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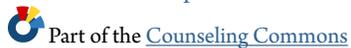
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Beyond the Pink Ribbon: An exploration of the experience of self-compassion in  
Western Australian women survivors of breast cancer

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## **Chapter Three**

### **Beyond the Pink Ribbon**

#### **3.1 Overview**

This chapter takes a brief look at issues that will be discussed in greater detail later in the body of this thesis (see Chapter 7). Psychosocial issues that accompany BC are reviewed from the point of view of their power to define and dominate a survivor's personal wellbeing and identity, from diagnosis through to end of life.

Continued advances in research and medical science means BC has become a condition that women of any race, class and creed in this 21<sup>st</sup> century can be anticipated to survive (Geffen, 2010). Advances in early detection and in treatment procedures in Western medical practice and research offer women with an early-stage diagnosis of localised or regional BC a more optimistic outlook than for other forms of cancer (Rowland, 2008). Despite advances in management of the disease, those same life-saving, risk-reducing treatments have a negative influence on physical, emotional and psychological well-being (Kukar, Watroba, Miller, Kumar, & Edge, 2014). This means that while increased numbers of women with BC will go on to lead a relatively normal life post treatment for BC, to do so will necessitate accommodation of the physical adjustments and emotional demands required for living with BC as a chronic health condition (Kukar et al., 2014). Although there may be a statistically similarities in the incidence of BC in women in industrialised societies (Parkin & Fernandez, 2006) each woman encounters a unique psychological journey (Dodds, 1999).

### **3.2 Cancer brings life changes**

Delivery of a diagnosis of cancer was once considered an almost certain death sentence generally accompanied by uncertainty about how long the person had to live, or the way in which the disease would progress (Dodds, 1999). For the person diagnosed with and treated for cancer the experience can be a traumatic one that generates intense emotional and psychological distress (Lindsay, 2009).

Now acknowledged as “a form of chronic condition with many unknown after-effects from treatment” (Loh, Packer, Chinna, & Quek, 2013, p. 331) BC is not an encapsulated event. It is the experience of navigating a disruptive, dynamic, uncertain journey through a series of linked stages (Elmir, Jackson, Beale, & Schmied, 2010) that will continue through life. Predictably, those stages move from diagnosis that results in active medical treatment and may include surgery, through the quest for physical survival, transition to survivorship, and on then for the balance of life. Through each of these “seasons of survivorship” (Leird, 2010) a woman diagnosed bears the burden of physical, emotional, psychosocial and spiritual disruption (Fischbeck, Maier, Nehring, Beutel, & Weber, 2012; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006). Survival brings with it the need for surveillance of the needs of survivors (Kukar et al., 2014). A survivor may be assessed as cancer free however, they are not free of the problems that accompany having had cancer (Miller, 2009).

The journey of BC is one of moving from initial identification of a lump, a feeling of un-wellness, or in some cases, a very surprising result from a routine mammogram or visit to a GP, to a situation that requires a woman to plot a thoughtful course through significant and demanding objectives. Those objectives include the need to respond to the initial diagnosis, decide on treatment options, complete treatment, manage both recovery and the desire to restore personal functional abilities, and at the same time maintain optimism and hope for the future (Brown et al., 2002; Dodds, 1999).

Currently, women diagnosed with BC have the right to collaborate with specialists about treatment options, can increasingly influence decisions about their needs for reconstruction, and ultimately make more informed choices about the

direction of treatment for themselves. However, similar to others who are diagnosed with another form of cancer, BCS have had no pre-diagnosis preparation for the shock of confirmation they have a life-threatening illness. Nor do they have any preparation for processing the rapid changes that take place once a diagnosis is made. At the time of diagnosis the woman may not have felt ill, or she may not have noticed or acknowledged breast or bodily symptoms that would indicate a serious problem.

### **3.3 The public face of the ‘battle with breast cancer’**

Breast cancer as a ‘social commodity’ has become a high profile disease that has as some of its ‘champions’ celebrities who encourage women to become empowered through knowledge and understanding of their body. In addition, well-known sporting identities who have lost loved partners to the disease, and film stars who have the disease, can promote aggressive action to avert a feared potentiality. Encouragement to fight against BC can provide women with motivation and a sense of power over an illness that crosses all social and political boundaries. Optimism and BC survivorship seem to make a ‘happy couple’, so why would we not celebrate the ‘marriage’ of these two? Yet, when connected to BC, the optimism imperative (Gibson, Lee, & Crabb, 2014) becomes a subtle, concerning, yet powerful enculturation of women, and Western society in general.

Creation of a ‘culture’ around BC happens through focused media coverage of the disease and the prevailing discourse about survival rates. However, subscribing to the desire of others for a woman to be optimistic about a positive outcome may not always be the healthiest direction for her to take. Fighting the fight, waging an ongoing war on cancer may mean a woman feels compelled to take personal responsibility for their survival (Gibson et al., 2014). The less than positive side of being optimistic could mean women become overly fearful of their body letting them down, or to feel a sense of failure if they do not maintain a recommended health care regime. Being optimistic, while socially sanctioned, can impose a restrictive ideal women may try to live up to in ways that are not psychologically healthy for them (Gibson et al., 2014).

### 3.4 Beyond the pink ribbon

In Western society a growing interest in personal displays of compassion has been taking place over the last two to three decades (Gibson et al., 2014). The symbol of the pink ribbon has become a powerful symbol of breast cancer awareness (Vineburgh, 2004). Activism in relation to BC emerged in the late 1980's (Gibson et al., 2014; Moore, 2010), and since the early 1990's the pink ribbon has become synonymous with awareness of breast cancer. It is important, here, to acknowledge the significant and crucial work done by awareness campaigns such as the National Breast Cancer Foundation the McGrath Foundation and Avon Cosmetic's Avon Million Crusade, among other organisations, in raising much-needed funds for research and BC support, and for providing Australian women with improved access to vital information about breast care and health. Clearly, as a result, "the way in which breast cancer is socially understood and personally experienced" has been redefined (Gibson et al., 2014, p. 2).

It is important also, to highlight that "the iconic attitude promulgated by pink ribbon culture (i.e., positive outlook, uber-femininity, warrior behaviour, collective rallying, survivorship) actually ignores men and isolates those women who have doubts, value gender neutrality, are private and ... are dying." (Hall, 2013, p. 280). Gibson and her colleagues (2014) have highlighted the concerning interpretation that BC awareness campaigns may in fact contribute to maintenance of sexualised views of women and unrealistic assumptions of what being feminine means.

In terms of extending awareness to more politically-driven action, Moore (2010), in her book *Ribbon Culture: Charity, compassion and public awareness*, refers to what she identified as a ribbon culture, developed within Western society, that can confuse raising 'awareness' with actual understanding of diseases for which ribbons are donned. Moore referred to the sociological implications of the now popular practice of public displays of awareness of issues of social and political justice or injustice. The result, Moore proposed, has been a 'commodification' of compassion. This has happened within a cultural climate where empathy has become associated with, and often becomes a replacement for, authenticity of experience (Moore, 2010).

In the desire to be seen as socially responsible, aware, and supportive of fund-raising for BC important considerations are missed. We need to also be aware of ways pink ribbon awareness, while productive and indispensable, may inadvertently contribute to a BC survivor believing that positivity and being proactive is the most socially sanctioned stance to adopt. Included in the optimism imperative is a sense that, for a woman, personal attractiveness includes two uniformly proportioned breasts. In the social world breast reconstruction provides a BCS a means by which they can fit back into the 'norm'. In some cases reconstructive surgery might mean that women have an opportunity to create what might be considered an 'even better or more perfect' stance. The BCS faces a social world that presents a confusing 'face' to BC. On the one hand BC awareness is promoted and on the other hand women may find themselves encouraged to conceal both distress and physical indications of their 'one – or no – breastedness' (Rubin & Tanenbaum, 2011).

Pink ribbon awareness campaigns may also unwittingly promote stereotypical beauty ideals, exclude from focus women who do not fit the stereotypical image of white, middle-class females with access to, at least regular, health care (Gibson et al., 2014). This is where Neff's (2003) concept of self-compassion could be explored to assess its potential to contribute significantly to efforts to reconstitute physical and emotional well-being post-BC. Counselling care and therapeutic interventions that cultivate increased SC as a means to reduce overall self-judgment and over-identification with negative rumination can help survivors of BC to reach a place of new life or healing that is authentic and integrative. In that process the very self-system that may have contributed to negative adaption to survivorship can be gently dismantled and eventually replaced, by the survivor, with a healthier self-relationship.

### **3.5 Survival: An urgent quest**

Current trends in medical 'consumerism' have indicated heightened demand for the person who becomes a patient to have greater access to more specific information about their health needs (Geffen, 2010). The person seeking medical advice or services is no longer a passive recipient of standardised care (Geffen, 2010,

p. 106). Whole-person multidimensional care models will include a broader range of services sensitive to the needs of the individual.

A benefit of advances in medical science is that specialists in the field of oncology now have access to vast amounts of information that increase awareness of the debilitating effects of post-treatment depression and anxiety. The hope is that this may lead to greater understanding that psychosocial care is necessary and beneficial throughout the long-term of survivorship, not just in the immediate post-treatment or end of life phases of the disease.

In conventional BC medical treatment regimes, front-line life-saving defences such as screening, surgical procedures, radiotherapy and drug treatment take precedence in planning for and achieving survival. Treatment for BC is a multidisciplinary approach that includes medical and surgical oncology and psycho-oncology (Thavarajah et al., 2015). For positive physical outcomes there is significant current and past research to substantiate the accepted argument that survivors of BC are primarily dependent on appropriate use of proven pharmaceuticals (Paskett et al., 2009). Provision of adequate education about living with the after effects of the disease, as well as about ongoing self-management have been considered useful for active engagement of survivors in maintaining personal wellbeing. Psycho-educational interventions have also been found effective in accelerate the reduction of negative affects which present and the completion of treatment (Dolbeault et al., 2009).

In the necessary push to arrest negative evolution of the disease and create optimal opportunity for physical survival, the importance and significance of psychological wellbeing and compassion for self as a critical element in both physical and psychological recovery must not be overlooked (Dossey, 2007). Therefore, this study concerned itself with a survivor's personal wellbeing when an illness that has generated a very real and present threat to life becomes a life-long companion. The challenge is that the combination of psycho-educative strategies and powerful pharmaceuticals are not always able to provide the answers for meeting psychosocial needs for those living with the after effects of BC.

The essential adaptation to and integration of life changes that a BCS makes in order to accommodate the after-effects of a life-threatening illness can become burdensome, emotionally testing and lengthy (Low et al., 2006). The BC recovery pathway is most commonly one of immediate reliance on the biomedical model. For women diagnosed, joining with the biomedical model may be lifesaving, or may provide an extended lifespan beyond what would have been possible without medical intervention. Physical survival takes urgent priority over any other consideration.

### **3.6 Adaptation: Meeting a different self**

Because the oncological clinician's first and only responsibility is to treat the disease the biomedical response to cancer is not designed to either support or explore a survivor's long-term emotional needs (Dodds, 1999). The biomedical response is equipped to concentrate on physiological repair and is a system not intended nor designed to provide assistance with the processing and containment of psychological experiences generated by ongoing uncertainty or existential distress (Kissane, 2014).

Medical science has made major life-saving inroads into the evolution of effective treatment and immediate post-treatment care (Geffen, 2010). However, recovery and restoration of psychological wellbeing also involves complex variables that include existential concerns that revolve around death and dying. Among these variables are factors such as the risk of personal demoralization (Kissane, 2014), aversive orientation to emotional experiences, and post-BC self-care as well as resumption and maintenance of relationships within family and social networks. Other variables include adaptation to a changed body image, re-establishing a sense of meaning, reconciling a pre- and post-cancer identity, encountering physical, emotional and spiritual stress, and, ultimately, a simultaneous encounter with both life and death (Sattman-Frese, 2009; Schaefer-Schiomo & Atwood, 2009; Tallman et al., 2007).

The elements of survival capable of producing uncertainty are echoed in research that indicates diagnosis, treatment and living with breast cancer across the long-term can increase the potential for distress in a range of aspects of life such as a woman's somatic, psychosocial and spiritual experiences (Bitsika, Sharpley, & Christie, 2010; Bower, Ganz, & Aziz, 2005; Low et al., 2006).

### **3.7 Suffering and emotional distress**

In Western society the prevailing dialogue surrounding mental health is such that subjective distress may be more commonly regarded both as an enemy of health and as something to be managed, or even eradicated, disguised as expeditiously as possible (Rubin & Tanenbaum, 2011). The impact of such a perspective is to effectively obscure the potential for emotional distress to serve as a ‘teacher’ from which a person could learn and grow. In an effort to regain a sense of control, prevent re-traumatisation through recurrence of the disease, or to combat feelings of helplessness, a BCS may join with a social world paradigm that works to either avert emotional suffering or numb a felt sense of emotional ‘dis-ease’. This means the mechanism of self-defence normally engaged to achieve protection against distress then becomes the same process that ends up turning against the survivor and increases their psychological vulnerability.

Occurring across a number of psychosocial dimensions the psychological consequences for some BCSs include feelings of confusion, uncertainty, confrontation with mortality, identification as a BC survivor, personal dignity, body image and functioning, limitations in life choices, and a degree of separateness or alienation from those aspects of social life a survivor was familiar with prior to BC (Piot-Ziegler, Sassi, Raffoul, & Delaloye, 2010). Given the potential for an anxious, fearful and stress-laden response to the life-penetrating news that one has cancer (Curran, 2011; Dodds, 1999), post-treatment there is also a plausible claim that the overall result for some survivors means they begin to exhibit symptoms of distress that mimic Post Traumatic Stress Disorder (PTSD) (Kornblith et al., 2007).

As a physical and emotional condition, the concept of suffering is often experienced as inconvenient, undesirable, and uncomfortable. It exposes vulnerabilities and challenges notions of expectation, as well as our concepts of the meaning of life (Arman & Rehnsfeldt, 2003). And yet, suffering, while sometimes traumatic and always unwelcome, also offers unique access to a turning point in life. A journey through suffering could be conceptualised as providing a doorway to personal transformation through acceptance of the challenges that suffering brings (Baník & Gajdošová, 2014). The BC ‘doorway’ is one that ‘users’ would likely not

want to re-visit despite the potential for growth and transformative affect to effect significant, change ‘for the better’.

Since cancer is a multifactorial disease, psychosocial care for the BC survivor (BCS) also needs to be viewed through a multifactorial lens. The uniquely personal way in which each woman constructs her BC experience highlighted attention that could be paid to personality factors, her interpretation of illness, her perceptions, her personal explanation of causality, her style of intra- and inter-personal communication, and the way in which she has responded to stressful life events. While personality factors may influence how a woman responds to her diagnosis and treatment, no association has, however, been found between incidence of BC and personality traits and expression of emotions (Bleiker, Hendriks, Otten, Verbeek, & van der Ploeg, 2008). The findings from Blieker and colleagues (2008) indicate that BCS can feel confident that their personality factors have not influenced the arrival of BC.

Negative self-judgment persistently directed at our “inner thoughts, feelings, intellectual attributes” has a corrosive effect on personality and has been “strongly correlated with a range of psychopathologies” (Long et al., 2009, p. 1849). The relevance of self-criticism for BC is that an internal commentary pre-occupied with focusing on one’s faults and mistakes has been found to generate similar physiological consequences as negative evaluative comments made to us by others (Gilbert & Irons, 2005).

Prior to addressing the different ways BC affects emotional functionality and wellbeing, it is important to consider that personal issues do not sit in isolation to each other. An interactive relationship between current personal issues and past experiences of illness, attachment style, the nature of close relationships, and the legacy of trauma or abuse can negatively affect a survivor’s framing of their experience. Pre-morbid psychological characteristics and the coping style of the survivor have been found to positively or negatively influence quality of life (Brunault et al., 2016). Age-related factors in non-metastatic BCS have also been cited as variables that negatively bias quality of life in survivorship. For example, emotional distress in a younger BCS may be related to loss of fertility or femininity,

body image, pain, and FoCR (Brunault et al., 2016). FoCR means any lumps, bumps, or times of simply ‘not feeling well’ can generate fear of a return of the disease.

For some women, self-esteem may be invested in a (personal) perception of how attractive they are perceived to be by others. In that case well-being may become contingent on maintaining an ideal standard that is perceived women in general set for themselves. For other women, self-esteem may be the by-product of unquestioning adherence to roles allocated in internalised sex-role stereotyping and complex power relations (Romeo et al., 2017). Additionally, conformity to culturally acceptable displays of emotion can preserve a person’s sense of self-esteem – at least momentarily.

The capacity to reframe a BC experience in a positive way has been found to lessen emotional distress in surgical BC patients, whereas self-blame and ruminative self-focus have been linked to passive or avoidant coping and associated with elevated emotional distress (Kim, Han, Shaw, McTavish, & Gustafson, 2010). The BCS who has high self-blame, low self-acceptance and feels isolated in her suffering are more likely to adopt avoidant coping strategies (Brunault et al., 2016; Kim et al., 2010). This means that therapeutic interventions tailored to BCS’ individual psychological factors that can either perturb or promote resourcefulness and self-reassurance.

Opening to more informed understanding of the variant influences on psychosocial survival for each woman post-BC, means being open to the emergence of a number of questions. One key question centres on what psychosocially-relevant factor could aid long-term maintenance of overall emotional equilibrium without risking: a) one’s emotional life becoming something that needed to be avoided, or at best, subdued; or b) one’s emotional expression becoming unnecessarily intensified in a way that exacerbates distress. These questions required thinking about the nature of a woman’s post-cancer relationship with her body, with herself, and with significant others, alongside what a woman feels she would need to maintain healthy personal relating throughout survivorship.

Therefore the focus of this study is to explore whether SC would be a useful and appropriate skill that could help women BCS nurture themselves, and assist them to optimistically navigate the inevitable stressors associated with diagnosis, treatment, recovery, and particularly, the ageing process. A benefit of being self-compassionate would be to increase the awareness of BCS that so-called ‘negative’ emotions are a natural part of the reactions to cancer, and provide a means of understanding their experience without judging development of, or vulnerability to, cancer as failure on their part.

### **3.8 A phenomenon of anti-suffering**

While, in general, feeling compassionate could be regarded as an agreeable experience, the very act of witnessing or of being present to another person’s suffering can generate feelings that are experienced in the observer as uncomfortable or unpleasant (Condon & Feldman Barrett, 2013).

In the wake of emotional disruption the tendency in Western society has been to promote a point of view as seen through a ‘lens’ of anti-suffering. To alleviate emotional suffering professional helpers are often expected to dispense expertise, recommend what should be done, provide strategies, and give authoritative guidance (Mearns & Thorne, 2013). The implication is that promoting a ‘stay with it and work through it’ perspective would be considered out of step with a ‘grin and bear-it’ viewpoint that has a stronger investment in a person ‘moving on and staying strong’. Coping mechanisms that ‘encourage’ a BCS to withdraw from “uncontrollable aversive changes in one’s environment” may at first be seen as “adaptive and thus ‘healthy’ ... but may become symptomatic of clinically severe depression” (Bitsika et al., 2010, p. 180).

Relevant to the dichotomy between an attitude of staying with it or an opposing attitude of moving on, staying strong, Markell (2002) has suggested that the transformative power and value in staying with and understanding our emotional suffering is the starting point for physical and emotional health. Similarly, Siegel (2009, pp. 156-157) stated that “emotion is a window into something changing” and that emotional integration of the personality is “at the heart of well-being”. When trauma, anxiety, or depression, activate a rigid but familiar response to

uncomfortable emotional states the resultant “unstable affective outbursts, intrusive thoughts, impulsive behaviours” deny the person access to an undistorted, kinder self. The argument from Markell (2002, p. 27) speculated that:

*It is through experiencing the strange flora and fauna of our inner life, which can disturb or frighten us or bring us to great love for others and true compassion, that the healing tendencies of the psyche begin to guide our lives.*

What Markell (2002) theorised was that adverse life experiences, given expression in the process of therapy, have the power to bring emotional healing and simultaneously generate beneficial and positive psychological outcomes. The outcomes proposed by Markell have been reiterated in the writings of Greenberg (2012, p. 697) whose clinical work and research leads to the conclusion that emotions are both “our greatest friends and at times our worst enemies”. These outcomes could be observed as a coming together – a coherence – in our emotional state: a state in which there we can be mindfully aware of our emotions, and the way in which they shape our perceptions, can be informed by them, and less driven by emotional reactivity.

Therefore, a therapeutic process of emotional transformation involves development of, and active engagement with, a capacity and willingness to encounter difficult feelings. The goal as proposed by Markell (2002) is not just to allow suffering to guide our lives in general, but to actively transform and integrate experiences of suffering and illness. If women survivors of BC are to be encouraged to stay with and process difficult feelings in what ways might they be appropriately and sensitively supported? What are the benefits, and what are the resources they need, or have, to feel nurturance through the process, and to ultimately build the skill of being able to nurture themselves and flourish in life?

The problem of emotional distress is likely to be addressed by the individual through various forms of defence by creating an imaginal and positive reality that becomes a place of refuge. Alternatively when the situation feels overwhelming a person can move into a substitute world of addiction (Sieff, 2008) whether that

addiction is food, substances, or another form of distancing oneself from the harsh realities of life. Self-medication, addiction, creating an imaginary positive reality, or professionally through application of more potent psychopharmacology, may only create a result of less likelihood of confident self-reassurance and self-integration.

### **3.9 Transition: Survivorship and opening to self-compassion**

When faced with adversity some people respond in ways that bring transformation, personal growth and significantly changed ways of relating with self and others (Durkin & Joseph, 2009). Examples of this have been reported in investigations by Dodds (1999) whose research with cancer patients in Western Australia analysed “how people diagnosed with cancer came to define and redefine their illness” (p. iii). Dodds (1999) focused specifically on “prominent discourses of healing and illness” and found that participants in her study regarded cancer as putting them on notice to significantly adjust their life direction and their relationship with themselves and with significant others (p. iii).

The optimistic outlook for a disease that Olson (2002) classified as “a horror known to every culture in every age”, makes the study of living with BC as a chronic or critical illness an important field to explore, particularly for the profession of counselling. Expanded understanding of the psychological issues that positively or negatively affect the relationship with self, and the world around a BC survivor, makes it incumbent on professional health carers to extend the capacity of existing programs and support services to offer appropriate, sensitive assistance.

With regard to emotional and psychological wellbeing, the concept of self-compassion appears to offer significant insight into a way support for BCS can help her navigate the inevitable stressors associated with diagnosis, treatment, recovery and the ageing process that comes with life post-BC. In practice this means that incorporating a focus on SC into psychosocial interventions and support services will require more than an extended list of treatment techniques to a skills-based repertoire for professional helpers (Mitchell, Murray, & Hynson, 2008).

The transition from being a cancer patient to a cancer survivor can initially be greeted with relief (Holland & Lewis, 2000). However, once unconfined by demands

and routines of a treatment regime, a BC survivor may experience uncertainty about whom she will now turn to for advice and support (Bessen et al., 2014). Furthermore, some women may feel inhibited around asking for help with intimate details of personal functioning, whether that be from a cancer support group, cancer care agency, a local pharmacist, or her immediate family.

### **3.10 Compassion**

Compassion for oneself has been linked, in recent studies to a number of positive life outcomes including reduction in experiences of low self-worth, depression and anxiety (Neff, 2003; Neff, Hseih, & Dejiththerat, 2005; Terry, Leary, Mehta, & Henderson, 2013). A specific definition of compassion and what might be observed in someone who is compassionate is, in one particular sense, not simple to describe in a clear and succinct language frame. Compassion may be defined in a number of ways. Contemplative traditions may refer to compassion as the wish to alleviate the suffering of others (Lutz, Brefczynski-Lewis, Johnstone & Davidson, 2008). In health-care professionals compassion has been aligned with enhanced empathy (Sinclair et al., 2016). Sometimes correlated with acts of selfless service (Neal, 2000), other authors posit that compassion is a mutually beneficial emotion that nourishes both giver and receiver (Kagan, 2014; Morse, Bottorff, Neander, & Solberg, 1991; Morse, Bottorff, Anderson, O'Brien & Solberg, 2006).

Compassion may often be thought of as a virtue, characteristic of heroic, larger than life people whose acts of service we could never, in reality, hope to emulate. Goetz, Keltner and Simon-Thomas (2010, p. 351) defined compassion as “the feeling that arises in witnessing another’s suffering and that motivates a subsequent desire to help”. Described also as “a mixture of love and sadness” (Seppala, Rossomando & Doty, 2013, p. 428) compassion could be said to be the intrapersonal experience of “recognition of suffering and the desire to help one who is suffering” (Goetz et al., 2010, p. 351). There is emerging evidence that confirms the very act of being compassionate brings significant benefit for an individual in terms of both their mental and physical health (Seppala, Rossomando & Doty, 2013).

The task to understand what the experience of compassion means for a particular person is not simple. In this respect language can become reductionist with

the power to diminish or negate the depth of an experience. It may feel easier to give compassion to another person through acts of kindness and generosity than to direct that same compassionate response toward oneself (Pauley & McPherson, 2010). The language of contemporary self-help processes may mean the words compassion, kindness, self-acceptance, self-forgiveness and self-compassion unfortunately become vehicles for a well-worn catalogue of clichéd interpretations. The integrity of what being compassionate means can get lost in rhetoric and overlooked in practice.

Despite the definitions, the meanings ascribed, and much-desired perception that we are now a more ‘aware’ society, awareness may not of itself result in deeper understanding of personal suffering or the suffering of another (Moore, 2008). Increased information and intellectual awareness are not tools that necessarily promote healing. They do, however, provide a starting point past which we must move in order to attend to individual needs for self-acceptance.

If compassion relates to the delicate undertaking of being able to suffer with another (Goetz, Keltner & Simon-Thomas 2010; Kagan, 2014; Young-Eisendrath, 2008) then the question to be answered is how we can better understand the intra-personal experience of compassion.

### **3.11 Self-compassion: Challenge and opportunity**

The significance of the construct of self-compassion for this study lies in its contribution to developing healthy attitudes to self and well-being through creation of a direct orientation to self-kindness and self-care rather than harsh judgment of oneself (Leary et al., 2007).

To consider whether self-compassion could be a significant feature of positive adaptation to living with BC it is important to first understand factors that negatively affect post-treatment emotional well-being. The distinctive psychosocial challenges of diagnosis and treatment for BC include anxiety and depression (Andreu et al., 2012; Burgess et al., 2005; Miller & Massie, 2006; Montazeri et al., 2001), shock, self-blame and self-criticism (Bennett, Compas, Beckjord, & Glinder, 2005; Dafter, Greenwald, & Block, 2006; Else-Quest, LoConte, Schiller, & Hyde, 2009; Friedman et al., 2010), shame (Bell, 2014; Hill et al., 2011), psychological stress

(Nekolaichuk, Cumming, Turner, Yushchyshyn, & Sela, 2011), stress in the process of returning to a ‘normal’, post-treatment body image (Przezdziecki et.al., 2013; Zimmerman, Scott, & Heinrichs, 2010), personal psychological agency, and for couples the renewal of sexual intimacy (Fobair et al., 2006), and the way in which a cancer diagnosis and treatment impacts on relationships in general (Dodds, 1999; Sperry, 2010). These factors may be ones that have their onset as a result of diagnosis and treatment, or, in the case of depression and anxiety, could be indications of a pre-existing vulnerability (Hill et al., 2011).

When ‘compassion’ is added to the word ‘self’ the overall perception of the concept of compassion becomes altered. Extending the word compassion to include the ‘self’ (i.e. self-compassion) may generate an internal struggle in the self-to-self relationship. What happens is an internal struggle can occur between preconceived notions of the negative evaluation of selfishness as opposed to the more socially acceptable – and admired – acts of selflessness. The dynamic tension between being kind to self and being selfish raises an important question. The cautionary question is whether, when confronted by painful, intense feelings, or adverse life circumstances, traits such as complacency, selfishness, and perhaps even narcissistic behaviours, mean selfishness can be mistaken for, or can masquerade as, self-compassion.

The concept of self-compassion gives rise then to another question about what happens for a woman post-BC in her experience and witnessing of her own and other survivors emotional processing. Defined as an internal mechanism that can replace self-blame, self-condemnation and being self-critical with a compassionate relationship with self, self-compassion has been found to enhance contentment with life (Gilbert, 2009). Research studies that have explored SC have suggested to direct associations with “social connectedness, emotional intelligence, happiness, optimism, agreeableness, extroversion and personal initiative” (Neff, 2011, p. 5).

### **3.12 The internal experience of self-compassion**

With a foundational principle of compassion for all life forms, SC is characterised by a capacity for gentleness, acceptance of, and kindness to self (Neff, 2003). That is, SC seeks to foster a healthy orientation to the self and to relating with others (Gilbert & Procter, 2006). Positively linked to adaptive self-regulation (Terry

& Leary, 2011), SC requires an individual to develop the ability to adopt a self-perspective that can accept that mistakes and disappointments in life are a very normal part of human existence. Furthermore, SC calls for a capacity to observe, experience and stay connected to feelings without identification with those feelings to the extent that they become foremost in a person's mind (Neff, 2009).

Self-criticism is characterised by a punitive and self-denigrating dialogue and has been associated with psychological difficulties (James, Verplanken, & Rimes, 2015). This means a self-critical person is likely to fear loss of self- and other-approval, has negative cognitive appraisals of self, and is hypersensitive to perceived criticism (Powers, Koestner, Zuroff, Milyavskaya, & Gorin, 2011). Fear has been said to relate to threat of ridicule or rejection, fear of being shamed, or being found lacking in some required skill or capacity (Sagar, & Stoeber, 2009). Reflection on the idea that as humans we are essentially flawed beings (Neff & Germer, 2013) generates, for some people, fear, resistance, and shame. Entrenched, repetitive, and distorted ways of looking at and experiencing ourselves and the world, create perceptions that obscure self-efficacy, resourcefulness and creative potential.

A healthy level of self-criticism can be useful as a motivator to assist in striving to 'getting things done' or pushing oneself to 'do (or be) better'. A certain level of self-monitoring could be regarded as the strength that provides safety in relationship. What this means is that judicious awareness of behaviours and thoughts guides our actions in ways that mean we are approved of and liked by others. The difference between healthy and unhealthy self-criticism seems to rest on whether relentless self-reproach emerges from fear of not being approved of or liked by others, or self-criticism is a means that provides constructive self-encouragement to act and think in a self-congruent and authentic way.

Excessive negative self-criticism, or self-critiquing, can be generated in instances where a BCS takes on personal responsibility for the burden of her illness at the same time as her emotional and physical resources are needed to generate sufficient personal endeavour for her ongoing survival. Research has determined that when a person is able to counteract self-punishment with self-acceptance the anticipated result would be the ability to provide self-reassurance (Fisher & Exline,

2010). In terms of thoughts and behaviours what having the capacity to offer genuine self-reassurance means is that this aspect of self-compassionate relating would be expected to reduce the burden of negative self-criticism.

Therefore, what would it mean if self-criticism could be transformed into an effective resource to adjust, positively, the condition of our thoughts and the direction of our behaviours? Rather than being regarded as an ‘ailment’ necessary to expel from the conscious mind, or to overwrite with positive self-talk, self-criticism, viewed through a different lens, could also be a constructive resource to sustain personal motivation (Kurman, 2003). The benefit of positive transformation would, ideally, reduce a tendency for continuing to make avoidable mistakes, or make decisions that are unproductive for our wellbeing (Gilbert & Procter, 2006). The result of fostering self-criticism as an effective rather than ineffective reaction to stressful demands is a capacity to pursue and achieve a meaningful goal. For example, a goal for a survivor of BC might be to structure life in a way that enhances a zest for living without placing them at risk of cancer recurrence.

Acceptance of the argument that self-criticism, of itself, not become tainted with a negative viewpoint (Gilbert & Procter, 2006) begs the question of how we might distinguish a healthy, positive form of self-criticism from more life-denying automatic negative self-criticism. With research providing evidence of the human potential for self-healing after loss (Mancini & Bonanno, 2009) the scope of self-discovery supported through the presence of a skilled counsellor could extend a way for hearts and minds to open, and help dissipate the corrosive effects of self-criticism, shame or guilt.

Despite identified negative effects on quality of life, relationships, physical well-being, and self image, psychological distress as a result of BC can go unrecognised and under-reported (Cancer Australia, 2011; Seok et al., 2010). Paradoxically, effective and beneficial progress in less radical treatment techniques can mean the challenges of living with BC become invisible or taken for granted. The shadowy side of advances in medical technology and scientific understanding of the workings of the human body is that the use of invasive procedures and expensive technology may be unquestioned.

A woman's recovery and restoration of her pre-breast-cancer identity has been said to be compromised by a demeaned sense of value of her body to herself and to others, of feeling that a physically altered body significantly reduces her personal attractiveness and femininity. Described as both an emotional insult and an assault on a woman's femininity and fundamental sense of self (Moore, 2010; Sheppard & Ely, 2008), BC and its treatment sequelae can destroy a woman's instinctive expectations of health and wellness.

Other quality of life factors that a woman with BC must contend with include alteration in sexual functioning and responsiveness (Dizon, 2009; Gilbert, Ussher, & Perz, 2010; Sheppard & Ely, 2008), surrender of control to a biomedical system, reduced margins of personal autonomy and control (Williams & Irurita, 2005), and significant challenges in returning to normal life, renewing social contacts and, for those in spousal or partnered relationships, re-establishment of intimacy (Little et al., 1998; Navon & Morag, 2004) and consideration about any sexual side-effects in survivorship (Graziottin & Rovei, 2007; Pillai-Friedman & Ashline, 2014).

### **3.13 Breast cancer and self-compassion-centred counselling**

The transformation of human emotional suffering and adverse life disruption is at the heart of counselling practice. With skilled support from professional helpers restoration from psychological fragmentation takes place in troubled hearts and minds. To work collaboratively with another person to bring about positive transformation is the essence of counselling as a helping profession. At the same time, being able to bear witness to the suffering of others is an essential trait in a counsellor, especially those counsellors working with clients who present with issues related to death and dying (Kirchberg, Neimeyer, & James, 1998), or those whose personal life experiences mean they are vulnerable to stress working with BCS. The well-known caution about the effects on counsellors of prolonged exposure to suffering calls for vigilance about maintaining the skills of connection and detachment (Benoit, Veach, & LeRoy, 2007). For client and counsellor, the therapeutic space can offer a 'stilling' and 'quieting' time for both mind and body. It offers a unique, short-term relationship based on the fundamental premise of offering openly caring and compassionate relating.

More than the sharing of cognitive information or a focus on cognitive and behavioural processes, counselling is an experience of confirmation for a person seeking emotional support. Through the counselling process the person can feel more certain of themselves, can feel as though they matter, and ultimately develop a more confident construal of self (Christopher & Maris, 2010; Teyber & McClure, 2011). Then, they are able to contribute more positively to their own wellbeing, and to the wellbeing and mental health of the community as a whole.

Contrary to popular perception, the task of counselling is more than a mere extension of the innate human caring bond (Neukrug & Schwitzer, 2006). For some the process will involve an exploration of the origins of their deepest longings and their impulses (Young-Eisendrath, 2008). Yet others may feel confronted and disturbed by conscious acknowledgement of a sense of limited control over the more challenging circumstances of their life. Understanding subjective distress and how to work effectively to help people untangle the mysteries of their lives are both central to a counsellor's capacity to effectively promote change (McLeod, 2013). Counselling offers a client the unique opportunity in a special environment to become a researcher of the phenomena of their own emotional life.

The collaborative counselling relationship provides a facilitative experience in which "the client is able to renew already existing personal resources, and augment them with new learning" (Cooper & McLeod, 2011, p. 35). The collaboration between counsellor and client helps the client find a level of self-acceptance previously untapped, in addition to the means to make positive life choices. This means that while the therapeutic alliance does not represent the entirety of benefits from undertaking counselling, it does provide a unique opportunity for a person to reconnect with and renew pre-existing, unexplored personal resources that become integral to a process of recovery. Recovery allows release from experiences that have significantly disrupted a client's sense of being in their immediate world. The short-term, intensive relationship created between client and therapist does, however, offer a definite source of transformation and enrichment for both participants (Neukrug & Schwitzer, 2006; Teyber & McClure, 2011).

### **3.14 Significance for counsellors**

Alongside extension of psychosocial support programs, there is the ongoing demand to enrich the personal capacity of professional helpers to sensitively and appropriately create conditions that promote emotional healing and engender hope. Paradoxically, counselling is the very process whereby a client is moved in a gentle, supportive manner toward exploring and becoming aware of the very suffering they have tried to medicate away, ignore, overlook or discount. In practice, the ability of a counsellor to be empathic and have the capacity to experience compassion is likely to be found through unconscious identification or alignment with a client's self experience (Cunningham, 2005). Similar sentiments are echoed by a Buddhist nun and scholar, Pema Chödrön, who commented that the practice of being compassionate, and offering compassion to others, is likely to confront us with awareness and fear of our own emotional pain.

Counsellors and professional helpers may find themselves faced with clients who enter the therapeutic process with a long term illness (Schaefer-Schiomo & Atwood, 2009), an uncertain outcome, and, in many instances, a progressively downward-oriented life trajectory. Training as a counsellor may not have prepared a skilled helper adequately to take on the role of working with and supporting, not only women with BC, but with clients who have an illness that is progressive and potentially fatal. Valuable skills are those that help a counsellor be able to distinguish between a person's experience of living with a chronic illness such as BC, the emotional impact of the likely trajectory of the illness, and the meaning they draw from their experience of illness (Schaefer-Schiomo & Atwood, 2009). Additionally, psychosocial challenges adjusting to life as a BC are not all necessarily centred within the person of the survivor.

Professional helpers benefit from increased knowledge and understanding of interpersonal and intra-personal relating, of complex issues that encroach on attitudes and perceptions of the body, and of overall psychological recovery and emotional well-being for women living with BC (Fossey, Harvey, McDermott, & Davidson, 2002). It is important for counsellors to be cognisant of ways to support women diagnosed and treated for BC to enhance their quality of life and manage the

psychological side effects of medical treatment as they process their transition into survivorship.

This study considers the usefulness of self-compassion as a personal faculty that offers women who have had BC the capacity to engage in encouraging, safe, open and honest expression of their emotional experience within their intra- and interpersonal relating. Thinking positively is not enough. Counsellors, particularly, are well placed to encourage and promote self-compassionate attitudes in people experiencing the vicissitudes of living with chronic illness. Implicit in this study is the potential to foster development of effective counselling strategies to encourage greater awareness of self-compassion and promote counsellor sensitivity to a woman's relationship with her post-treatment body and her relationship with significant others.

### **3.15 Chapter summary**

Research projects provide evidence from which policies, practices, and effective service delivery can be reviewed to assess what strategies and interventions are currently working well for BCS (Fossey et al., 2002). Systematic analysis of what is already perceived to be effective affords the prospect of being fluid, flexible, and imaginative in attitudes about the direction of enhancement of self-understanding, self-kindness and warmth in both the client as well as in the professional helper.

This chapter has provided an overview of the dynamics that emerge in living with the aftermath of BC. The outline of some challenges of living as a BC survivor gives an entre into the antecedents to psychological distress. Additionally, the conversation is begun about self-compassion as a way in which women could be supported to relate with themselves in such a way as to improve quality of their emotional life during their BC recovery experience as well as across the years of survivorship.

Extending current understanding of the psychological issues that positively or negatively affect the relationship with self and with the social and emotional world as experienced by women living in BC survivorship, makes ongoing review and assessment of psychosocial support for BCS a useful and essential path to follow.

The implication is that a philosophical, conceptual, and therapeutic practice framework for counselling strategies that would gracefully ‘arrest’ the inevitable consequences of harsh self-judgment, without creating yet another way an inner critical voice can continue to judge would be supportive for women, post-BC. The aim would be to foster a happier and hopeful approach to life for those survivors whose capacity for emotional self-healing is temporarily trapped. Whatever the level of social standing, self-esteem, power or powerlessness, so-called deficiencies in education or position, or cultural complexity, the construct of self-compassion seems to be a resource that can constellate an internal, and sometimes disconnected ‘mosaic’ of symptoms, emotions and needs.