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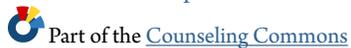
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Beyond the Pink Ribbon: An exploration of the experience of self-compassion in Western Australian women survivors of breast cancer

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## **Chapter Two**

### **Introduction**

#### **2.1 Overview**

Breast cancer (BC) is an old disease faced by women across centuries (Olson, 2002; Verrill, 2009). An extraordinarily complex disease (Downs-Holmes & Silverman, 2011; Vuong, Simpson, Green, Cummings, & Lakhani, 2014) BC strikes at the very core of womanhood (Cromptvoets, 2003; Galgut, 2007; Rubin & Tanenbaum, 2011). This form of cancer challenges notions of both what the female breast symbolises for a woman, and what it has come to represent in society in general.

The female breast has a nutritive function as an object of nourishment and human kindness, evidenced in the suckling role (Boyd, 2001; Levin, 2006), and at the same time female breasts are objectified and portrayed as a prime source of sexual fantasy and desire (Boyd, 2001; Galgut, 2007; Levin, 2006), the purpose of which is often represented in the media as something to be looked at, played with, and enjoyed by people other than the woman herself (Duvall, 2014).

One of the profound difficulties for a woman diagnosed is that loss of, or significant change, to one or both breasts presents a highly visible challenge to her sense of self (Cromptvoets, 2003). Her identity as a woman is confronted, and post-treatment the BC survivor can be faced with disturbance to her sense of “femininity, sexuality, and of herself as ‘normal’” (Cromptvoets, 2003, p.137). She is no longer her emotional self either. The question of self-value arises in relation to whether a woman is drawn to conform with socially endorsed ideals of both physical

attractiveness and external looks promoted as beauty and femininity in women (Moore, 2010). BC is not a cosmetic process (Van Der Wiel, 2013). Nothing remains the way it was before the words ‘it’s breast cancer’ enter a woman’s emotional orbit. Past traumas can be triggered at any time throughout her BC experience, not just during diagnosis or medical treatment (Galgut, 2007), and de-rail a desire to remain hopeful and untouched by the trauma that is BC.

When a woman feels as though her body has failed or betrayed her, her sense of personal value and attractiveness suffers because the body does not ‘live up’ to the standard set by either the woman herself, or her perception of the expectations of a positivity-g geared society. Those expectations are that a woman, in her young years, needs to be physically attractive, feminine, energetic, sexually active, and able-bodied (Sulik, 2011; Trusson, Pilnick, & Roy, 2016). Living with breast cancer can mean the outlook for life feels bleak at times, and both hope and confidence can fade to a vague shadow of their former ‘selves’.

In the life-defining moment of receiving a BC diagnosis, a flood of decision-making, emotional and psychological stress, and choice of treatment, changes a woman’s sense of personal meaning (Documet, Trauth, Key, Flatt, & Jernigan, 2012). Her hopes, dreams, expectations and future-oriented plans are rapidly swept away. The complexity of BC is that long after a formal treatment regime concludes, the negative after-effects of having had this disease continue to destroy a woman’s instinctive expectations of wellness as she experiences disruption to her physical, emotional and spiritual well-being (Elsheshtawy, Abo-Elez, Ashour, Farouk, & El zaafarany, 2014).

During recovery and re-integration into life post-treatment, personal identity can be subsumed under the label of being a BC survivor. Some women lament this identification; others may feel overwhelmed by the tasks of survivorship; others may marshal their personal resources to do battle. Rather than judge self as a failure, or feel the need to ‘do’ more, be different, or become engaged in making unhelpful comparisons with other women who may be esteemed by society for their ‘battle’ against BC, self-compassion highlights a means of moving through the experience of a life-threatening illness in a self-kind and self-sustaining way (Neff, 2003).

The landscape of older life can be radically redefined as the words ‘breast cancer’ and ‘survivor’ begin to intrude or dominate a woman’s identity, her sense of purpose and meaning as age advances and she becomes one of the older women living with the after-effects of BC.

In terms of emotional and psychological well-being the concept of self-compassion (SC) as hypothesised by Neff (2003) provides significant insight into a way post-BC women can be supported to navigate the inevitable stressors associated with the diagnosis, treatment, recovery process and survivorship. Three central components of self-compassion make this an appropriate and valuable topic for investigation in relation to the post-treatment experience of Australian women who have survived BC.

The capacity to relate with oneself in a kinder way elicits a “softer, friendlier relationship with physical discomfort and difficult feelings” (Germer, 2009, p.67). In short, being self-compassionate provides a self-protective strategy that could buffer against the negative impact of having had BC. Development of a more accepting, less critical, habit of relating with oneself has been identified as able to facilitate an ability to discern how to relate with oneself in ways sensitive and open to emotional, physical and spiritual needs (Akin, 2014; Alma, 2008; Alma & Smaling, 2006; Dodds, 1999). The outcome for women living with BC could be expected to be the ability to gently counteract ingrained self-criticism, self-blame, self-judgment. The hope would be that minimisation of an internal self-denying dialogue could create a mindful, self-affirming connection between body, feelings and mind. In the face of increased rates of diagnosis and increased years of survivorship, fostering compassionate communication with self and others affords a valuable tool for self-acceptance (Germer, 2009) to guide a survivor through the intricacies and nuances of living long-term post-BC.

## **2.2 The heart of this study**

In this study it was found that despite the idiosyncratic nature of the journey each participant had made through and beyond BC, their narratives combined to highlight common experiential ground by way of similar emotional reactions, and mutually experienced thoughts and behavioural responses. Clearly, the process for

women includes universally occurring ingredients - such as response to diagnosis, decision-making and treatment options, post-BC medication, in addition to the nature of the relationship with self and with significant others. In this study significant others reported a 'roller coaster ride' of emotions while trying to "be strong". They spoke of learning to live in the moment, of changes to their life, and positive changes in their relationships. Counsellors interviewed spoke of being the ones whose work required them to "bear witness" to the physical and emotional suffering of their clients who were BC survivors. Putting aside their personal response to the suffering they witnessed, these professional helpers spoke of their committed desire to help women survivors find "nourishment from within" themselves.

Bearing in mind the predominance in social consciousness of the nature of BC along with fear-based assumptions about the level of susceptibility to the disease (Galgut, 2007; Moore, 2010), this study examined whether an attitude of self-compassion could influence the way a woman communicates with herself, the way in which she nurtures herself, and acknowledges and attends to her physical and emotional needs, and the way in which she communicates her needs to others. This study looked at the nature of the relationship women living with BC have with themselves, their body, and with significant others. In particular, this research explored women's understanding and experience of self-compassion.

Increased numbers of BC survivors means the focus for those diagnosed with BC is now much broader, with current treatment directions not confined merely to awareness and prevention, or to the medical processes involved (Schernhammer, Haidinger, Waldhör, & Vutuc, 2009). Treatment in the 21<sup>st</sup> Century includes not simply a more open dialogue on the medical aspects of the disease, but over recent decades has included greater awareness of the psychologically and socially disruptive effects of BC and the impact on long-term survivorship (Meneses & Benz, 2010). This awareness has been matched by acceptance of new ways to understand and engender psychological well-being of women diagnosed with BC (Schernhammer et al., 2009).

Using a phenomenological lens, this qualitative study focused on emotional well-being in West-Australian women with breast cancer (BC) and specifically

investigated ways in which women survivors of BC understood the idea of self-compassion, and experienced self-compassionate relating with themselves, their body, and with significant others. At the heart of this study was consideration of whether counselling with a focus on compassionate communication with self and others could assist women to develop and nurture self-kindness for themselves and their body.

A purposive sample of 17 participants was drawn from women aged between 35 and 70 years of age who had completed treatment for primary BC and had been disease free for a minimum period of 12 months. Participants were women living in the Perth metropolitan area of Western Australia. They were invited to take part in an individual, in-depth semi-structured interview, followed by three one-hour focus groups. Once all interviews were completed, participants were invited to engage in three four-hour sessions (12-hours in total) of a specially designed Personal Reflection Program based on an expressive, creative arts approach to enhance self-discovery. The focus of the program was raising awareness of self-kindness and self-nurturance.

Data was also gathered using one-on-one semi-structured interviews, from three participants who each were a significant other (eg. spouse) in the life of a woman with BC. In addition, three counsellors who had worked with women with BC were invited to take part in a one-off, individual, semi-structured interview.

### **2.3 The lens of self-compassion**

Self-compassion (SC) has been defined as a conscious process of turning compassion inward towards oneself so an emotionally supportive self-relationship can replace a blaming, condemning, self-critical one (Gilbert, 2009). An emotionally supportive relationship is one that enacts a flexible attitude towards oneself when experiencing emotional pain, and has an awareness of one's life as meaningful (Neff, 2011; Neff, Kirkpatrick, & Rude, 2007; Pauley & McPherson, 2010; Yarnell & Neff, 2013). Consistently demonstrated in research data as "negatively correlated with measures of depression, anxiety, self-criticism and rumination" (Pauley & McPherson, 2010, p. 130) evidence has indicated that being self-compassionate facilitates resilience and coping (Leary, Tate, Adams, Allen, & Hancock, 2007). Positively linked to social connectedness, self-determination, and feeling

interpersonally connected to others (Neff, 2003), available evidence has found that self-compassion is integral in development of an adaptive strategy for emotion-organising and generation of positive emotions that foster psychological well-being (Akin, 2014; Zessin, Dickhäuser, & Garbade, 2015). Focused on the “emotional stance that individuals take towards themselves when faced with an experience of failure or suffering” (Neff, Hsieh, & Dejitterat, 2005, p. 265), self-compassion has been found to contribute to stable patterns of emotional regulation (Leary et al., 2007; Neff, 2003; Neff, Kirkpatrick & Rude, 2007; Germer & Neff, 2013) in addition to reduction of symptoms in PTSD (Kearney et al., 2013), to a decrease in functional disability in defence personnel with symptoms of PTSD (Dahm et al., 2015), as well as less reduction in a tendency to engage in avoidance strategies related to unpleasant or distressing experiences (Thompson & Waltz, 2008).

#### **2.4 Background to the study**

Cancer is an unanticipated trauma that does not present as an encapsulated event. A complex disease that can be overwhelming, feared and stressful (Tallman, Altmaier, & Garcia, 2007), cancer brings pain and suffering on a number of levels. Being diagnosed with and treated for cancer confronts and challenges a person’s view of how life was expected to unfold (Dodds, 1999; Donovan-Kicken & Caughlin, 2010; Duric et al., 2007; Schulz, 2006). What characterises the experience of life with cancer is a sense of isolation from life as it was previously known, unreality about the current situation, as well as a persistent sense of having some unexpected limitations imposed on one’s emotional and physical life (Dodds, 1999; Duric et al., 2007; Little, Jordens, Paul, Montgomery, & Philipson, 1998; Schulz, 2006).

In recent decades evaluation of treatment regimes for BC have challenged once routine application of aggressive treatment such as the radical mastectomy (Anderson, 2014; Harbeck & Gnant, 2017). There remains, however, general awareness that when a mastectomy becomes the option to achieve an optimal outcome, a woman undergoes irrevocable alteration to her body and her life (Little et al., 1998). Less well understood is that even without the need for a mastectomy, once diagnosis is made and treatment begins, suffering for the woman survivor becomes an experience of the whole person, not just of the body or a part of the body

(Crompvoets, 2003; Galgut, 2007; Przewdziecki, Sherman, Baillie, Taylor, Foley, & Stalgis-Bilinski, 2013).

Amidst unpleasant emotions generated by confrontation with diagnosis of breast cancer, a woman is 'called' to urgently engage in and manage complicated interactions and negotiations with professionals in the medical domain (Bristow, 2002). There are a range of medical interventions to be navigated, such as chemotherapy, radiation therapy, possibly surgery, and hormonal treatment, each with their own type of side-effect (Arman & Rehnsfeldt, 2003). The resultant tension between the need to respond to a range of stressors that require cognitive acuity, self-perceptiveness and the need to consider relational functioning. Additionally, a woman may be faced with a range of social and economic and employment demands (Acitelli & Badr, 2005; Kayser, 2005) that add a more stress-inducing dimension to the process of absorbing the existential question with which she has been confronted.

## **2.5 Survival: Life beyond the pink ribbon**

Beyond BC it is essential to consider how best to create and plan emotional support that seeks to optimise women's personal resources for psychological and emotional well-being throughout survivorship. Several significant factors combine to underpin the value of exploring an individual's personal coping mechanisms and their approach to living with BC as a chronic illness. In general, Australian women can now expect to live longer and healthier lives than their counterparts of several decades ago. However, rises in population numbers brings an associated rise in the reported incidence of BC (Johnston, 2014). Australians diagnosed with BC have a 90% chance of surviving at least 5 years beyond diagnosis (Australian Institute of Health and Welfare [AIHW], 2017). Enhancements in contemporary medical technologies now offer an increasingly positive prognosis for the future of significant numbers of women diagnosed with BC (Johnston, 2014).

Women with a history of BC currently comprise the largest and most prevalent group of cancer survivors (Brennan & Houssami, 2011; Ganz et al., 2002; Knobf, 2007; Smith, Singh-Carlson, Downie, Payeur, & Wai, 2011). These increased survival rates beyond initial treatment mean larger numbers of women will expect to look forward to longer life post-treatment for BC (Gilbert & Procter, 2006; Pieters,

2009). This means significant numbers of women will need to continue to meet the ongoing physical and emotional adjustments required for living with the legacy of a chronic illness such as BC (Przedziecki et al., 2013). Some survivors of BC will become long-term users of ongoing remedial medical treatment, as well as users of resources focused on emotional and psychological wellbeing (Esteva & Hortobagyi, 2008; Lijovic et al., 2008; Robb et al., 2007; Worden, 1989). This would be especially so for older women survivors who may develop concurrent co-morbidity, or have a pre-existing disease or mental health issue when diagnosed for BC (Pieters, 2009). Given that extended years of survival is now a critical issue for living in the aftermath of BC, it would be normal to expect that women will seek greater understanding and information about what to expect for their future and how they can cope as they experience cancer's lingering consequences (Harris et al., 2009; Worden, 1989).

Aging can no longer be associated solely with increasing physical frailty and a legacy of personal losses (Pieters, 2009). Issues related to longevity in survivorship become even more critical for a woman as she encounters challenges associated with the aging process (Mehnert & Koch, 2008; Robb et al., 2007). This means extended knowledge and understanding of the emotional experience of survivors of BC is useful to ensure the quality of available psychosocial support post-BC meets the needs of a woman as her years of survivorship extend into the future. There exists a need for a range of emotion-focused and problem-focused interventions to be considered when devising best practice for older women with a chronic illness. Emotional responses can change as a person ages, and anxiety and depressive mood linked to fear of cancer recurrence (FoCR) has been said to reduce in an older BCS (Vahdaninia, Omidvari, & Montazeri, 2010; Frazzetto et al., 2012; Champion et al., 2014). Yet, lifelong symptoms associated with BC have been found to persist and impact quality of life (Champion et al., 2014). This means that regardless of whether progressing age means a BC survivor becomes more 'accepting' of changes to her body and its functioning, or becomes less vocal about any disruption to life that BC-related symptoms can bring, problems of living with BC are compounded by age (Champion et al., 2014).

Once treated for BC the risk of recurrence remains persistent across the life-span for many women. Some research has found that a cancer-free existence for a woman living with BC has been shown to be predictive of positive adaptation and better quality of life (Brown et al., 2002). However, the term cancer-free differs somewhat from the term ‘disease-free’. A cancer-free survivorship brings with it challenges associated with psychosocial, physical, and spiritual wellbeing (Brennan & Houssami, 2011; Pieters, 2009). While a woman may emerge from treatment cancer-free, recent research has suggested that short-term and long-term positive outcomes of adjuvant therapy treatment that involves chemical control of the disease may have variances in the time lapse needed to gain a guarantee against risk of recurrence (Jatoi et al., 2015). This time factor could be of particular importance as women BCS age and for whom amelioration of negative emotional states and stress could prove important for their ongoing physical wellbeing (Graham, Christian, & Kiecolt-Glaser, 2006; Mehnert & Koch, 2008).

Some evidence points to a significant number of BCS living with anxiety arising from fear of recurrence (Custers et al., 2015). To be disease-free then would mean finding ways to live free from anxiety-based bias toward FoCR. Research has indicated that women with a prior history of depression may be particularly susceptible to BC-related fear of recurrence (Janz et al., 2014). Past trauma (Galgut, 2007) and “past experience of stressful ... life events” have been “associated with the length of the disease-free interval in women with metastatic breast cancer” and regarded as indicative of the “possible long-lasting effect of previous life stress” (Palesh et al., 2007, pp. 233-239). These findings have clinical implications that call for consideration of self-compassionate relating as an intervention to lessen the impact of post-treatment anxiety or self-directed negative thoughts and feelings.

The promise of a disease-free existence is not the only factor to be considered in the aftermath of treatment. Survival across the short or long term may bring expectations from the woman herself, as well as from significant others, of a reasonably rapid restoration of her family, social or community roles, and resumption of a fulfilling existence (Dodds, 1999; Sulik, 2007). Challenges include personal functioning, resumption of sexual intimacy, short or long-term limitation in physical activities, increased prevalence of future development of chronic disease, return to

and maintenance of employment (Becker, Henneghan, & Mikan, 2015; Pieters, 2009). Issues related to restoration of lifestyle for the whole person, not just the person who has been ill, become important for psychological wellbeing (Robb et al., 2007; Schapira, 2014; Stergiou-Kita et al., 2014). The work of balancing care for the self alongside care for the needs of others generates for survivors the task of how relational harmony can be maintained. The effort required by this balancing act has been found to be less intense in a person who engage a self-compassionate response when encountering negative situations (Yarnell & Neff, 2013).

Recurrent personal and social challenges to psychological adjustment to living with BC as a chronic illness are commonly reported as a significant risk factor for later development of pervasive experiences of depression and anxiety (Robb et al., 2007). In addition to the increase in reported incidence of BC, and increased likelihood of survivorship, there are cultural and social constructions that surround the BC experience. For example, a positive thinking imperative may prevail in the social and familial world of the survivor. On the face of it, evidence offers useful insights into SC and its capacity to make significant alteration to the way a person responds to criticism, blame and failure. This then provides compelling reasons to explore whether it is appropriate for clinical approaches in post-BC-treatment psychological care to be refreshed or extended to include the teaching of Neff's (2003) construct of self-compassion. From the evidence provided by disciplined research, exploration of SC as a valuable construct on which to base development of psychosocial support mechanisms, as well as view inclusion in training of professional helpers, appears to be an appropriate focus for counsellors and mental health care specialists.

Findings from research literature on both BC and on SC (reviewed in Chapter 5) revealed that development of self-compassionate intra-personal skills to encounter distressing thoughts and emotions brings the opportunity for personal decision-making to be guided by what a person thinks, feels, and needs. For women, this perspective contrasts a viewpoint that they are often guided more by concern for what others think, feel or need. In line with literature on patient empowerment and care for the person with a chronic illness (Bulsara, Ward, & Joske, 2004), support for a woman to develop an interactive, inseparable self-relating system characterised by

self-acceptance, kindness and compassion, engenders healthy tolerance for distress and motivation to greater self-care (Pauley & McPherson, 2010). Reduction in personally-hostile, critical self-dialogue is to stabilise and sustain a woman's sense of personal empowerment during times when she experiences mixed emotions and finds it difficult to describe and express how she feels (Vigliotti, 2010).

Personal empowerment offers the experience of optimism and positivity to BCS, and has been reported to provide a sense of control or mastery over the experience of illness (Bulsara et al., 2004; Furzer et al., 2014). Being determined to find a way forward and having a sense of personal empowerment during all stages of an illness (Bulsara et al., 2004), can suggest a valuable interface with the central aspects of the construct of SC. A significant intersect between these two concepts would likely occur in a person who had developed a capacity to engage in acknowledgement and willing acceptance of their illness, and who also experienced that illness as a catalyst for hope rather than despair (Bulsara et al., 2004).

To include SC as a positive approach in the range of responses to BC-induced distress, the spotlight first needs to focus on how a woman may already employ 'mentalising' tools that help her interpret, resist, or make sense and meaning of her own and others experiences. Mentalising has been defined as awareness of and being able to perceive our own and others' thoughts from either what is observed or what is inferred (Brüne & Schaub, 2012; Franks & Whitaker, 2007). Usually regarded as a positive 'tool' that aids self-management of emotional discomfort (Launay et al., 2015), it may be possible that the same skill of mentalising has the potential to also provide a distracting and inhibiting defence mechanism. A distinctive feature of mentalising is the notion that humans are able to make inferences about thoughts and feelings (Launay, et al., 2015). What complicates this simple idea is that conclusions reached by an individual may not always be correct. In consideration of BC survivorship, mentalising may be the very 'skill' that could aid avoidance of dwelling on the emotional content of an illness experience, or alternatively, aid symptom self-management so as to cope with existential concerns by suppressing any inner emotional chaos (van der Kolk, 2014).

Substantial research has been dedicated to the impact on health of negative emotions, and the contribution of depression and anxiety to poor health outcomes (Ganz et al., 2002; Robles, Glaser, & Kiecolt-Glaser, 2005). There is currently a growing body of research that focuses on positive emotions and the contribution psychological constructs play in immune functioning and health (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Reiche, Nunes, & Morimoto, 2004).

Management of symptoms and adoption of coping mechanisms can offer a sense of control and short-term relief as a woman moves from the threat of cancer to the fear of recurrence (Vigliotti, 2010). While a locus of control has been argued to determine how a person adapts to adversity (Arraras, Wright, Jusue, Tejedor, & Calvo, 2002), the problem remains that attempts to keep control over disruptive psychological reactions may end up circumventing the ability to ‘metabolise’, or internally resolve, emotional distress. Habitual methods of coping through cognitive, emotional or behavioural disengagement (e.g. suppression and rumination, obsessive focus on detail), that have, until the ‘arrival’ of BC, aided management of emotionally stressful life events become unproductive post-treatment. Unfortunately, in survivorship these habits may become the ‘skills’ that continue to be used to over-regulate cancer-related distress in the hope of a more positive emotional outcome.

The relevant argument here is that when maladaptive emotional and cognitive processes remain unaddressed these become the major influences on a woman’s ability to cope and maintain wellbeing (Vigliotti, 2010). This means a survivor may find themselves unable to take action that could alter the nature of a negative self-relationship. Women who survive BC also may challenge two dominant narratives: what it means to her to be both a woman and a survivor of BC. Post-treatment the risk is that without the ability to develop healthy internal mechanisms to encounter and stay with difficult emotions a survivor may find themselves unable to utilise those same emotions to effectively evaluate information coming from a range of external and internal sources.

Emotions are a way we provide information in our interactions with ourselves and our social world (Leung et al., 2014). Our emotions have been said to serve as social signals (Hareli & Hess, 2012). Access to a broad emotional range, and in

particular the ability to express negative emotions has been considered important for psychosocial wellbeing (Lieberman & Goldstein, 2006). Restriction on emotional expression in BCS has, for some decades, received specific attention especially in relation to emotional wellbeing and positive improvement in adaptation to BC (Lieberman & Goldstein). The risk is that to avoid emotional awareness or expression of negative emotion so as to avoid physiological and emotional overload threatens to negatively influence the potential for positive adjustment to a traumatising event (van der Kolk, 2015). On the other hand, emotional awareness would be anticipated to result in the capacity for a care-giving outlook in self-to-self relating, for instance, and being able to generate feelings of compassion and warmth towards oneself when feeling anxious or threatened.

## **2.6 Personal resourcefulness: Being self-compassionate**

Evidence suggests that self-compassion is integral in development of an adaptive strategy for emotion-organising and generation of positive emotions that foster psychological well-being (Akin, 2010). Therefore, this study explores whether the concept of self-compassion, or the lack of it, is a significant factor in hindering or transforming emotional healing from the suffering associated with the experience of BC.

A central argument in this study is that development of a self-compassionate relationship with oneself will actively encourage a mindful and gentle shift away from any unconscious tendency to avoid or deny our emotional pain. Integral also is the idea that SC can eradicate the inclination to engage in coping mechanisms that emphasise a need to control emotional responses and avoid difficult feelings (Germer, 2009). For the woman recovering from treatment for BC, attempts to ignore her own suffering might in the short term lead her to coordinate efforts to make a premature return to a 'situation normal' way of living. However, such a focus could be detrimental to her psychological health over the long-term. Accordingly, a fundamental premise underlying this study is that conscious mobilisation of personal resourcefulness and self-efficacy in a self-compassionate way would be an invaluable personal capacity for providing relief from traits of perfectionism, self-reproach, self-condemnation, the burden of shame or isolation, or fear of negative evaluation.

To support a woman to be able to organise, understand and cope with the emotional challenges of BC, it is important to understand the nature of the experience for those who add BC to their list of life events. For the woman who is required to participate in the complexities of decision-making and health care as they live in the long shadow of treatment for BC, self-compassion may provide an important function in the creation of positive adaptation. Of interest is what intrapsychic processes interfere negatively with relating with oneself in a self-compassionate way.

## **2.7 Self-criticism and mis-communication**

A harshly critical relationship with self is revealed in cognitive distortions such as attribution of blame for events to oneself, feeling misunderstood, rumination, or unrelenting 'shoulds' and 'musts'. Self-criticism has been positively linked to depressive symptoms whereas self-compassion has been negatively linked with depressive symptoms (Zhang et al., 2017). Therefore it is important to be able to distinguish between a kinder self-relationship and being critical of oneself. The 'inner critic' is the name given to a manifested inner voice that sounds and feels normal to the person. In effect the inner critic interferes with one's psychological functioning and forms part of various psychological disorders (Stinckens, Lietaer, Leijssen, 2013).

When communication between survivor and caregiver is replete with misinformation, misinterpreted and misread messages, or if the way of communicating with oneself is characterised by anxiety, or harsh or unrealistic expectations, fear of negative evaluation, or a tendency to de-press essential truths about who one is, then it would not be surprising relational functioning could end in less than satisfying outcomes. When internal experience is rife with negative self-evaluation, self-judgment, neediness, and self-criticism these tendencies create barriers to healthy communication both within the self and in relationship with significant others (Campos, Besser, Ferreira, Blatt & Glazer, 2012; Leary, Tate, Adams, Allen & Hancock, 2007; Neff, 2003; Neff, Kirkpatrick & Rude, 2007; Stinckens et al., 2013).

## **2.8 Living in the ‘long shadow of breast cancer’**

The personal, financial and social cost of an illness such as BC makes clear the value of the search for ways to help women develop a self-compassionate attitude that will facilitate healthy intra- and inter-personal relating for living with the physical, psychological and psycho-social consequences of BC. Findings in studies such as those by Bettencourt, Molix, Talley, Schlegel, and Westgate (2008), Dodds (1999), and Low, Stanton, Thompson, Kwan, & Ganz, (2006), have highlighted the need to continue exploration into ways to diminish distress and support positive personal adaptation to living with the insecurity that BC imposes on people’s lives (Midtgaard, Stelter, RØRth, & Adamsen, 2007).

For a woman who experiences a serious health challenge such as BC, post-treatment psychological care that would encourage development of self-compassion could add constructively to her life after treatment in what appears to be a fundamentally effective and positive biomedical health-care model. The biomedical model offers care for the physical realities of life and it is only in recent years the profession has been prompted to offer compassionate, holistic responses to the psychological and spiritual needs of BC survivors (Dossey, 2007). Therefore, an essential step to take is extending clinical understanding of how SC could enhance psychological wellbeing for the mental realities of life for women experiencing negative late effects of BC and its treatment.