definitions of compassion]

- What do you think of these definitions?
- Is there one that you prefer?
- What do you/don't you like about them?

[Depending on the participants' conceptualisation of compassion, the word 'compassion' may be substituted for the remainder of the interview with other words the participant uses (e.g. kindness) if it is deemed that continued use of the word 'compassion' would prevent them from engaging in the interview]

Focus on compassion from others:

What do you think about other people being compassionate towards you/showing you compassion?

- How have people shown you compassion? What things have people done for you that you think were compassionate?
- Who has shown you compassion in the past?
- When is it easy to accept compassion from others?
- When is it hard to accept compassion from others?

- What does it feel like when other people are compassionate towards you/show you compassion (versus times when they are maybe not quite so understanding or forgiving)?
- What are the good things about other people being compassionate towards you?
- What things aren't so good about other people being compassionate towards you?

Focus on compassion towards others:

What do you think about you showing compassion to other people?

- How have you shown compassion towards others before? What things have you done for others that you think were compassionate?
- Who have you shown compassion for in the past?
- When is it easy to be compassionate towards others?
- When is it hard to be compassionate towards others?
- What does it feel like when you show compassion towards other people (versus times when it is more difficult to be quite so understanding or forgiving)?
- What's good about being able to show compassion to others (e.g., when they make mistakes)?
- What isn't so good about showing compassion to others (e.g., when they make mistakes)?

Focus on compassion towards self (self-compassion):

What do you think about being compassionate towards yourself?

- How do you tend to react with yourself when you make mistakes/get things wrong/don't do as well as you wanted to?
- How do you show yourself compassion? What things do you do for yourself that you think are compassionate?
- When is it easy to be compassionate towards yourself?
- When is it hard to be compassionate towards yourself?
- What does it feel like when you show yourself compassion (versus times when you are maybe not quite so understanding/forgiving of yourself)?
- What's good about being able to be compassionate towards yourself (e.g., when you make mistakes)?

- What's not so good about being compassionate towards yourself (e.g., when you make mistakes)?

How do you think people could learn to be more compassionate with themselves?

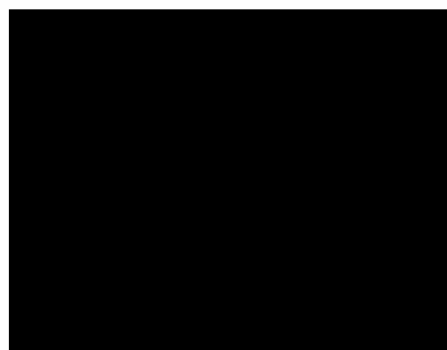
Focus on other constructs:

We have talked about quite a few things today that have all linked together in different ways. What other ideas or experiences that we have not thought about do you think would link to our discussion?

Do you have any other thoughts about anything that we have talked about? Or do you have any comments about the discussion itself?

Appendix H

Research governance and ethical approval from the three Youth Offending Services
(anonymised)



24 April 2016

Dear Sian,

Re: *Compassion towards self and others among young people involved with youth offending services because of sexually harmful behaviour*

I write to confirm that the [REDACTED] Service Ethics and Research Board have approved your above titled research proposal.

In undertaking research at [REDACTED] Service, you are formally agreeing to provide us with your final research paper upon completion of the work within three months of the estimated end date you gave on the [REDACTED] Proposal form.

Your research paper must be submitted in both paper-based, bound format and as an electronic PDF file. You will be contacted shortly after the estimated end date to confirm submission of your work.

Copyright for completed research is retained by the author(s) as standard but [REDACTED] reserves the right to use and reproduce research, including data, it has approved, either partially or in full, both internally and externally. Authors will be accredited where their research report is so used.

Your research will be made available to [REDACTED] practitioners.

Yours sincerely,

[REDACTED]



Hi Sian,

Thank you for your proposal, it's looks really interesting.

The Head of Service is happy for the research to go ahead as long as the parental/carer consent is given for all participants as you said.

It might be worth thinking about the language you use, as many of our cases do not come through criminal justice routes (more often social care) so many have not been convicted of an 'offence'. We tend to refer to incident/s as sexually harmful behaviour in most cases (just looking at further information form). It also might be worth considering keeping the language reasonably simple, as many of the people in the service have some learning/neuro difficulties. Some young people may not know what compassion means but I see you will use some examples. Just from personal experience of doing qualitative research you might find that there are a lot of questions-if people are at all talkative you can get a huge amount of data from just 5 or 6 questions....with teenagers though they can be more brief with responses so you might be ok!

I'll leave it with [REDACTED] to liaise with you and identify potential participants. Good luck!!

Warm wishes

[REDACTED]

[REDACTED]

Consultant Counselling Psychologist
Youth Offending Service

[REDACTED]

Boot Julie <Julie.Boot@cambridgeshire.gov.uk>

|
Fri 22/07/2016, 16:30

Good afternoon Sian

I have received no objections to your research application and therefore happy to confirm approval is granted for you to proceed.

With kind regards

Julie

Appendix I

Ethical approval from University of Essex

02 March 2018

MISS S. WILLIAMS

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Dear Sian,

Re: Ethical Approval Application (Ref 15031)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

[REDACTED]

Ethics Administrator

School of Health and Human Sciences

cc. Research Governance and Planning Manager, REO
Supervisor

Appendix J

Initial coding

Key: Interviewer (black); Participant (blue)

73	[Like, 'ooo, I was only asking!' [laughing]. But yeah, you don't really know how they're gonna react to	Comment [SW1]: Not knowing the other limits ability to judge reaction
74	you anyway.] So, I find it easier just to ask the people I know, otherwise you're just gonna get a	Comment [SW2]: Risking being harmed if you veer from what you know (safety)
75	punch in the face, and I don't need anymore of those [laughs].	
76	That point, just, before I forget that point, I know you're kind of half joking it sounds about the	
77	punch in the face, but actually, it's an important thing, because do you think that sometimes, if you	
78	tried to show compassion and it's the wrong thing for that person, that actually, it can have a	
79	negative impact? Um, like, when you sort of say there about getting a punch in the face, do I take	
80	that to mean that actually, people can react negatively sometimes?	
81	[Yeah. They can tell you to mind your own business.]	Comment [SW3]: Rejecting compassion
82	Right.	
83	[Which, I get, but if you're giving the vibe that you're... wanting attention, or something... You don't	Comment [SW4]: Recognising/interpreting need for compassion
84	do that expecting someone to tell you to mind your own business. [Like it's, like a baby, like crying,	Comment [SW5]: Misjudging compassion
85	silent means it's upset and not wanting attention, but if you're crying and making a song and dance	Comment [SW6]: Appraising cues to suffering
86	of it, you know you want attention. It's like a baby doing that and then saying 'no I don't want	Comment [SW7]: Mismatch between cues to suffering and intention
87	nothing to do with you']	
88	Mmm. So it can be quite confusing it sounds?	
89	[My brother, yes! [laughs].	
90	So your brother...	
91	And he's 11.]	Comment [SW8]: Experiences of mismatched cue to suffering and compassionate response with brother
92	Right, ok.	
93	[Yeah. So, yeah. You need... It's about reading how they are. But if you, like, like I say, it's easier if	Comment [SW9]: Being sensitive to cues from the other
94	you know them. Cos you get used to them and you know how they act, or react.]	Comment [SW10]: Knowing the other makes responses easier to predict
95	Yeah. Ok. Something else you said earlier on was about, um, perhaps if you, one of your friends is in	
96	a bit of a bad place, you might, sometimes might, it might only take sitting down with a coffee and	
97	some doughnuts I think you said? I thought that was quite a nice image of something you might do	
98	for someone to um, give them the time to talk to you.	
99	[I know he just won't talk without doughnuts [laughs].	Comment [SW11]: Using knowledge of other in deciding how to act
100	[Laughs]	Comment [SW12]: Knowing what they like
101	[That's the bribe. I get doughnuts, you talk!]	Comment [SW13]: Transactional interaction
102	Ok! So it's a way of getting people to open up to you?	
103	Yeah. Yeah.	
104	I see. So, it sounds like that's obviously something quite physical isn't it, to give somebody	Comment [SW14]: Respecting their choice
105	something. Um, are there, is that kind of the main way that you might show somebody compassion,	Comment [SW15]: Promoting agency
106	by giving them something, or are there other ways that you can do that?	Comment [SW16]: Using knowledge of the other to aid compassion
107	[Not necessarily, sometimes you just say 'right, talk, or if you don't wanna talk I'll give you space' it's	
108	it's their choice]. But I know with that particular person, doughnuts is a way in. But, like I said,	
109	knowing people helps.]	

Key: Interviewer (black); Participant (blue)

110 Yeah.

111 But, if you don't know them, you need to be careful of what you say and how you do it and,
 112 otherwise you're likely to, just push them away more or either that get dedked for your trouble. But,
 113 you need to just be careful how you, how you treat people anyway...

114 Yeah

115 But, yeah, be careful.

116 What do you think might, so, let's just, for example, say there was a situation where you did try to
 117 ask somebody what was up and they did push you away, what, what do you think it might be that
 118 might make them do that, why would they...

119 Probably because it's private or...

120 Ok

121 Delicate information or, they probably might just not like you anyway

122 Right

123 Like, I can remember I made a really bad mistake when I was bullied at school. One of the guys was
 124 really down who actually bullied me a lot, and I went up to him and said 'what's wrong?' and then he
 125 bullied me more for asking him what was wrong, and I don't really know why, that, I tried to help
 126 them, even though they'd done nothing but cause me ache for years upon years, and I just asked
 127 him, quite simply, 'are you ok?' and he was like 'it's nothing to do with you.' Then he started pushing
 128 me over, all sorts, and I just think 'wow.' That, that that was... yeah... that's the, why I'm now very
 129 cautious with... Like, my friends, I can just like, say anything to them, and we can swear at each
 130 other and have a joke, cos I don't take it seriously cos I know them. But if some guy, or you, or
 131 anyone else, come up to me in the street and says 'it's got nothing to do with you, F off' I'm like,
 132 'well fine, I'll go back to my doughnuts.' But [laughs] you don't, you need to be careful of what you
 133 say to people. Espedaly when you're trying to help them. Like, you was only trying to help them,
 134 they, they're, you didn't go up to them to get treated like that. So, yeah, you... some people just like
 135 being grumpy I think.

136 So do, do I take from that example then, that, the fact that you've experienced that, that you've
 137 tried to reach out to someone and they've sort of, been quite horrible to you actually, um, that
 138 that's affected the way you would then treat people that you don't know so well?

139 Yeah

140 That's where the caution's come from?

141 I try and keep well away. Like, other people know them people better than I know them. Like I
 142 know my friends better than other people know them. So if I stick to the people I know, and help
 143 them, I can focus on their issues more, and other people can help the grumpies do what, do their
 144 thing. Cos, whether they're, like, if they're like that to people that they know, the people they
 145 know are used to that, so it will shock them less than it would shock me, and probably hurt me more
 146 than it'd hurt them. So, if I stick to my friends and they tell me to 'F off' I'd be like 'nah, we're
 147 talking' but if someone else told me to 'F off' I'd be like 'fine, your loss. You do your thing, I'll do my
 148 thing.'

Comment [SW17]: (not) knowing the other

Comment [SW18]: Being careful

Comment [SW19]: Getting it wrong

Comment [SW20]: Losing connection / feeling isolated

Comment [SW21]: Getting it wrong posing threat to self

Comment [SW22]: Choosing what to share

Comment [SW23]: Importance of relationship

Comment [SW24]: Getting it (compassion) wrong

Comment [SW25]: Misjudging compassion

Comment [SW26]: Learning from past negative experiences

Comment [SW27]: Importance of knowing the other

Comment [SW28]: Being careful to protect self

Comment [SW29]: Unexpected outcome

Comment [SW30]: Some people are grumpy

Comment [SW31]: Seeking distance from unknown others

Comment [SW32]: Avoiding unpredictability

Comment [SW33]: Sticking to what/who you know

Comment [SW34]: Friends take care of friends

Comment [SW35]: Protecting self from expected hurt

Comment [SW36]: Adapting helping behaviour depending on the other

Key: Interviewer (black); Participant (blue)

149 So the relationship between the person giving the compassion and the person receiving it is quite
150 important to how you would respond to that?

151 Yeah.

152 Ok. What, are there particular things that – you've talked about a lot of stuff already, but when you
153 think about just the word compassion and what it means, are there particular images that come to
154 mind, or people that come to mind that you really associate with compassion.

155 [guess it's more like a pep talk and pat on the back, I guess, like comforting someone, I think that's
156 all I see from it. [like, with my friends, I don't, like, take the mickey out of them] br, I just like, we
157 need to talk about it and sort it out cos you're being depressing and it's depressing me, and when I
158 get depressed it's not great. [so, I try and help people more, and they help me back in return, and it's
159 just a cycle, they help me I help them]

160 Right.

161 [so it's a trusting as well] cos if I trust them with the things that's upset me, they trust me back. [so if I
162 don't trust someone, I'm not gonna tell them what's wrong. It's like me blurting out my whole life
163 story to you, and, you know, it, it wouldn't help me cos then I'd be panicking 'oh god [researcher]
164 knows this, [researcher] knows that, [researcher] could tell people this and that' and, rumours, like
165 I've experienced before, spread almost as quick as a fire in a forest, it's not great. So, I know I can
166 trust my friends, I mean, that friend might tell another friend who knows, but, I know my friend
167 group and I know the limits it would go. But if I, I don't know you or who you know, so it could be all
168 over London by tonight, and I know people in London, and that wouldn't be great. So... Yeah, it's,
169 it's about knowing who you're talking to and who you're, what you're saying to people as well. Like
170 you can show, you can show you trust in someone, and they can show that you can trust them, but it
171 might not necessarily be true.]

172 Yeah. No I get, I understand what you're saying there, and it's, that trust's a key part of that

173 [hence the punch in the face]

174 Yes. Yeah, so that's been quite an important, um, learning curve it sounds for you, and and
175 experience?

176 [like, I thought I could trust that girlfriend but then she went out with a guy who hurt me quite badly
177 last year, and, she said beforehand, like, she tried to comfort me about it and say 'no everything's
178 fine' and everything, and then she goes out with him. [that's compassion and being stabbed in the
179 back afterwards, which didn't help the compassion in the first place cos that weren't showing
180 compassion. That was 'I'm gonna try and find out what's gonna get to you and then I'm gonna just
181 mess you up anyway.' And that's why you need to be careful.]

182 Yeah. So it's important to, for the person you would show compassion, to have trust with them

183 Mmhmm.

184 And it sounds like what you're saying is that there's also some sort of understanding that actually
185 they'll be able to return that at some point if you were to need that?

186 [Not stab you in the back.]

187 Ok. Now, I know you used it just as an example, but I just wanted to reiterate in terms of this
188 interview, just because you're talking about, kind of, people stabbing you in the back and saying

Comment [SW37]: Defining compassion

Comment [SW38]: Pep talk

Comment [SW39]: Pat on back

Comment [SW40]: Respecting the other's suffering

Comment [SW41]: Not ridiculing/humiliating

Comment [SW42]: Gaining benefits for self from helping other

Comment [SW43]: Reciprocal interaction/transaction?

Comment [SW44]: valuing trust

Comment [SW45]: Reciprocal trusting

Comment [SW46]: Compassion in the absence of trust is risky – threat to self?

Comment [SW47]: Trying to help in absence of trust runs risk of harm

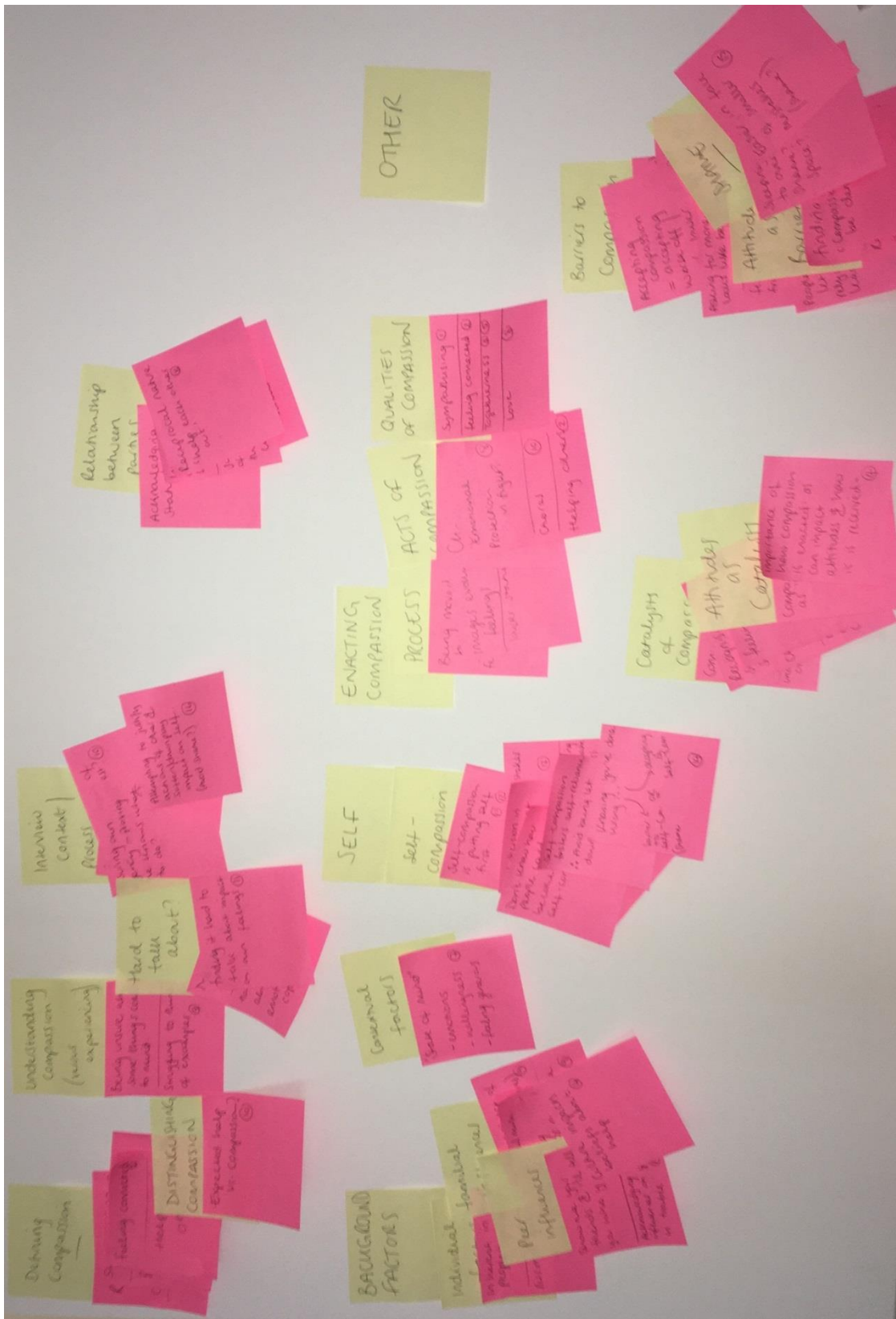
Comment [SW48]: Past experience of trust being broken

Comment [SW49]: Meaning of compassion can change overtime

Comment [SW50]: Mutual respect

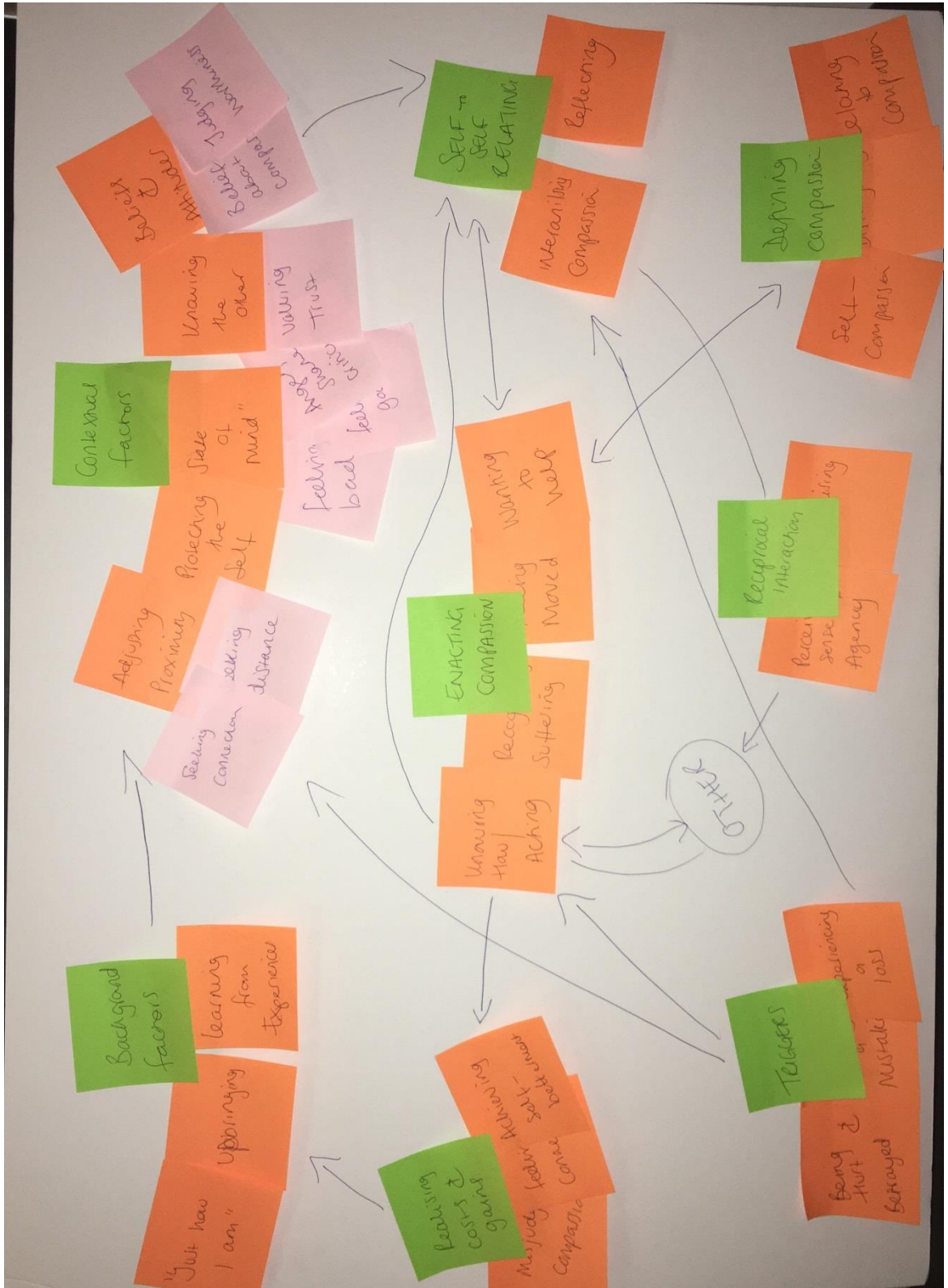
Appendix K

Focused coding



Appendix L

Theoretical coding



Appendix M

Memo

01.07.17 - Valuing trust

The importance of trust featured again in the final two interviews. I wasn't necessarily expecting this to be a central theme at first, as I wondered if young people might speak about compassion in quite general terms – drawing on examples of charity and/or the kinds of explicit suffering that confront us in our everyday lives for which there are strong social scripts (homelessness, etc.), but I have been surprised at the level of personal experience participants have shared. (I wonder why I didn't expect them to articulate this level of personal experience? Was I perhaps making similar assumptions to some of the staff at the YOS and expecting this will be too complex a topic for young people?!). Nevertheless, trust seems very important. I don't think I have guided anyone to the topic of trust, but must go back and double check my line of questioning before it arises.

But why is trust so important? Well, it seems to provide some reassurance about the others' intentions. When compassion is sought from others, communicating suffering appears to represent an exposure of vulnerability – in fact, some participants have spoken about experiences of seeking help from others and in turn being ridiculed or having their difficulties shared with others without their permission. When offering compassion to another, some participants have talked about being able to trust that the other won't respond in a way that will present a risk to them – “get a punch in the face for my troubles” as participant 4 put it. In this way, it seems to link inextricably to the importance of ‘protecting the self.’

05.07.17 - Another thought occurred to me when I looked back over participant 4's transcript. There is something about the perceived genuineness of the others' compassionate act... I had initially conceptualised this as linking to perceived agency in deciding/wanting to help – and I think that still holds true – but there does appear to be a link to trust here as well. Something

about trusting the other's actions/compassion come from a genuine place of valuing the self and wanting to help? I think this could be important in terms of professionals working with young people as they maybe need to trust that professionals truly want to help and this may be harder to believe if you have had a multitude of experiences where people have let you down or behaved in a way that communicates they don't really care? I must go back through the data to clarify these links.

Appendix N

Reflexive journal entry

31.03.17: Interview 7

Just arrived home from meeting with participant 7. I was thinking lots about the interview on the way home in the car and I'm not sure quite what to make of it. It was definitely the shortest interview so far and I found myself doing considerably more prompting and 'space filling' than previously I think. He was a pleasant young man and I didn't think he seemed particularly nervous, although I did sense at times he may have been a little unsure of what I meant in my questioning. The funny thing was, having spent most of the interview giving very short, often single-word answers or responding with 'I don't know', as soon as we reached the end of the interview he launched into quite a detailed story about what he had been up to the night before and how he had helped his foster carer out with various things (feeding the dogs, making her a tea). I am wondering now what had got in the way of us having some more detailed discussion during the interview? Could it have been the subject matter – too abstract, unfamiliar perhaps? Or maybe it was the set-up of me asking questions and him feeling he needed to know the right answers? I tried lots of reassurance during the interview but something definitely got in the way. I'm a bit worried I may have been too directive in some of my questioning because of his difficulty(?) engaging. Must take note of this when transcribing and coding. I'm wondering whether ideally, this participant group should be interviewed by someone they already have knowledge of and have built rapport with? An idea for future research perhaps?

Good news though! [YOS worker] thinks he may have another two, or possibly even three, cases who may be suitable to take part. One of whom is a female! I've let him know how keen I would be to interview her given the fact gender differences have been raised in previous interviews – and of course the fact that it seems to be such a rarity that girls fall under the YOS for HSB. Fingers crossed!