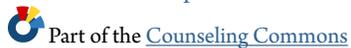

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Beyond the Pink Ribbon: An exploration of the experience of self-compassion in
Western Australian women survivors of breast cancer

Helen Wilson
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Chapter Eight

Relevance of self-compassion for counselling

8.1 Overview

“Ribbon awareness”, especially the pink ribbon movement has brought hyper-visibility to BC (Bell, 2014; Sulik, 2011). However, benefits survivors might receive from this heightened public profile need to be measured against the potential for invisibility of struggles some BCS encounter in daily living (Koczwara & Ward, 2015; O’Keeffe, 2004). Those struggles relate to efforts to maintain both a healthy physical as well as a healthy psychological self. Maintenance of a positive self-relationship becomes paramount at a time when intense connection from medical support has diminished and a BCS seeks to re-establish themselves in a social world unaffected by cancer. Establishing restoration of a pre-cancer self, can be a challenge for women who experience pressure to comply with the performance expectations in socially dictated roles of wife, mother, caretaker, and nurturer (Hesse-Biber & Leavy, 2013; Sulik, 2011). In addition, the culture that surrounds BC in Australia means BCS carry mean women perceive they are responsible for taking steps to care for their health through diet and exercise, in the hope that this will limit the chances of recurrence. Survivors are may also feel responsible for finding the personal endurance to survive, regain their femininity through accepting and following examples modelled, and strive for a return to the ‘normality’ of their pre-BC life (Gibson et al., 2014).

Although an optimal approach to the care of psycho-social needs of BCS may not yet have been clearly formulated or universally accepted (Halpern et al., 2015; Howell et al., 2012), awareness of the extent of variables involved in health care for BCS means the spectrum of treatment and recovery currently reflects more of an holistic 21st Century perspective (Brennan & Houssami, 2011; Geffen, 2010; Rettger et al., 2015; Reyes, 2012; Rowland, 2008). In addition to improved clinical outcomes

to BC, emergence of a coordinated, and refreshed, care etiquette for BCS calls for consideration of support for the whole person (Geffen, 2010). Ideally a BC care approach to psychosocial needs and EWB would combine an interest in physical, psychological, social and spiritual wellbeing of BCS (Ben-Arye & Visser, 2012; Carlson, Speca, Patel, & Goodey, 2004; Dodds, 1999; Howell et al., 2012; Koithan, 2009).

Psychological factors that impinge on physical and psychological well-being have been well-researched in relation to BC and quality of life for a survivor (Fallowfield & Jenkins, 2015). In addition the genesis and incidence of post-BC depression and anxiety have been extensively documented (Burgess et al., 2005; Deshields et al., 2006; Enache, 2012; Hanchate et al., 2010; Hill et al., 2011; Hopko et al., 2015; Kvillemo & Bränström, 2014; Reich et al., 2008). What stands out from a variety of studies is an overall desire to positively support an uncomfortable transition and improve quality of life for BCS.

The data gathering process for this thesis involved collection of information about the experience of ensuing complexities of the self-relationship post-BC. Collection of the narratives of BCS involved personal interviews in addition to, for some participants, engagement in OtSC sessions and a Personal Reflection Program. The valuing of open-hearted self-care for their own emotional and physical well-being presented itself consistently as a quality to life that the women sought, or at very least, felt was highly desirable.

The actual dialogues with participants were interpreted as suggestive, however, of a 'return', after initial treatment, to less than healthy habits that could be viewed as reflection of learned inclinations toward less-than-compassionate self-relating. The emergent indications were that influences of past relational and attachment experiences continued to dominate the self-relational aspect of life. This return to habitual patterns of self-relating was something that seemed to call for particular attention. Each of the women spoke optimistically about the likelihood of a lengthy survivorship. None of the women had, prior to participation in this study, chosen to engage in any personal development. Their focus had definitely been on physical survival. The question this thesis sought to explore was, in part, the

contribution of counselling with a self-compassionate focus as a way to nurture self and improve overall survivorship experiences for BCS across the long term. It was hypothesised that in the evolving ‘landscape of survivorship’ SC could sustain emotional resources needed to contain negative feelings evoked by unwanted remembrances of the treatment regime. Similarly, there was a question about fear of cancer recurrence and whether training in SC could provide relief from what might have been a lifelong pattern of ruminative coping.

The public perception is that there is awareness and understanding of the ‘common-sense notions’ constituting the central concepts of both counselling and SC. The direction of SC is to be self-forgiving, to kindly acknowledge one’s humanity, as well as allow oneself (and others) not to be perfect (Neff, Kirkpatrick, & Rude, 2007), promotes a balanced attitude toward the self, and especially self in relation to others (Hall, Row, Wuensch, & Godley, 2013; Wegdan, 2012). Importantly, while large numbers of people may claim to be aware of the basic tenets of SC, the practice of being self-compassionate can slip away when adversity challenges emotional equilibrium. What this generalised ‘awareness’ and generalised ‘emotional amnesia’ highlights is that while the concept of self-compassion may be reasonably simple to explain, and the ‘doing’ of SC comfortable to embrace at a cognitive level, the ‘being’ aspect of SC takes time and practice (Desmond, 2016). SC calls for both practice and engagement and requires a willingness to become exquisitely aware of all aspects of ourselves without comment from a self-critical internal ‘voice’ (Desmond, 2016).

As a profession, counselling requires a practitioner to be able to understand a client’s suffering and their loss of control (because of BC), and at the same time convey nurturance and a deep sense of compassionate caring for personal and environmental stressors clients face (Corey, 2015). Significant benefits as a result of psychosocial interventions such as counselling means when confronted with intense emotional reactions to either past remembrances or future fears a woman does not find herself standing alone in the face of overwhelming emotions.

Of therapeutic endeavours it would be safe to say that “most therapists assume that compassion is an important part of psychotherapy” (Germer & Neff,

2013, p. 856). Importantly, research findings into the specific concept of self-compassion have unequivocally indicated that kindness to self, capacity to tolerate difficult feelings without over-identification with those feelings, and embracing a 'bigger picture' perspective of life challenges can be a predictor of mental health (Neff et al., 2007, p. 909).

Routine, ongoing care for BCS now requires that psychosocial care be well integrated into a perspective that shifts the focus from “how long to how well patients live” (Fallowfield & Jenkins, 2015). Part of the problem may be lack of a “generally accepted definition of what constitutes good-quality counselling” (Kaakinen, Kyngäs, & Kääriäinen, 2013, p. 2705) that is offered beyond crisis counselling, offered either at the time of diagnosis or in the time when medical treatment has been completed. In addition there is also a lack of acknowledged processes for assessment of the quality of counselling provided to chronically ill adults (Kaakinen et al., 2013, p. 2705). The presence of a person trained to be able to listen and provide emotional support is important for BCS. Post-treatment for BC a survivor may have used up all their available physical and psychological resources or may not have in place available social supports (Bohart & Tallman, 1999). The implication and relevance for counselling is a challenge to the notion that the process of re-educating a mind to think differently is the most effective way to have a person make clearer life choices and take action steps.

What this means is that provision of individualised client-focused care for emotional needs of a person with a chronic illness requires skills, knowledge and understanding of “when [patients] are psychologically ready to make changes and to encourage changes at a pace that suits the [‘patients’] needs” (Gambling & Long, 2010, p. 225). Even in its simplest version, however, good quality professional counselling, as a process for psychosocial wellbeing for BCS, would be expected to support a qualitative shift that offers a survivor the ability to carry their experience of BC less heavily.

Counselling with self-compassion as a key ‘resource’ means that a BCS can adopt the skills of giving affective nurturance to themselves through self-caring actions that become part of life. Bringing SC as the basis to help shift a woman’s

emotional proximity to her BC experience means that event can be safely explored in a way that will enhance rather than detract from her quality of life. Self-kindness and the skills of SC are then tools for living that can support the post-BC woman to psychologically create a place of “inner safety and refuge” (Germer & Neff, 2013, p. 866).

To be self-compassionate would stand in contrast to sporadic engagement in self-care or self-nurturance, isolated to a time when BCS regard themselves as ‘ill’. Cultivation of SC, over time and with the support of counselling that seeks to promote an increased desire for wellbeing and a capacity to proactively make changes in life, makes SC highly relevant for counselling BCS.

With regard to cultivation of a more self-compassionate way of relating with self and the world, engagement with counselling can support development of ‘inner life skills’ (ILS). Development of ILS has been hypothesised as a perspective or attitude towards oneself that can favourably influence restoration of a diminished, or lost, self-communication as well as foster a ‘self-connected’ mindset (Pearson & Wilson, 2009). In contrast to a technique-driven approach, connection with one’s ILS makes a therapeutic approach highly compatible with the core principles of SC.

The potentially active component of ILS is the notion that deeper awareness and understanding of our emotional state positively aids attempts to solve challenges that arise in social living (Keltner & Haidt, 2001). The notion of ILS supports regarding a client’s capacity for [emotional] self-healing and self-regulation as an integral part of a counselling process (Bohart & Tallman, 1999). Contact with emotions in a non-judgmental and self-reassuring way has been found to predict improved mood, develop authoritative self-knowledge and at the same time generate self-kindness and self-comfort (Odou & Brinker, 2014).

The idea behind development of ILS is not to find ways to avoid any unpleasant realities of life, but rather to create a mindset that is open to both the joys and pains of life without getting lost in, or overwhelmed by, either perspective (Pearson & Wilson, 2009). The corollary of self-connectedness has been found to be reduction in negative affect and improvements in coping with difficult emotions

(Oudou & Brinker, 2015). This makes SC critical for managing side effects of medical treatment as the BCS transitions from patient to survivor. More importantly is the encouragement being self-compassionate brings as BCS encounter late side effects associated with BC. Additionally connectedness with self has been argued to foster more harmonious relationship with external social and emotional environments (Kristeller & Johnson, 2005; Reyes, 2012). Associations between the disparate elements of positive self and other relationships are depicted in Diagram 8.



Diagram 8: Associations between elements of healthy relating

8.2 Relevance of counselling and self-compassion for breast cancer survivorship

The relevance of counselling and SC for BCS is that the unfolding of a natural psychological healing process, through active participation in their therapy, can be extended with provision of a client-focused, pluralistic approach to counselling (Cooper & McLeod, 2011). In practice counselling sessions would be tailored to suit an individual survivor's readiness to engage, their current emotional needs and level of distress tolerance, and consideration of whether anticipated outcomes are compatible with their lifestyle (Pinto-Gouveia et al., 2014). Tailoring therapy so that it includes an intervention that can promote self-acceptance and self-forgiveness is likely to enhance the effectiveness of counselling for BCS.

One significant aim in counselling support for BCS would be to avoid 'difference blindness' (Smith & Shin, 2014). In the case of BC, difference blindness refers to assumptions that women survivors of BC would, in general, benefit from a

therapy that was identical in technical style, and created as a formulated, manualised approach. This means that while survivors will have commonalities in their psychosocial needs, the expression of that need may be different in each person. This may call for revision of how the psychosocial needs of women survivors of BC are interpreted and understood within clinically-driven environments.

SC as an important emotional regulation strategy is foundational to communication guided by a frame of mind that “enables one to clearly observe one’s experience of the present moment, whether positive or negative and to be mindfully aware of one’s maladaptive patterns of thought, feeling and behaviours” (Pinto-Gouveia et al., 2014, p. 312). This holds potentiality for times when BCS feel confronted by “painful life situations that may be outside [their] control” (Neff & Germer, 2013, p. 856). With SC as the ‘backbone’ of a therapeutic process, BCS can gain a sense of connection rather than isolation in their suffering. Understanding and practicing the concept of seeing life events in a ‘bigger picture’ along with the habit of self-nurturance when recalling difficult emotions can provide a ‘safety net’ for in-session exploration of intense emotional pain.

Being able to access a state of SC leads to a deeper sense of connectedness with self (Desmond, 2015; Neff & Germer, 2013). To be self-compassionate has also been found to be a “defense strategy from emotional pain through self-nourishment” (Gerber et al., 2015, p. 399). Gerber and colleagues (2015) suggest that counselling that significantly fosters self-kindness and an attitude of self-nourishment could offer BCS a corrective experience that would positively offset a sense of aloneness and isolation in their suffering.

8.3 Counselling for breast cancer survivors

Cancer challenges a person with a ‘double-edged sword’. On the one hand the person is confronted with the fact that life is limited and at the same time the person has the opportunity to evaluate their life and to choose how to live their future (Vos, 2015, p. 886). Counselling for BCS requires a professional to locate or devise interventions that can help a woman integrate the experiences of facing mortality, being opened to the reality of their life, and the opportunity to re-build a life with new meanings (Keitel & Kopala, 2000).

There are two critical aspects of counselling that a BCS may not have in her everyday life. In the first instance counselling offers a supportive interpersonal relationship that provides the opportunity to think about past, present and future together with another human being. Essentially this means time spent with a supportive other can help mobilize hope and renewed optimism. Secondly the therapeutic context provides a beneficial ‘workspace’. In their daily lives BCS may not have a time, place, or emotionally safe space to focus productively on what has happened and how they want their future life to be (Duncan et al., 2010).

Relevant for counselling is the self-care story a woman may have woven for herself. This life narrative may be one created as a way to survive adverse earlier life circumstances, or to cope in the face of previous experiences of hardship, neglect, or abuse. Additionally, the social convention has traditionally regarded women as the ones who devote time and energy to caring for others. Time and energy can often be given, but this giving may be at the expense of a woman’s own physical and mental health.

A range of rational reasons may deny a woman access to, or ability to seek and maintain, a counselling process. Factors that impede accessing emotional support include illness, fatigue, cost, time, and/or a busy post-BC work/life schedule (Keitel & Kopala, 2000). The problem may also be that “many mental health professionals are not sensitive” to the “realistic obstacles” that impede a survivor’s engagement in a counselling process (Keitel & Kopala, 2000, p. 146).

As an adjunct to the idea that BCS may revert to previous, familiar patterns of coping to manage daily and existential demands, Vos (2015) has referred to the idea of there being periods of “heroic coping” (p. 898) in which a cancer survivor willingly faces the realities of life with courage. The dilemma is that coping ‘heroically’ does not always present the healthiest of ways to generate a self-beneficial reinterpretation of life after cancer. Optimistically, Vos (2015) also posited that there will be times of oscillation away from heroic coping. This would represent a time when a cancer survivor pulls back and would be able to relax a sense of their role as the ‘giver’ being vitally essential. The assumption is that there are times when BCS may be open to support for dissolution of self-denying efforts that no longer serve cogent purposes in daily living.

8.4 Change and transformation

Change and transformation for BCS carrying a burden of negative emotion can be aided through counselling support that works to functionally reverse residual trauma as well as practice adaptive patterns of relating for the future. Within the therapeutic relationship a client can do more than ventilate emotions. Foundational to the exchange is a sense of safety fostered by the human, caring, respectful presence of a therapist (McLeod, 2013; Welfel & Patterson, 2005). Reflective dialogue and emotional communication combined with experiential tools such as creative journaling (Pearson & Wilson, 2009), storytelling, or construction of a symbolic narrative of challenge and change create a restorative focus (Knight, 2002; Pearson & Wilson, 2009; Thompson, 2014). The outcome, ultimately, would be to open new avenues for relating with self and other.

Counselling can provide time and space for any existential concerns of the BC event story to be fully processed. That process takes place through collaborative co-construction of a refreshed self-dialogue; a dialogue that is healing without needing to be heroic. Evidence from research reveals that “existential discussions should be considered in any cancer-related supportive approach whether preventive, curative, or palliative, and not be deferred only until the advanced stages of cancer or at end of life” (Lee & Loiselle, 2012, p. 123).

The social world may harbour romantic notions of how a person should recover from BC (Sulik, 2011). Rather than supporting a survivor to struggle deeply with their experience the presumption may be that a survivor will reach a faster return to normality through suppression of the emotions of an affect-charged event such as BC. Finding themselves emerging from what had previously been a place of unknowing, some survivors endeavour to create new meaning and re-build a post-BC life with a new – and future – horizon: the new normal. Others make an alternative choice and seek a return to a remembered normality in life in all the colours and shapes it was pre-BC. From a self-compassionate stance neither choice would be considered right or wrong.

A participant in this study reported here spoke eloquently about finally arriving at a position of being able to acknowledge that a person with BC may die

“healed but not cured [of BC]”. ‘Healing’, in a psychological sense, has been theorised to involve a reinterpretation of life (Siegel, 2003). Referred to as something more than an outcome of successful therapy, healing is said to result from an active personal process that ultimately seeks a new beginning rather than bringing to an end something unwanted (Fosha, 2009).

8.5 The art of counselling

Counselling practice that has at its heart a SC focus invites BCS to join a process that extends beyond normalisation of feelings and the offering of a confidential space in which emotional distress can be expressed. To support the practice of SC means a counsellor would take time with a client to discover and explore how reactivity could give way to healthy responsivity to self. Provision of a safe compassionate container for a survivor’s emotional distress, reduces stress and fosters self-awareness, and gentler openness to self-knowledge (Gilbert, 2007). Recent research has found that fostering a relational reconstruction of the self can increase the “ability to manage interpersonal struggles” and cope with long-term strains (Stang, 2016, p. 161). Integration of self-compassionate self-talk would seek to re-orient a BCS to gradual moderation of habits of self-criticism and self-blame (Pidgeon, Ford, & Klaassen, 2014). This means survivorship can take on the mantle of a transformative experience in which a person would be able to ‘hold’ the memories of their BC reality rather than surrendering to a tendency to pull away from emotion-laden memories of the events or to be overwhelmed by ruminative analysis of the experience (R. Neimeyer, personal communication, August 5, 2017).

Relationship has been recognised as a ‘vessel’ that can foster intense personal growth (Corey & Corey, 2014) as well as provide positive adjustment to a life stress such as BC (Manne et al., 2004). From a personal construct perspective, however, it is conceivable that relationship can be both a source of emotional healing as well as emotional harm (Baker & McNulty, 2011; Leitner & Faidley, 1999). Therefore an uncomfortable reality exists that the nature of the relationship with self or with others can add significantly to an individual’s psychological suffering (Bolger et al., 1996). The extent of intrusion from BC in interpersonal relating has been found to differ for BCS, and for some women that disruption to the relationship may not persist as highly intrusive beyond physical recovery (Sohl, Levine, Case, Danhauer, & Avis,

2014). However, for some women the intrapersonal relationship may continue to focus, for instance, on debilitating after-effects of BC, or on lessened personal attractiveness, or lack of support, could be expected to benefit if adaptive self-compassionate responses became embedded in interpersonal dialogue, especially when encountering other-relationship stress.

According to the established principles of SC, self-compassionate relating offers non-judgmental, kind, self-reassurance, not just when life offers less than pleasant circumstances, but as a way that would promote personal thriving and flourishing across the years of survivorship (Akin, 2014; Liss & Erchull, 2015; Satici, Uysal, & Akin, 2015). The result is hope and optimism of being able to reclaim mentally healthy participation in a productive and fulfilling life. The hypothetical stance is that SC promotes expanded openness to self that involves a willingness and capacity for self-comfort and a tender, self-comforting, heart-centred relationship with self (Akin, 2014; Desmond, 2016; Gilbert & Procter, 2006; Leary et al., 2007; Neff, 2003; Raque-Bogdan, Ericson, Jackson, Martin, & Bryan, 2011).

Self-compassionate counselling practice supports the BCS in learning to ‘titrate’ negative reactions to events (Neff & Germer, 2013, p. 857). Through self-compassion the reality of bittersweet emotions that can arise once medical treatment has ceased can be understood as both personally accessible and changing. The result could be expected to have a direct and positive influence on self-care and self-nurturance as well as reorganising relationships with significant others. This means that rather than counselling being regarded as offering self-care strategies that operate from a reparative basis, self-care support focused on SC training could function as a restorative aspect of life.

Traditionally, women have defined themselves in relation to and in connection with others, devoted to others, responsive to their needs, attentive to their voices (Gilligan, 2011). Therefore, for some women, the practice of SC may stand in opposition to a concentration on a pre-existing mindset that compassionate care is something offered to others first and foremost (Goldstein, 2003). SC focused counselling would aim, then, to empower survivors of BC to discover the ways they seek to define and express themselves in relationship with self and with others.

The research evidence of SC as a way to activate innate soothing and self-regulating functions (Gilbert, 2009) together with the exploration into the meaning of SC for participants in this study, has emphasised the considerable relevance of SC for the field of counselling. Neff's (2003) description of SC parallels one of those common-sense notions that large numbers of people may claim to have realised, but which is essentially a notion easily forgotten, or buried under the weight of emotional adversity.

What remains important and relevant for counselling is the prospect individual or group therapy offers BCS to access skilled support to explore the place of SC in both the traumatic and the transcendent aspects of their lives. In the therapeutic interaction a counsellor can provide positive guidance and strength when a woman may, temporarily, not be able to regain or locate her own sense of meaning and personal control. By virtue of their training and proactive approaches to explore deeper understanding of life events within the context of a client's lived experience, counsellors are in a unique position to help empower women BCS to use SC. An anticipated outcome from this process would be positive life change across a range of domains consistent with post-traumatic growth (Ruini, Offidani, & Vescovelli, 2013).

When a woman lives with a previously diseased or surgically-changed body, reliance on dictionary-type explanations of her psychological processes or rationally-focused solutions to emotional challenges may obscure the chance to become emotionally intimate with herself, either once again or perhaps for the first time. Before encouragement to rush to return the body and the self to a socially acceptable article, there is a need for women to tolerate and sustain self-permission, as well as being willing and open to accept their post-treatment body and mind (Crompvoets, 2003).

Importantly, not all women survivors of BC who experience distress initiate or accept an invitation to counselling (Riba, 2006). Nor is it ideal that women be coerced, no matter how gently or persuasively, to accept involvement in counselling or support group sessions. Given that freedom of choice remains non-negotiable, there is, nevertheless, evidence of the importance of ongoing research into training of counsellors that encourages development and implementation of ways to sensitively

and appropriately assist women survivors. A capacity for dual awareness of past and present events that have shaped the identity of a BC survivor enables a counsellor to understand what is happening in the current moment while simultaneously being aware of how responses to emotional reactivity may have their origins in the past (Ogden, 2015). Unchallenged, habitual patterns of relating, as well as customary interpretations of life events, can deny discovery and resolution of emotions related to adverse life events. Acceptance of this premise directs emphasis toward the training of professional counsellors who choose not to train in a conventional path of psychology.

The link between SC and attachment style has already been the subject of contemporary research (Raque-Bogdan et al., 2011). The evidence is that the self-relationship is not the only aspect of life that benefits from being self-compassionate. Found to engender emotional resilience (Gilbert & Procter, 2006), SC actively neutralises a sense of threat (associated with feelings of insecure attachment, and defensiveness). In addition to its threat-deactivating capacity, SC generates feelings of self-soothing, self-reassurance and promote 'caregiving' to oneself (associated with feelings of secure attachment and safety) (Gilbert & Procter, 2006).

The giving of compassion to clients as they begin to develop compassion, acceptance, and understanding toward themselves is considered a core skill and requirement of the counselling relationship (Cooper & McLeod, 2011; Neukrug & Schwitzer, 2006; Teyber & McClure, 2011). The therapeutic alliance provides a client with an experience of a secure attachment that echoes theoretical frameworks Bowlby (1982) developed as a way to identify varying patterns in human relating. It follows that counselling professionals most likely will feel charged with the task of cultivating a felt sense of goodwill between themselves and their clients. That sense of goodwill is gained as the counsellor works to develop a positive therapeutic alliance (Ivey et al., 2016; McLeod, 2013; Neukrug & Schwitzer, 2006).

For women living with physical and emotional consequences of the after-effects of BC the anticipated consequences from a counselling process that has at its core the practice of SC would be a stronger sense of self-awareness, self-understanding and connection with their ongoing and changing needs throughout

survivorship. The development of a more accepting, less critical, self-relationship will facilitate an enhanced ability to discern how to relate with oneself in ways sensitive to one's uniquely individual emotional, physical and spiritual needs.

8.6 Self-compassion and the professional counsellor

As the Australian population ages and BC survival rates remain optimistic, it is expected that more women survivors will seek the support of counselling services. Psychosocial services can be regarded as an integral part of a comprehensive treatment program for BC. To work effectively and be able to encourage and empower survivors to formulate a revitalised personal narrative, counsellors would ideally have undergone training in self-compassion principles and practices.

The need for counsellors to attend to self-care is not a new idea. Because of awareness of vicarious traumatisation, burnout or compassion fatigue, the psychological well-being of the person of the counsellor is a critical preventative health measure within the profession (Skovholt & Trotter-Mathison, 2014). This means that SC has relevance in counselling for both a client as well as for the counsellor. While professionally counsellors take the part of benign receivers of narratives of distress and disturbance, neither the 'servant' nor the 'served' is exempt from a human need to feel that we matter or that we have significance. Sustainable PWB is just as important for the helper as it is for those who are helped. A connection between counsellor health and SC can be found in research that identified SC as a positive mediator of PWB (Hollis-Walker & Colosimo, 2010). The indications are that while other self-care measures may be normal practice for counsellors, development of SC during their process of 'formation' as a counselling professional could form an integral aspect of PWB – an aspect of training that may have been overlooked by counsellor training programs (Patsiopolous & Buchanan, 2011). Reflecting recent research, interviews for this study highlighted that a new-found appreciation of self and life, improved self-management, and opportunity for relational reconstruction presented as key areas in which emotional growth was experienced as a result of having faced BC (Schulman-Green & Jeon, 2014).

8.7 Chapter summary

BC is a choice-less event but one that, paradoxically, is also rich with choice. What emerged from the exploration for this study was that an important component of a BC ‘survival pathway’ involved receipt of appropriate, sensitive and yet active, therapeutic responses that could enhance emotional prosperity for women in their personal experience of survivorship.

In this study with its interest in particular elements of psychological support that provide a ‘model’ for BCS of a renewed yet sustainable way of being, the hypothetical stance taken was that counselling practice with SC at its core could likely offer a persuasively positive, growth and health-focused process. Personal counselling attended to with a qualified professional, trained in SC, offers the potential to address the potential for self-nurturing amendment to a woman’s understanding of her attitude to self-care. The strength and relevance of SC for counselling practice for survivors of BC becomes evident when the focus shifts to develop a life practice of SC through short-term support from a professional counsellor.

In conclusion, the elegance of a particular form of therapy or the efficacy of it is not the critical factor. What is important is whether for a particular client the exploration of SC within the therapeutic relationship has encouraged positive self-regulation, greater understanding of a BCS mental wellbeing, and fostered a caring and kindness for self within the client.