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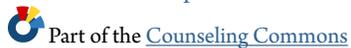
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Beyond the Pink Ribbon: An exploration of the experience of self-compassion in  
Western Australian women survivors of breast cancer

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## **Chapter Nine**

### **Implications for counselling practice and training**

#### **9.1 Overview**

Cancer is a disease that, metaphorically, can be represented as an ongoing war on a constantly changing battlefield. Contributing to this concept, medical science has encouraged optimism through research that ignites an ever-present hope of new ‘weapons’ to vanquish the threat of the disease. While improved cancer treatments have led to undeniably improved patient outcomes in the form of extended life expectancy (Riba, 2006), a sense of isolation from life as it was previously known and unreality about their situation continues to characterise the post-BC experience for some women (Little et al., 1998).

There is now a socially-anticipated, and statistically growing improvement in BC survival rates through a combined process of “public awareness and education, early detection and diagnosis and research into improved therapies” (Jacobs & Finlayson, 2010, p. 363). Despite these gains the pervasive and practical dilemma of emotional distress that can interfere with positive movement forward in survivorship means there exists a need to strike a balance in the domain of care. That balance will entail managing a vital focus on maintenance of physical wellbeing alongside simultaneous engagement by a survivor in the task of self-enquiry, self-care and emotional wellbeing. Positive health outcomes can depend, in part, on identification of ways to facilitate development of a woman’s psychological resources as well as determine and respect her motivation in regards to meeting personal bio-psycho-social needs.

In this study what was found was that participants who were a) survivors of BC, b) counsellors working with women with BC, and c) husbands of women who

had BC, all had an acute awareness of the way in which the journey through BC involved not just physical repair, but one that involved a 'liminal' psychological experience for women diagnosed. The uniqueness of the experience meant each, in their own way, entered an unfamiliar terrain in which previously taken-for-granted assumptions were challenged, discarded, or hoped-to-be-maintained. When reflecting upon their experience from diagnosis through until the time of interview, the majority of women participants spoke of the journey being a transformative one. They gave examples of how post-treatment they had moved across perceived boundaries about expression of who they were and who they wanted to be. In particular those 'boundaries' were ones that seemed to reflect accepted imperatives about their role within the family. The participant husbands also reported experiences of transformation within themselves in terms of life priorities and life directions. Participant counsellors spoke about the sadness and the joy they experienced in helping women integrate the experience of a life-threatening illness and subsequent treatment into life. Those counsellors also spoke about the shock, disruption, fear, and stress experienced by all the women they supported as the familiar world was deconstructed in a short timeframe. Important perspectives held by the participant counsellors was that the abrupt move from one life state to another needed to be met, above all, with sensitivity and compassion for the woman and her family.

In its most simplistic definition, counselling involves a therapeutic intervention and the communication of that intervention. Ideally counsellor and client form a collaborative relationship to work together in the process of structuring sessions, identifying the focus, as well as the pacing and progress of the therapeutic work. That process would require acceptance of the psychological effect BC has on identity, perceived sense of self, and attitude to life demands continual revision and extension of counsellor knowledge and understanding (as discussed by Den Oudsten, Van Heck, Van der Steeg, Roukema, & De Vries, 2010; Han et al., 2010).

With BC as the most commonly diagnosed cancer in women (Malek & Silliman, 2007; Riba, 2006), it would appear that professional counselling can invite people affected by BC to participate in the process of mutual involvement in creation of a new self-vision for the woman treated and for family adjustment to BC. Additionally counselling would provide support for partners and family members to

explore the complexities of thoughts and feelings they have about BC and its impact on their lives (Moestrup & Hansen, 2015).

## **9.2 Counselling with BC survivors**

To assist women in their post-BC quest towards construction of an intended or preferred ‘future’ a trained, professional counsellor can engage in a collaborative dialogue that has as its central characteristic a mutual involvement in creation of a vision of the woman as well, not ill. In this study the participant counsellors regarded a key ingredient of their work was the encouragement for women with BC to develop a flexible and optimistic view of themselves, and others, as well as the summoning up the courage to be imperfect in a society that appears to prize perfection.

The adjustment to living with the legacy of BC needs to be considered as a process that unfolds over time; adjustment is not something that happens in the immediate months post-treatment. Revision of counsellor knowledge and understanding would mean the counselling process could better assist women in this adjustment in a number of ways. Counsellors’ enhanced understanding of the impact on women of living with BC could help their clients relate with their post-treatment mind, feelings, and body through a multi-dimensional lens. Using that lens counsellors can assist women to nurture the multi-dimensional psychological self. A multi-dimensional lens includes their identity as a woman, their identity as a survivor of BC, their perspectives on power and powerlessness, as well as developing recognition of their individual unique abilities, supported by enhanced self-compassion.

Certain characteristics have been said to be particularly important “in dealing sensitively with the life-and-death issues” presented by the BC survivor (Keitel & Kopala, 2000). Tolerance for the physical and emotional suffering of a client is an essential ingredient in counselling and this was referred to by the participant counsellors in this study who talked about “bearing witness” to the suffering of the women and their families who struggled with adjustment to BC. Similarly, a counsellor can be effective in working with the psychological ‘fallout’ from BC if they are comfortable to talk about death and dying. The BC survivors as well as the significant others who took part in this study gave mixed responses about the topic of

mortality. One woman who seemed to struggle to make sense of what had happened, expressed intense anger at knowing her diagnosis was terminal. Others spoke only about working to ensure they were in the population of women who survived BC. Overall it seemed as though most of the participant women were either not anxious about the thought of death, or they had expressly avoided thinking about their own mortality. The participant counsellors expressed sorrow at the thought of any of their clients succumbing to the disease. One of the significant others whose wife had died from BC recounted that they had tried to ignore the fact that her diagnosis was terminal until such time as it was an unavoidable reality.

The counsellor whom a client experiences as trustworthy, genuinely caring, and keen to understand a client's own worldview and experiences is more likely to be effective in terms of creating a sense of connectedness between themselves and a client (Knox & Cooper, 2010). Counselling is a process that offers the client an opportunity to explore, discover and clarify ways of living more satisfyingly and more resourcefully. As such, counselling can resist being a service used to create distressed and vulnerable people as socially acceptable commodities who then 'fit' more appropriately with societal norms.

Working to encourage positive life change is one of the key ingredients of professional counselling. In that process of fostering positive change, counselling must be able to provide the opportunity for a client to feel deeply heard in a way that they may rarely have previously experienced (Crago, 2012). This would include being able to hear and understand the client's relationship to concerns about aloneness, making sense of life, death, and choice (Moestrup & Hansen, 2015). Counselling also involves as an interpersonal process in which each person communicates to the other that they feel heard, understood, and for the client, respected.

Counsellors working with post-BC women are effective when able to adopt a therapeutic approach that inherently has a positive view of women. Many of the intrinsic deficiencies with regard to counselling women using traditional approaches have, in recent decades, been addressed (Enns, 2003). Despite greater acceptance of a wide range of social roles for women gender bias and stereotypical labelling of

women remains a reality. When compared to views held in past decades it would appear that tendencies for bias and stereotypical labelling of women have undergone major alterations (Enns, 2003). With 21<sup>st</sup> Century constructions of BC women are now more able to speak openly about their experience of the illness

The potential for countertransference needs to be understood by a counsellor. Facing the person who has had BC means, to some extent, facing oneself and facing the question of whether, given the prevalence of BC, they too may one day be diagnosed with the same disease. Similarly it is important for the counsellor to be aware of their own orientation to life and death (Keitel & Kopala, 2000).

The therapeutic relationship presents the prospect for both counsellor and client to grow personally, and professionally, through the encounter with the other. Counselling is a setting in which a client affected by BC needs to feel safe to talk about issues such as fear of cancer recurrence, fear of the aging process, as well as decision that need to be made about their own life. Sharpley, Bond and Agnew (2004) conducted a survey in Australia into attitudes toward counselling and found that a majority of respondents listed “fear of confronting, expressing and reliving unpleasant experiences” as the most “frequently mentioned personal drawback” to attending counselling (p. 101). Feeling embarrassed, the dilemma of trusting another person with one’s deeply personal perspective on life experiences, and the social stigma of attending counselling were also viewed by respondents as potentially unhelpful for a person seeking emotional support (Sharpley et al, 2004, p. 101). The indication from this study could be that the perceptions about, and disposition a person holds toward, counselling may offer either a way through emotional suffering, or conversely a cognitive state that constrains expression.

### **9.3 What has already been offered: What can be offered**

No single model of counselling can claim authority over positive outcomes for clients. Some interventions have been offered face-to-face and some in an online context. The participant counsellors in this study held a fundamentally similar approach to counselling that had as its basic premise psychodynamic theory. All three participant counsellors worked in a face-to-face context with clients and/or their families. The literature reviewed for this study has indicated that psychosocial

interventions include both individual and group therapies from a range of theoretical frameworks explored in a range of different approaches such as Cognitive-Behavioural Therapy psycho-education (Ye et al., 2018), mindfulness practice (Niazi & Niazi, 2011), meditative practice (Yun, Song, Jung & Yu, 2017), as well as using creative arts such as writing (Jensen-Johansen et al., 2013).

For people living with cancer a range of therapeutic initiatives have been trialled and found to be helpful to alleviate a range of BC after-effects. Those initiatives have included a Behavioural Activation Treatment (BAT) and problem-solving intervention (Hopko et al., 2011; Hopko et al., 2015), cognitive-existential group therapy (Kissane et al., 2003), education and peer support groups (Mens, Helgeson, Lembersky, Baum & Scheier, 2016), supportive-expressive group therapy (O'Brien et al., 2008), dance/movement therapy (Ho, Lo, & Luk, 2016), mindful exercise (Tacón & McComb, 2009), Mindfulness-Based Stress Reduction (MBSR) (Birnie et al., 2010), meditation (Dodds, 1999), as well as peer support groups offered by organisations such as the Cancer Council in Australia. Peer support groups for BC survivors offer social support, can improve coping skills, and help reduce a sense of isolation and distress. Each of these aspects of meeting in a group can be regarded as potential protective factors for mental health and have been shown to improve survivors' wellbeing across the short-term (Mens, Helgeson, Lembersky, Baum, & Scheier, 2016). However, authors of the Mens et al study (2016) found that gains made in their exploration of an education and peer support program were positive in the short-term but with clear indication of the tendency for gains to dissipate over the longer term.

A study into individual versus group exercise and counselling program for BC survivors found higher compliance among women participants attending individual exercise and counselling sessions than those assigned to group sessions (Naumann et al., 2012). The exercise and counselling program was conducted over a 9-week period, however, to date no follow-up data appears available to consider whether personal gains made in the individual or the group sessions were sustainable across the longer term.

Ideally, the implications for long-term survival with BC, and potentially co-morbid conditions, would encourage alertness by health care providers to the contribution to BC care that can be made by counselling from a stance underpinned by a female-focused, self-compassionate model of therapy. In essence, the counselling practitioner is able to assist a BC survivor by exploring ways in which she is able and willing to make positive transformations. The starting place for positive transformation would appear to be to locate and foster self-acceptance. To engage in this process the counsellor and client would be encouraged to collaboratively review not only strengths and intrapersonal resources, but also any practical difficulties that might emerge as a hindrance to her development and ensuing empowerment process. This latter step would entail some vigilance about subtle privileging of aspects of identity and gender over other dimensions (Keitel & Kopala, 2000).

From a feminist perspective the argument would be that counselling is, and counsellors are, able to be aware of cultural perceptions of “how breast cancer is constructed and how breast cancer is positioned” (Gibson et al., 2014, p. 523). Gibson et al have discussed the perception that women are in control of their illness trajectory by virtue of information provided and support offered, through “practices that maintain their femininity” and self-surveillance (p. 524). Women are encouraged to feel empowered in Australian society also by sharing the narrative of their experience with others. Representations of women survivors usually depict a person who is youthful, without any visible signs of the struggle that has taken place (Sulik, 2011). The challenge for women survivors of BC is not to ‘believe the advertising’, but to discover their post-BC identity for themselves. As the period of time of survivorship extends a second challenge is not to revert to pre-BC automatic patterns of nurturing and caring for others without including herself in that equation. Awareness in counsellors that some women may not see their giving to others as self-sacrifice or denying themselves, but may feel happiest and most valued when giving, would shed light on a woman’s perception of her role. The participant survivors in this study talked about how they valued the role of being the one who could help others; they did not regard that as self-sacrificing.

Counselling can support people through the fear, isolation and distress that attends BC through co-creation of an individualised model for positive change. Through counselling that can be tailored to meet the values, beliefs and lifeworld of the client, positive change in BC survivorship comes to be regarded as a position that also accepts the negative changes and what a 'new normal' means for them. O'Hara (2013) has referred to hope, in part, as the practice of patience. Living into a 'new normal' means patience and hope is required. Hope and self-efficacy for women with BC has also been found to be linked to the quality of life of their male spouse (Duggleby, Wendy, Heather, Dan, & Roanne, 2014). These authors found that the quality of life of male spouses of women with BC influenced the degree of support they were able to give their wives. Therefore, the degree of hope and self-efficacy a BC survivor perceives herself to have post-treatment, and the sources of hope and would be an important resource for a counsellor to assess and understand to be cognisant of any challenges in helping a couple living with BC find and foster hope.

Within the therapeutic setting contact with strong emotion has been described by Fosha (2000) as a pivotal contributor to metamorphoses of the self. Fosha (2000) argued that it was this paradoxical contact and expression of the previously inexpressible that figures as the central agent responsible for therapeutic change. In short, the psychological experience of BC can typically be deeply emotional, constructed within the rules, values and social world of not only the survivor but her family, and yet that emotional response may not fit with the cultural context of the survivor. Additionally, sensitivity to the pacing as well as the development of narrative processes within counselling sessions is a useful consideration for counsellors as a survivor processes and (re)constructs viable meaning systems (Neimeyer, Klass, & Dennis, 2014).

There is respect for emotions as complex, multi-layered experiences that elicit multiple concerns and generate a range of responses (Mesquita & Frijda, 2011). For example, the experience of emotional distress that can companion BC survivorship may have as its antecedent in pre-BC unresolved psychological distress, as suggested by Burgess and colleagues (2005), and corroborated in a 2012 study exploring the trajectory of emotional distress from first year post diagnosis to 6-year survivorship (Lam, Shing, Bonanno, Mancini, & Fielding, 2012).

#### **9.4 Survival and readiness to explore self-compassion**

The work of Eugene Gendlin (Madison, 2014) has long promoted the idea of being mindful of discovering and understanding the need for a workable distance from emotion. Drawing on Vygotsky's socio-cultural theory of learning in addition to the foundational tenets of counselling theory, the notion of there being a 'zone of proximal development' (ZPD) and a 'more knowledgeable other' (MKO) (John-Steiner & Mahn, 1996; Poehner, 2012), supports the potential for SC to become a transformative intervention in counselling's repertoire for emotional healing. Therefore, understanding both the ZPD and MKO would mean a step by step process to integrate SC into life after the experience of BC. The key construct Vygotsky proposed was that ZPD and MKO significantly influence developmental and learning processes (John-Steiner & Mahn, 1996; Poehner, 2012). This means that appropriation of the practice of SC would involve a steadily-paced, sensitive revisioning of previously developed self-constructions, carried out as a collaborative 'development' between counsellor and client.

The process of collaborative development would require the counsellor to mediate between difficulties encountered in learning to be more SC with the task of learning to meaningfully assess the survivor's process of change (John-Steiner & Mahn, 1996; Kees et al., 2005; Poehner, 2012) as a way to advance self-compassionate communication. In simple terms, in the light of the concepts of ZPD and MKO, through dialectical processes, a counsellor, using guidance and encouragement, can interact supportively with a survivor to extend and enhance self-discovery and self-knowledge. This may best be achieved at a pace and in a way that is able to be tolerated, integrated and sustained by BCS. When asked about the meaning, for them, of the term self-compassion, women participants, as well as significant other participants, in this study the response was often that it was about kindness to yourself. Responses from those two groups of participants also highlighted the fear of self-compassion. The most reported fear, in both survivors and significant others was the fear of being self-centred or selfish. Commonly held beliefs about SC, that it is more akin to selfishness, complacency, weakness, self-pity, and narcissism have been acknowledged and reported in the literature on SC (Neff, 2015). In responding to concerns about SC being selfish, Neff points out that self-kindness and self-attentiveness in meeting one's own emotional needs means a greater capacity to focus on the needs of others. Counsellors have an

understanding that for a client to embrace being kinder to themselves is one of the positive steps forward in a counselling process. Student counsellors could be introduced to the concept of SC and over the course of their study could explore their perspectives on SC and its impact on the therapeutic relationship and place within a counselling process.

### **9.5 Implications for counsellor training programs**

The counselling profession's deep appreciation of the interconnectedness of language, thought, and feeling along with the benefits from time for evaluative self-reflection, create an environment ideal to support BCS engagement in a transitional process. Curiously, however, language can also be reductionist and can limit proximity to the feelings of an emotional experience (Wilberg, 2004). Additionally, not all illnesses have a mind-body element (Broom, 1997). Counselling processes underpinned by understanding of the relationship between body, mind and feelings takes into consideration bio-psychosocial symptomology, the mind-body relationship, and interactions between these systems and their capacity to influence health and pathology (Broom, 1997; Broom, Booth, & Schubert, 2012; Cohen, 2011). Important skills for counsellors are to attend to the body's way of communicating so as to avoid unwittingly re-traumatising a client (Helsel, 2015). This would mean being able to encourage a client to actively notice and become aware of, in a carefully graded way, physical sensations in the body, and to acknowledge the recording, at a physiological level, of bodily responses to the trauma of BC.

Counsellors and professional helpers who provide psychological support for women with BC will find themselves faced with significant numbers of clients who enter their therapeutic process with the legacy of BC as a chronic illness (Schaefer-Schiumo & Atwood, 2009). For some of these clients, their illness will have an uncertain outcome and, in a number of instances, may have a progressively downward-oriented life direction. To work with BC survivors, skills and strategies are needed that can rapidly distinguish between a woman's illness experience, the emotional impact of the likely trajectory of her illness, and the meaning she makes of that illness (Schaefer-Schiumo & Atwood, 2009).

Participant survivors in this study wanted not to have their identity defined or classified by the fact that they had survived BC (Surbone, Annunziata, Santoro, Tirelli, & Tralongo, 2013). The women survivors reported that what they wanted was to gain control over their lives once again, and did not want to feel controlled by the need to consider BC. The participant significant others also remarked that regaining control over BC had been important to them. Observations by this researcher, of both the survivors and significant others was that the majority preferred to adopt a positive thinking model for living. While it seemed from their reports that the choice to do so was applauded by family and friends, this ‘model’ may also be the very thing that supported a desire not to think about death and dying.

BC survivorship will impinge, in both overt and covert ways, on a woman’s attitudes and perceptions of self-identity, her self-concept, and her self-relationship. This means counsellors can be most helpful and facilitate change when equipped with enhanced knowledge and understanding of the complexity of personal issues BC forces upon the individual (Fossey et al., 2002). Women, husbands and counsellors in the three different participant groups in this study may, at times, have experienced feeling demoralised about the future for the persons affected by BC (Kissane, 2014). In contrast, all but three of the participant survivors in this study did not speak about feeling demoralised. In contrast their dialogues highlighted a focus on significant relief at having navigated their way through diagnosis and treatment. They reported feeling a new strength in themselves for managing rigours of that process. Post-BC a survivor may not give voice to, or find words for, a new awareness of themselves as physically and psychologically vulnerable - and finite (Vos, 2015). Counsellors trained to understand that the legacy of chronic illness generates emotional complexity can offer psychological security to explore and find meaning, encourage and support autonomy in decisions to be made, and help discover insight into the richness of living.

What counsellor training can address is more subtle forms of bias that may persist unchallenged and undetected in a therapist’s conceptualisation of a case. Counsellor training courses in Australia are, by and large, populated by female students, and counselling professionals are also primarily female led, with 78.8% of counsellors being female (Department of Employment, n.d.). These facts do not

automatically mitigate against outdated, genderised attitudes toward a female client. Therefore, the implication for counsellor training programs is a commitment to training in non-sexist frameworks that embrace feminist, constructivist, postmodern ideology.

To effectively support well-being in a client without assuming that a client's worldview and values will automatically parallel their own, a student of counselling would ideally develop awareness of their particular worldview and the culture that created or influenced that view (Duncan et al., 2010; Ivey et al., 2016). There is less likelihood then of the BC survivor's views being overlooked or 'missed'. The other implication for training of the counselling student is an awareness of inherent bias in therapeutic approaches that may privilege an individualistic perspective. Through experimenting with being self-compassionate, a counsellor will likely experience the challenge to move from prioritising other responsibilities over nourishing their own wellbeing (Desmond, 2016).

There is an onus on providers in the helping industry to continue to seek out, qualify, and follow best practice (Fossey et al., 2002). One stand-out aspect of best practice would involve the capacity for reflection by counsellors about potential counter-transference and transference that may occur during the therapeutic process (Riba, 2006). A counsellor may have had a close relative, friend or colleague, or previous client, with BC and such an occurrence requires mindful awareness of feelings, perceptions, grief processes while offering support to a client. Therefore, self-awareness, an understanding of one's personal values, views and the meaning made of life experiences, could be assumed to be an automatic adjunct gained through the process of studying counselling. Without some insight into self-awareness the risk is that the counsellor who is not self-aware is less likely to be effective within the professional interpersonal relationship that is so crucial to the intimate emotional process that occurs within counselling. Attention paid to the interpersonal relationship in therapy requires awareness of issues of power and values as well as awareness of one's orientation to any variations in traditional gender roles and behaviours (Enns, 2003). The counselling skill to develop is the capacity to hear an as-yet unheard voice of the client – a voice that heralds the change desired by the client.

Listening as a skill can be taught, or misconstrued by students, merely as something of a prelude to giving a response that demonstrates a therapist's ability to empathise or offer an insightful response to what a client says. If regarded as 'waiting time' until it seems appropriate for the counsellor to speak then an opportunity is missed and listening becomes more of a mental activity than a state of embodied resonance with a client (Wilberg, 2004). In contrast, the capacity and skill for a counsellor to 'stay' in the 'pregnant pause' with a client, giving time for the client to reflect, allowing emotional and auditory space so they can listen to themselves and their body deeply, offers an opportunity for transformational experiences for the client.

Wilberg (2004) has referred to "maieutic listening" as the skill of being able to be with and bear a client's feelings. This approach stands in opposition to a more conventional therapeutic approach in which a client is encouraged to translate bodily felt experiences into language understandable by the 'other'. Wilberg's approach (2004) has argued that the therapeutic alliance therefore has the potential to offer something different to the usual work of amelioration of distress. The participant counsellors in this study may not have used the term "maieutic listening", however, their reports of their work with survivors of BC indicated that in response to the emotional state of their client population they intuitively moved to the space that allowed them to be with and bear the feelings being expressed in counselling sessions.

While reports from the participant survivors implied that extended counselling support had not been considered necessary beyond the initial first year after treatment, it is possible that this reflected a national (Australian) lack of clarity about what professional counselling has to offer, what it involves, or the life benefits to be derived. It is clear from the major themes that emerged from interviews that there were a number of psychological, emotional and existential issues or questions that were of high interest to the survivors. The participant survivors concerns about self-worth, guilt, and self-blame and their recognition of a tendency to put their needs second to those of family and friends suggested that their own existential questions may not have been addressed until they were diagnosed with BC.

Indications are that a rudimentary understanding and factual knowledge of the processes involved and the milestones of the psychological and psychosocial

process from diagnosis, through recovery and on to survivorship would be a prerequisite in supporting the psychological needs of BCS across the life span. This would also encompass understanding the particular needs of the aging BC survivor and how it might differ from the emotional experience and needs of the younger BC survivor. Therefore, knowledge of a developmental perspective, in addition to awareness of the changing somatic resources of the older survivor would be fundamental to supporting the aging-with-BC process. One way this could happen would be for counsellors to have an understanding of the body-mind relationship and to support a BCS to draw on that relationship to achieve a sense of overall wellbeing. In this study, the researcher's experience of 'sharing' in a world of vulnerability and challenge through the process of gathering data has suggested that preparation of counsellors to support this particular population would benefit from developing a high level of self-awareness in trainee counsellors. Experiential training would ideally support trainee counsellors to bring awareness of habitual reactions they may have when emotionally reactive, or tendencies towards lack of self-compassion toward themselves.

Overwhelmingly, the women participants in this study highly valued the opportunity to share their personal narratives of their experience. An implication for preparation of counsellors, and not just those who plan to work with this population, might focus on the value of person-centred active listening as opposed to a counselling approach that might encourage moving to 'do' something, or provide coping strategies in the short term. In other words this would mean counselling, first from a perspective to encourage the emerging narrative.

The art of listening is lauded in conventional teaching texts currently in use within counsellor training programs (Ivey et al., 2016; Neukrug & Schwitzer, 2006). It is highly appropriate for a trainee counsellor to demonstrate the skill to offer professional responses in line with their chosen theoretical and practice framework in a way that is sensitive to the emotional state and needs of a client. Over the course of their training, student counsellors develop skills that encourage the ability to activate in a client a feeling of being listened to. Feeling listened to is, however, a different experience to the experience of being heard (Wilberg, 2004). What appeared to be of value to the survivors and the significant others in this study was the experience of being heard, in a

psychologically safe context, that offered a sense of their being time and space in both the interview and group processes, for each participant to hear and reflect on the comments they had made before needing to give time to another person. To influence the extent to which a chronic condition affects a woman's adjustment to that illness, a counsellor needs to be skilled at giving space, time and support for a client to speak *with* feeling rather than simply speaking *about* feelings (Wilberg, 2004).

Participant survivors in this study welcomed the opportunity to have a safe and private context proceeded tentatively and only revealed their narratives once they had arrived at a place of psychological safety. Given that each journey of the participant survivors was highly individual, counselling educators would need to emphasise a flexible, integrative and pluralistic perspective to meet the needs of the survivor and their significant others (Cooper & McLeod, 2011). Additionally, the themes from the participant counsellors suggested that "bearing witness" and not "putting band-aids all over the place" ie attentive listening was what was most helpful to their client population. Furthermore, different stages of the cancer 'journey' evoked different psychological and emotional needs in the participant survivors in this study. This means that counselling for BC survivors and their significant others will not be a 'one size fits all' approach. Respecting the needs and interests of each individual BCS is paramount to effective counselling. Just as the findings in this study cannot be generalised because of the individual differences reported, so there is no overall guiding template that can be applied to counselling a vulnerable population such as BCS. The recommendation for counsellor training is to establish the skills of critical enquiry, sensitivity to pacing, and awareness and recognition of the application of a variety of practical resources for working with survivors and their significant others.

## **9.6 The place of self-compassion training**

Whether a woman's post-treatment body is a one, two, or no-breasted form, the sense of personal safety and certainty in life has been temporarily dismantled. Their training may not automatically have prepared a counsellor well to take on the role of offering emotional support for women living with BC. Counselling women relies on a capacity to offer support through clinical application of approaches that are free of bias (Enns, 2003). Counsellor training programs in the 21<sup>st</sup> century aim to

provide solid research bases for course constituents and recognition is given to assisting the student counsellor. There is also recognition that ideally the student be exposed to knowledge to understand and be able to adequately address issues for women “related to power differences, gendered family roles” and the emotional legacy associated with “physical, sexual and emotional abuse” (Enns, 2003, p. 13).

Self-compassion is not easy. Desmond (2016) claimed that “our tendency as humans is to judge and criticise ourselves for any way that we fail to measure up to our idealized standards” (p. 3). From this study’s exploration into SC with a group of women who survived primary BC, it seems critical that student counsellors be supported to develop a capacity and willingness to ‘be’ and ‘bear’ with another person’s emotional suffering (Keitel & Kopala, 2003; Wilberg, 2004).

Professional counselling with a self-compassionate focus can offer support for women to move closer to their illness experience in a mindful way in order to move away from the more stressful aspects of it. Given that the principles of SC offer the potential to experience emotional pain without an accompanying and sometimes unbearable sense of aloneness, SC could be regarded as something of an antidote to the traumatic aspects of the experience (Przedziecki, Sherman, Baillie, Taylor, Foley, & Stalgis-Bilinski, 2013). The indication from the literature reviewed and from the reports of participants in this study, is that the counselling process is well-placed to offer a woman the string of emotionally supported experiences that will aid secure strengthening of her self-compassion. At very least SC provides a significant mediator between beneficial life adaptation for the BC survivor, and depression and anxiety. Using SC as the basis to help shift a woman’s emotional proximity to her BC experience means it can be safely explored in a way that will enhance rather than detract from her quality of life. What is important is that when confronted with intense emotional reactions, the healthier path is for a woman to find herself not standing alone in the face of overwhelming emotions (Fosha, 2006).

## **9.7 Chapter summary**

There is acknowledgment of extensive research on a broad range of personal issues that emerge from diagnosis and treatment for BC (Cappiello et al., 2007; Razavi et al., 2002). Unfortunately, data has indicated that “barriers exist to receipt

of mental health care in comparison to physical health care” (Henderson, Evans-Lacko, & Thornicroft, 2013). Perceptions of social or family stigma about the implications of seeking counselling support in the aftermath of BC treatment can result in avoidance of or delay to care. The implications for the counselling profession would appear to bring forward a case for education programs to offer students of counselling active engagement in training in self-compassion. At very least, counselling educators with a workable understanding of the concept of self-compassion and its potential to positively influence the outcomes of counselling for some clients can help de-mystify cultural or socially constructed myths around selfishness, self-centredness, self-esteem and self-compassion. Exploration of self-compassion need not necessarily mean a confrontation with unpleasant emotional experiences that have been repressed. What is understood from research into SC is that future suffering can be transformed when a person is self-compassionate (Reyes, 2012).

Self-kindness need not entail uncovering intrapersonal or interpersonal wounds from the past, although this may happen in the process of any historical review of a lack of self-compassion. What counselling educators can bring forward is the findings from research that SC can help both the professional, and their clients, bring wisdom and insight to themselves in their practice. This firstly requires active acknowledgment of any internal experience of suffering (Reyes, 2012). The counsellor who can embrace self-compassionate relating for themselves can then be guided by the three core principles mentioned in Chapter 4 (pp. 134) in relation to awareness of their client’s perspective on isolation and aloneness in suffering, as well as hope for recovery from debilitating emotion-laden experiences and negative self-talk.