UNIVERSITY OF DERBY

Developing and measuring compassion-based interventions for cancer patients and survivors

Key words: compassion, compassion-focused therapy (CFT), cancer, survivorship

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STATEMENT OF ORIGINALITY

The work contained in this thesis is original except where due reference is made. It has not been and shall not be submitted for the award of any degree or diploma to any other institution of higher learning.

Signature:

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List of Abbreviations

ACT	Acceptance and Commitment Therapy
BI(s)	Beneficial Intention(s)
CAs	Contemplative Approaches
CAM	Complementary and Alternative Medicine
CBT	Cognitive-Behavioural Therapy
CBCT	Cognitively-Based Compassion Training
CBI(s)	Compassion-Based Intervention(s)
CCT	Compassion Cultivation Training
CFT	Compassion-Focused Therapy
CforC	Compassion for Cancer (Training Programme)
CFV/CFI	Compassion-Focused Visualisation/Compassion-Focused Imagery
CMT	Compassionate Mind Training
CTs	Complementary Therapies
EBP	Evidence-Based Practices
ER	Emotion Regulation
ERQ	Emotion Regulation Questionnaire
FBRs	Fears, Blocks, and Resistances (to Compassion)
FoR	Fear of Recurrence
IASP	International Association for the Study of Pain
LKM	Loving-Kindness Meditation
MAAS	Mindful Attention Awareness Scale
MAT	Mindful Attention Training
MBCT	Mindfulness-Based Cognitive Therapy
MBCT-Ca	Mindfulness-Based Cognitive Therapy for Cancer
MBCR	Mindfulness-Based Cancer Recovery

MBSR	Mindfulness-Based Stress Reduction
MBI(s)	Mindfulness-Based Intervention(s)
MLQ	Meaning in Life Questionnaire
MSC	Mindful Self-Compassion
MM(R)	Mixed Methods (Research)
NVCC	Non-Verbal Communication of Compassion
R-AAS	Revised Adult Attachment Scale
PPBCT	Persistent Pain after Breast Cancer Treatment
PTG	Post-Traumatic Growth
PTGI	Post-Traumatic Growth Inventory
PSS	Perceived Stress Scale
SDT	Self-Determination Theory
SWLS	Satisfaction with Life Scale
SRB	Soothing-Rhythmic Breathing
SMP	Spacious Mind Practice
TIM	Trauma-Informed Mindfulness
TSM	Trauma-Sensitive Mindfulness

Abstract

Previous research on mindfulness and compassion has indicated that training programmes based on these modalities (contemplative practices) have been effective with various clinical populations, including somatic patients (Carlson, 2012) to differentiate between them and psychological patients. The current PhD research programme aimed to develop and evaluate an evidence-based psychological management programme for cancer patients and survivors in stages 0-IIIC. The programme primarily incorporates the main conceptualisations and practices of Compassionate Mind Training (CMT), which itself is based on Compassion-Focused Therapy (CFT), or is considered to be the tools used in CFT (Gilbert, 2010a).

Overall specific aims included:

i. The investigation of a new cancer intervention based on contemplative approaches – mainly compassion-based approaches;
ii. Development of a comprehensive psychological training programme for cancer patients and survivors;

With specific objectives to:

i. Test and implement compassion-based interventions (CBIs) as a means to greater (dispositional) mindfulness, meaning of life, satisfaction with life, emotion regulation, attachment styles, and post-traumatic growth (PTG) improvement (by facilitating coping with a range of stressors associated with cancer and developing capacities for self-regulation and self-soothing);
ii. Determine whether there were differences between the level of mindfulness, PTG, meaning of life, satisfaction with life, emotion regulation, attachment styles – before

taking part in a compassion-based programme, after the last session, and two months later (follow-up).

To meet these aims and objectives, the PhD comprised these studies:

- Study 1 (pilot) with a non-clinical population (one group), included using qualitative measures;
- Study 2 (initial study) with a clinical population (one group), included using qualitative and quantitative measures (mixed methods);
- Study 3 (main study) with a clinical population, (two groups), included using qualitative and quantitative measures (mixed methods).

The findings were divided into quantitative and qualitative results (in appropriate chapters). Based on the described benefits and recommendations it can be concluded that there was a value of CforC being delivered to cancer patients and survivors similar to the experiences of the non-clinical group. Additionally, both cancer patients and survivors reported changes in the way of approaching oneself (e.g. being able to relax and be more self-compassionate) and various aspects one's experience (e.g. having more understanding), including differences in relating to one's body, pain, and other people.

Quantitative analyses revealed improvements in satisfaction in life, mindfulness, perceived stress, meaning of life, emotion regulation, attachment, and partially in post-traumatic growth. These results show promising avenues for compassion-based interventions being used with cancer patients and survivors. The results show an important potential of the CforC in its ability not to only to increase a compassionate attitude and behaviour but also instances of mindfulness. Thus, another important benefit of mindfulness is the fact that mindfulness can lead to meaning and positive reappraisal. CforC training and CBIs can also trigger processes

associated with safeness, including feeling safer in relationships and being able to feel a bond with more fellow beings. CforC may serve as a vehicle to evaluate current relationships, their patterns and dynamics in a way that ultimately allows individuals to feel more connected to others. CforC can therefore serve as a catalyst for allostasis and provide patients and survivors with cognitive, emotional and relational benefits. Furthermore, practical recommendations have been given as to how to teach and supervise CforC.

Another area that still needs to be investigated further is how CforC can help with managing pain as self-compassion may be important in pain adjustment. Further studies should be employed, including running confirmatory studies with larger samples, in order to replicate all of the results mentioned and explain the processes behind them and closely look at all the practices employed in CforC as it is not yet clear what specific factors influence all of the aforementioned changes.

Dedication

To all the people, past, present and future. Hope this will be of benefit to you and others.

May you be healthy, may you be well, may you be safe, may you flourish.

To quote the poet Walt Whitman:

"…I celebrate myself, and sing myself,

And what I assume you shall assume,

For every atom belonging to me as good belongs to you".

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Chapter 1. Introduction to Compassion-Based Interventions in Cancer and its Rationale.

In the Western world both cancer patients and survivors often experience symptoms of anxiety (Curran, Sharpe, & Butow, 2017; Inhestern et al., 2017), depression (Jia et al., 2017; Inhestern et al., 2017; Yi & Syrjala, 2017; Maas et al., 2015), post-traumatic stress disorder (PTSD) or post-traumatic stress symptoms (PTSS) (Smith, Redd, Peyser, & Vogl, 1999; Alter et al., 1996; Mei Hsien Chan et al., 2017), pain (Nersesyan & Slavin, 2007; Harrington, Hansen, Moskowitz, Todd, & Feuerstein, 2010; Moye et al., 2013), insomnia (Roscoe et al., 2007) and/or cognitive impairments or dysfunctions (Biegler, Chaoul, & Cohen, 2009). In the face of their illness, cancer patients are subjected to a long list of doctors' appointments, medical examinations and procedures. Many cancer patients also go through unemployment, and in some cases, relational losses, financial struggles, sexual difficulties, experience cognitive problems due to emotional distress, suffer from physical disabilities and/or suffer from identity crises (Atkins & Goodhart, 2013). Unfortunately, the experience of cancer does not end with one's treatment termination and symptoms may be experienced long after treatment has ended (Stanton, 2015). Additionally, some patients and survivors ruminate about the possibility of relapse, which is often referred to as fear of recurrence (FoR), and dying (Simard et al., 2013) or the "Damocles syndrome" (Smith and Lesko, 1988; Quigley, 1989; Herold & Roetzheim, 1992). Introducing a comprehensive psychological intervention, therefore may add to improvements in the quality of life of those patients and survivors, which leads to the importance of investigating various psychological management interventions.

Previous research on contemplative practices, which mainly includes mindfulness and its variations, has indicated that training programmes based on these modalities have been effective with various clinical populations, including somatic patients (physical health and disease) or more specifically, cancer patients (Carlson, 2012) and cancer survivors

(Schellekens et al., 2016). Yet, what still needs to be tested is how different forms of contemplative practice work in cancer care, namely compassion-based interventions (CBIs). Whilst mindfulness and mindfulness-based interventions (MBIs) facilitate the exposure to both internal and external phenomena, they do not combine the cognitive recognition with affective appraisal which is needed for the full therapeutic benefit to be realised (Gilbert, 2014). In addition, the flow of self-compassion is also a better predictor of symptom severity and quality of life in mixed anxiety and depression than mindfulness (Van Dam, Sheppard, Forsyth, & Earleywine, 2011).

It also needs to be noted that currently the secular mindfulness practice is often used in its narrow and "decontexualised, individual level" understanding (e.g. solely enhancing attention, awareness of the present-moment, and stress reduction) (Purser & Milillo, 2015). It also needs to be pointed out that the type of mindfulness that has been mentioned here predominantly refers to the eight-week Mindfulness-Based Stress Reduction (MBSR) and its limitations. In contrast, other modalities of mindfulness like the Mindful Attention Training – MAT (Wallace, 2006) are more complex and not only touch on mindfulness but also awareness and/or luminosity.

Based on these examples, mistakes need to be avoided in terms of designing, implementing, and teaching of compassion – so it would not be an expression of "sensual romanticism" (Purser & Milillo, 2015) as many associate compassion with predominantly love and kindness (P. Gilbert, personal communication, 2018). This represents a myopic vision as compassion demands courage in the first place, including the courage of seeing various aspects of oneself, others, and the world (P. Gilbert, personal communication, 2018).

One of the psychotherapeutic and contemplative modalities based on compassion and employed for therapeutic purposes is called Compassion-Focused Therapy (CFT). CFT has been effective in various circumstances, including facilitating emotion-regulation (Finlay-Jones, 2015; Diedrich, 2014), improving interpersonal and social relationships (Crocker & Canevello, 2012), and helping traumatised individuals (Au et al., 2017). Other researchers like Rockliff et al. (2011) found that exercises designed to increase self-compassion are associated with reduced levels of cortisol, a stress-related endocrine biomarker, and increased heart-rate variability. Higher scores on self-compassion measures have also been negatively associated with self-criticism, depression, anxiety, rumination, thought suppression, and neurotic perfectionism, and positively associated with life-satisfaction, social connectedness, and emotional intelligence (e.g. Neff, Rude, & Kirkpatrick, 2007). Pace et al. (2009) have additionally found a positive correlation between compassion-focused meditation practices and innate immune and behavioural responses to psychosocial stress (Pace et al., 2009). Additionally, greater frequency of compassion meditation practice relates to reductions in mind wandering to unpleasant topics and increase in mind wandering to pleasant topic (Jazaieri et al., 2016).

In addition, preliminary studies suggest that vagal nerve activity can predict prognosis in cancer (so far only with metastatic patients) because of its neuroimmunomodulatory effects of vagal nerve activity (Gidron et al., 2014). Indeed, it has been hypothesised that adequate vagal nerve activity can modulate tumour growth (Mravec et al., 2006) and that high vagal tone may reflect flexible top-down brain regulation of immune and physiological activity (Ohira et al., 2013). Vagal nerve-activating treatments are also potentially helpful in pain conditions which often occur in cancer (De Couck, 2014). Additionally, salivary biomarkers might be useful when assessing stress states (Kitajima et al., 2011; see also Duarte et al.,

2015). Thus, it can be hypothesised that training in compassion could play an important role in the psychological and physical welfare of cancer patients and survivors.

Compassion-based interventions may provide cancer patients and survivors with the means to self-regulate and self-soothe amidst experiencing their human vulnerability (Trindade et al., 2018). Moreover, in some cases certain compassion-based practices can lead to additional benefits such as finding meaning and/or purpose (of life) and/or resilience (to adverse situations amidst illness and post-illness) (Frederickson, 2008). However, before a discussion of compassion and CBIs can be pursued, it is important to look at the description of any clinical population for which a specific treatment is being proposed to better tailor specific techniques, theoretical underpinnings and gain insight into specific issues that this group is faced with. In this particular case, cancer patients and survivors.

1.1. Cancer: Understanding the Nomenclature, and the Issues of Cancer Patients and Survivors.

1.1.1. Cancer Survivors and Cancer Patients.

"*Illness is the nightside of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place*."

— Susan Sontag (1979, p. 3)

As observed by Sontag (1979), as human, sentient beings we are all vulnerable to illness and at some stage we may fall to one of the categories of illness infliction: being a patient, survivor or a friend/family member of one. Thus, to start with one should clearly define who a "cancer

patient" and a "cancer survivor" is as these seem to be confusing terms and sometimes used interchangeably. In other words, the issue of terminology is not always clear in cancer studies. For instance, people who have not reached the five-year threshold, but have already finished their treatment, do not have a label and yet they constitute the group that is highly vulnerable to mood disorders and other post-treatment and post-illness consequences (Mehta & Roth, 2015).

There are various definitions of cancers survivors but the most prevalent ones define survivor as being any person diagnosed with cancer, from the time of initial diagnosis until his or her death, and this definition has later been extended to include family, friends and caregivers who are touched by a cancer diagnosis in any way (Feuerstein, 2007) which further adds to the confusion. This vague description of terms would consequently imply an overlap between the two terms: cancer patient and cancer survivor. In contrast, the Committee on Cancer Survivorship from the (American) National Cancer Policy Board (2004) highlight the fact that some professionals say that one cannot be considered a survivor until they complete initial treatment, while others claim that survivors are those who live beyond five years of diagnosis. Furthermore, survival is divided into three seasons: acute; extended; and permanent. Additionally, as stated by Mullan (1985), survivorship should not be treated as a by-product of cancer care and research. It may be concluded that, in fact, this should be the primary goal which includes not being oblivious of one's quality of life.

As there is no consensus among experts on the usage of these terms, and for the sake of clear differentiation between the two groups (cancer patients versus cancer survivors), which may be exposed to distinctive issues, I will follow in the footsteps of Ganz (2011) and similarly to her, use a "broad and all-inclusive definition" therefore define cancer survivors as all patients who have completed their treatment, even if they have not reached the five-year threshold.

The term patient will be reserved for those who are currently receiving treatment. Thus, both groups will be explored in terms of their psychosocial and physiological/medical issues.

1.1.2. Psychosocial Consequences.

Cancer, to use the expression delivered by Lehrman, Jarski, Rea, Gellish and Vicini (2012), is a "cascade of distressing symptoms", and one of the symptoms relates to psychosocial responses. Concerning psychosocial responses to cancer, in 1980, Meyerowitz summarised the main areas of challenges for cancer patients into three categories that will be experienced to some degree at various stages of cancer treatment, and by all individuals. These remain valid today: (1) psychological discomfort (anxiety, depression, or anger), (2) behavioural changes caused by physical discomfort, marital or sexual disruption, or altered activity level, and (3) fears and concerns related to body image, recurrence, or death.

To update the above taxonomy, the following minor changes have been made and a fourth dimension created: (1) psychological discomfort/emotional distress (anxiety, depression, anger, stress, trauma-related issues and other emotional consequences), (2) behavioural and functional changes caused by physical discomfort (including pain) and medical consequences, work, financial, relational and sexual disruption, or altered activity, (3) fears and concerns related to dramatic changes: body image (corporality), recurrence, or death, and (4) positive disintegration, concerned with finding meaning/purpose of life (including post-traumatic growth – PTG).

The last aspect was added as some patients and survivors report the importance of experiencing cancer in relation to how they have changed their attitudes and lifestyles (Spelten, Sprangers, & Verbeek, 2002; Patterson et al., 2003; Laranjeira, Ponce Leão, & Leal,

2014). This taxonomy is not a clear-cut one as there may be an overlap between various aspects. However, the four dimensions can be used as a roadmap for psychological support personnel in order to be sensitive to the comprehensive experience of cancer patients and survivors. These are expanded upon below.

1.1.2.1. Dimension of Psychological Discomfort and Emotional Distress (including Anxiety, Depression, Anger, Stress, Trauma-related Issues and other Emotional Consequences).

The first issue that most psychologists working with cancer patients and survivors are aware of is that a diagnosis of cancer and consequent treatment can provoke emotional distress and physiological stress (Speca et al., 2000). Cancer-specific stress also includes alterations in biological responses, such as shifts in immune cell traffic and facilitation of inflammation (Kang et al., 2012). Distress is most common when cancer patients are first diagnosed and subsequently begin their treatment, but is less common in remission (Gao et al., 2010). There are, however, reports of patients suffering distress long after the completion of cancer treatment (Bleiker et al., 2000).

These differences raise the questions of when best to start interventions for those with cancer and what methods are most effective for well-being interventions for both cancer patients and cancer survivors. Somewhat answering this question, Holland and Alici (2010) report that the prevalence rates of distress vary depending on the type of cancer and its prognosis. This is important as different or differently/individually/specifically tailored interventions might be needed for different groups of cancer patients depending on their cancer type, prognosis, cancer stage, treatment, gender, and feasibility; due to all of the aforementioned. According

to some researchers the cancer stage is not important in terms of rates of psychosocial distress[1] (Reich et al., 2008), but rather the personality, resiliency pre-cancer diagnosis and previous psychiatric history of cancer patients are (Nakatani et al., 2013). For example, women at greatest risk of distress, anxiety and/or depression include those with a history of psychiatric illness (Mermelstein & Lesko, 1992; Bloom et al., 1987; Penman et al., 1987, Reich et al., 2008), a lack of a confiding relationship, high neuroticism, and minority status (e.g. racial/ethnic) (Reich et al., 2008).

This stated, cancer stage might still be important in the development of other emotional difficulties: i.e. how medical adaption depends on the cancer stage when diagnosed, type of treatment, and long-term prognosis (Rowland & Massie, 2010). Taking into consideration all of these facts, it seems that it may be beneficial to introduce psychological support at all stages of cancer care and for all groups of patients and, to use the expression favoured by Jon Kabat-Zinn, prevent patients who are "falling through the cracks of the medical service" (Kabat-Zinn, 1979).

According to some studies, 20% - 30% of (breast) cancer patients suffer from anxiety and/or depression during the first postoperative year (Goldberg et al., 1992). It is important to consider that the percentage of affected patients varies depending on individual studies: in a longitudinal study of (breast) cancer patients by Vahdaninia et al. (2010), 22.2% suffered from depression, and 38.4% from anxiety at 18 months post-treatment of the cancer, whereas in a longitudinal study of cancer patients by Schou et al. (2004) 12% suffered from depression at diagnosis and 9% after 1 year; while 34% suffered anxiety at diagnosis and 26% after 1 year. In a study by Gozum and Akcay (2005) 53.2% of Turkish cancer patients receiving

[1] This referred to breast cancer patients.

chemotherapy were reported to be depressive. These different studies indicate that irrespective of the stage of illness, type of cancer or time in remission, both cancer patients and cancer survivors experience high levels of anxiety and/or depression. Thus, it should be clearly stated that all groups of patients and survivors should be included in psychological management programmes, and this would involve creating separate or combined groups (e.g. male, female, all types and stages of cancers).

There is also recent data relating to PTSD as a consequence of breast cancer (Arnaboldi et al., 2014). In a study by Arnaboldi et al. (2014), incidence of PTSD symptoms was around 20% in newly reported breast cancer patients (with the median age of the sample being 47 years). PTSD is an anxiety disorder triggered by traumatic experiences (including experiencing/witnessing an illness) and can, for example, result in flashbacks (reliving the event/s), withdrawal from places, situations or people involved in the traumatic event. The aforementioned findings have important implications for making sound decisions about treatment options when one is experiencing symptoms of PTSD and is also faced with other emotional challenges, i.e. how ready are patients to make appropriate decisions, and how well-informed doctors are in terms of their patients' emotional state. Most reports and studies show that such emotional consequences are often misdiagnosed and undertreated (Reich et al., 2008). Thus, future emotional management training programmes should address these issues, e.g. help patients and survivors stabilise their emotional landscape and therefore facilitate making sound decisions about their health and general life situation. In fact, this is one of the rationales for creating new training programmes such as the newly established CBIs (Kirby, 2016).

1.1.2.2. Dimension of Behavioural Changes Caused by Physical Discomfort: including Pain, Marital or Sexual Disruption, or Altered Activity Level and Fears and Concerns Related to Dramatic Changes: Body Image (Corporality), Recurrence, or Death.

This dimension refers to issues in cancer care that include behavioural changes and fears related to changes such as body image and functioning. Some of the identified challenges due to changes in appearance for cancer patients include: scarring, loss of sensation, swelling (lymphoedema or in severe cases elephantiasis), onset of menopausal symptoms, hair loss, weight gain or loss, ulcers, hormonal changes, and use of prosthesis (Harcourt, 2010). It has been documented that women receiving mastectomy have significant impairment in body image (Bogaarts et al., 2012). Brandberg et al. (2008) found that patients reported problems with body image. For example, 44% reported dissatisfaction with scars, 48% reported feeling less sexually attractive and 48% reported feeling self-conscious. Of note, older breast cancer survivors also experience concerns in terms of their body image, a fact often neglected by health professionals (Fenlon et al., 2013).

In some, physical consequences of invasive treatment options can be highly important, and the way patients perceive their bodies is a factor that needs further investigation. For a cancer patient or a cancer survivor, especially those who undergo radical surgery, the experience is that of having a different body altogether, breaking it into pieces and consequently having to learn to "embody'' it once again (Piot-Ziegler, 2010). This process of "embodiment" can be facilitated by appropriate psychological exercises present in various contemplative training courses, and at times may result in post-traumatic growth (PTG).

Also concerning the topic of bodily issues, there are several medical armamentaria for cancer patients. Each drug has different resulting side effects. These side effects may include changes

to blood count, sickness, tiredness (fatigue), hair loss (alopecia), experiencing sourness in one's mouth, and ulceration, and reduced fertility (Priestman, 2005). Furthermore, Priestman (2005) lists: damage to the heart, nerves, skin and/or kidneys, allergic reactions, eye complications, diarrhoea and constipation; and in terms of side effects of hormonal therapies for breast cancer: menopausal symptoms, cancer of the womb, thrombosis, and osteoporosis. Another important issue is cachexia (weight loss), predominant in 25% of female (breast) cancer patients (Fox et al., 2009). Skeletal morbidity is also noted to be a consequence of adjuvant treatment occurring both in early and advanced stages of cancer (Walkington & Coleman, 2011). Thus, cancer can have severe, profound and long-lasting medical and physical consequences such as experiencing pain long after the initial treatment or illness. Hence, it seems that psychological interventions can be also helpful in that area.

One of the most-often quoted issue concerns pain. The International Association for the Study of Pain – IASP (Merskey et al., 1979) describes it as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" (p. 250). According to Breast Cancer Care UK, pain after surgery includes experiencing phantom nipple pain and real nipple pain. Another important issue is hyperalgesia, or increased sensitivity to pain. It is important to note differences in experiencing pain between patients who have had their lymph nodes removed and those who have not: the former group experience more pain.

Smith and Wu (2012) also mention persistent pain after breast cancer treatment (PPBCT) with prevalence as high as 50% worldwide in breast cancer survivors. Sheridan et al. (2012) report a similar percentage at between 24 and 36 months postoperatively. IASP also states that pain can be considered chronic when it continues after three months, but in the case of cancer three months is too long to consider it chronic according to those who treat it, because of the nature

of both the treatment and illness (Smith & Wu, 2012; International Association for the Study of Pain, 2002). This implies the need to introduce pain management techniques as part of psychological interventions before any symptoms even begin.

According to Van den Beuken-van Everdingen et al. (2007) "in cancer patients, pain is one of the most feared and burdensome symptoms" (p. 1437). In meta-analyses conducted by Van den Beuken-van Everdingen et al, 64% of patients with metastatic or advanced stage disease, 59% of patients on anticancer treatment and 33% in patients after curative treatment, experience persistent pain (which at times is used interchangeably with "chronic pain"). Thus, to survive cancer does not mean for the pain to go away. Aaronson et al. (2014) emphasise the fact that pain is often overlooked in cancer survivors because of the limited number of studies on post-cancer pain syndrome. Here, one should further make the distinction between pain and suffering, as the level of physical pain experienced by an individual does not necessarily make them suffer more, or less. The level of suffering depends predominantly on one's perception of their experience, and their personal circumstances.

In terms of suffering it concerns one's identity and poses a threat to the integrity of a person (their entire personhood) and their future (E. Cassell, personal communication, 2015). It can refer to feelings and experiences of disconnection (Kanov, 2005), physical or emotional pain, trauma, existential crisis (E. Cassell, personal communication, 2015). Suffering is therefore about how patients perceive their pain experience and the way they emotionally react to it. Suffering is also about the meaning patients ascribe to their condition. One can refer to somatic and psychic suffering (Wittman et al., 2009); how one suffers does not necessarily depend on the severity of their illness. Viktor Frankl's view is that suffering ceases to be suffering when it takes on meaning (Frankl, 1946/2004). Young (2004) gives the following formula for suffering: *suffering = pain x resistance.* This suggests that the more one resists, the more they

suffer or in fact create secondary pain. Based on such studies, one can conclude that psychological interventions facilitating analgesia should be further studied and developed.

1.1.2.3. Dimension of Positive Disintegration, finding Meaning/Purpose of Life: including Post-Traumatic Growth.

Post-traumatic growth (PTG) is another area of change among cancer patients and survivors and refers to the positive outcomes some experience. Werdel and Wicks (2012) explain the definition for PTG as "the positive psychological changes as a result of enduring stress and trauma" (p.12). PTG includes enhanced interpersonal relationships, increased appreciation of life, sense of increased personal strength, greater spirituality, and positive changes in life priorities and goals (Calhoun & Tedeschi, 2006). PTG can also be described as "positive disintegration", which emphasises anxiety and psychological tension as a means to psychological growth (Dąbrowski, 1979). Sears, Stanton, and Danoff-Burg (2003) report that 83% of breast cancer survivors experienced positive changes. The diagnosis of cancer is one of those "seismic events" (Tedeschi & Calhoun, 2004), which can lead to post-traumatic growth, although this depends on the way patients perceive particular events. PTG is associated with younger age, longer time since diagnosis, greater cancer-related stress and greater perception of threat, positive/adaptive coping, religious coping and seeking social support (Danhauer et al., 2013). Based on a study by Danhauer et al. (2013), PTG can develop soon after cancer diagnosis, but it also concerns cancer survivors. For example, in a study by Sears et al. (2003), 83% of breast cancer survivors experienced positive changes. Thus, the relation between PTSD and PTG is unclear (Koutrouli et al., 2012). Therefore, introducing new comprehensive psychological interventions could potentially aid PTG and reduce adverse psychological effects of cancer diagnosis and consequent treatment.

In summary, from a review of the dimensions of psychosocial consequences described earlier in the current chapter, it is evident that anxiety and stress (distress), depression and low mood; body image; pain and comorbid health issues are concerns and/or challenges cancer patients face (see Table 1). However, post-traumatic growth (PTG) is identified as a potentially positive outcome of cancer. To conclude, different cancer groups might need different interventions, depending on their stage of cancer, metastasis, age, and psychological profile and history (e.g. somatic versus psychic suffering). These are important in light of the development of a new psychological cancer management training programme and poses the question of what specific aspects should be included. It is also of crucial importance to include psychological interventions that might potentially be beneficial in terms of post-traumatic growth, so that patients not only cope better with their illness and treatment procedures but also to facilitate emotional resiliency. This may be achieved by introducing appropriate psychological management training courses and one of the courses that may cover all the necessary content is a compassion-based training (i.e. Compassion for Cancer training programme). For example, compassion-based training is already used effectively to treat psychological distress, anxiety and mood disorders (Kirby, 2016).

Considering this, it is important to review the concept of compassion, its potential benefits, its various aspects, as well as the way it is already modelled into specific therapeutic interventions and techniques.

Table 1. Main psychophysical symptoms for cancer patients and survivors.

	CANCER PATIENTS	CANCER SURVIVORS
ANXIETY	Curran, Sharpe, & Butow, 2017	Osborn, Demoncada, & Feuerstein, 2006
DISTRESS	Gao et al., 2010	Bleiker et al., 2000
DEPRESSION	Jia et al., 2017	
POST-TRAUMATIC STRESS DISORDER	Mehnert & Koch, 2007	Mei Hsien Chan et al., 2017
PAIN	Grond, Zech, Diefenbach, Radbruch, & Lehman, 1996	Nersesyan & Slavin, 2007
INSOMNIA	Savard, Savard, Simard, & Ivers, 2004	Roscoe et al., 2007
COGNITIVE IMPAIRMENTS	Biegler, Chaoul, & Cohen, 2009	Castellon et al., 2010
POST-TRAUMATIC GROWTH	Scrignaro, Barni, & Magrin, 2010	Cormio, Muzzatti, Romito, Mattioli, & Annuziata, 2017

1.2. Semantics of Compassion and its Description in Western Biobehavioural Science.

1.2.1. Various Meanings and Aspects of Compassion.

Before discussing specific conceptualisations of compassion in more detail, it is important to have a deeper understanding of the word itself and its various aspects. Not only for the sake of "semantic hygiene" which also refers to logics and addresses the issue of how to avoid conceptual errors due to any language misuse (Korzybski, 1933). A thorough understanding informs the entire compassion-based training and affects the quality of its delivery. It may also change the whole process depending on the language used, referring both to method (e.g. wording, tone) and specific system of language (e.g. English, Spanish). As Jinpa (2015) notes, one needs to be aware of cultural embeddedness when using specific terms such as compassion, empathy, sympathy, and altruism. It also needs to be noted that compassion is a

word that evokes various responses and discussions, both on the side of its proponents and critics (Berlant, 2004), and it seems that the word "compassion" has been verbicided by being used in such terms as "compassion fatigue" or "compassion stress" (Figley, 1995). Thus, until the argument regarding conceptualisation is resolved (if at all possible), or there is at least greater societal understanding gained in terms of the scientific concept of compassion, the meaning might be misrepresented and confused with other terms used colloquially, which denote distinctive aspects e.g. empathy, sympathy.

The description of linguistic variations is also not futile if one understands that without it there is the danger of only understanding compassion from the perspective of English speakers and their language, and thus the concept may fall victim to misrepresentations. In order to avoid this obfuscation, it is important to look at different languages and their definitions of compassion as in some cases they imply and emphasise different aspects, and in other cases, the actual meaning of compassion. Thus, it is even more consequential to be able to understand its meaning *ad unguem* in various cultures (see Table 2). For instance, when investigating the term compassion, one first needs to look at its etymology. That is being able to analyse the true meaning of the words and its origins, referring to various sources, including cultural variations and connotations, semantics and semiotics. According to the Cambridge International Dictionary of English (CIDE), for example, in the English language compassion is "a strong feeling of *sympathy* and sadness for the suffering or *bad luck* of others and a *desire to help* them" (Cambridge International Dictionary of English, 1995, pg. 273). Similarly, Merriam-Webster Online Dictionary defines compassion as a ''*sympathetic* consciousness of others' *distress* together with a *desire to alleviate it*''. Both definitions are quite similar and mention suffering/distress, sympathy and the desire to act in the face of others experiencing difficulty, with the latter being similar to most current psychological definitions of compassion (this will be discussed later in the text).

The English word itself derives from Latin, where *com* means "with/together", whereas *compati means* "suffer with" (*pati* meaning "to endure, undergo, experience"). Interestingly, compassion is loan-translation of Greek *sympatheia* (n.d.) which exists in the English language as 'sympathy' and the word sympathy currently has a different meaning. In the 19th English dictionary sympathy refers to "fellow feeling, mutual sensibility (currently sensitivity), "the quality of being affected by the affection of another" (Johnson & Walker, 1828, p. 724). In addition, in the same dictionary it states that pity means "compassion, sympathy with misery, or tenderness for pain" (Johnson & Walker, 1828, p. 546). Compassion cannot be confused for pity or *Schadenfreude*. Consequently, there might be a historical and cultural confusion between the words compassion and sympathy, but most aforementioned definitions point to the fact that sympathy is seen as part of compassion, and the latter is a more encompassing concept.

To mention a different linguistic sphere, in the Polish language, compassion (Pol. *współczucie*) describes "*emotional solidarity* with the sufferer" (PWN On-line Dictionary, 2016), which can be translated into the psychological term *empathic concern* or *sympathy*. It is important to mention that the word solidarity itself connotates something that is shared, in cooperation, interdependent. In Polish, the word may also mean not being on an "equal footing" with the person experiencing distress. What is important about the Polish *współczucie* is the fact that the "współ" means joined or common and thus *współczucie* may be translated into "common-passion'. Similarly, in Tibetan, the word *nyingje* is never singular which interestingly corresponds with the idea of compassion always being all-directional and relational (i.e. self and others). This shows that different linguistic spheres may emphasise different aspects of and dimensions to compassion that are not exhibited in other languages. Thus, this can influence individuals' understanding of what compassion entails and how it

should be exhibited. Moreover, it reveals one's understanding of their hypocognitive experiences as lack of conceptual knowledge confines what people perceive, are aware of, and how they retain that information (Wu & Dunning, 2019).

Table 2. Examples of the meaning of *compassion* in various languages.

Family of languages	Language	Word	Meaning
Indo-European (Italic)	Spanish	*compasión*	Feeling of pain, tenderness, and identification with the problems of another.
(Balto-Slavic)	Polish	*współczucie*	Emotional solidarity with the sufferer
Sino-Tibetan	Mandarin	*cí beī* (慈悲) or *tóngqíng* (同情)	Mercy or benevolence. The first character means "same/similar/alike. The second character means "feeling/emotion/passion/love. Can also mean sympathy.
	Tibetan	*nying je* (ཉིང་རྗེ)	Powerfully manifested compassion.
Niger–Congo	Igbo	*ọmìikō, òm ịkō*	Lowliness; sweetness; mercy; pity; compassion.
Afro-Asiatic (Semitic)	Hebrew	*rachuwm* (רחום)	womb

To add to the conceptual confusion, not only is there a linguistic, semantic and/or semiotic confusion, but also a scientific one. There is not a single clear-cut definition or even an agreement on the definition of compassion in Western behavioural sciences (see Table 3).

Table 3. Selected definitions and constructs of compassion.

Compassion	Taxonomy	Definition	Components
Lazarus (1991) after Blum (1980)	Emotion – not to be confused with empathy which is an emotional capacity and a process	Being moved by another's suffering and wanting to help	None described
Goetz et al. (2010)	Emotion/feeling and motivation	Feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help.	(1) feeling and (2) motivation
Nussbum (2001)	Emotion	Painful emotion occasioned by the awareness of another person's undeserved misfortune	Involves three thoughts: (1) suffering is serious, (2) not entirely the victm's fault, (3) eudaimonistic thought. It may involve the thought that the person who's suffering is similar to oneself (Srinivasan, 2014).
Jazaieri et al. (2013)	Inherent human quality	Based on the definition by Tenzin Gyatso (the Dalai Lama): basic quality of human beings rooted in the recognition of and desire to alleviate suffering, and gives rise to prosocial behaviours (Gyatso & Jinpa, 1995)	(1) an awareness of suffering (cognitive component), (2) sympathetic concern related to being emotionally moved by suffering (affective component), (3) a wish to see the relief of that suffering (intentional component), and (4) a responsiveness or readiness to help relieve that suffering
Gilbert (2014)	Motivation	the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it	
Carducci (2009)	Personality trait	None given.	
Neff, Kirkpatrick, and Rude (2007) (referring to first flow of compassion: self-compassion)	Skill	Can be defined as extending compassion to one's self in instances of perceived inadequacy, failure, or general suffering.	(1) being mindful, rather than overidentifying with problems; (2) connecting with others, rather than isolating oneself; and (3) adopting an attitude of self-kindness, rather than being judgmental (Neff, 2003).
Thomas and Menage (2016)	(core) value, (observable) behaviour,		

	and an emotional response		
Crawford et al. (2014)		An awareness of, or sensitivity to, the pain and suffering of others that result in taking verbal, nonverbal or physical action to remove, reduce, or alleviate the impact of such affiliation (based on the definition by Gilbert, 2014)	
Kanov (2004)			Noticing – being aware of another person's suffering, feeling – responding emotionally to the suffering/ exhibiting emphatic concern, and responding – desire to alleviate the suffering.
Wahl (2015)		Compassion is an experience (or feeling) of strong intention to assist a person to ultimately realise that their belief in separateness from the rest of the world is the source of all of their suffering (emptiness) At the same time, the experience of compassion has the component of intelligence - it is not ignorant. This allows the person who experiences compassion to be aware of the context of the situation, and skilfully choose an appropriate area of suffering which needs to be addressed (i.e. recognise and address)	(1) common (shared) feeling with the world, (2) a way of *com*municating with the phenomenal world, which includes responsiveness by skilful means (wisdom) to alleviate the suffering (discomfort, fear, doubt, stress, pain) of the other and oneself. Compassion includes stages of realisation.

In fact, it has been suggested by some researchers that the idea of compassion is a multidimensional construct (Jazaieri et al. 2013), which would to some degree correspond to the Buddhist conceptualisations (this will be discussed later). Others describe it as "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help" (Goetz et al., 2010, p. 351). This is very different to the (Tibetan) Buddhist understanding,

which until recently did not have a word for feeling or emotion (currently *tshor myong* – experience of feeling), since emotions are seen as simply part of all other mental activities (Dreyfuss, 2002). Other researchers see compassion as a motivation (motivational force of human relating) (Gilbert, 2014), emotion (Haidt, 2003), or even as a personality trait (Carducci, 2009), or, in contrast, a skill that can be developed rather than a static trait (in regard to the flow of self-compassion; Neff, Kirkpatrick, & Rude, 2007). Some also regard it as a core value, observable behaviour, and an emotional response all in one (e.g., in occupational therapy practice; Thomas & Menage, 2016). Lazarus (1991) describes it as "being moved by another's suffering and wanting to help" (p. 289), which is somewhat similar to what Gilbert (2014) elaborated upon based on the definition by Tenzin Gyatso (the Dalai Lama): as compassion being "the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (p. 19). Crawford et al. (2014, p. 3591) are even more specific by describing it as "an awareness of, or sensitivity to, the pain and suffering of others that result in taking verbal, nonverbal or physical action to remove, reduce, or alleviate the impact of such affiliation". Thus, it is best to view compassion as a complex phenomenon and not merely as a feeling but as a proactive and prosocial stance and behaviour.

For the sake of expanding one's understanding (with various complexities) and application of compassion, one also needs to explore descriptive definitions. In order to immerse into such descriptive definitions, which would include specific components encompassing various aspects of compassion, Jinpa (2015) defines compassion as a complex multidimensional construct that is comprised of four components: (1) *an awareness of suffering* (cognitive component), (2) *sympathetic concern* related to being emotionally moved by suffering (affective component), (3) *a wish* to see the relief of that suffering (intentional component), and (4) a *responsiveness* or readiness to help relieve that suffering (motivational component; Jazaieri et al., 2013). Ekman (2010) divides compassion into: emotion recognition, emotional

resonance (identical or reactive), familial compassion, global compassion, sentient compassion, heroic compassion (immediate or considered). In Gilbert's (2011) conceptualisation there are six attributes: sensitivity, sympathy, care for well-being, distress tolerance, non-judgement, and empathy. There are also other aspects that need to be considered, e.g. Ng (personal communication, 2017) emphasises that compassion seems to be seen as a subjective disposition, and also emphasises its relational feature and the fact that it is also "in relation to" and not just on its own. He states that:

> *"... compassion arises co-dependently in moments of encounter in relation to a field of forces, passions, bodies, objects, and structures impacting on the capacity to be responsive or not, to the ontological precariousness of the existential fact of mortality, that is also reproduced by the workings of power in uneven material conditions of living and dying"* (E. Ng, personal communication, 2017).

In summary, it seems that most definitions, including descriptive definitions of compassion, include the affective/visceral, and in some cases, cognitive or motivational/intentional components, but lack the response found on reason (reasoning) and wisdom (Strauss et al., 2016). As the ancient Buddhist scholar, Gyalse Thogme (Khyentse, 2007) puts it: compassion is *"...shining from the great sun of his wisdom and love, warm rays of teaching, debate, and composition*" (p. 11). In other words, compassion cannot be separated from wisdom; and in this case wisdom is understood as an insight into the nature of reality which translates into experiencing "emptiness" (Williams, 2009) the realisation of one's interconnectedness and lack of permanent substance (traits). Thus, last but not least, in Buddhism compassion also requires the realisation of emptiness, understanding that the ultimate reality means the lack of one true, constant self and the lack of substance of phenomena, or that objects (including sentient beings) are empty of their own existence. Another explanation would state that emptiness is understood as the ability to expand one's mental parameters and detach oneself

from formal concepts of self (Hopkins & Napper, 1996). The part relating to the phenomenon of emptiness is missing in all currently existing definitions, in the West.

Additionally, in both Sanskrit and Pali, the word *karuna* (compassion) is not only the "wish that others be free from suffering, as distinguished from loving kindness (Sansk. *maitri,* Pali metta) and the wish that others be happy", but it is also stated there that "compassion is to be developed in the following manner: fillings one's mind with compassion, one pervades the world with it, first in one direction, then in a second direction, then a third, a fourth, then above, below, and all around" (Princeton Dictionary of Buddhism, p. 424). Thus, it can be conceptualised that compassion has different dimensions or stages of realisation to which to some extent relates to Gilbert's conceptualisation of compassion.

In the current training programme, it has been proposed that compassion is an experience or, in the first instance, feeling, of strong intention to assist a person to ultimately realise that their belief in separateness from the rest of the world is the source of all of their suffering (emptiness). This intention then leads to a motivation to act (compassionately). At the same time, the experience of compassion has the component of intelligence - it is not ignorant. This allows the person who experiences compassion to be aware of the context of the situation, and skilfully choose an appropriate area of suffering which needs to be addressed (i.e. recognise and address – act upon).

1.2.2. All-dimensional Compassion.

One other issue that needs to be explored are the various flows of compassion. Even though Neff, Kirpatrick, and Rude (2006) clearly state that self-compassion "offers a conceptual alternative to Western, more egocentric concepts of self-related processes and feelings" (p.

139), when one predominantly focuses only on one flow of compassion, without the other two flows, it still leaves one in the egocentric position. It is also important to mention that in the current psychological conceptualisation, compassion includes three flows, directions or skills of compassion: the ability to give compassion to oneself (self-compassion), to give to others, and finally, to receive it from others (Gilbert, 2010). One begins with self-compassion because *nemo dat quod non habet* (no one gives what they do not have). The significance of including three flows refers to compassion being relational, in other words in relation to others and not only to oneself (i.e. interdependence, relatedness). According to the current programme's descriptive definition, compassion is understood as having two components: (1) common, shared feeling with the world (interdependence), (2) a way of communicating with the phenomenal world, which includes responsiveness by skilful means (discerning wisdom of knowing and doing) to alleviate the suffering (e.g. discomfort, fear, doubt, stress, pain) of the other and oneself. The first aspect includes empathy/sympathy and common humanity, and the latter: skilful means activities based on knowledge and insight that help alleviate various forms of suffering. It is similar to the definition by Tenzin Gyatso, the 14th Dalai Lama who states that compassion is "a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it" (Gyatso & Jinpa, 1995, p. 12).

This is described as having two psychologies or two different sets of skill, and in Compassion-Focused Therapy this deep commitment is combined with trying to prevent suffering (Gilbert, 2014). The first skill is about the ability to see and be with distress or discomfort, and the second about specific actions to alleviate it. Additionally, Martha Nussbaum (2001) states that compassion for another requires belief in common humanity, which is similar to the definition of the word compassion in Polish, which includes solidarity.

Interestingly, similar to what Nussbaum has stated, Neff and Pommier (2012) in their conceptualisation of self-compassion include 'common humanity', alongside self-kindness and mindfulness. This is important when reflecting on the fact that compassion is always in relation to the other (relational): either other beings or other aspects of self. This may have a profound significance not only in relation to therapeutic practices focusing on the individual, but in a broader sense of societal shift of paradigms as compassion goes beyond the individualistic focus and is also more systemic in its orientation rather than encouraging the solipsistic philosophies. This is also important as it emphasises one's awareness of interconnectedness.

In anthropological terms, the proliferation of compassion can be seen as William Ury's third stage of human history called "knowledge society"; when the value of all humanity is being considered (Ury, 1999): human beings learning to respect and learn on the basis of cultural heritages. Again, this highlights relationality of compassionate approaches. Compassion is always a relational concept and stands in opposition to solipsism: it is through other minds (people) that we learn to be ourselves. It is also a rank-free phenomenon, inferiority/superiority, in contrast for instance to pride, and a "care-taking emotion" (Oveis, Horberg, & Keltner, 2010). Additionally, by increasing compassion towards others one increases it towards oneself as well (Breines & Chen, 2013). This relational component will be discussed in Chapter 5.

1.2.3. Modern-day and Secular Presentation of Compassion.

As mentioned above, the concept of compassion cannot be uncoupled from the Buddhist teachings since most modern-day Western psychological interventions which are based on contemplative approaches in terms of tools and conceptualisations (e.g. Mindful Self-

Compassion - MSC, Compassion-Focused Therapy - CFT) are rooted in this specific set of philosophies and its tools. It does not mean that one who uses CBIs should thereby become an active, practising Buddhist. Having said that, those that practice should at least have a comprehensive understanding of Buddhist underpinnings because otherwise the curricula may become corrupt, oversimplified and commodified into 'ego-driven products', devoid of its true meaning and potential, as is often the case of mindfulness (Purser & Loy, 2003). To avoid this conceptual corruption, it is, for instance, important to know that in Buddhism compassion is always present in attendance with wisdom (Sansk. *prajñā*), which is a form of insight and refers to three aspects: understanding the phenomena of impermanence, suffering, and emptiness. Compassion in the Buddhist tradition is also part of the "four immeasurables" qualities or states (Sansk. *brahmavihāras*), alongside sympathetic joy, equanimity, and loving kindness, all of which keep the mind in balance or should be practised simply because they are the intrinsic qualities of the mind (Phakchok Rinpoche, personal communication, 2013).

In addition, it is also important to look at the obstacles to compassion or what Alexander Berzin (personal communication, 2009) describes as "enemies of compassion": its direct and indirect enemies. Its direct enemy is a harmful attitude which one can understand as not caring, having the wrong view or ignorance. The indirect enemy refers to grief or being overwhelmed by suffering, which in Western terms can be applied to experiencing "empathy fatigue" which is wrongly called "compassion fatigue". Another issue that needs to be mentioned is the fact that Western (psychological) approaches can be at times selective and tend to choose the pleasant or easier aspects of Buddhism (Smith, 2010), which is often ascribed to the "New Age" movement. In fact, compassion is needed exactly because of the fact that life at times is providing one with unexpected circumstance, filled with various forms of suffering, and one needs to have a thorough understanding of the phenomena. Thus, when referring to the

Buddhist sources, one needs not only to look at the concept from the *Hinayana*[2] (or *Theravada*) perspective, which seems to be a predominant source of borrowing in Western science, including Western types of mindfulness practices (Husgafvel, 2016) but most importantly analyse it from the *Mahayana, Vajrayana* or even *Dzogchen*[3] perspectives and its soteriological nature. These perspectives emphasise the idea of a *Boddhisattva,* or a person who has got *bodhichitta*, the aspiration to help and serve all sentient beings reduce their suffering and do so until there is not a single sentient being suffering. The virtue of *Boddhisattva* is therefore to serve others and does not only follow the *arhat* principle of primarily "enlightening" (liberating) oneself[4] [5], which may to some degree correspond to the first flow of self-compassion; i.e. limiting one's own distress.

Compassion can therefore yet again be referred to as encompassing levels (or stages): first it is the level of indifference which corresponds to the *hinayana* perspective in Buddhism, in other words it is the notion of doing no harm (*ahimsa*). The second stage concerns befriending ourselves with the closest people to us and the final stage includes all beings in our circle of compassion (this corresponds with the stages of the *tong-len* practice which will be discussed in Chapter 4). Thus, compassion is the way to cease self-deception or holding the belief of being separate from others (King, 1963). This also one of the definitions of Buddhist emptiness (Sansk. *shunyata*) in relation to interdependence. Interdependence in this understanding refers to how everything and everyone are interrelated but is not only prescribed to Buddhist traditions. As Marcus Aurelius (1989, p. 31) says:

> *"Constantly think of the universe as one living creature, embracing one being and soul; how all is absorbed into the one consciousness of this living creature; how it*

[2] In Tibetan Buddhism the teachings are divided into three "vehicles" or *yanas*: Hinayana, Mahayana, and Vajrayana. This can both refer to different schools of Buddhism or different stages of spiritual development.
[3] Dzogchen does not necessarily have to be considered part of Buddhism.
[4] The word *boddhichitta* itself means "enlightened mind and/or heart", in Tibetan *changchup kyi sem* – mind of awakening (Trungpa, 2013).
[5] This naturally is a much-simplified explanation.

encompasses all things with a single purpose, and how all things work together to cause all that comes to pass, and their wonderful web and texture".

Centuries later, the former president of the Czech Republic stated the following:

"...In today's multicultural world, the truly reliable path to coexistence, to peaceful coexistence and creative cooperation, must start from what is at the root of all cultures and what lies infinitely deeper in human hearts and minds than political opinion, convictions, antipathies, or sympathies — it must be rooted in self-transcendence..." (Havel, 1994, http://www.worldtrans.org/whole/havelspeech.html).

The above quotation exemplifies the perennial (philosophy) and universal aspects that compassion represents.

Focusing back on Buddhism, it is also very important to distinguish true compassion from "idiot compassion", which is a term popularised by the late Chögyam Trungpa Rinpoche, borrowed from Georgij Gurdjieff (Moore, 1991). It can be defined as a senseless, reactionary, reactive compassion, or in other words compassion of the ego (or ego's vanity). Idiot compassion is not really about the person who is in need, but about one's way to satisfy their emotions and to feel good. This type of compassion is controlling, manipulative, seductive, it is about 'doing' (Trungpa, 1989), and should be distinguished from the complex and challenging nature of true compassion and other types of oversimplification of what compassion is in terms of its concepts and practices, e.g. compassion always being about niceness and compromise.

1.3. Compassion in Western Psychology and Clinical Practice.

1.3.1. Therapeutic Modality of Compassion: Basic Theoretical Introduction.

The aggiornamento of the ancient compassion approaches is the main purpose of several modern-day psychological therapies and training courses. One such therapeutic model is Compassion-Focused Therapy (CFT). CFT, is one of the third wave Cognitive-Behavioural Therapies (CBT), and is receiving much empirical support regarding its usefulness in respect to psychological well-being (e.g. anxiety, depression, stress, PTG). It is also concerned with the introduction of CBIs. However, there are also other training paradigms that apply to compassion in full or partially, e.g. Mindful Self-Compassion (MSC) training, Compassion Cultivation Training (CCT), certain versions of Acceptance and Commitment Therapy (ACT). The uniqueness of CFT, however, lies in its "preparedness to really take on suffering that is crucial and addressing the dark side" of humankind and functioning rather than just focusing on love and kindness (P. Gilbert, personal communication, 2018).

CBIs and more specifically, CFT, can be of benefit to cancer patients and survivors, but investigation of their efficacy among this population is minimal. What can also be of benefit to this particular group is the fact that, according to CFT, training in compassion is about learning to bring balance to three types of emotion regulation systems which correspond to three different neurophysiological systems (Panksepp, 1998). These are: (1) the threat system, which is focused on threats to self-protection, (2) the incentive/resource seeking system, which is focused on wants and achievements, and (3) the soothing contentment system (affiliative system), which is focused on safeness and connectedness (Gilbert, 2009, p. 193). In other words, Gilbert (2009) describes compassion as "behaviour that aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging in order to benefit another person" (p. 193). This is initiated (learnt) in the soothing-affiliative

system when one is learning how to be safe, at ease, how to bond through being in a caring environment, being taken care of and learning through observing another being (secure bond). Therefore, this can be linked with the concepts of *attachment and detachment* as it is teaching how to bond well and be independent well. This leads to the next topic: attachment.

1.3.1.1. Attachment and Detachment.

According to Scheff and Retzinger (1997) a good (secure) bond is the balance between being too close and too far (engulfment versus isolation). Again, this can be compared with the notion of compassion (secure attachment; Ainsworth & Bell, 1970) and detachment. Detachment (or non-attachment) is a concept derived from Buddhism and stands in contrast to clinging, obsessing about/fixating on (anxious-ambivalent attachment; Ainsworth & Bell, 1970), or ignoring (anxious-avoidant attachment; Ainsworth & Bell, 1970). Compassion-focused interventions should facilitate cultivation of a secure attachment and thereby healthy detachment at times. It is also important to mention that it has been suggested that compassion includes mindfulness but goes beyond it to include the soothing contentment-affiliative system (C. Germer, personal communication, 2013). Thus, mindfulness solely allows us to slow down physiologically and mentally but does not provide the emotional experience of safeness. In the words of Donna Hicks (2013, pg. 2) “safety and vulnerability share a complex connection” and is the message also shown in CFT.

1.3.1.2. Suffering in Compassion.

"*Human beings are not by nature kings, or nobles, or courtiers, or rich. All are born naked and poor. All are subject to the miseries of life, to frustrations, to ills, to needs, to pains of every kind. Finally, all are condemned to death. That is what is really the human being; that is what no mortal can avoid. Begin, then, by studying what is the most inseparable from human nature, that which most constitutes humanness*"

– Jean-Jacques Rousseau, Emile, Book IV (1979, p. 61)

There is also one more important aspect of compassion illustrated in the above quote: the *explicitness* of suffering as a means to develop compassion and for instance positive results such as post-traumatic growth (PTG). This explicitness is the fact that there is no compassion without understanding suffering and its roots. Traditionally in Buddhism, there is no compassion without suffering (this is what may be called the "explicitness of suffering"), and in this way, it can be understood as the driving force of all religious evolution (Weber, 1948), and as the antithesis of "moral indifference towards suffering" (Wilkinson, 2005), or on the other hand, "embracing suffering" in Judeo-Christian traditions. Similarly, compassionate approaches emphasise the necessity of learning from one's suffering of all forms: mental, physical, and relational. Thus, understanding the nature and sources of suffering helps prevent and alleviate it.

It is also important to mention the dualism of how suffering and pain are understood in the West, in other words, the dichotomy between mind and body (Kleinman, 1992). When discussing suffering one should distinguish it from pain, which can be at times understood as a "specific bodily experience" (Edwards, 1984) or "embodied experience" (Wilkinson, 2005). Also, it is possible to experience pain without suffering which can be described as "the distress

of suffering pain" (Wilkinson, 2005) or secondary suffering. Suffering can also be described in other different categories. One category refers to something than cannot be shared, the "unsharability" of suffering (Wilkinson, 2005), and yet it is shared by all humans (common humanity).

Apart from the physical (somatic, physiological) suffering, one can also be aware of experiencing "social suffering" (Marx, 1867; Weber, 1948; Durkheim, 1973) or even "political suffering" (Srinivasan, 2014). Contrary to what Wilkinson (2005) is saying, the moral obligation to care for the suffering of others is not a "peculiarly modern social trait" but a very ancient one. This can be therefore referred to as the concept of compassion which emphasises the importance of caring for oneself and others in the face of suffering and also as an evolutionary need and skill.

In summary, it is important to understand the phenomenon of multidimensional expressions and sources of suffering (i.e. various types and expressions of suffering) in order to know how to manage it more appropriately.

1.3.1.3. Suffering and Dignity.

Suffering is also closely linked to the concept of *dignity*; in suffering one often is denied having it and yet needs it desperately because it is every being's fundamental right (Hicks, 2013). Dignity is their birth right, unlike respect, which one needs to earn (Hicks, 2013). In other words, people need their suffering to be recognised and themselves recognised because of it (in conflicts, illness) (Hicks, 2013). In the foreword to Hicks (2013), Desmond Tutu describes dignity as a basic human need such as appreciation, recognition, and the feeling of inherent worth (Tutu, 2013). He also describes dignity as "the perception of worth in the other"

or as the “answer to the inertia of an everyday life ruled by feelings of uselessness” (Tutu, 2013). Furthermore, Hicks (p.1) described dignity as an “internal state of peace with the recognition and acceptance of the value and vulnerability of all living beings”. In this way it is closely related to the concept of compassion, providing safeness (Hicks simply calls it safety) and therefore leading to the experience and possibility of freedom and genuine connection. Not recognising how one’s dignity is not respected, for instance in illness, can be what Hicks calls a “dignity violator”, and equates loss of dignity with the suffering of loss, amidst the losses of connection to other and life itself. Hicks also describes dignity as something that precedes survival, and again in that sense, it resembles compassion. Hicks’ model includes ten elements: acceptance of identity, inclusion, safety, acknowledgment, recognition, fairness, benefit of the doubt, understanding, independence, and accountability.

1.3.1.4. Shame.

Shame is also closely related to dignity, which can be understood as a form of disconnection from the community (internal and emotional banishment). It is also concept central to CFT and an experience that relates to many cancer patients and survivors. What is important to stress is the fact that shame does not need to be negative. It only becomes negative when it is not acknowledged (Scheff & Retzinger, 1997), shared and/or communicated to bring about closeness with others (Lynd, 1958). It also needs to be noted that the negativity of shame is a Westernised perspective, or even a linguistic phenomenon ascribed to the English language (Scheff & Retzinger, 1997) or Judeo-Christian tradition. As Scheff and Retzinger (1997) note in French there exists two types of shame: one negative referring to disgrace (*honte*), and the other positive referring to modesty (*pudeur*). Therefore, contrary to what Tangney (2005) is saying, shame can also be an adaptive emotion.

1.3.1.5. Different Directions of Compassion.

A further issue that distinguishes CFT from other training formats is the inclusion of three flows (or directions) of compassion as mentioned above, and not just the combination and balance of the three affective systems. In other words, one first individuates and then integrates, which once again refers to various stages of experiencing compassion; one learns to be self-compassionate, to receive compassion and to transmit compassion to other beings. It is quite a common occurrence that one may be accepting one of the flows, but not the other, e.g. being able to express compassion but not to receive it. This is very important especially if one looks at what is occurring when one of the flows is missing, and for instance familial compassion or parental empathy which leads to less systemic inflammation and better emotional regulation (both for providers and recipients) results in physiological cost to parents (Matczak, DeLongis, & Chen, 2016). This would mean that providers (carers/parents) should also be able to give compassion to themselves (self-compassion) in order to maintain a full balance in caring for others.

1.3.1.6. Other Features.

A final individuating feature of CFT, although this list is not exhaustive, is the fact that it draws on evolutionary theory, moralistic biology, and Neo-Darwinism. Neo-Darwinism is a modern synthesis of Darwinian evolution through natural selection with Mendelian genetics, in which compassion is seen as an innate trait that facilitates survival, in Darwin's terms "sympathy" (Ekman, 2010). This type of Darwinism also draws on, and is implicitly supportive of, the four inheritance systems: genetic, epigenetic, behavioural and symbolic, and the interaction between them (Jablonka & Lamb, 2014). This can lead to the following conclusion: that compassion should not be cultivated and rather be *"unblocked*" since it is at

the core of who human beings are, in terms of biological/affiliative processes. For example, devoid of compassion, humans would not be able to survive ("survival of the kindest"; Keltner, 2009), and the question concerns the way in which one can actuate it, i.e. integrating the implicit and explicit processing emotional systems (Gilbert, 2010). Thus, CFT is a model that incorporates the concepts of drive and motivation, as well as threats, alongside compassion; in other words, biosocial goals and motivations – for sex, status, achievements, and affiliation. In order to reach this natural state and balance between the emotional systems one may follow specific contemplative practices.

1.3.2. Training in Therapeutic Compassion.

Compassionate Mind Training (CMT) is part of Compassion-Focused Therapy (CFT), one of the CBT 3rd Wave Therapies (Carvalho, Martins, Almeida, & Silva, 2017). The current PhD research and consequent training programme are based on Compassionate Mind Training (CMT) developed by Paul Gilbert (2009), which includes diverse contemplative exercises based on mindfulness and compassion approaches, and psychoeducation embedded in evolutionary, social and anthropological sciences. Although psychotherapeutic in its nature, CMT is not a form of group psychotherapy. CMT is also not a peer support group but it can serve this role (similarly to MBSR). In a review of the CMT approach, Gilbert (2009) found that CMT` reduces shame and self-criticism in chronically depressed patients. In brief some of the training aspects of CMT include breathing (e.g. the soothing rhythm breathing exercise), imagery (various compassion-focused visualisations or imagery – CFV or CFI) and bodily exercises (e.g. method acting/role playing).

The formal compassion practices, which are based on the Vajrayana path (Tibetan Buddhism), are drawing on magical realism (Ger. *Magischer Realismus*; Roh, 1925) – which means

combining both the real (psychoeducation and knowledge based on research and science) and magical (imagery work). To explain this method in more detail: in the compassion-based exercises, the "real" refers to the focus on its practical (scientific), tactile (touch), corporal side (movement, posture, senses and sensing). On the other hand, the magical draws on imagery work and metaphors (imagination, visualising) in trying to develop specific compassionate qualities or attributes in order to be revealed in all life circumstances. In CFT this would be translated into the transformative skills that involve imagery, attention, reasoning, behaviour, sensory and/or feeling. Of note, whilst specific practices will be more fully discussed in Chapter 4, in synthesis, compassion can be developed in specific ways. These include contemplative/reflective and meditative practices combined with studies/psychoeducation. This corresponds to the three types of wisdom: *sutamayi panna* (wisdom that is only heard), *cintanmayi panna* (wisdom gained by thinking, analysing) and *bhavnamayi panna* (experiential wisdom). This concept somewhat resembles the Greek concepts where wisdom can be integrated as *sophia (transcendent wisdom)* and *phronesis (practical wisdom)* (Trowbridge & Ferrari, 2011). In Tibetan Buddhism it can classically be developed through the means of various "mind training" practices such as *lo-jong* (mind training), contemplation of the "four immeasurables" (*Brahmaviharas*), the practice of the *Paramitas*, and/or the *tong-len* practice (which is part of the mind training).

1.3.3. Other Training Modalities.

When developing a new training format, one needs to look at the existing options for the purpose of comparison and most importantly – *entia non sunt multiplicanda praeter necessitatem* (entities should not be multiplied beyond necessity). As mentioned before, CFT is the only recognised and comprehensive psychotherapy among compassion paradigms used in the West, as all other paradigms are designed as training courses and not necessarily

therapeutic models. Among these training formats, there is *Compassion Cultivation Training (CCT)*, a model which explicitly focuses on compassion and includes three flows of compassion. CCT that was developed by Thupten Jinpa from Stanford University with the help of an interdisciplinary team. CCT is a structured protocol that consists of a two-hour introductory orientation, eight once weekly two-hour classes, and daily compassion-focused meditation practice. In this model compassion consists of four key components: (1) an awareness of suffering (cognitive/empathic awareness), (2) sympathetic concern related to being emotionally moved by suffering (affective component), (3) a wish to see the relief of that suffering (intention), and (4) a responsiveness or readiness to help relieve that suffering (motivational) (Jazaieri et al., 2012). As is the case of many curricula, it has not been described how specific practices and themes were chosen for this specific training.

A further training model, *Cognitively-Based Compassion Training (CBCT)***,** was developed by Geshe Lobsang Tenzin Negi at Emory University, USA. CBCT provides eight weekly, two-hour classes and a "booster" CBCT session four weeks later. The results of the feasibility of CBCT for breast cancer survivors was tested with positive results in terms of participants' psychological well-being (Dodds et al., 2015). The uniqueness of this training lies in its application of *lo-jong*, a Tibetan Buddhist contemplative mind training set of techniques (which includes reflecting on various slogans), and *lamrim*, gradual stages of spiritual development. However, no description has been provided regarding the curriculum development or its content. In different samples, CBCT training was found to reduce salivary C-reactive protein in a foster care program for adolescents (Pace et al, 2013) and reduce peripheral inflammation in adolescents in foster care with high rates of early life adversity (Pace et al., 2012). Yet again, however, no description has been provided regarding the curriculum development or its content.

Mindful Self-Compassion (MSC) training programme also explicitly targets compassion or more specifically one of the flows of compassion: self-compassion. MSC was developed by Christopher Germer (Harvard Medical School) and Kristin Neff (University of Texas). The effectiveness of the MSC itself in terms of various clinical applications has not yet been tested. However, to expand this approach focuses on the premise that in a similar way that we care about and nurture other people, we can also care about and nurture ourselves. Neff and Pommier (2012) suggest that: (1) greater self-compassion is linked to less anxiety and depression, (2) exercises designed to increase self-compassion are associated with reduced levels of cortisol and increased heart-rate variability (HRV), and (3) there is less rumination, less perfectionism, fewer negative emotions such as distress, irritability, hostility, no thought and emotion suppression, and finally better emotional coping skills.

Enhancing Self-Compassion Programme (ESP) is a programme developed in Japan by Kohki Arimitsu (2016) based on the approach employed by Gilbert (2010), Gilbert and Procter (2006) and finally, Henderson (2010). It is a seven-week training which includes LKM, mindfulness, imagery, letter writing, three-chair work, compassionate behaviours, and relating to self-critical thoughts. Other training programmes based on CFT (both its main concepts and practices) also exist but have not been yet tested, e.g. *Compassion Based Living Course – CBLC* (from the Netherlands) or *Mindfulness-Based Compassionate Living – MBCL* (from Scotland).

Sustainable Compassion Training (SCT), previously *Innate Compassion Training (ICT)* is yet another training that differs from most in clearly stating that compassion is not a self-help, individualistic technique and thus focuses on systemic issues as well (Makransky & Lavelle, 2016). It has been designed for those "who serve" (teachers/educators, carers, social workers, parents, health professionals, contemplative and spiritual teachers, teen and young adults,

community and organisational leaders). In this model compassion is understood as having four aspects: loving affection, empathic concern, a compassionate wish for others to be free of suffering and its sources, and wisdom (Lavelle, 2017). This particular model focuses on three modes of care: receiving care, deep self-care and extending care (Lavelle, 2017).

It can be concluded that only CFT comprehensively tackles various aspects of compassion (e.g. traits/qualities needed, the three flows of compassion), and is the only conceptualisation that is not only multidimensional in its description of compassion, but also in terms of its references to various sources such as biology, evolutionary science, sociology, anthropology, psychotherapy, and contemplative (Eastern) practices. It also needs to be noted that most curricula and their tools are not freely available.

1.3.4. Various Aspects of Compassion.

As aforementioned, compassion is a multidimensional issue and one cannot discuss compassion without referring to other specific issues, i.e. self-esteem, empathy, sympathy, dignity, suffering, altruism and common humanity (see Table 4). The understanding of these concepts translates into how one manages the training (both as the trainer and trainee), further such concepts limits conceptual and practical misunderstandings of particular aspects present in the conceptualisation, for instance related to self-cherishing and self-esteem.

Beginning with the concept of *self-esteem,* it needs to be noted that compassion cannot only be limited to self-compassion, as then one may end up with the subscribers of the "self-esteem cult". This will only solidify the unhealthy "self" or "me-ness", or the ever-present sense-of-I, "reinforcing our egoic condition" (Smith, 2010). The sole idea of self-esteem is a cultural phenomenon of Western individualistic societies and its individualistic metaphysics (Van

Norden, 2017). It has to be noted that it was Nathaniel Branden, a former associate of Ayn Rand who herself professed "rational and ethical egoism" and lay foundations to neoliberalism (Zuidhof, 2010). Branden himself was one of the greatest promoters of self-esteem which differs from the original concept by William James: what James was referring to was "success divided by pretensions" (Roache, 2007). This had a different meaning to modern interpretation as it was referring to how one views oneself based on the desired versus accomplished goals. In contrast, Branden's concept developed into what he called six pillars of self-esteem, and one may argue to some extent this resembles the concept of Neff's self-compassion. To expand, in Branden's (1987) conceptualisation of self-esteem, these are (1) living consciously, (2) self-acceptance, (3) self-responsibility, (4) self-assertiveness, (5) living purposefully, and (6) personal integrity, emphasising what can currently be called mindfulness and kindness. The difference is Neff's emphasis on common (*shared*) humanity, whereas Branden defended individualism and personal autonomy. And yet they both fall for the predominantly American idealising of self (Slater, 2002) which leaves one primarily focusing on the self and one's needs. Therefore, one should be careful in not only focusing and emphasising *self-compassion*, but to include the other two flows of compassion (the "three-flow approach" of CFT).

Self-esteem also involves 'self-esteeming' (Ryan & Brown, 2003) and constant evaluating of the self. In this regard, the notion and process of compassion is more similar to dignity which is constant (not dependent on any external circumstances, praises) and not based on any deeds or comparisons. To further defend the claim of self-esteem being socially dangerous: Ellis (2002) criticised the concept as individually and socially destructive, and there are other psychologists and researchers who came to the same conclusion (e.g. Baumeister et al., 2003; Emler, 2001). It can therefore be concluded that one should go beyond the first flow of compassion, in the same way one should go beyond mindfulness that only focuses on individual welfare, cognitive enhancements and reducing levels of stress without taking into

account ethical and moral/altruistic prescriptions. The ethical inspiration can start by reflecting on the aspect of *common humanity* which is a term first used in moral and political philosophy, but which lacks a precise definition (Nussbaum, 1990; Monroe, 1996). In conclusion, the reflection on common humanity, may serve as a buffer against solely cultivating solipsistic interests and wellness, and this leads to the concept of common humanity.

The concept of common humanity has also recently gained recognition in psychology thanks to the concept of self-compassion, the term popularised by Kristin Neff. Common humanity is one of the three aspects of self-compassion (along with mindfulness and self-kindness), and stands in contrast to self-isolation (Neff, 2003). In descriptive terms, Neff understands common humanity as a feeling of being connected to other people rather than being isolated. This understanding seems to be limited as the concept of common humanity is not only applying to going beyond individual isolation, but it also implies crossing tribal divisions. McFarland, Brown and Webb (2013) published the first article trying to describe common humanity as a psychological construct and developed their measure called *the Identification With All Humanity Scale (IWAH)*. McFarland et al. (2013) also suggest the idea of developing and teaching the idea of identification with all humanity, but do not state how this should be done nor do they define the concept. Trying to immerse into a descriptive definition, it may be argued that common humanity is closely linked with the concept of altruism (Monroe, 1996) since altruists perceive themselves as part of mankind, and see themselves in tune with all mankind and not so much part of a specific group or sub-group (Monroe, 1996): "a sense of belonging to one human family". Although defining altruism[6] itself is challenging, Monroe (1996) points out that there is a lack of consistent definition and suggests defining it as "a

[6] It would be important to make a distinction between altruism and common humanity as even in their etymology the two words emphasise two extremely different positions: the word altruism is derived from the Latin *alter* which means other, whereas common humanity implies both that something is prevailing, widespread, widely encountered and shared. It is therefore not about *the other* but about *us*.

behaviour intended to benefit another, even when this risks possible sacrifice to the welfare of the actor" (p. 415). She then goes on to explain it further by saying that altruism:

(1) must entail action (it is not about having merely good intentions),

(2) the action must be goal-directed (this may be either conscious or reflexive),

(3) the goal of the act must be to further the welfare of another (no secondary gain should be expected for the actor),

(4) intentions are more important than consequences,

(5) the act must carry some possibility of diminution in my own welfare,

(6) sets no conditions: no reward is expected (Monroe, 1996)[7].

Described in this way, altruism closely resembles compassion in its current understanding. Interestingly, empathy is not an important factor for being altruistic (Monroe, 1996), which again resembles compassion as one does not have to always *feel* compassion in order *to be* or *act* compassionately. It can therefore be stated that common humanity *can be* the foundation and prerequisite for altruism, which in turn can be understood as the expression of compassion, in other words prosocial behaviour that is at times at the cost of sacrificing oneself.

To clarify the definition of common humanity[8] and its specific aspects are now being proposed in order to understand the phenomenon better and include them in the development of a compassion-based curriculum. These aspects include: (1) feelings of interconnectedness and interdependence (includes a feeling of belonging to one human race), (2) no comparing (i.e. no inferiority nor superiority), (3) awareness of the fact that suffering and personal inadequacy are shared human experiences (common human weakness and vulnerability), and (4)

[7] Pure altruism versus particularistic altruism (Monroe, 1996)

[8] Whether common humanity can include common speciesism is yet to be discussed and tested – the phenomenon of discriminating individuals on the basis of their species membership is called speciesism (Singer, 1975).

awareness of common human attributes (needs and capabilities). As Karen Wegela reflects "it is our interconnectedness that is reflected in natural compassion" (2016, p. 8). This is what one may refer to as eudemonistic interconnectedness. Common humanity also includes the component of human capabilities which constitute ten qualities of dignity: life; bodily health; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment (Nussbaum, 2006). All the qualities seem to be congruent with the concept of all-dimensional compassion.

Apart from common humanity, two other concepts that are present in the current conceptualisation of compassion (based on CFT), and thus are important to mention: *empathy and sympathy* (see Table 4.). Empathy is a word closely related to compassion and the term itself was first introduced by the British psychologist Edward Titchener[9] in 1909 and taken from the German *Einfühlung* (feeling into) or *Einfühlungsvermögen*[10] (understanding, empathy/capacity for). Its origins also come through aesthetics and arts when the viewer was looking at a piece of work and experiencing it as the artist intended (Bloom, 2016). Some scholars such as Lipps even call it "inner imitation" (Debes, 2015). Thus, experiencing empathy is also an aesthetical *experiencing*.

Empathy can currently be classified into either cognitive (mentalisation/mentalising) or emotional (affective) empathy (Manczak, DeLongis, & Chan, 2016), rarely are these two joined making what is called "projective empathy". Additionally, a few writers mention that there are also behavioural and moral types of empathy (Jeffrey, 2016). In short, empathy can be seen as experiencing the world as you think other people would (Bloom, 2016). It can inspire compassion, but compassion does not need to inspire empathy. According to Sprecher

[9] Edward Titchener (1867 – 1927), founder of *structuralism.* Studied under Wilhelm Wundt.
[10] This word was later re-translated in German as *Empathie* and is used till this day.

and Fehr (2005) there is also a clear distinction between empathy and what they called, "compassionate love". Similar to Hume, Bloom encourages what one can label as "rationality of experiencing" empathy (Hume, 1978; Bloom, 2016), and this may correspond to the need of applying intelligence or rationality in compassion-based practices (which stands in contrast to idiot's compassion). What Bloom (2016) is suggesting is to become aware of what positive and negative sides there are to empathy, as empathy can embrace tribalism by associating with just the one party and retaliating against the other. Compassion in turn, allows to go beyond individual-to-individual empathy. Additionally, empathy can also lead to avoidance, whereas compassion is a proactive stance (Peters & Calvo, 2014).

It is also important to make a distinction between empathy and sympathy; sympathy is a concept often confused and conflated with empathy. The two concepts are similar but not identical (Chismar, 1988). According to Hume (1978) sympathy is closely related to "humanity", "fellow-feeling," and "benevolence". Hume (1978) at times also uses these terms interchangeably. The term itself comes from the Ancient Greek *συμπάθεια* which can be translated into "the state of feeling together". In German, the term *Mitgefühl* would be used, which in fact is the same word for compassion, in Polish there is no distinction between these two terms. Contrary to empathy, some say that one who experiences sympathy does not have to emotionally or conceptually feel what others are experiencing (Debes, 2015) whilst others disagree (Eisenberg & Strayer, 1987).

A final central aspect of conceptualising compassion and CBIs, including CFT, is the concept of wisdom. When discussing wisdom, one needs to carefully distinguish between the Western and Eastern concepts of wisdom. Starting first with the Western views, Kramer (1990) defines wisdom as:

"*the organismic integration of relativistic and dialectical modes of thinking, affect, and reflection; a perspective on reality developed within interrelationships*" (p. 326).

Similarly, Birren and Fisher (1990) describe it as:

> "*the integration of the affective, conative, and cognitive aspects of human abilities in response to life's tasks and problems. Wisdom is a balance between the opposing valences of intense emotion and detachment, action and inaction, and knowledge and doubts. It tends to increase with experience and therefore age but is not exclusively found in old age* (p. 326).

Many other models also emphasise wisdom as the integration of various systems (Pascual-Leone, 1990; Orwoll & Perlmutter, 1990; Csikszentmihalyi & Rathunde, 1990), also focused on not knowing, doubting, uncertainty (Brugman, 2003; Mecham, 1990; Kitchenere & Brenner, 1990), pragmatics, solution-finding (Baltes and Smith, 1990). Wisdom therefore can be integrated as *sophia (transcendent wisdom)* and *phronesis (practical wisdom)* (Trowbridge & Ferrari, 2011). This would resemble the concepts in Buddhism, where one encounters *prajñā* (Sanskr.), which refers to insight and discriminating (discerning) knowledge, and *upaya* (Sanskr.), which refers to skilful means (or skill in action), or in other words to *kusala* and *akusala* i.e. what is helpful and what is detrimental. This specific aspect of wisdom can be later applied in specific circumstances such as illness in order to alleviate the pain and suffering of the experience of one's circumstances.

To summarise, it seems that the main processes of compassion (see Table 4) would include common humanity, which implies interdependence in contrast to Westernised and neoliberal concepts of independence and solipsism; rational empathy and sympathy, combined with integrated wisdom, in which the states and feelings of empathy/sympathy inspire

compassionate being (in terms of thinking and doing). Combined together, compassion helps maintain or rebuild one's dignity and the dignity (care for) of others.

Table 4. Overview of compassion processes.

Compassion can be *realised* through: studying, contemplating (reflecting), and practising formally and informally (applying in life).
Compassion is *linked* to: dignity, empathy/sympathy, common humanity, wisdom (*sophia* and *phronesis*), In Buddhism – also loving kindness, equanimity, altruistic joy (part of the "four immeasurables", alongside compassion).
Compassion *expresses* itself in: altruistic (prosocial) behaviours, wise altruism ("skilful means").

1.4. On Contemplative Approaches (Similarities and Differences) and Cancer.

In order to employ the practical wisdom and its resources one needs to first look at existing models. One of them includes using contemplative approaches (CAs), which have gained more recognition both in the scientific and therapeutic realms over the past twenty years in Western medicine and psychology, including psychotherapeutic interventions. These should not be confused with complementary therapies (CTs). CTs include only bodily focused interventions (i.e. acupuncture, energy therapies), whereas contemplative approaches can be part of CTs or complementary and alternative medicine (CAM). CAs include such modalities as mindfulness, compassion, or the now almost forgotten, and controversial, transcendental meditation (TM). For comparative (methodological and conceptual) reasons in respect to the curriculum developed within this body of research, Mindfulness-Based Stress Reduction

(MBSR) programmes were employed as the main point of reference. This was because mindfulness-based interventions (MBIs) are the most frequently studied CA paradigms with cancer patients and survivors (Ledesma & Kumano, 2009; Huang, He, Wang, & Zhou, 2016; Haller et al., 2017), and they can provide rationale for the architectural foundation of the current programme to be similar to already established MBIs (e.g. eight-week format, approximately two hours per session).

Since 1995 mindfulness meditation has been employed to help raise levels of melatonin in breast and cancer patients (Mission, Teas, Heber, Wertheimer, & Kabat-Zinn, 1995). In MBIs, mindfulness can be described as one of the tools to reduce harmful psychological and physiological side effects of cancer, and it refers to the ability to see our thoughts, emotions and bodily sensations as a passing phenomenon rather than a solid reality that defines our identity. Carlson and Speca (2010) define mindfulness as "paying attention to whatever comes up in the present moment; allowing it all to rise and fall of its own accord, without trying to change anything; and being with things as they are" (p. 10). Programmes based on mindfulness, such as Mindfulness-Based Stress Reduction (MBSR), have long been used to improve the lives of different patient populations, including cancer patients.

Recently, specific programmes have been introduced based on the MBSR principles and framework: Mindfulness-Based Cancer Recovery (MBCR), and in a more psychotherapeutic setting (namely Cognitive-Behavioural Therapy - CBT), what is now known as Mindfulness-Based Cognitive Therapy for Cancer Patients (MBCT-Ca). MBIs primarily focus on mindful coping strategies: accepting and managing symptoms by reducing levels of stress enhancing immune functioning. It does not necessarily emphasise ethical or social issues. These interventions improve the quality of life of cancer patients. This is profoundly important as it lays the foundation of "calm abiding", in other words, maintaining the mind in a calm state

by means of stabilising and then expanding our attention, enhancing both emotional and physical/physiological functioning.

MBIs have been successful in "improving the quality of life of cancer patients by helping patients cope with symptoms and side effects, reducing harmful levels of stress hormones and enhancing immune system' performance" (Carlson & Speca, 2010, p. 4). Yet many mindfulness-based approaches lack the soothing and relational qualities of compassionate approaches, which activate the affiliative and soothing system (Gilbert, 2009). One other difference is that MBIs do not explicitly use the discomfort, stress or other forms of suffering, which is often experienced in cancer, as a means to inspire PTG. Hence, in this specific conceptualisation and practice, mindfulness is limited to a moment-to-moment awareness of one's body, thoughts, feelings and surroundings (inter- and intra-relational processes). MBSR has been shown to clinically reduce symptoms of anxiety, psychological distress and secondary depression (Kabat-Zinn, 1992), amplify immune functioning (Davidson et al., 2003), and enhance behavioural self-regulation (Lykins & Baer, 2009). By comparison, there are few studies that focus explicitly on the relationship between cancer and compassion, or explicitly employ CBIs for cancer patients and survivors, although efforts are being made in various versions of contemplative approaches to investigate their helpfulness, predominantly in mindfulness but these also include mixed paradigms, e.g. third wave CBT combined with mindfulness (e.g. in ACT). Other examples include the application of yoga, t'ai Chi, transcendental meditation (TM) or Mind-Body Bridging (MBB) (see Table 5 for review).

Table 5. List of contemplative approaches supporting cancer patients and survivors.

Name of intervention (training programme)	Population tested	Studies
Mindfulness (MBIs)		
Mindfulness-Based Stress Reduction (MBSR)	Various cancers and stages (adults) – cancer patients and survivors, e.g. **6wk MBSR**[11] **(**Huang & Shi, 2016); survivors of breast cancer (Lengacher et al., 2009)	lower levels of depression, anxiety, and fear of recurrence, along with higher energy, physical functioning (Lengacher et al., 2009)
Mindfulness: Mindfulness-Based Cancer Recovery (MBCR)	Various cancers and stages (adults) – cancer patients	Improving stress symptoms, anxiety, depression, mood and symptoms, such as fatigue and sleep problems (Carlson, 2013)
Mindfulness-Based Cognitive Therapy for Cancer (MBCT-Ca)	Various cancers and stages (adults) – cancer patients and survivors	None provided, examples only based on MBCT, MBSR or MBCR
(Partially using mindfulness) Acceptance and Commitment Therapy	Various cancers and stages (adults) – cancer patients, e.g. adults with advanced cancer (Low et al., 2016).	Trial feasibility (Low et al., 2016); reduced negative affect, increased positive affect (Arch & Mitchell, 2015)
Compassion (CBIs)		
(1st flow of compassion with elements of mindfulness): Mindful Self-Compassion (MSC) (online format – video conference)	**Posttreatment (young adult) cancer survivors**	**(Campo et al., 2017)**
Compassion (1st flow): Self-compassion-based writing intervention	Breast cancer survivors	Lower levels of negative affect and an increased self-compassionate attitude during exposure to difficult memories related to body image (Przezdziecki & Sherman, 2016)

[11] This in essence is not MBSR. MBSR can only last for 8 weeks, if it is shorter it becomes a different mindfulness-based training but longer constitutes what MBSR is.

Compassion: Cognitively-Based Compassion Training (CBCT)	Breast cancer survivors (adults)	Potentially beneficial for the psychological wellbeing of breast cancer survivors (Dodds et al., 2015)
Other		
Yoga (mainly various versions of Hatha Yoga)	Various cancers and stages (adults) – cancer patients and survivors	(Stan et al., 2016); a promising approach (Sharma, Lingam, & Nahar, 2016).
T'ai Chi	Various cancers and stages (adults) – cancer patients and survivors, e.g. lung cancer	(Pan, Pei, Li, Wang, Liu, & Lin, 2018)
Transcendental Mediation (TM) **** there are ethical issues linked to TM***	Breast cancer patients (adults)	(MacLean et al., 1997)
Mind-Body Bridging (MBB)	Cancer survivors (any type of cancers)	Sleep disturbance (Lipschitz, Kuhn, Kinney, Donaldson, & Nakamura, 2013).

Also, mindfulness and compassion training programmes produce distinct results even in terms of emotional processing and mental function (Desbordes et al., 2012). The practice of compassion to be mentioned in the context of cancer is a recent development and there are currently few studies focusing on this topic. For instance, Przezdziecki et al. (2013) investigated the relationship between body image disturbance, self-compassion and psychological distress in cancer patients. It was reported that a lack of self-compassion may produce negative effects, whereas self-compassion may be a buffer against rumination, and consequently anxiety and depression, which can stem from rumination. Similar results were noted in a study by Pinto-Gouveia, Duarte, Matos, and Fráguas (2014). Here, self-compassion was associated with decreased psychopathological symptoms of stress and depression, and better quality of life in patients with chronic illnesses, especially in patients with cancer. Further, Pinto-Gouveia et al. (2014) found increased levels of self-compassion helped patients adjust better to their illness. Perhaps of most relevance, a specific compassion-based

intervention called Cognitively-Based Compassion Training (CBCT) has been used with breast cancer survivors (Dodds et al., 2015) for improving depression and enhancing well-being. Cortisol was also assessed, and the preliminary results showed that it was a successful intervention. However, further studies are needed to replicate this and investigate other benefits. Thus, a new, comprehensive training programme based on compassion may not only look at the aforementioned aspects (e.g. psychological distress) but also issues such as increasing emotion regulation due to formally training in compassion.

It is also important to add that CBIs comprehensively tackle psychological issues that are of concern for cancer patients and survivors. These issues include depression, shame, anxiety, sexual problems, body image, pain, insomnia, well-being and levels of compassion – among some of the issues mentioned by patients and survivors. Having said this, one needs to note that most of the issues have not been evaluated with the populations of cancer patients and survivors. Therefore, it is necessary to develop and evaluate comprehensive training programmes for the benefit of current and future cancer patients and survivors.

1.5. Summary and Conclusions.

As the research in compassion is growing, it would be important to look at the mental and potentially physical health of somatic patients (including cancer patients and survivors) in order to evaluate processes associated with various aspects of compassion and its practices, i.e. see if and how compassion works, and in what particular areas of difficulties (clinical and non-clinical issues). For the sake of tackling the questions of clinical feasibility and effectiveness, specific research questions have been asked, which are described in the next section.

1.6. Research Questions and Hypotheses.

In order to employ the potential of a novel CBI (for cancer patients and survivors) and explore previously reported benefits, a specific training programme has been developed and tested. The research questions were the following:

I. Does training in compassion relate to greater disposition for mindfulness?

II. Does training in compassion relate to lower levels of perceived stress?

III. Does training in compassion relate to greater life satisfaction?

IV. Does training in compassion relate to greater meaning in life?

V. Does training in compassion relate to greater emotion regulation?

VI. Does training in compassion relate to better attachment styles?

VII. Does training in compassion relate to higher levels of post-traumatic growth?

The identified hypotheses are:

Research hypotheses:

Concerning research problem I.

1. Participants in compassion-based training (study group) will be characterised by increased frequency of mindful states on a daily basis after the training and in the follow-up.

Concerning research problem II.

2. Participants in compassion-based training (study group) will be characterised by lower perceived levels of stress after the training and in the follow-up.

Concerning research problem III.

3. Participants in compassion-based training (study group) will be characterised by higher levels of life satisfaction after the training and in the follow-up.

Concerning research problem IV.

4. Participants in compassion-based training (study group) will be characterised by a better sense of meaning in life in two dimensions (presence of meaning and search of meaning) after the training and in the follow-up.

Concerning research problem V.

5. Participants in compassion-based training (study group) will be characterised by a better emotional regulation in two dimensions (cognitive reappraisal and expressive suppression) after the training and in the follow-up.

Concerning research problem VI.

6. Participants in compassion-based training (study group) will be characterised by higher levels of being comfortable with closeness, feel that they can depend on others, and are less anxious or fearful about such things as being abandoned or unloved, after the training and in the follow-up.

Concerning research problem VII.

7. Participants in compassion-based training (study group) will be characterised by higher levels of the ability to be successful in reconstructing or strengthening their perception of self, others, and the meaning of events, after the training and in the follow-up.

The primary objectives of Study 1 (pilot study, non-clinical population) were: (a) to evaluate and determine the application and order of particular interventions (practices and exercises) chosen for the training programme, (b) evaluate and determine the order of specific weekly themes of the training programme (structure), and (c) to determine any potential obstacles (number and nature of exercises, inquiry). The development of CBIs in terms of working with cancer patients is described in Chapter 2, overall methodology in Chapter 3 and the study's results in Chapter 4. The following chapters will also focus on the description of the process of developing a new training modality (Chapter 2 in terms of running a pilot study and Chapter 5 in terms of looking at specific techniques and processes).

The primary objectives of Study 2 and 3 (clinical populations) were to investigate if an eight-week training programme based on compassion is associated with changes in mindful states, stress, satisfaction, emotion regulation, post-traumatic growth (as assessed by appropriate questionnaires and qualitative measures) and confirm the appropriate weekly themes once again – this is described in Chapter 3 which focuses on the methodology and methods.

Chapter 4 discusses the results of the pilot study (non-clinical population) and Chapter 6 those of the initial and main study combined (clinical populations). Chapter 5 focuses on the practices and processes of CforC. The overall discussion follows in Chapter 7.

Chapter 2. Development of a Compassion for Cancer (CforC) Curriculum for Female Breast Cancer Patients in Stages I-III and Cancer Survivors.

Science cannot solve the ultimate mystery of nature. And that is because, in the last analysis, we ourselves are a part of the mystery that we are trying to solve. Science cannot solve the ultimate mystery of nature, for in the final analysis we ourselves are part of the mystery we are trying to solve".

– Max Planck (1932, p. 217)

As stated in the previous chapter, compassion can be defined as "a sensitivity to the suffering of self and others with a deep commitment to relieve and prevent it" (Gilbert, 2014). Leading from this, compassion can be described as encompassing two different sets of skills or attitudes. The current curriculum and subsequent training programme are based on the concepts and skills of compassion and focus on how to suffer less in cancer and how to cultivate states of connectedness, even in the face of a potentially life-threatening illness. The initial focus is on the intention of courage and ultimately kindness (warmth), which inspire our motivational systems, and ultimately change behavioural patterns towards oneself and others (both external and internal processes).

2.1. Rationale, Piloting and Initial Observations.

The current training programme incorporates tools and philosophical foundations of Compassion-Focused Therapy (CFT). CFT belongs to the third wave of cognitive-behavioural therapy and was developed by Paul Gilbert (2009). It includes diverse contemplative exercises based on compassion approaches. It is the first psychotherapy which explicitly uses compassion as both its target outcome and the basis of its tools. Targeting compassion may

be helpful for cancer patients and survivors since higher levels of compassion are associated with psychological and physiological benefits.

The process of developing and running a course is not only based on relevant research but is also inevitably personal, based on personal and professional experience. This experience includes experiences of formal and informal practices, and one's specific inclinations: philosophical inclinations, emotional and professional needs. It also often begins by simple clinical observation and intellectual reflection by a qualified practitioner of what is missing in the therapeutic realm or conceptual disagreement about specific issues, e.g. the need to identify distorted cognitions in Cognitive Behavioural Therapy; the case of mindfulness-based stress reduction trying to help "untreatable patients" (MBSR; Kabat-Zinn, 1979/1990)[12]; or the need to combine cognition with emotion in CBT by introducing CFT. Thus, this chapter will present details of the process of development and potential applications of a psychosocial intervention, initially created for breast cancer patients and survivors and later expanded to other groups of cancer patients and survivors. This intervention is called *Compassion for Cancer (CforC)*, and is based on Compassion-Focused Therapy (CFT) (Gilbert, 2010a). Additionally, the background of the designer (myself) will be described. The main purposes of this chapter are to: i) further describe relevant CFT theory in terms of how it has been applied in practice; ii) explain the process of development of the curriculum; and iii) provide an introduction to first evaluation of its application in clinical practice which will be

[12] As explained by Kabat-Zinn (2003) the intention of developing MBSR was twofold: (1) MBSR as a training vehicle for the relief of suffering and (2) MBSR as a model. The eight-week Mindfulness-Based Stress Reduction (initially named Stress Reduction and Relaxation Program – SR&RP) was designed as a ten-week course (later changed into an eight-week programme) for chronic pain patients to be able to emotionally, cognitively and bodily self-regulate in difficult situations such as stress and chronic pain (Kabat-Zinn, 1982). It was also intended for patients who "fall through the cracks" in the health system not feeling satisfied with traditional management of their issue and feeling that their condition was not improving (Kabat-Zinn, 1982). Another ambitious aim of developing MBSR was to present it as one of the "infinite number of skillful means for bringing the dharma into mainstream settings" (Kabat-Zinn, 2011).

subsequently described in detail in Chapter 3 in terms of methodology and methods and Chapter 4 and Chapter 6 in terms of results respectively.

2.2. Compassion for Cancer (CforC) for Cancer Patients and Survivors.

CforC training is based on the theoretical foundations of CFT, but also incorporates knowledge of cancer research and clinical expertise in that area (described in Chapter 1). This is particularly important when working with cancer patients who might need specific additional compassion tools to address issues such as pain management, body image, stress and depression/low mood; all of which are often experienced in the course of cancer illness and concurrent treatment (Hopwood, Fletcher, Lee, & Al Ghazal, 2001).

As noted in Chapter 1, cancer patients often experience symptoms of anxiety, depression, PTSD, pain, insomnia and cognitive impairments (Ahles, Root, & Ryan, 2012). CFT addresses some of these issues, i.e. anxiety, depression, anger and fears of various natures, but until recently did not address the issue of physical pain (Gilbert, 2010a; Parry & Malpus, 2017). Aaronson et al. (2014) emphasise that pain is often overlooked in cancer survivors because of the limited number of studies on post-cancer pain syndromes. He argues that issues of physical pain should be viewed as part of a constellation of symptoms that would include fatigue, anxiety, depression, and sleep disturbance. Of note, some cancer patients also describe positive outcomes associated with their experiences including post-traumatic growth (PTG). Therefore, while CforC aims to be a comprehensive training programme which tackles anxiety, fear, depression, anger, issues of body image, pain management, and shame, it also aims to increase levels of psychological growth.

Whilst it is acknowledged that there are other contemplative traditions (for example, mindfulness) that focus on the issue of psychological management of cancer, the research briefly reviewed here highlights the relevance of developing and running cancer-specific compassion-based training courses. Indeed, mindfulness can at times be seen (and therefore misrepresented) as a neutral trait or skill and is often simply used as an enhancement for cognitive processing in terms of stabilising attention, improving memory function and other cognitive processes (Mrazek, Franklin, Tarchin, Baird, & Schooler, 2013). This is often referred to as "sniper's mindfulness" (Ricard, 2015). Thus, whilst such interventions include practices which are open, non-judgmental, and focused on the present moment, they do not include the qualities of kindness and compassion. As previously stated, compassion-based interventions not only focus on the regulation of difficult emotional and physical states, but also help generate restorative and supportive emotions and skills; these are particularly important in cancer treatment and care (Kennifer et al., 2009). However, it is important to state that in this pilot only the experiences of healthy participants were included.

Compassion itself does not evoke the same emotional indifference. Furthermore, the well-meaning intention of mindfulness to reduce our suffering (understood as emotional, physical or relational suffering or pain; loss or gain) by the means of detaching oneself from the solid identification of "me-ness" can paradoxically solidify suffering if the compassion component is missing or simply not explicit enough. This may be due to the fact that other flows of compassion, beyond self-compassion, are not explicitly incorporated into the formal training i.e. the ability to receive and to give compassion. Therefore, it is possible that one may end up in a "narcissistic loop" by being overly invested in oneself, and not considering interconnectedness, emotional and material reciprocity (Smith, 2010; Trungpa, 2002).

Considering the above, the current training programme aims to raise levels of compassion in cancer patients and survivors as a means to improve overall well-being. As Germer and Neff (2013) state: "we give ourselves compassion not to feel better, but because we feel bad" (p. 386). Since there are certain aspects of life we cannot escape, but one can still learn to suffer less and, while not discarding suffering, one can also see other important aspects of life. The training proposed through CforC aims to support the skill of self-regulation (emotional/physical) and mind-body connection through both formal and informal practices. It aims to help patients cope with both the physical and emotional pain of their condition and equip them with experiences and skills that can be used long after the completion of the training.

2.3. Piloting.

2.3.1 Background.

As described in Chapter 1, there are already contemplative models that focus on helping patients with cancer, and cancer survivors, cope with their situation (e.g. mindfulness-based interventions). There are also compassion-based approaches that help with various circumstances, mainly of an emotional and physical nature (explained in more detail in the previous chapter), but do not focus on cancer specifically, e.g. Mindful Self-Compassion training (Germer & Neff, 2013), Compassion Cultivation Training (Jinpa, 2015), Compassion-Focused Therapy (Gilbert, 2009; 2010b). The proposed CforC training integrates ideas from both approaches (mindfulness and compassion) and its structure is modelled upon the structure of the Mindfulness-Based Stress Reduction (MBSR) programme.

The intention to develop MBSR was twofold – as a training vehicle for the relief of suffering and as a model of understanding suffering and its relief (Kabat-Zinn, 2003). The current

training model shares a similar premise. Importantly, mindfulness was designed for patients who were falling through the cracks of the medical services, but the current issue might be that now a subset of these same patients may be falling through the MBSR/MBIs/mindfulness cracks. As highlighted above, the difference between mindfulness and compassion interventions may be that compassion not only regulates difficult emotions and cognitions, but also generates supportive, soothing skills. Thus, the intention of CforC is to provide a more comprehensive intervention. Indeed, the premise here is that an intervention that focuses on compassion-based exercises, in addition to mindfulness, may be a more helpful programme for cancer patients and survivors than a basic mindfulness course such as MBSR.

It is also important to describe the process of developing a specific curriculum as this is rarely discussed in psychological literature, apart from anecdotal accounts (e.g. Acceptance and Commitment Therapy; Hayes, Strosahl, & Wilson, 2011). In fact, the process of developing and adapting many therapeutic and training curricula is often unclear and no rationale is given for changes made. It can be assumed that the main methods employed by most qualified "architects" is by trial and error, practitioners' clinical intuition, clinical observation, case studies and other informal processes rather than by systematic, formal evaluation. Descriptions of the development of comprehensive psychological training programmes can be absent, vague and hard to find and mainly focus on the final outcomes of a particular treatment efficacy (e.g. McHugh & Barlow, 2010). That is why it was deemed important to describe the present training programme and its development, including its potential future applications.

In terms of designing and evaluating the training, the trainer first consulted other mindfulness and compassion teachers (for example Christopher Germer, Jon Kabat-Zinn, Paul Gilbert, Wendy Wood, Russell Kolts). However, each individual had a different idea on how to run

and design courses and at times shared contradicting theoretical views and understanding. This is similar to having supervisors from different schools of psychotherapy; each might give contradictory advice dependent upon their skills and theoretical perspectives, not to mention their life and professional experiences. This additionally influences their philosophy and tools, with these attuned to their own values, personal style, underpinning research studied, and their patients' needs. Given the substantial work on compassion by Gilbert and others (Gilbert, 2009; Gilbert, 2010; Gilbert, 2014; Kirby, 2016; Matos et al., 2017), the decision was made to use an adapted version of CMT which constitutes CFT tools and practices.

2.3.1.1. Trainer's Background.

As mentioned in the previous paragraphs it is important to mention the architects of specific interventions as they influence the overriding philosophy of any paradigm – as paradigms are not devoid of their creators' subjectivity. Having stated this, it would be important to include a description of the current intervention architect and their background in terms both of professional experience and contemplative practices.

Julia E. Wahl is a psychologist (MA in Social Clinical Psychology), who also completed a 5-year Relational Process and Integrative Psychotherapy (a combination of Transactional Analysis, Psychodynamic approaches and Gestalt psychotherapy) with Richard Erskine, who himself studied, among other people, with Lauren and Fritz Perls. Among her clinical supervisors were Richard Erskine (Integrative Psychotherapy), Maria Marquardt (Ericksonian Therapy), Gregor Zvelc (Integrative Psychotherapy), Wanda Paszkiewicz, and Christopher Germer. Julia has also been attending many mediation retreats, both Buddhist and secular, among them one with Jon Kabat-Zinn and Saki Santorelli for MBSR teachers, professional training sessions, workshops and courses (e.g. with Jon Kabat-Zinn – MBSR, Christopher

Germer - MSC, Paul Gilbert, Chris Irons, Kate Lucre, Wendy Wood – CFT/CMT, Christopher Willard, Antonia Sumbundu – MBCT, Kelly Wilson – ACT, Richard Erskine – TA, Gestalt, psychodynamic therapies, Maria Marquardt - Ericksonian therapy, Bogna Szymkiewicz – Process-Oriented Psychotherapy). In her personal practice she has been practising and studying Vajrayana Buddhism (Nyingmapa, Kagyu, Dzogchen) since her teenage years, with such teachers as Phakchok Rinpoche, Dzigar Kongtrul Rinpoche, Tenga Rinpoche, James Low, Tomasz Pietrzykowski ("Vajra Pollack"), Simon Luna, and Herbert Elsky. This particular mention, of all the influences, is important as it informs specific thinking, especially in terms of integrating various influences, both in psychology and contemplative approaches.

Julia has also been involved in introducing MBIs to Poland and is a founding and former board member of both the Polish Mindfulness Association and the Polish Association for Psychotherapy Integration. Further, she is also one of the authors and organisers of the 1st Conference on Practical Application of Buddhism in Western Psychology; Mindfulness: Theory and Practice, Warsaw, Poland, 2008. In her clinical work Julia also conducted individual and group therapy; introductory workshops to mindfulness for law enforcement professionals (police force and prison/correctional officers) at the Hospital of the Ministry of the Interior and Administration in Otwock near Warsaw, Poland (Department for the Treatment of Neurotic Disorders); and led anger management workshops with Polish directors of prison administration. Further, she has been working with various clinical and non-clinical groups, individually and in group settings (e.g. with individuals and companies like Nestle, AstraZeneca, Roche, Ever Pharma, Forum Media Poland. In total running over one hundred workshops, retreats and training programmes. She has also worked clinically with cancer patients and survivors since 2012; firstly introducing them to mindfulness, and gradually learning that compassion was the missing component and how soothing it has been proved to be, based on the experiences described above. In terms of cancer, Julia became interested in

this particular issue as result of her own mother becoming ill, and subsequently noticing how prevalent cancer and other forms of illnesses have become. This experience led to wanting to establish appropriate psychological interventions which would tackle the issue of illness, starting with cancer patients and survivors. The experience described above also informs the quality of the subsequent work.

Having considered cancer-specific issues as described in Chapter 1., the next issue concerned clinical considerations in terms of applying contemplative practices.

2.4. Clinical Considerations and Contraindications for Contemplative Practices.

2.4.1. Somatopsychology.

It also needs to be noted that the specific population of interest (cancer patients and survivors in the CforC training) falls into the category of somatic or somatopsychological patients, to be distinguished from psychosomatic or mental health patients (Weiss et al., 2017). This specific category emphasises specific somatic aspects, illness and the ensuing treatment/post-treatment as focal, and not the mental issues that may also be dealt with if necessary, which may follow. CforC is seen here as a preventive measure, and the description of psychological dimensions of cancer is detailed in Chapter 1. To describe it further, somatopsychology is a science concerned with the psychological impact resulting from physiological diseases and disability, as opposed to psychosomatics, which deals with the psychological influences on the body, and takes into account social factors (e.g. interactions with others) (Lewin, 1935). According to Lewin's somatopsychology theory (Lewin, 1935), our self-worth is influenced by feedback from others (i.e. as a result of our interaction with them) and how we perceive (interpret) it. This theory also applies to disability, which can also occur to varying degrees as a result of cancer, depending on the diagnosis and subsequent course of treatment and its

effects. On the other hand, disability, even if it is mild to moderate, can significantly affect how a person perceives themselves. There may be a sense of stigmatisation or even discrimination on the part of others, which is associated with diminishing the value of a person and losing a sense of (internal) control on their part. The sense of internal control is very important due to the fact that it may reduce any negative emotional impact of stigmatisation and negative attitudes on the part of others. This control may be invoked by appropriate grounding, described later in this current chapter.

Having considered the somatopsychological factors it would be important therefore to look at contraindications for applying contemplative approaches and practices.

2.4.2. Working Appropriately with Contemplative Approaches: Various Phenomena, Myths, and Misunderstandings.

"To meditate is to suffer intelligently"

– Barry Magid (personal communication, 2018)

In terms of clinical considerations, even though the specific group was not diagnosed with any mental health issues, the trainer (Julia) considered their own clinical experience and recent research in the area of positive and negative side effects of meditative and contemplative practices (e.g. Lindahl et al., 2017) and trauma-informed mindfulness (TIM) or trauma-sensitive mindfulness (TSM) (Treleaven, 2018) with the latter describing precautions also being significant to a compassion-based training or compassion-based approaches in general. Additionally, fears, blocks, and resistances (FBRs) will be discussed. These are described in the following paragraphs.

In terms of precautions what was anecdotally known to meditation instructors and meditators for many years has only recently started to be studied and still little is known in terms of prevalence of such experiences (Lindahl et al., 2017; Wielgosz et al., 2019; Schlosser et al., 2019). Previously, certain myths or misunderstandings concerning meditation were raised by such researchers as Willoughby Britton (2017), including the following five basic assumptions concerning meditation and challenges occurring due to one's practice and previous experiences: (1) previous history of vulnerability and thus assuming that challenges only happen to participants who have previous history of trauma and/or psychological issues; (2) challenges correlate with the length, intensity and amount of practice; (3) challenges occur due to lack of proper guidance, e.g. no meditation instructor; (4) challenges do not occur during official MBIs; and finally, that (5) challenges seldom occur. To describe it in more seriousness, Treleaven (2010) even coined a term "contemplative dissociation" which is defined as "a disconnection between thoughts, emotions and physical sensations that is exacerbated by contemplative practice" (p. 20). Others issues that may observed during meditative practices refer to: "spiritual bypass" or "bypassing" (Welwood, 1984) which "mindlessness masquerading as mindfulness" (Pollak, Pedulla, & Siegel, 2014, p. 25) which may refer to pretending to have reached higher states of consciousness and denying human emotions, i.e. practices used for avoidance purposes. Thus, it is important to understand the nature of meditative practices, and particularly its processes and what these result in.

Another example of challenging experiences (or precautions) is the phenomenon of *makyo*, which is a term that comes from the Japanese Zen Buddhism (see Table 6). Even for people with a healthy mental structure and no previous history of psychopathological symptoms, such as psychotic states, there may still be experiences related to this phenomenon. *Makyo* literally means "ghost cave" and is a metaphor for various forms of hallucinations, perception changes, perception distortions that may occur during meditation practice. Often practitioners give this

experience meaning, but from a purely cognitive level, they can be an attempt by the brain to fill the stillness. This phenomenon is not considered important in itself, i.e. content or form of this experience, yet in some cases, the phenomenon of *makyo* can lead to a sense of derealisation and depersonalisation. However, on the other hand, it may be a positive experience as it has the potential to show one the opportunity to free themselves from one's way of experiencing of themselves and the world. If it persists, particularly after the formal practice, it is possible that one needs to change a given form or meditation instruction, and in some situations, even psychiatric or psychotherapeutic consultation is necessary.

On a purely conceptual level, the lack of knowledge and depending on the tradition from which a given practice originates, many experiences or concepts about meditation may be misunderstood. The statement itself, which often appears today claims that "there is no bad meditation", this assertion is incorrect particularly when based on clinical reasons. First of all, on a purely technical level, a given instruction may be misunderstood. For example, when a practitioner enmeshes various instructions with each other, thereby forgetting or not even being aware of the different functions of individual practices (meditation exercises). When a specific instruction on imagery work is added to the breathing practice, the practice itself changes significantly and may have completely different effects from that when only focusing attention on the breath, without the added component of imagery work. At the level of meditative effects themselves, meditation can be "bad", if for example, it leads to a what is called "meditative freezing", again which may lead to previously described dissociation (Lindahl et al., 2017; Trelevean, 2018). Meditation, as part of a secular mindfulness approach, is not about being devoid of having emotions, but about having a tool to regulate one's emotions. In other words, it is about reducing over-reactivity or automatic, non-reflective responses to emerging emotions (as described in Chapter 1). Internal stillness in itself, allowing the mind to do what it does, applied excessively leads to so-called "meditation

sickness", or falling into emptiness, complete absorption in itself. In turn, too much attachment to pleasant experiences may lead to practitioners being too attached to certain experiences, e.g. pleasure, bliss, and this is often referred to as a "insight corruption" (Lindahl et al., 2017).

Thus, different experiences may occur during the meditation process, both pleasant and unpleasant, and there is actually no such as thing as bad meditation in that specific sense. Pleasant meditative experience at times may signify covering up certain processes. This is not to say that pleasant experiences are not to be experienced or in fact, needed. In the tradition of Tibetan Buddhism, there is a term *nyam*, which refers to a wide spectrum of meditative experiences that may relate to both experiences of bliss, joy, clarity of thoughts, lack of thoughts, but also to intense physical pain, physiological disorders, experience of paranoia, anger, anxiety or sadness. The interpretation of the experience depends on the individual context – a notion that will be covered in the next paragraphs.

In terms of TIM and TSM, which also applies to compassion-based formal practices and setting, the first rule involves making sure that all participants know how to ground themselves (physically and emotionally), and that this strategy is not only encouraged but may be required or even deemed necessary at times, e.g. changing one's focus from the internal (breath) to the external (e.g. using one's senses by the means of visual cues, touching an object). This is also closely related to the general principle of safety which is facilitated by instructors (trainers) and provides literal and emotional space to adjust one's practice accordingly, and without shaming (discipline in practising formally and informally is seen as self-kindness). Other aspects may include specific diversity issues, which may refer to other aspects of safety such as making sure that people from all communities feel safe e.g. the LGBT community.

The cues provided by Treleaven (2010) include being careful to language used (e.g. language being invitational and not directional) and providing participants with multiple options, which is consistent with the trainer's (Julia E. Wahl) experience. Additionally, Treleaven's five principles of TSM (Treleaven, 2018) refer to: the role of attention, arousal, relationship, dissociation, and social context. More specifically, all the principles apply to certain responsibilities on behalf of the instructor, even if one is not a trained clinician, such as understanding the neurophysiology of trauma and what may trigger it (arousal), having the ability to spot symptoms (tracking), ways in which one can regulate it and gain stability (containment and grounding), and understanding relational and societal aspects of both the trauma and meditation training experience, e.g. group practice challenge. All these principles are included in the curriculum, e.g. by specifically implementing grounding practices, and in the process of supervising trainers, e.g. by teaching TSM.

Table 6. Examples of myths and traps related to thinking about or the meditative process itself.

• "There is no bad/incorrect meditation".
• "Perfect meditator" - incorrect assumptions about the person practising meditation (e.g. one needs to be perfect in all areas of life).
• "Burying emotions", shallow emotions, emotional freezing.
• Excessive rigour or being too loose (during or after the meditation process), not only related to how we physically practise (e.g. in relation to meditative position), but also in the context of attitudes towards one's practice and ourselves alone (i.e. adequate self-compassion is required, in other words, "affectionate discipline").
• Assumption that meditation is a form of psychotherapy.

• *Vipasiana-upakkilesa* is a phenomenon of "insight corruption," or the false belief that one's euphoric experiences are synonymous with insight.

• The phenomenon of *makyo* – various forms of hallucinations (visual, sound or sensory phenomena).

• The phenomenon of *nyam* (refers to a wide spectrum of meditative experiences) – experiences such as bliss, clarity, temporary lack of thought or conceptualisation that may have its opposite effect, e.g. lack of thought may be associated with ignorance, loss of interest, and relativism.

• Lack of attachment, e.g. relating to certain important issues, people, activity that may result in indifference, inertia, lack of commitment.

• Following / clinging to / seeking stimuli - this may include the phenomenon of *makyo* or one's confusion in terms of the distinction between the experience and genuine realisation.

• "Here-and-nowism", David Brazier's term (2013). It refers to one's disconnection from the context of the past and future, the historical-political-social context. It can lead to indifference, lack of commitment (compassion), and lack of appropriate action.

• The assumption that meditation (especially the practice of mindfulness) is only a reinforcement of cognitive processes - this is also associated with one's lack of knowledge and understanding of the functions of meditation and its broader context.

Another issue that needs to be taken into account, especially when working with compassion-based approaches, concerns what is known as fears, blocks, and resistances (FBRs) to compassion, these refer to inhibiting factors (Gilbert & Mascaro, 2017). As Matos, Duarte and Pinto-Gouveia (2017). Clinical research implies that certain people experience self-compassion or receiving from others as aversive with the link to psychopathological symptoms remaining unclear, and pointing to certain psychopathological indicators (e.g. as self-criticism, insecure attachment, alexithymia, fears of happiness, increased symptom of

depression, anxiety and stress) (Gilbert et al., 2011; Matos, Duarte, & Pinto-Gouveia, 2017). Such fears may be due to previous experiences, e.g. being shamed, or one's perceptions, e.g. it is not safe to be/feel safe. When working with FBRs, Matos, Duarte and Pinto-Gouveia (2017) suggest simply addressing such challenges during any interventions, and thus the hypocognitive emotions become clear to participants and are normalised.

Having mentioned all the potential phenomena arising due to contemplative practices and subsequent protective measures that need to be considered, it also needs to be stated that one may not completely be rescued from any challenges during meditative practices, and some challenges are in fact required, and may vary depending on the type of practice. The overriding rule is that if one cannot do beneficence, the importance lies in the Hippocratic Oath, an act of non-maleficence, which states that at least *primum non nocere* (first do no harm).

2.5. Theory and Rationale for CforC.

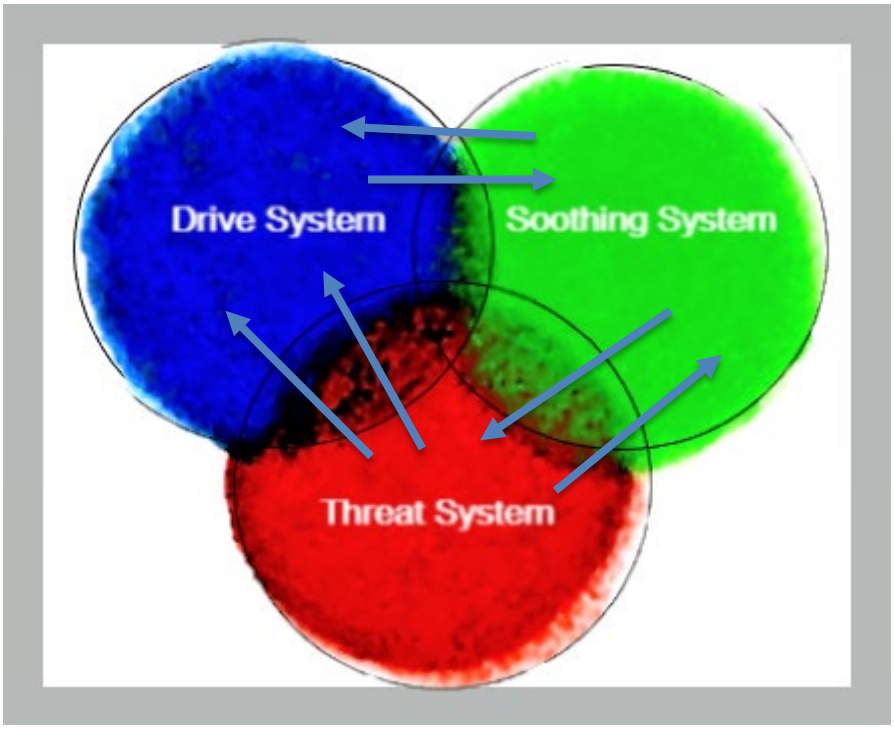
2.5.1. General Overview.

When designing a programme, and first having considered all the precautions, it is important to refer to its main goals; what it aims to achieve and its philosophical foundations. CforC is a contemplative approach congruent with basic Buddhist philosophy concerning suffering. Suffering therefore signifies "suffering or unsatisfactoriness and painfulness of mundane life" (*duhkha*) (Buswell & Lopez, 2013). Yet CforC goes beyond this by incorporating not only Buddhist meditative traditions but also research from Western social science, including evolutionary psychology (Gilbert, 2010b). The current curriculum and training based on compassion is hence another set of tools of skilful means (*upaya*).

Training in compassion is, according to Gilbert (2010a), about learning to bring balance to three types of emotion regulation systems (see Figure 1): (1) the threat system that focuses on threats to self-protection, (2) the incentive resource seeking system, or drive system, that focuses on wants and achievements, and (3) the soothing contentment system (affiliative system) that focuses on safeness and connectedness (Gilbert, 2010b). In the case of cancer, the threat system can be triggered by a cancer diagnosis, treatment procedures, relational and financial losses, body and/or sexual changes and even just by the waiting for the diagnosis. The drive system concerns being able to cope with treatment, finish treatment and go back to some of the pre-diagnosis/pre-treatment activities. The soothing system is about being able to be with, and alleviate symptoms of, emotional and physical pain, and relational difficulties.

Figure 1

Three affective or emotion-regulation systems (circles)

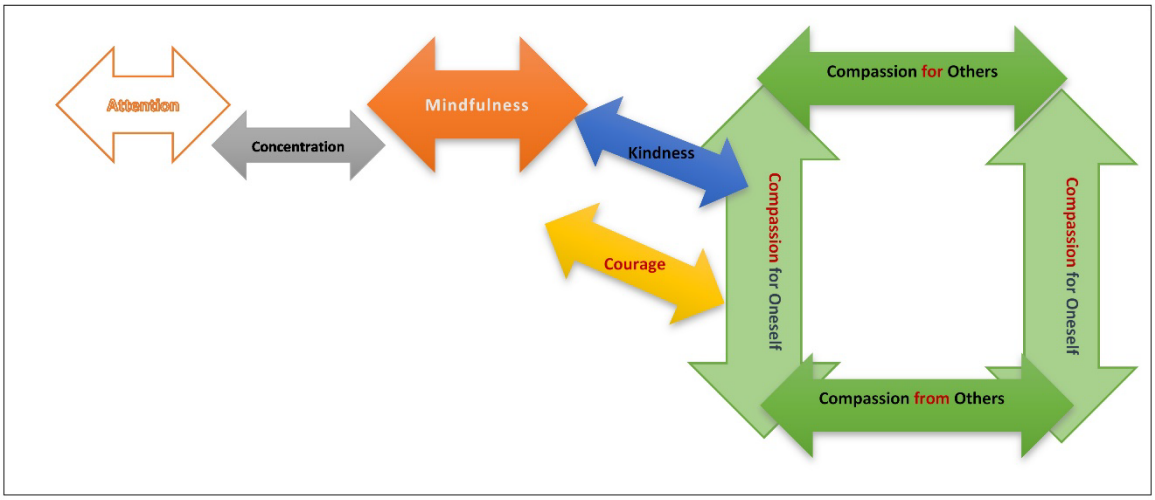


Note: Based on CFT (Gilbert, 2010). The common part (overlapping) is a state (static situation) that joins two basic states. The arrows symbolise the transition between basic states (dynamic).

Additionally, CforC not only refers to different affective and motivational systems but it makes use of various emotion regulation tools (see Figure 2). Drawing on Germer (personal communication, 2011), three main emotion regulation skills are included in the curriculum: attention, mindfulness, and compassion (see Figure 2.).

Figure 2

Emotion regulation skills



Attention is the ability to focus on one object, e.g. be with one's thoughts, emotions or external phenomena such as sounds, smells, etc., and sustain attention on it (concentration), as well as the ability to shift focus when necessary (flexibility of attention). Mindfulness refers to expanded awareness, but is not *awareness* in itself which constitutes a different mode of being; and moment-to-moment awareness of our body, thoughts, feelings and surroundings. It also implies openness to be with various experiences (internal and external such as bodily sensations, thoughts, feelings, and sounds) without rejection or aversion. The basic axioms are that awareness and mindfulness are inseparable, with mindfulness helping regain the natural state of awareness (*naturalness* and *effortless resting)* and ultimately leading to *emptiness, naked awareness* and/or *knowingness* (T. Pietrzykowski, personal communication, 2018).

In the first phase, mindfulness is also about familiarisation with internal and external phenomena by means of systematic expansion of attention, which is preceded by courage, the willingness, strength and sensitivity to be with difficult phenomena, and facilitated by kindness (warmth). In the first phase mindfulness is also a stabilising (grounding) practice and allows one to slow down; in so doing, one can soothe as well as provide oneself with safeness. Yet it does not necessarily make us more connected to others. Mindfulness also entails equanimity; learning to respond rather than react, to have an "even-minded state" (Desbordes et al., 2015). It concerns the ability to be with various internal and external phenomena without rejection or aversion. This expanded awareness should implicitly include kindness/warmth (a gentle way of behaving and acting, with a gentle facial expression and voice tone) and courage (the willingness, strength and sensitivity to be with difficult phenomena), these leading to compassion. Compassion is, however, the explicit facilitation of these qualities, via motivation, rather than the implicit assumption they will develop from expanded awareness. Therefore, compassion is the ability to soothe and support the difficult experience and inspire what is supportive.

Compassion is also the main focus of CforC and includes the three circular flows/directions (Gilbert, 2010b; and depicted in Figure 2); compassion as an ability to give oneself compassion, compassion as an ability to receive compassion from other(s), and compassion as an ability to give compassion to other(s). The whole process of compassion recognizes that one can notice that "something is going wrong" in other sentient beings or in ourselves, e.g. some form of suffering. With mindful compassion, one can spot suffering, and can feel sympathy and experience empathy, which inform us about the situation as well as the probable root of the problem. Through (gaining) wisdom and our experience, one recognizes that suffering stems from the belief in our separateness (Kornfield, 2002). However, compassion differs from empathy and/or sympathy as it provides a motivation to act, in contrast to

mindfulness which does not necessary inspire motivational processes. The main aspects and skills of both compassion and mindfulness approaches are described in Table 7.

Another important aspect of compassion in CforC is the explicitness of suffering, the undeniable fact that there is suffering, as a means of developing compassion and post-traumatic growth. Compassionate approaches emphasise the necessity of learning from one's suffering of all forms, i.e. mental, physical, and relational. Compassion releases, develops and increases feelings of *commonness* and *togetherness* that alleviate belief in our separateness. Taken together, compassion increases both the wisdom and courage to clearly see how we function as human beings, and common humanity, as well as the feeling of interconnectedness and interdependence with the human race together with the drive to act.

Table 7. Description of other skills.

In the current training format, the following main aspects have been incorporated (some overlapping with mindfulness):
OVERLAPPING WITH MINDFULNESS: • (Cognitive part) Concentration (regulated attention) – stability of the mind, ability to shift attention when necessary. • Mindfulness – moment-to-moment awareness of your body, thoughts, feelings and surroundings (inter and intrarelational); ability to be with various internal phenomena. • Equanimity – learning to respond rather than react; "even-minded mental state" (Desbordes et al., 2014) towards all experiences and objects (regardless of their valence), one of the aspects of mindfulness. SPECIFIC FOR COMPASSION:

Compassion – wise intention (directed at what is helpful and wholesome) and wise active behaviour for the alleviation of the suffering of oneself and others.

- Wisdom – clear seeing of how we function as human beings (= knowledge + experience/contemplation).
- (Affective part) Common humanity – feeling of interconnectedness and interdependence (includes a feeling of belonging to the human race), not comparing (awareness of the fact that suffering and personal inadequacy is a shared human experience, this being the wisdom aspect).

2.5.2. Similarities and differences between Compassion-Focused Therapy, Compassionate Mind Training and Compassion for Cancer: Compassion-based Approaches.

Given the fact that CforC draws upon CFT and its tools (CMT) it is important to look at the changes concerning "classic CFT/CMT". It should also be defined what is meant by "classic CFT and/or CMT" in terms of its basic theory and practices (interventions) whilst keeping in mind that the latter is not yet fully determined as certain experiential practices employed in CFT/CMT are still being added and tested out (Maratos et al., 2019). It also needs to be noted that having consulted various CFT/CMT theorists and practitioners, it is clear that there is not one mutual understanding and agreement as to what classic CFT or CMT training and curricula are (e.g. James Kirby, Russell Kolts, Wendy Wood).

As there are various models of compassion in the realm of training and therapeutic programmes, as described in more detail in Chapter 1, it is important to emphasise what distinguishes CFT from other conceptualisations; CFT was "developed with and for people who have chronic and complex mental health problems linked to shame and self-criticism",

who often come from difficult backgrounds" (Gilbert, 2010, p. 4). CFT is not only borrowing from evolutionary and social psychologies, interpersonal neurophysiology but also to certain degree from the *Abhidharma* teachings, most predominantly, the concepts of sensitivity and motivation, and Tibetan Buddhism practices (Gilbert, 2010). Other elements include intentional focus, theoretical and in terms of its interventions, on the positive emotions of well-being, safeness, contentment (Gilbert, 2010). CFT is also is an approach which is "de-pathologising" (symptoms or the person who exhibits them), contextualised (looking at various factors influencing human beings), systemic (based on one's history, background, culture), and process-oriented rather than focused on the disorder (Gilbert, 2010). It incorporates a multimodal compassionate mind training with two compassion circles, inner and outer; one focused on the attributes and the other on the skills training, that help develop, cultivate, deepen these attributes (Gilbert, 2009a). The attributes include sensitivity, sympathy, care for well-being, distress tolerance, non-judgement, and empathy; the skills focus on attention, imagery, reasoning, behaviour, feeling, and sensory. The key here is to cultivate a compassionate mentality, versus a threat or competitive mind, and four specific qualities of compassion (strength/courage, wisdom/understanding/non-condemning, warmth/kindness, and commitment/responsibility). This would counterbalance any acts of cruelty towards oneself or others, e.g. self-criticism/criticism, ruminating, neglect, mistreatment.

In terms of its interventions, the generic description states that CFT incorporates work on such skills as attention, reasoning, and rumination, one's behaviour, emotions, motives, and imagery (Gilbert, 2010). More specifically, it also refers to and uses Socratic (Platonic) dialogue, guided discovery (called inquire in CforC), psychoeducation; thought, emotion, behavioural and somatic monitoring, behavioural experiments, e.g. in CforC include as part of post-class explorations, compassion-focused imagery, working with one's different parts

(multiselves) or enactment of different selves, mindfulness, learning emotional tolerance, expressive (letter) writing, distinguishing shame-criticising from compassionate self-correction and out-of-session work and guided, formal practice (Gilbert, 2010). To be more specific, the core and notable practices, include soothing breathing rhythm, imagery work such as the safe place, developing the compassionate ideal, compassionate self, compassion flowing in (into oneself) and out. It must be pointed out that all of the aforementioned practices are included in the CforC curriculum. Examples of specific practices and post-class explorations are referred to later within this chapter.

Previously CMT was understood as simply the tools ("training exercises") used in CFT, currently they often refer to a more literal meaning of an actual training format/programme (Ashworth, Gracey, & Gilbert, 2011; D. Steare, personal communication, 2016; R. Kolts, personal communication, 2020), e.g. only in one intervention CMT is referred to as "CMT strategy", "CMT tool", "CMT intervention", "CMT training" which can further add to the conceptual and practical confusion (Ashworth, Gracey, & Gilbert, 2011). In the current CforC training, CMT is primarily understood as such tools, with CFT's psychoeducation, e.g. three circles, "tricky brain", and old/new/social brain distinctions. This is in accordance with Lucey (2017) who states that when elements of CFT are combined, they form a curriculum entitled CMT.

It also needs to be once again stated that CMT is not a standard training but varies depending on the trainers and both their way and understanding of applying CMT with such variations as the two-week CMT (over the period of two weeks) (Matos et al., 2017) or the 6-module CMT (over the period of twelve weeks) (Maratos et al., 2019). There also does not exist one concise professional training or written guideline similar to the Mindfulness-Based Intervention Teacher Competence (MBI-TAC, Crane et al., 2012) created for MBSR/MBCT

curricula. – These are also debatable as there is an ongoing discussion about identifying specific skills and competencies of MBIs teachers, and the way how these can be demonstrated, embodied and externally evaluated (Wolf & Serpa, 2015). Therefore, a similar rout should be followed in CBIs in terms of discussing, evaluating, and designing an appropriate guide for trainers.

To describe CMT more specifically, and as stated by Maratos et al. (2019), CMT is about developing compassion motivation for oneself and others; this motivation should be combined with compassionate way of feeling, thinking, and behaving. Maratos et al. (2019) also note that in CMT psychoeducation plays a key role, and that CMT does not involve assessment of psychological issues/clinical formulations. Moreover, the authors state CMT may be a better fit for larger groups than CFT, and additionally CMT may be also better fitted for endemic groups rather than individualised problems, and its applicability is broader (Maratos et al., 2019). Furthermore, the study by Maratos et al. (2019) shows another example of the application of CMT, specifically investigating effects of a six-session CMT over the period of twelve weeks in a school setting (staff). In that case "implementation effectiveness" and feasibility were met, with increases in self-compassion and significant decreases in self-criticism (Maratos et al., 2019). This shows the need to further operationalise how CMT-based or CMT-inspired groups should be conducted (e.g. number of sessions, number of participants, what format for which population would be most adequate).

In terms of differences and similarities between CMT and CforC, in the CforC training all compassionate mind attributes and skills were kept intact (included in the programme). The main difference between CforC and CMT lies in the addition of certain practices in CforC which are not present in Gilbert's original presentation. The practices include *tong-len* (for oneself and others), common humanity practices, compassionate body scan (first introduced

in MSC training; C. Germer, personal communication, 2013), walking meditation with compassionate intention (reflecting on intention), spaciousness meditation practice, and compassionate voicework (to be distinguished from exploring one's tone of voice). These practices are described in detail in Chapter 5.

Also, as described earlier in the chapter, the nature of the training has changed from a more mindfulness-oriented to compassion-oriented. This development was dictated by the trainer's (Julia) initial professional background (being a mindfulness trainer), and gradual experiential immersion into specific CFT concepts. Compassion-based practices were not foreign to the trainer due to both her professional background (workshops in MSC, supervision with Christopher Germer), and personal experience in the Buddhist practice of the Mahayana/Vajrayana Buddhism tradition. This was important as the majority of formal meditative compassion-inducing practices in CMT come from this specific framework: Mahayana/Vajrayana tradition as oppose to the Hinayana (Theravada) tradition present in the majority of present-day MBIs (Braun, 2013; C. Germer, personal communication, 2015).

Another important aspect of the current training is that CforC is created around a specific structure (weekly themes) but is process-oriented in its nature – which reflects the nature of compassion-based practices (C. Germer, personal communication, 2015; R. Kolts, personal communication, 2020). In this way, it resembles MBIs which are about "be(ing) present with all your heart in that (teaching) endeavour, (which) takes precedence over the curriculum" (Brandsma, 2017, p. 13). These (weekly) themes, sessions and their movable and non-movable parts are discussed in detail in the next section.

2.6. CforC – Description of Curriculum.

CforC was developed as an eight-week programme, with weekly 2-2.5-hour long sessions. The length of sessions depends on the logistics, i.e. room availability, type of patients including their current state, stage of treatment or post-treatment) following the predominant convention of training courses and programmes being conducted in the eight-week format. Each session consists of guided meditations, gentle movement exercises such as gentle stretching, compassionate touch or walking meditation, didactic lecture, and group discussion (inquiry), which is also part of the experiential learning/psychological debriefing process after each exercise. The course also includes a half-day session on a Saturday or Sunday, preferably in the second half of the training programme. The half-day practice included up to five hours of practice and 1 hour of group discussion. Between classes, students deepen their participation by practising 10-30 minutes a day with meditation recordings and have daily home assignments, described in their Home Practice Manual. The main practices include (1) (compassionate) intention meditation (reflecting on intention), (2) soothing rhythm breathing and awareness of breathing, and (3) various compassion-based practices and exercises. These practices and exercises incorporate the three flows of compassion; compassion for oneself, compassion received from others, and compassion for others. Both soothing rhythmic breathing and awareness of breathing practices enables participants to have access to the soothing/contentment system (Gilbert, 2010a) and help maintain a grounding, safety practice. In turn, this allows participants to explore more visual and possibly emotionally stimulating practices of compassion (various compassion-based practices and exercises). The practice of emptiness, here called “contemplative practice”, initially included in the pilot study, was removed as it went beyond the scope of compassion-based practices and it was important to focus on the core compassion practices.

Eight weekly sessions (themes) have been designed and included in the final version of CforC. Each session is focused on a different aspect of compassion practice and philosophy:

Session 1. What is compassion? The challenge and courage of compassion. What is attention and mindfulness?

Session 2. Compassionate Self.

Session 3. Emotions and Different Selves.

Session 4. Pain and Suffering.

Session 5. Compassion for Others. Embracing our Common Humanity.

Session 6. Cultivating our Compassionate Self.

Session 7. Openness to Compassion and Spaciousness.

Session 8. Further Cultivation.

Starting with the first session, before exploring compassion-based practices, it was important to primarily establish the skills of attention and mindfulness. In other words, groundedness was emphasised, by practising soothing rhythm breathing as a means of mental stability as compassion can trigger challenging memories or FBRs (Gilbert, 2009). Hence, initially participants need to stabilise and prepare their mind to gain security and confidence in terms of their own practice, and most importantly, confidence in themselves and what they are capable of and how safe they are feeling during the practices. They also learn to physiologically and mentally self-soothe, e.g. by using the soothing rhythm breathing practice, and learn how to cope with various thoughts, emotions and bodily sensations through a variety of compassion-based exercises. Through different practices, participants can learn about their innate potential, as well as the ability to be focused and mindful, even if only for a few seconds.

In moments of difficulty with compassion practices, participants can then always retreat to mindfulness/grounding practices, which are also included in the curriculum. These enable them to be anchored in the present moment rather than in the world of their fantasies, ruminations, hopes or fears or "*makyo*-like" experiences. Participants are taught not only to be able to calm their minds but also their bodies. This is introduced by means of different soothing breathing exercises, which are later more explicitly cultivated in the practices directed at pain relief (session 4).

The first two sessions are focused on establishing the basis for safety and safeness, one's true intention and commitment for participating in the course (intention-motivation-change). The theoretical foundations are also explained; the evolutionary reasons behind suffering, e.g. explaining the "wandering mind" ("conceptual proliferation") phenomenon in the context of evolution and the new vs. old brain, and the means to alleviate some amount of this suffering (through compassion). During the first two sessions, the concepts of attention, mindfulness and compassion are also explained as the three tools to regulate our emotions and emotional (affective) states. The next six sessions focus more directly on specific compassion-based exercises, including cultivation of a compassionate set of skills, in terms of thinking, responding to emotions and behaving, and thus, aim to teach participants to look at their experiences, themselves and others from a compassionate perspective, irrespective of the nature of the experience. This is done through a variety of exercises that can be classified into three categories: imagery work, body work, and breathing work. They are all based on the principals of compassion. Additionally, contemplative and psychological education are also part of all the sessions and included in the materials. The training course ends with a recap of all the practices, provides an opportunity for the participants to choose their own set of practices and enables them to reflect at both the benefits and challenges of formal and informal practising.

2.6.1. Specific to CforC: Movable and Non-movable Components.

In terms of the "movable" and "non-movable" elements these referred to certain practices (exercises), and whilst "movable" (optional, changeable) meant that specific practices may either be moved from one session to the next one or omitted altogether, the "non-movable" (critical, core) referred to fidelity of the conceptual and practical framework of the CforC training. The fidelity in terms of the practices will also be discussed later in the chapter. The two practices that were "non-movable" during all the sessions was the cultivation of intention (opening of each session) and dedication/final cultivation of intention (end of each session). The decision concerning "movable" and "non-movable" (and appropriate changes) were initially made during and after the pilot study; based on the appropriate feedback received from the participants and supervisors (academic and clinical). These changes were later kept based on the feedback from the clinical populations' studies and supervisors.

More specifically, during Session One, it was important (the "non-movable" part) to present the conceptual core aspects including the three emotion regulation systems; the knowledge on the "tricky brain" (how the brain works, the old and new brain paradigm); the three flows of compassion; the two psychologies of compassion (sensitivity and motivation); at least one basic exercise that cultivates positive emotions of well-being, safeness and contentment (e.g. soothing rhythmic breathing, SRB). The "movable part" would involve presenting one other practice (e.g. safe place) as it could be introduced during session two. Additionally, home assignments are also part of the curriculum. These home assignments were instead referred to as post-class explorations because the latter does not carry the same Prussian model of education which is often associated with harshness, oppression, and criticism. Post-class explorations after session one included engaging in compassionate, kind, tender activities or participating in such activities with compassion, kindness and tenderness, e.g. kindly brushing

one's teeth (to be distinguished from mindful activities), filling out the table on the three affective systems, reflections on one's intention, and one formal practice (SRB).

In Session Two the key ("non-movable") theoretical framework involved: introducing (compassionate) imagery work ("non-movable"); calming the mind by introducing the concept of mindfulness, further cultivating slowing down and soothing by the means of the SRB and safe place practices; and the compassionate ideal imagery ("non-movable" practices). The compassionate colour was a "movable" (optional) practice. Post-class explorations after session two included continuing the practice of SRB, engaging in compassionate activities, reflecting on intention.

Session Three focused on the different (multiple) parts of self and deepening the functions of various emotions, four qualities of compassion ("non-movable" theory) and the compassionate self being the "non-movable" practice. Post-class explorations after session three included continuing the practice of SRB or practising the compassionate self, engaging in compassionate activities, reflecting on intention, and on fears of and blocks to one's compassion.

Session Four included the compassionate body scan, *tong-len* for oneself ("non-movable" practices), and grounding in the body practice being the "movable practice". In terms of the theoretical parts the issue of pain, suffering and emotion regulation is discussed. Post-class explorations after session four included formally practising compassionate body scan, *tong-len* for oneself and SRB, other explorations included reflecting on the issue of common humanity. This was explained in detail during the class.

During Session Five the compassionate body scan, *tong-len* for oneself, and the grounding in the body practice are all three "non-movable" practices with the addition of common humanity practice, *tong-len* for others ("movable practices"). Post-class explorations after session five included formally practising compassionate body scan, *tong-len* for oneself and SRB, making a list of all the kind people in one's life.

Session Six included the spacious mind practice (spaciousness), common humanity, and *tong-len* for others as the "non-movable" practices. The appreciation of others was a "movable" practice. Post-class explorations after session six included formally practising compassionate body scan, *tong-len* for oneself and SRB, and making a list of all the people to whom one is grateful.

Session Seven involves the practices of *tong-len*, the appreciation of others, spacious mind as the core ("non-movable" practices). Post-class explorations after session seven included practising compassionate body scan, *tong-len* for oneself, spaciousness practice, and SRB; making a list of all the things one is grateful for.

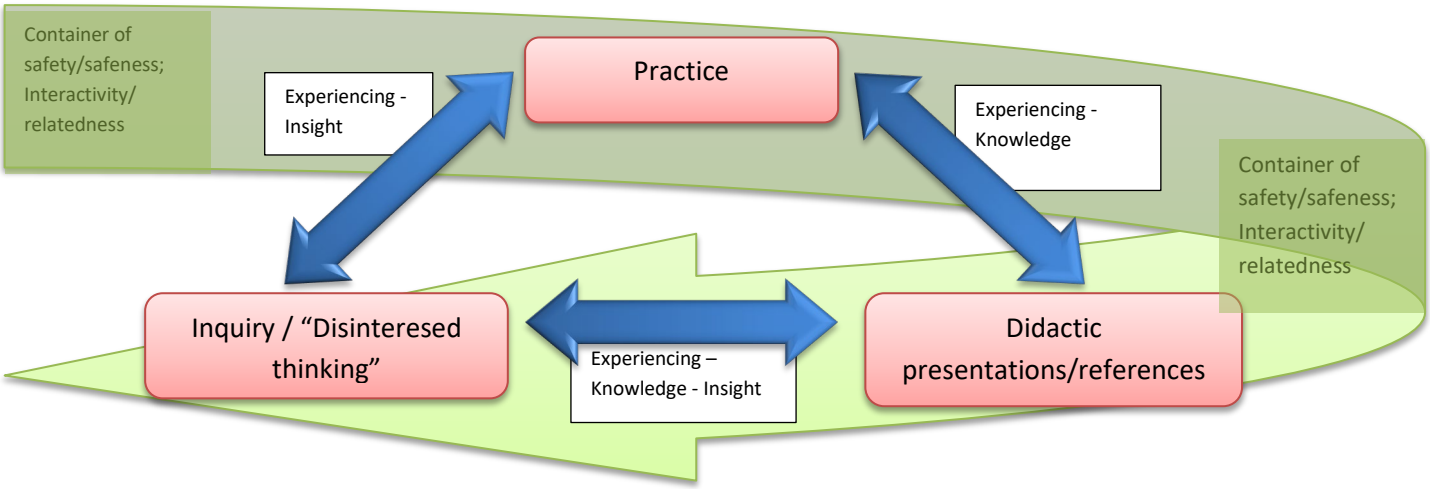
During the final session, Session Eight, the main part concerns providing ample time to summarise the whole process of CforC in terms of personal changes for each of the participant. The practices that are recommended to be included during the sessions are *tong-len* for oneself and others, and compassionate self (sitting or walking/enacting/embodying).

Also, similarly to MBIs, teaching methods included three core elements: (1) practice (formal), (2) inquiry (reviewing personal experiences including asking about the experiences of one's practice, making participants more engaged by asking questions and using the technique of

"disinterested thinking"), and (3) didactic presentations (which are also interactive, and at times are part of the inquiry) (see Figure 3).

Figure 3.

Teaching methods of CforC



Note: Adapted based on the mindfulness training trinity (Brandsma, 2017). Teaching methods facilitated by underlining processes (e.g. experiencing).

To recap, the main changes to CFT/CMT in terms of the practices included adding *tong-len* for oneself and others which at the time of the creation of CforC curriculum was seen as an additional practice in CFT (P. Gilbert, personal communication, 2013/2014), and reflections on common humanity, the latter tailored specially for the CforC training. Other added practices are described earlier in this chapter and a detailed description is laid out in Chapter 5. In terms of the practice of *tong-len* nothing has been published in terms of a consistent training model for CFT or CMT categorically stating that *tong-len* is a specific component (J. Kirby, personal communication, 2020; R. Kolts, personal communication, 2020).

It also should be stressed that CforC is not seen as a psychotherapy but as a training format and thus is based on: CMT; the emergent work on CMT rather than CFT (since CforC is not

a type of psychotherapy); and as such does not include clinical conceptualisations or interventions. More emphasis is placed on formal (contemplative) practices (including during the sessions), with each session gradually focusing more on the practice than psychoeducation.

It also needs to be noted that CforC is at its early stages and future modifications are likely to be introduced, similarly to the history of other contemplative approaches such as MBSR and CFT/CMT. Therefore, it is important at this early stage to include issues concerning fidelity, incorporating fidelity of implementation.

2.7. Monitoring Fidelity of CforC.

Development of a comprehensive psychological training programme also requires taking into account issues of fidelity and how to measure it. This presents a problem as there is no standardised methodology for measuring fidelity (Waltz et al., 1993; Dusenbury, Brannigan, Falco, & Hansen, 2003). In general terms, fidelity is synonymous with integrity or adherence, and in therapy (or psychological interventions) "adherence refers to the extent to which a therapist uses the specific techniques of a particular therapy approach; and competence is the degree of skilfulness in their delivery" (Dinger, Zilcha-Mano, Dillon, & Barber, 2015, p. 1-2). One way of assessing adherence through self-reports from the people who deliver specific interventions about themes and exercises covered during specific sessions (Dusenbury, Brannigan, Falco, & Hansen, 2003). To be more specific, there are various types of fidelity, for instance, treatment fidelity may deal with the degree to which an intervention maintains its original form (Cohen et al., 2008) or how implementation reflects intentions of its developers (Kimber, Barac, & Barwick, 2019). Yet what is often omitted from research into fidelity is practitioner (trainer) perspectives concerning specific processes which help sustain fidelity resulting in intervention outcomes (Dusenbury, Brannigan, Falco, & Hansen, 2003;

Kimber, Barac, & Barwick, 2019). Fidelity of implementation is another type, which in itself, presents a variety of definitions, as this may refer to (1) strict adherence to specific methods of implementation (confirming theoretical underpinnings), (2) completeness/dosage (amount of programme delivered) of implementation, (3) quality of delivery, (4) participants' level/degree of engagement/responsiveness, or (5) how similar or different a programme is to other similar modalities or what distinguishes it critical features in terms of practices and theory (Dane & Schneider, 1998; Dusenbury, Brannigan, Falco, & Hansen, 2003). In terms of fidelity of implementation, it allows researchers to monitor changes or refinements and how these result in terms of interventions outcomes. Additionally, the practice adds to the information concerning feasibility (the likelihood of specific interventions being delivered with fidelity) (Dusenbury, Brannigan, Falco, & Hansen, 2003). McGrew et al. (1994) also emphasise fidelity which is concerned with determining critical (core) elements of effective programs. The essential elements concerning CforC are described earlier in this current chapter.

Having considered the above issues, the four criteria based on fidelity of implementation were considered when accounting for fidelity in CforC (fidelity of implementation, supervision, and model) in terms of: dose/completeness (e.g. amount of the programme covered; Pentz et al., 1990); quality of delivery (e.g. not only "robotically re-enacting" a curriculum/script but for the methods facilitating interactivity whilst maintaining core functions); programme differentiation and adherence (e.g. themes and practices covered by trainers); and finally, participants' engagement.

Further, it was assumed that in order to deliver good and efficient quality of training, all trainers should have: 1) general clinical skills, 2) ample theoretical understanding of the model, 3) good experience in terms of one's own personal (formal) practice (Wielgosz et al.,

2019). Thus, each of the trainers was asked to describe to the CforC training designer/supervisor the theory for each of the sessions in their own words and the function of each of the practices. This was to demonstrate their understanding of the underlying philosophy, tools, processes, including the core (non-movable) elements of the CforC training.

It is also important to refer to what may be called "fidelity of embodiment" which relates to specific qualities of trainers (e.g. compassion) and which constitutes the most subtle, nuanced, and debatable category (Brandsma, 2017). In terms of the two other trainers, who conducted sessions with the clinical population (cancer patients and survivors), namely Małgorzata Wawrzynkowska and Magdalena Mazurkiewicz, they met the above criteria. Małgorzata (Małgosia) Wawrzynkowska is a qualified psychooncologist and therapist, trained in Rational Behaviour Therapy, Cognitive-Behavioural Therapy, a certified therapist in the Simonton method (for cancer patients and survivors); Małgorzata is also a certified coach and mentor. Magdalena Mazurkiewicz is a psychologist (MA in Social Clinical Psychology, PhD researcher at the PrejudiceLab – Goldsmiths University, London and SWPS University of Social Sciences and Humanities, Warsaw), certified coach (ICT), trained in Process-Oriented Psychotherapy (e.g. with Arnold and Amy Mindell, Max and Ellen Schupbach). She is also a mindfulness teacher (participated in teacher training programmes with teachers from the Oasis Center for Mindfulness at the University of Massachusetts, among them with Jon Kabat-Zinn, Saki Santorelli, Florence Meleo-Meyer). She developed and led mindfulness and compassion workshops and training programmes (for both clinical and non-clinical populations), e.g. at the hospital of the Ministry of the Interior and in multiple business settings. Both Małgorzata and Magdalena have been practicing meditation, contemplative approaches for many years, and together they have over 30 years of professional experience, including both secular and Buddhist practices (e.g. Goenka – vipassana, Tibetan Buddhism).

An evaluation of the first trial (pilot study) of CforC is outlined in Chapter 4. The following chapter, Chapter 3 focuses on methodology, including methods and philosophical underpinnings.

Chapter 3: Methodology: Philosophical Underpinnings of Research and Methods.

3.1. Introduction.

"…All research is interpretive; it is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied"

– Denzin & Lincoln (2005, p. 22)

This chapter focuses on the methodological considerations, including the underlying philosophy of the chosen methodology and specific methods used. The following chapter also explains and argues for the methodological decisions made, including the epistemic issues concerning the studies. Moreover, the following paragraphs outline the research strategy, method, data collections issues, the type of data analysis, ethical underpinnings, and potential limitations. The methodological specifics of each study will be described in the next chapter, whilst the current chapter focuses on general methodological issues across all the studies, including common features of all studies.

This current chapter will first focus on ontological and epistemological considerations, then on the mixed methods approach applied in the studies with clinical populations (with the non-clinical population only qualitative approach was applied), and finally on measurement issues in questionnaire studies, e.g. rationale in terms of choosing and validity of particular questionnaires.

3.1.1. Ontological and Epistemological Perspectives.

"The importance of context, substantive theory, practical resource constraints and opportunities, and political dimensions of social research as equally important bases for practice decisions… It is time to balance the philosophical, conceptual, practical, and political considerations so relevant to our inquiry"

– Greene & Caracelli (2003, p. 108).

As described in the above quotation methodological choices do not appear in a void, determined by philosophical assumptions of ontology or nature of reality (*Weltanschauung*; Checkland & Holwell, 1993) and epistemology, and therefore it is important to describe the main premise of one's research stance (Cameron, 2011). In the current research the main epistemology, i.e. assumptions in terms of how one knows the world, and how knowledge is acquired (Creswell, 2009) or the relationship between the researcher and the researched, applied the approach of pragmatism, which is also in congruence with MMR, described later in the chapter, and which "embraces plurality of methods" (Kaushik & Walsh, 2019, p. 254).

Commonly, in terms of one's epistemological position one can assume the positivistic paradigm of quantitative data being objective, tangible, and fragmentable (Sale et al., 2002; Mentzer & Kahn, 1995) or one that is based on interpretivism which helps "understand a phenomenon but not to explain or predict" (Mentzer & Kahn, 1995, p. 232). A more balanced view therefore combines the two paradigms: one that argues for objectivity; and one for subjectivity. To avoid the risk of provoking bias and invalidating data gathering, analysis, interpretation, and conclusions, in the studies with clinical populations, the researcher (Julia E. Wahl) was not the practitioner/trainer of the CforC intervention but instead two other trainers ran the CforC intervention (training programme).

Based on the assumption of the necessity of incorporating both perspectives of ontology and epistemology, mixed methods were used in the studies with clinical populations, which is in congruence with a balanced philosophical view of subjectivity and objectivity. To further explain, the interpretive approach was needed for the sake of evaluating how promising, feasible and appropriate the intervention was for specific individuals.

3.1.2. Appropriateness of the Research Design: Mixed Methods.

Apart from the pilot study with the non-clinical populations, the studies with the clinical populations employed mixed methods research (MMR). MMR concerns both research design in terms of philosophical underpinnings and methods of inquiry and argues that the combination of quantitative and qualitative approaches facilitates a better understanding than choosing one approach over the other (Creswell & Plano Clark, 2007) and is therefore a more pragmatic approach (Cameron, 2011). In other words, is the antithesis of the 'either or' approach and MMR the "third methodological movement" (Teddlie & Tashakkori, 2010). According to Teddlie and Tashakkori (2010) what distinguishes MMR from other approaches is "the rejection of the either-or at all levels of the research process and subscription to the iterative, cyclical approach to research" (p. 16).

Another way of looking at the rationale behind applying MMR involves the three Ps of paradigms, pragmatics and politics (Brannen, 2005) or the more developed version, the five Ps of, paradigms, pragmatism, praxis, proficiency and publishing (Bazeley, 2003). To be specific, paradigms involve researcher's epistemological, ontological, and methodological perspectives (Denzin & Lincoln, 2008). Moreover, MMR "offers a practical and outcome-orientated method of inquiry that is based on action and leads, iteratively, to further action and the elimination of doubt" (Johnson & Onwuegbuzie, 2004, p. 17).

In the current research, both qualitative and quantitative methods were used. The qualitative being used solely in the pilot study with a non-clinical population (preliminary testing), and both qualitative and quantitative methods were used with the clinical population. The application of MMR stems from the intent and appropriateness of such an approach: small numbers of participants and the need to deepen the exploration of the complex research topic, which are the rationales for conducting MMR (Santos et al., 2017). In terms of qualitative methods, the obvious constraint involves the subjectivity of researchers, including one's personal viewpoint and set of skills that determine the interpretation of data regardless of the chosen strategy in terms of analysis (e.g. thematic analysis). Therefore, by combining the quantitative method with the qualitative method one avoids missing valuable data that might otherwise escape by solely focusing on the one paradigm.

Overall, mixed methods were used for both pragmatic and synergistic reasons. Additionally, other purposes for mixing methods included complementarity which refers to the "development or the use of results from one phase or a study to develop another phase; initiation or the intentional analysis of inconsistent qualitative and quantitative findings to derive new insights; expansion or using multiple components to extend the scope of a study" (Burnett, 2012, p. 77).

In terms of the sequence, first informal interviews were conducted with various professionals and patients, concerning both specific patients' needs (described in Chapter 1) and training specifications in terms of theory and practices (described in Chapter 2 and 5 respectively). Secondly, a literature review was conducted. Based on these strategies, an appropriate curriculum was designed. Ethical considerations also played an important role in the overall design. They are described in the paragraphs below.

3.1.3. Ethical Considerations.

Ethical considerations should come first as the researched area involved sentient beings. Ethics are defined as "a set of concepts and principles that guide us in determining what behaviour helps or harms sentient creatures" (Paul & Elder, 2006, p. 2), *primum non nocere* (first, do no harm) is the obvious starting point, and thus both all potential risks and benefits were considered. For all studies, including the pilot study, informed consent was obtained using forms containing information about procedures, potential benefits and risks involved, possibility of withdrawal from the study, confidentially, debriefing, researcher contact details, researcher's supervisors and their contact details. Additionally, the issues such as project purpose, research purpose, participation selection process, any other discomfort, were explained orally. No deception was involved at any point of the studies, e.g. participants not knowing what type of training in which they were participating in.

Due to the nature of the population (somatopsychological: cancer patients or cancer "survivors", this is described in Chapter 2) it was also important to take into account physical limitations and provide a comfortable and comforting environment by making sure that there were appropriate facilities. These included yoga mats, blankets, chairs and appropriate instructions that followed so any type of rigidity would be avoided in terms of the physical and psychological environment. The issue of equality was also considered, in terms of religion and sexual orientation. It needs to be noted that currently Poland is still a homogeneous country or a country with a script of taboos, and as such issues of cultural differences and sexual orientation did not appear. However, for the future studies and training programmes, and especially if the training programme would take place in countries culturally diversified, this needs to be taken into account in terms of sensitivity, e.g. not assuming one's sexual orientation, religion, cultural background.

All these ethical issues were considered when designing the CforC intervention (training programme). The process of designing an intervention is described in the next section.

3.1.4. Designing an Intervention.

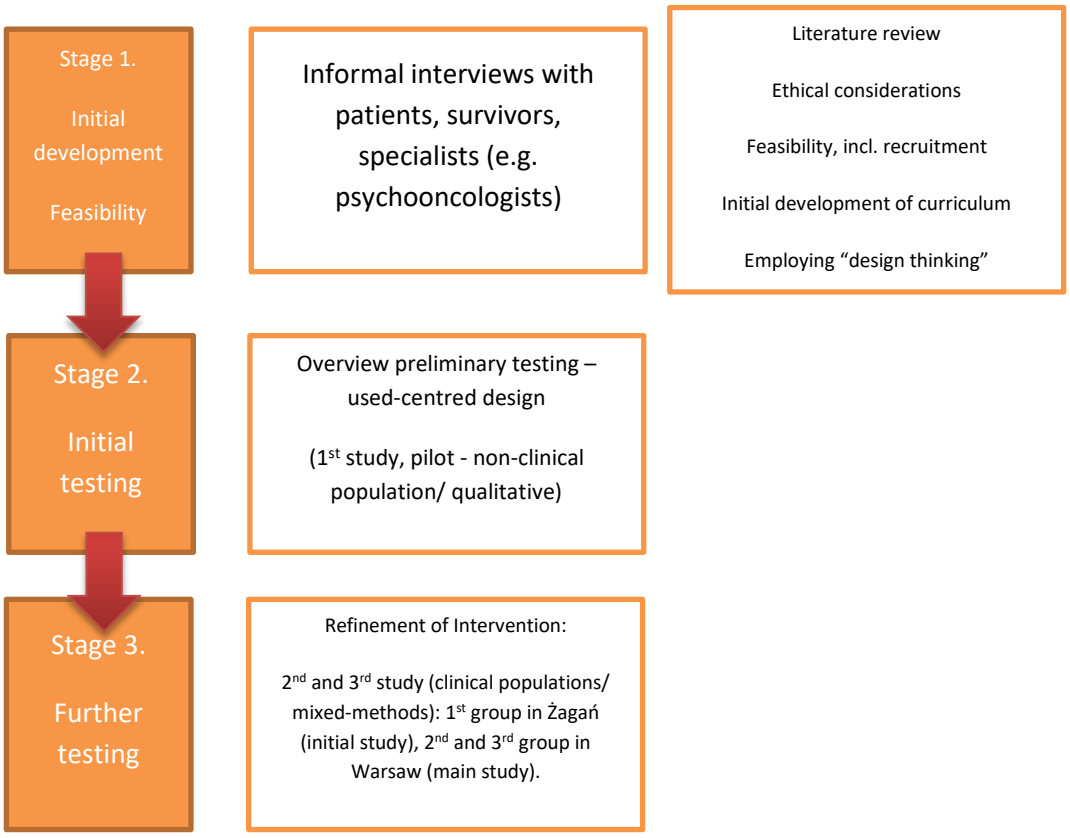
There is a vast array of literature on how to evaluate psychological interventions. Unfortunately, the same does not apply to designing interventions and implementation takes years on many occasions (Wight, Wimbush, Jepson, & Doi, 2015). Therefore, a novel, six-step essential approach called Steps for Quality Intervention Development (6SQuID) (Wight, Wimbush, Jepson, & Doi, 2015) was followed in the design process of CforC: (1) defining and understanding the problem and its causes; (2) clarifying which causal or contextual factors are malleable and have greatest scope for change; (3) identifying how to bring about change: the change mechanism; (4) identifying how to deliver the change mechanism; (5) testing and refining on small scale; (6) collecting sufficient evidence of effectiveness to justify rigorous evaluation/implementation.

The first stage of designing a study included having to consider all essential ethical and feasibility issues, e.g. criteria for inclusion, exclusion, access to recruitment which is described in more detail in the next sections of this chapter (see Figure 4.) which corresponds to step 1, 2, 3 and 4 of 6SQuID (Wight, Wimbush, Jepson, & Doi, 2015). This stage also required the nomothetic and idiographic knowledge to be considered (understanding of the general and particular respectively; Sammut, Foster, Salvatore, & Andrisano-Ruggieri, 2016) based on appropriate literature review as expertise in theoretical underpinnings is crucial in order to develop an intervention (Yeager et al., 2016) and conducting informal conversations with both patients and appropriate specialists (e.g. E. Cassell, personal communication, 2014). Design thinking should also be applied and refers to an approach that is problem-focused (problem-

focused customization), and specifically user-centred design which prioritises one's subjective experience (Yeager et al., 2016). As stated by Yeager et al. (2016) user-friendly design has a "bias towards action" as in the second stage one is learning from users and refining specific "products" which also prevents running inadequate, large, infeasible and costly interventions (Figure 4). This stage corresponds to step 4 (again) and 5 of 6SQuID. Stage 3 concerned applying CforC with clinical populations and refining the interventions and this corresponds to step to 5 (once again) and 6 of 6SQuID.

Figure 4

Flow chart demonstrating specific stages of the research project



Stages (1-3) will be described in the following sections in reference to specific studies, starting with the pilot study, non-clinical population.

3.1.4.1. Recruitment: Inclusion and Exclusion Criteria.

The first trial of CforC focused on a non-clinical, healthy population (non-cancer) to ensure the practices were of practical and ethical value (preliminary testing). The inclusion criteria included physically and mentally healthy females in the UK, between the ages of 30 and 65. For the clinical groups (cancer patients and survivors), the initial inclusion criteria included being mentally healthy cancers' patients and survivors of female breast cancer (stages I-IIIC), between 30 and 65 years of age. The age criteria were considered for the confounding variable (of age-related changes) to be avoided (such as neurological changes). The reason for not including patients with diagnosed psychological issues also were instilled for the sake of confounding variables to be eliminated, and related to the nature of the intervention, i.e. somatopsychological/cancer patients' and survivors' experiences being the main research interest and not those of patients that may otherwise have mental health concern as the main diagnosis. The inclusion criteria were changed due to feasibility issues of not being able to recruit patients from one specific cancer group, e.g. it was decided for the clinical population to be extended to other groups of (type of, not stage of) cancer patients, participants between 28 – 65 years of age, and the studies to be conducted in Poland, after a failed attempt to recruit clinical populations, cancer patients and survivors, in the UK and later set up an NHS-based series of studies. This change allowed to recruit an appropriate number of participants as the worry was that it would be not feasible to recruit enough patients from one type of clinical population, e.g. female cancer group.

The exclusion criteria were: acute depression, organic brain damage, bipolar disorder, PTSD (post-traumatic stress disorder), physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as DID – dissociative identity disorder), anti-social behaviour, suicide risk, LD (learning disability), criteria for PD (personality disorder), and

severe social anxiety. This exclusion was only applicable if the patients received a formal diagnosis of the named conditions, by an appropriate professional. Specific recruitment issues are referred to in the description of specific studies, starting with the pilot study (non-clinical population).

3.2. Pilot Study: Non-Clinical Population.

3.2.1. Participants.

No previous experience of mindfulness and/or compassion practices was required from any of the participants, within all the studies). Participants in the pilot with a non-clinical population (initial testing) were recruited by email from university staff mailing and people interested in compassion (via the Compassionate Mind Foundation), as well as face-to-face from free practice mindfulness evenings. Prior to being recruited, all participants completed a registration form to evaluate mental and physical health. Based on this evaluation they were excluded, as discussed above, if they had any of the following conditions: acute depression, organic brain damage, post-traumatic stress disorder, physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as dissociative identity disorder), already receiving therapy, anti-social behaviour, suicide risk, learning disability, personality disorder, and/or severe social anxiety. These criteria were dictated by the need to exclude other psychological issues to obliterate the research results. Specific group demographics are described in Chapter 4 (pilot study) and Chapter 6 (initial and main study combined).

3.2.2. Procedure.

Each session lasted 2-2.5 hours (by convention of the predominant training model for contemplative approaches), was dedicated to a different theme and was comprised of various

contemplative practices, followed by discussion. A break for coffee/tea was also included. All sessions in the pilot study were conducted by Julia E. Wahl, a qualified psychologist and a mindfulness/compassion teacher with many years of experience; practising contemplative practices since 2001 and professionally/clinically since 2009.

After each session, participants were asked to evaluate the session, i.e. most beneficial practices, changes to the exercises, structure, theme, and/or what was missing (see Table 8). They were also asked to evaluate the overall training programme after the completion of the whole training programme (i.e. gains, initial intentions, challenging aspects, aspects to be used in daily life, improvements to be made and additional issues), similarly to the pilot study. At the end of the programme participants from all three groups were also invited to a focus group.

Table 8 – Evaluation questions.

(WRITTEN FORM – W1) AFTER EACH SESSION
Which exercise was the most beneficial for you and why?
Would you change anything about the exercises? Why and what?
Would you change anything in terms of the structure of this session? Why and what?
What do you think about the theme of this session?
Was there anything missing for you during this session? If yes, please explain what it was.
(WRITTEN FORM – W2) AFTER THE WHOLE TRAINING
What brought you to this training? What were your expectations of it? Why have you stayed?

Tell me about what you thought of the overall presentation of the course? Things like the length, the format, the facilitation, and the materials.

Is there anything else that you think could be improved for future courses? Any expectations that you had that weren't met? What would you see as the ideal course?

How important has this course been to you and why?

What have you gained from the course?

What aspects of the overall course did you specially enjoy?

What aspects do you think you will take into your everyday life?

What aspects challenged you (if any)?

Anything else you would like us to know?

3.3. Initial and Main Study with Clinical Populations (Cancer Patients and Survivors).

3.3.1. Participants and Recruitment.

Three groups participated in the training, one in the city of Żagań (initial study), in the Lubusz Voivodeship, Poland and the other two in Warsaw (main study), the capital of Poland. Both cancer patients and survivors were included in the study, including all types of cancer in stages I-III. The inclusion criteria were the same as in the previous, non-clinical training group, described earlier in this chapter, (mentally healthy patients). Similarly, no previous experience of meditation, mindfulness and/or compassion practices/training was required. The group in Żagań was recruited through a private psychotherapy clinic, and the two groups in Warsaw via Facebook posts, colleagues (word of mouth), private email databases, organisations for cancer patients and survivors. Also, similar to the non-clinical group, all participants completed a registration form to evaluate their mental and physical health.

Ultimately, 33 participants were included in the training programme (comprising 32 female and one male participant). The groups comprised 14 in the first group (Żagań), 9 in the second (Warsaw I), and 10 in the third (Warsaw II). The average age was 48.5 years. Amongst the main reasons for participating were: coping with stress, coping with illness, coping with pain and physical limitations, coping with emotional lability, looking after oneself and one's needs, being more compassionate towards yourself and others, gaining internal balance. Specific groups' demographics are presented in Chapter 6.

3.3.2. Procedure and Instrumentation.

The participants of the CforC training programme were asked to fill in the seven questionnaires, described later in the chapter, before the start of the first session, after the last (eighth) session and two months after the last session (two-month follow-up). Additionally, the participants were asked to fill in an evaluation form after each session, and after completion of the whole training, these were described within the pilot study section, and finally participate in a focus group.

Based on the curriculum creator's reflections and experiences, which include running over one hundred compassion groups, retreats, workshops and evaluating the pilot study, subtle yet important changes were made. These included adding additional practices: compassionate body scan (with compassionate focus), the practice of *tong-len* for oneself and others (described in the previous chapter), additional movement exercises focused on evoking compassion, compassionate self-touch, practices of gratitude and evoking common humanity (described in detail Chapter 5). The usefulness of these practices will be described in thematic analysis of the data collected, and practice specifications described in Chapter 5.

Similarly to the pilot study, each session lasted 2-2.5 hours. The same order was followed as with the non-clinical group with each session being dedicated to different themes, various practices (at times repeated) and discussion time. This was followed by participants being asked to evaluate the session. For the sake of triangulation all sessions were conducted by two independent trainers, with adequate professional backgrounds, in two different cities: Małgorzata Wawrzynkowska, a qualified psychooncologist and Simonton therapist (in Żagań), and Magdalena Mazurkiewicz, a qualified psychologist and mindfulness teacher (in Warsaw).

In the studies with the clinical populations (cancer patients and survivors) the survey included demographic information on the age, occupation, type of illness and treatment, previous experiences in contemplative practices. Seven questionnaires were employed and analysed to further explore the benefits of CforC in dimensions of mindfulness, emotion regulation, attachment, perceived stress, post-traumatic growth, satisfaction in life, and meaning of life.

A thematic analysis was once again used in order to look at what compassion practices meant to participants, how they engaged with various practices, why they participated in the training programme, and what they perceived to be the benefits of the practice itself and its processes (based on focus groups and open-ended questions). Thematic analysis was used as it independent of theory and epistemology and is compatible with both essentialist and constructionist paradigms in psychology (Braun & Clarke, 2006). Moreover, its advantages include flexibility, accessibility to researchers with little experience of qualitative research, allows for participants to be collaborators, and finally, is a method easy to learn and follow (Braun & Clarke, 2006).

A set of seven questionnaires was employed as a quantitative measure (described in detail later in the chapter) to assess differences before and after the 8-week training course, and in the 2-month follow-up, in the following dimensions: perceived stress; post-traumatic growth; mindfulness; meaning of life; satisfaction in life; attachment and emotion regulation. This quantitative analysis will be described in the next paragraphs.

Additionally, the two trainers (Małgorzata Wawrzynkowska and Magdalena Mazurkiewicz) were asked to answer a set of questions concerning their experience, intentions (see Table 9) based on the work by Frances Maratos on CMT in schools (F. Maratos, personal communication, 2018). This is very important also in terms of seeing of how the training course may affect the trainers themselves and how they evaluate the processes and practices of CforC. The experiences of the two trainers are described in Chapter 7.

In the current training programme, it is important to mention that the two trainers had previous experience in both practising and teaching contemplative approaches, and a therapeutic experience, e.g. appropriate psychotherapeutic training, having worked with various clinical groups of patients, including cancer patients. The trainer received appropriate training and supervision by the CforC creator (Julia E. Wahl). This included supervision on a weekly basis during the course of the 8-week training courses to explain further the themes, concepts and practices occurring in each weekly basis, and to discuss participants' experiences. The fidelity was tested by going through the checklist of core practices, topics and weekly post-class explorations, i.e. confirming that all essential practices and topics were covered. A detailed description concerning fidelity is included in Chapter 2 and once again referred to in Chapter 7.

Table 9. Evaluation questions for trainers.

- **Experiences in terms of running contemplative training courses (contemplation, meditation or similar):**
- **What was your intention as to running the training course, in terms of yourself and others?**
- **What have you observed in terms of the group? What do you think the participants gained from the meetings? What challenges do you think they were faced with during the training course? (if there were such)**
- **What challenges directly connected with the training course have you experienced?**
- **What have you personally gained from the training course?**
- **Which practice was the important to you, and why?**
- **Which session/theme/topic has been the most important to you, and why?**
- **What other groups/populations do you think may benefit from this kind of training (apart from the oncological population)?**
- **Is there anything you would like to change in the training course, and if so – why?**
- **What advice/suggestions would you give to other trainers?**
- **Is there anything else you'd like to add? What other question would be important to ask? (if there is such a question, please write down your answer as well).**

Further, similarly to the pilot study, qualitative methods included open-ended questionnaires which were used after each session as described earlier in this chapter. Further, three focus groups were conducted two months after the last session, for each of the groups, and the content of both open-ended questionnaires and focus groups was analysed using thematic analysis. The process of thematic analysis is described in Chapter 2 and is understood as a "rigorous thematic approach which can produce an insightful analysis that answers particular research questions" (Braun & Clarke, 2006, p. 97). The data has been analysed by hand and by using Atlas.ti 8 software, a computer program used predominantly in qualitative research or qualitative data analysis, on both the original Polish version of transcription and the English

translation. All names have been changed to maintain anonymity regarding the focus group interviewees.

The audio recordings of the focus groups of all the respondents were listened to a number of times for accuracy. The translation and transcription of all the focus groups were translated from the Polish into English by the researcher. The first part of the translation focused more on the semantics rather than verbatim translation or any linguistic considerations. The oTranscribe (online) software was used to transcribe all recorded content from the three focus groups.

Only questionnaires that had their Polish version adapted and normalised and which had appropriate descriptions of conceptual rationale, were used. Accordingly, the Self-Compassion Scale (SCS) was not used as it had an erroneous conceptual description in Polish (e.g. confusing Kabat-Zinn's conceptualisation with the one described by Langer) along with no access to the manual for analysis. All of the questionnaires used are described below to test each of the hypotheses as described in Chapter 1.

Concerning research problem I. – MAAS.

Participants in compassion-based training (study group) will be characterised by increased frequency of mindful states on a daily basis after the training and in the follow-up.

The Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) is a 15-item scale that can measure the frequency of mindful states on a daily basis (general and situation-specific statements) and is designed to assess a core characteristic of dispositional mindfulness, namely, open or receptive awareness of and attention to what is taking place in the present. Psychometric properties: factor analyses with undergraduate, community and

nationally sampled adult, and adult cancer populations have confirmed a single factor scale structure (Brown & Ryan, 2003; Carlson & Brown, 2005). Internal consistency levels (Cronbach's alphas) generally range from 0.80 to 0.90. The MAAS has demonstrated high test-retest reliability, discriminant and convergent validity, known-groups validity, and criterion validity.

It was incorporated in the study to explore the possibility of compassion training increasing the frequency of mindful states on a daily basis. Mindfulness is one of the fundamental tools to self-regulate oneself in terms of difficult emotions (such as sadness, anxiety, anger). The version used (Polish version; *Skala Świadomej Obecności)* was adapted by Radoń (2014). Radoń reports Cronbach's alpha of 0.81- 0.85.

Concerning research problem II. – PSS.

Participants in compassion-based training (study group) will be characterised by decreased perceived levels of stress after the training and in the follow-up.

The Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983) is a 10-item scale which was designed to assess the degree to which people perceive their lives as stressful. Cronbach's alpha of the PSS-10 was evaluated at > 0.70 in all 12 studies in which it was used, the test-retest reliability of the PSS-10 was assessed in four studies and met the criterion of > 0.70 in all cases (Lee, E-H., 2012). It was incorporated in the study to see whether compassion-based interventions were able to lower levels of stress. The version used (Polish version; *Skala Odczuwanego Stresu)* was adapted by Ogińska-Bulik and Juczyński (2009); they report Cronbach's alpha of 0.86.

Concerning research problem III. – SWLS.

Participants in compassion-based training (study group) will be characterised by higher levels of life satisfaction stress after the training and in the follow-up.

The Satisfaction with Life Scale *(SWLS)* (Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S., 1985) is a 5-item instrument. It can measures global cognitive judgments of satisfaction with one's life. The scale does not assess satisfaction with specific life domains, such as health or finances, rather it allows subjects to integrate and weigh these domains in whatever way they choose. Internal consistency level (Cronbach's alpha) = 0.89. This was incorporated in the study to assess satisfaction with people's lives as a whole and usually requires only about one minute of a respondent's time. It determines whether practising self-compassion and compassion improves one's satisfaction in life. The version used (Polish version; *Skala Satysfakcji z Życia)* was adapted by Juczyński (2001): it reports a Cronbach's alpha of 0.81.

Concerning research problem IV. – MLQ.

Participants in compassion-based training (study group) will be characterised by a better sense of meaning in life in two dimensions, presence of meaning and search for meaning, after the training and in the follow-up.

The Meaning in Life Questionnaire (MLQ) (Steger, M.F., Frazier, P., Oishi, S., Kaler, M., 2006) is a 10-item questionnaire designed to measure two dimensions of meaning in life: (1) Presence of Meaning (how much respondents feel their lives have meaning), and (2) Search for Meaning (how much respondents strive to find meaning and understanding in their lives). Cronbach's alpha value for this questionnaire = 0.88. It was used in the current study to determine whether practising self-compassion and compassion can affect one's perspective on the meaning of life. There are two subscales: Presence and Search. Presence is positively

related to well-being, intrinsic religiosity, extraversion and agreeableness, and negatively related to anxiety and depression. Search is positively related to religious quest, rumination, past-negative and present-fatalistic time perspectives, negative affect, depression, and neuroticism, and negatively related to future time perspective, close-mindedness (dogmatism), and well-being. Presence relates as expected with personal growth self-appraisals, and altruistic and spiritual behaviours. The version used (Polish version; no Polish title given) was adapted by Kossakowska, Kwiatek and Stefaniak (2013): they report Cronbach's alphas of (MLQ-P subscale) 0.86, and (MLQ-S subscale) 0.87.

Concerning research problem V. – ERQ.

Participants in compassion-based training (study group) will be characterised by a better emotional regulation in two dimensions (cognitive reappraisal and expressive suppression) after the training and in the follow-up.

Emotion Regulation Questionnaire (ERQ) (Gross & John, 2003) is a 10-item scale designed to measure respondents' tendency to regulate their emotions in two ways: cognitive reappraisal and expressive suppression. Cronbach's alpha for reappraisal was 0.79; for suppression it was 0.73 (Gross & John, 2003). It was utilised to see whether compassion-based interventions help in terms of regulating emotions better. The version used in the current study (Polish version; *Kwestionariusz Regulacji Emocji)* was adapted (but not normalised) by Kobylińska (2015).

Concerning research problem VI. – RAAS.

Participants in compassion-based training (study group) will be characterised by higher levels of being comfortable with closeness, feel they can depend on others, and are less anxious or

fearful about such things as being abandoned or unloved, after the training and in the follow-up.

The Revised Adult Attachment Scale (R-AAS; Collins, 1996) is a measure of adult attachment based on the AAS (Collins & Read, 1990), which assesses close interpersonal relationships and is measured using a 5-point Likert scale. It consists of 18 items. The internal consistency of the subscales has been evidenced using clinical and non-clinical samples with Cronbach alphas of 0.77 for closeness, 0.78 for dependency, and 0.85 for anxiety (Collins, 1996; Eng, Heimberg, Hart, Schneier, & Liebowitz, 2001).

It was incorporated to see whether compassion-based interventions help the individual to be comfortable with closeness, feel they can depend on others, and are less anxious or fearful about such things as being abandoned or unloved. The version used in the current study (Polish version; *Zrewidowana Skala Przywiązania u Dorosłych)* was adapted by Adamczyk (2012). Exploratory and confirmatory factor analyses confirmed the factor structure of the original English-language RAAS, for all the subscales translated into Polish: Close; Depend; and Anxiety. All three subscales showed good internal consistency. Cronbach's alpha for the three subscales were 0.75 (Close), 0.76 (Depend), and 0.86 (Anxiety).

Concerning research problem VII. – PTGI.

Participants in the compassion-based training (study group) will be characterised by higher levels of the ability to be successful in reconstructing or strengthening their perception of self, others, and the meaning of events, after the training and in the follow-up.

The Post-Traumatic Growth Inventory (PTGI; Tedeschi & Callhoun, 1996) is a 21-item scale which has utility in determining how successful an individual is in reconstructing or

strengthening their perception of self, others, and the meaning of events. It has an internal consistency (Cronbach's α) 0.96, and item-total correlations range from 0.59 to 0.82 (Bonsu et al., 2012). It was incorporated in the current study to see whether compassion-based interventions help the individual grow in the face of difficulty. The version used (Polish version; *Inwentarz Potraumatycznego Rozwoju*) was adapted by Ogińska-Bulik and Juczyński (2010). The Polish version of the PTGI has obtained satisfactory psychometric properties. They report Cronbach's alpha coefficient was 0.93, internal stability (assessed by test–retest) 0.74.

3.3.2.1. Evaluation of Instrumentation: Questionnaires and Scales.

"*From a critical point of view, the many statistically significant results of natural-scientific psychology have ambiguous theoretical meanings because they are based on the proliferation of incompatible theories and research programs operating with different models of the human being and different research practices*"

– Thomas Teo (2005, p. 34)

When evaluating self-report measures such as questionnaires and scales, one needs to look at two aspects, its psychometric qualities (reliability and validity) and conceptual (theoretical) underpinnings. Here, the focus will be on the latter as the former has been extensively studied elsewhere: MAAS (Van Dam, Earlywine, & Borders, 2010), MLQ (Steger et al., 2006) , ERQ (Ioannidis & Siegling, 2015), RAAS (Collins, 1996), PTGI (Osei-Bonsu et al., 2012) , PSS (Cohen, 1986; Taylor, 2015), and SWLS (Pavot & Diener, 1993). Additionally, as described by Teo (2005) one needs to be critical of the measures used and not approach them as the absolute truth.

To begin with, the major criticisms can be referred to MAAS. There exists evidence of MAAS (Brown & Ryan, 2003) being criticised, for instance according to Bergomi, Tschacher and Kupper (2013), MAAS measures mindfulness rather narrowly focusing on the attention component. It is also a one-dimensional measure, previously comprised of a presence and an acceptance factor. The acceptance factor did not result in an "explanatory advantage over that shown by the presence factor alone" (Brown & Ryan 2004, p. 244) and it was concluded that it was already functionally present in the concept of mindfulness. However, according to the critique by Bergomi, Tschacher and Kupper (2013), this was challenged by the validation study of the Philadelphia Mindfulness Scale in which there the explanatory importance of the acceptance factor associated with well-being was revealed and found in the general awareness component. There are even authors who go further in describing MAAS not to be a measure of mindfulness but a completely different phenomenon like an agitated lack of attentiveness (Grossman, 2008), everyday attention lapses (Carriere et al. , 2008), or automatic pilot and its effects (Williams, 2010).

The MLQ has also been criticised for its lack of context. It is not clear what kind of meaning is being implied in the questionnaire, whether this meaning may be associated with pleasure, success or something transcendental (Wong, 2014). Additionally, if one does not search for meaning this may be due to various factors as indicated by Schnell (2009) and Wong (2012c, 2014): indifference or the fact that the meaning has already been found, or that it is associated with something different from the examples given in the MLQ.

The major criticism of all scales and measures is to do with their validity in real life; in response to real situations rather than just the imagined ones (Kever, Pollatos, Vermeulen, & Grynberg, 2015). Another issue is to do with generalisability, as most scales have been

developed based on a specific and limited populations, in many cases these do not include somatic populations such as cancer patients and survivors.

Such criticism once again proves that MMR is an appropriate approach as it eliminates any bias inducted by either solely conducting quantitative or qualitative research. In spite of these concerns it can be concluded that there is value of CforC being delivered to cancer patients and survivors based on the quantitative data referring to the dimensions of mindful states, stress, satisfaction, emotion regulation, post-traumatic growth, satisfaction, and meaning. All of the changes and processes are discussed in Chapter 5 and the presentation of results concerning the clinical groups in Chapter 6.

3.3. Summary.

In the current chapter the ontological and epistemological perspectives have been described in reference to mixed-methods and its rationale. The pragmatism and comprehensiveness of the MMR was also discussed and defended. Ethical considerations have been reviewed and the specifications of designing and running a novel approach discussed, including various stages of the research project.

Furthermore, the general methodological issues across all the studies, including common features of all studies have been described including issues of recruitment, inclusion and exclusion criteria, procedure, instrumentation (questionnaires) in reference to appropriate research problems. Results concerning both non-clinical populations will be presented in Chapter 4 and 6 respectively.

Chapter 4. Results: Pilot Study.

In the previous chapter methodology and methods were described. In the current chapter I will present results based on the thematic analysis concerning the pilot study with a non-clinical population, starting with the description of participants.

4.1. Participants.

Eleven female participants were recruited in the UK; two did not start due to personal reasons. Nine participants attended the first session, and five participants remained on the course until week 8 (see Table 10). Participants attended two (25%) to eight (100%) sessions. Reasons for attrition and non-attendance included lack of time to practice, ill health or family issues.

Table 10 – Information on Participants.

Participants (pseudonyms)[1]	Age	Employment	Number of sessions attended
1. Ann	53	Lecturer	2
2. Hannah	43	Lecturer	2
3. Eve	58	Lecturer	3
4. Fiona	38	Homemaker	7
5. Stacey	55	Lecturer	3
6. Alison	57	Mental Health Recovery Worker	7
7. Liz	31	Mental Health Nurse,	8
8. Sarah	35	Social Worker	6
9. Kate	51	Support Practitioner	7

4.2. Data Analysis Overview.

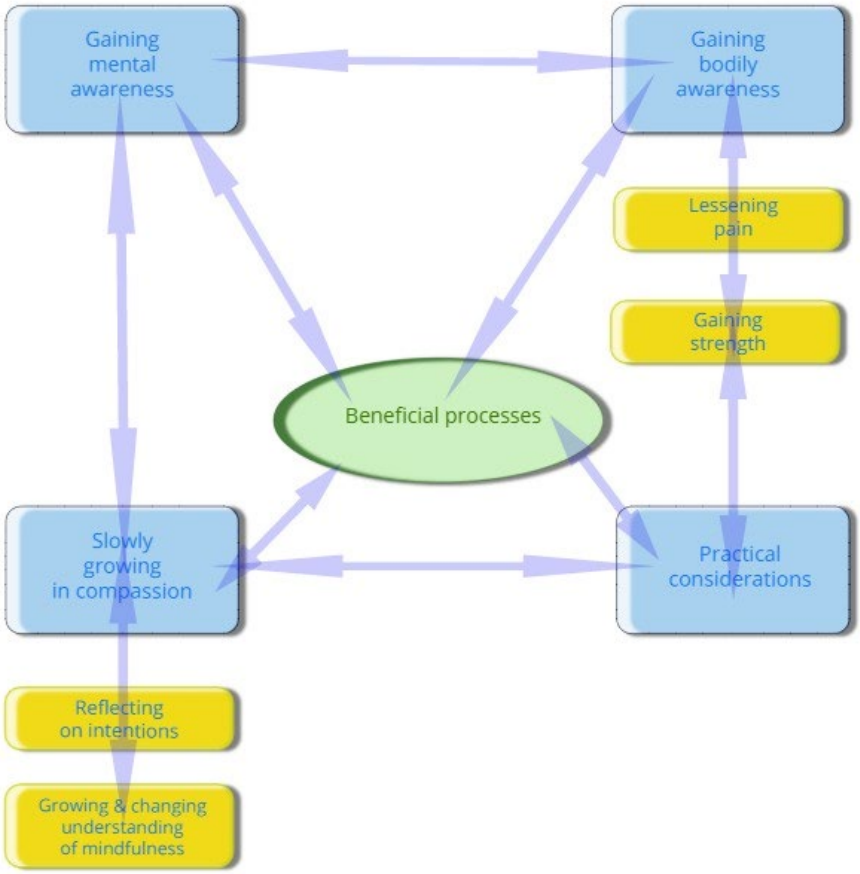
The analysis was based on participants' written evaluation after each session (W1), written evaluation after the whole training (W2) (see Table 8) and focus group (F) contributions at the end of the programme (focus group questions were based on the W1 and W2 feedback). The questions included in the evaluation sheets (Table 8 in previous chapter) were based on the recommendations from the official MBSR teachers' training curriculum. Thematic analysis was used to identify recurrent themes (patterns of meaning) in the data due to it pragmatics and flexibility (Braun & Clarke, 2006). This analysis was employed collectively across questions from both forms and the focus group (five participants out of eleven took part), rather than for each open-ended question/form individually. All phases of analysis have been followed: familiarising with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the results (Braun & Clarke, 2006). Engaging with epistemological issues about the status of the data was avoided and the purpose kept simply to identifying the key themes (patterns); i.e. to understand participants' experiences of the pilot programme.

Based on the thematic analysis, four themes (see Figure 5.) were identified as (1) "gaining mental awareness", (2) "gaining bodily awareness" (which included two sub-themes: "lessening pain" and "gaining strength"), (3) "slowly growing in compassion" (which again included two sub-themes: "reflecting on intentions" and "growing and changing understanding of mindfulness"), and (4) "practical considerations". These themes focused on the participants' experiences and training process. The first three themes have been described by classifying meditative practices into three groups that have different cognitive mechanisms: attentional mechanisms (attention regulation and meta-awareness), constructive mechanisms

(perspective taking and reappraisal) and deconstructive mechanisms (self-inquiry; Dahl, Lutz, & Davidson, 2016).

Figure 5

Thematic map: beneficial processes.



4.3. Beneficial Processes.

Theme 1: Gaining mental awareness.

This theme signified gaining insight (as an ongoing process) into, and stabilising or self-regulating, one's feelings, emotions and thoughts; this was the first objective of the course. It

also illustrated two types of intentions for participating in the programme: Working with difficult thoughts/emotions, and the promise of learning about mindfulness.

The first intention referred to the ability to cope with emotions and thoughts better, therefore being better at self-regulating, and becoming more mentally and emotionally resilient:

> *"…in regards where I was emotionally, these spiralling emotions and thoughts. And emotions that I wasn't able to kind of get a hold on. So, my main drive was that I was aware that my thoughts and feelings were spiralling out of control and decided to do something about it to help me"* (Sarah – F).

This theme also dealt with issues such as participants being able to understand their feelings:

> *"The feelings one helped me see how they can all mix up, feel the same"* (Kate – W1).

This understanding is crucial, since in order to generate supportive emotions, one first needs to learn about and be able to regulate emotions, especially the difficult ones (Folkman & Lazarus, 1985).

Another lesson derived from the pilot, and what this specific theme describes, concerns the losses that participants may experience due to cancer (supporting previous findings). The healthy participants may have perceived various losses due to their condition and circumstances; although resources, skills, or identities might at times cover up for them. Before one can gain new resources and/or a new identity, it is important to first establish what has been lost (E. Cassell, personal communication, 2015); this includes understanding one's difficult emotions and this aspect should be emphasized in future training programmes. Importantly, this suggests the need to recommend introducing new concepts and techniques slowly, to help participants work on deeper levels of emotional difficulties.

Theme 2: Gaining bodily awareness.

This theme referred to the general insight into one's physical processes or bodily experiences, the way one related to these experiences (e.g. pain) and the body itself. It aligned with another objective for the course, regulating the physical aspect of oneself, including pain symptoms. Based on the focus group feedback, it was noted how important body-oriented practices (i.e. bodywork, movement) were:

> *"Would be interested in mindfulness with a bit of an exercise. Because I like the body work*" – (Sarah – F).

When considering future courses with patients with cancer, the development of bodily awareness may be particularly important, as women with breast cancer can have even significant body-related issues due to their illness, treatment and the symptoms that follow (Rosenbaum & Kabat-Zinn, 2012). Therefore, it is advisable that any specific curriculum employs more body-oriented practices and repeats these throughout the course of the training, to help patients gain bodily awareness in helping them lessen symptoms of pain and gain strength, i.e., groundedness in the body.

a) *Lessening pain and suffering.*

This sub-theme described the slow learning process of accepting one's bodily condition, physicality, and the ability to change the way one approaches their pain. The feedback from participants indicated that through working with pain on a mental level, one can change how physical pain is being experienced. Pain was a personal and important topic for this non-clinical population, which highlighted the aspect of common humanity of all humans experiencing some kind of physical or mental suffering:

> *"Looking at pain. Was surprised by what came up"* (Kate – W1).

"Pain/suffering – related to current situation well" (Ann – W1).

This topic is also of great importance to cancer patients, who often report difficulties with physical and emotional burdens of pain (Cassell, 2004). In Western culture pain is still often to be avoided, glorified or ignored all together, regardless of the number of publications and statements that say otherwise (Post, Blustein, Gordon, & Dubler, 1996; Quintner et al., 2010). This attitude may stem from the still predominant Cartesian mind-body dualism (Krippner, 2017; Van Oudenhove & Cuypers, 2014). This attitude does not support patients to be with pain and the whole body in a way that would be helpful. This also illustrates the difference between pain and suffering, as it is stated in the old saying: "*pain is inevitable, suffering is optional*" (source unknown). Within the course one aim was therefore to lessen the mental pain (suffering) and for individuals to be able to gain a new perspective, as demonstrated by Fiona:

"Interesting to focus on pain and suffering without the pain and suffering" (Fiona – W1).

b) *Discovering strength.*

This sub-theme related to the ability to find groundedness and a new identity through basic body exercises that focused on finding strength in the body, e.g.:

"Body awareness/strength exercises. Coming back to myself – my identity" (Sarah – W1),

"The power + strength one. I felt different about my body, more accepting" (Alison – W1).

Focusing on the body in a new way can strengthen our sense of self, and harmonise both the body and mind:

"Strengthening exercises – better posture, more resolved mind" (Hannah – W1),

"The standing meditation. It was interesting to experience meditation not sitting. I found I felt more grounded and felt it more in the body" (Fiona – W1)

When considering this theme, in order to be open to pain (whether it is physical, emotional and/or relational), and experience it fully, participants find additional resources to be with pain. As a result, specific exercises have been incorporated into the curriculum (which will be described in Chapter 5).

The "discovering strength" sub-theme also highlights a critical issue for future courses that are aimed at patients with cancer. This includes the ability to be in pain and discover one's strength in the midst of it. This alludes to one of the rationales for developing this particular training programme; although other contemplative modalities have been successful in introducing positive changes to the lives of cancer patients in terms of their coping skills, symptom management and immune system boost (Carlson & Speca, 2010), they lack the explicit soothing and relational quality of compassion (Gilbert, 2009). They also do not explicitly use suffering as a means to inspire post-traumatic growth, or only do so implicitly (Hanley, Peterson, Canto, & Garland, 2015). However, any form of suffering can teach us to be more resilient and more connected to ourselves, to other people and to what is of essential importance, in what often seems to be a completely alienating experience. To paraphrase Davies (2012), suffering is not necessarily a medical problem but is what makes us human and can help us in our development as humans.

Theme 3: Slowly growing in compassion.

This theme covered the aspects of compassion and its processes. It was composed of two sub-themes: "reflecting on intentions" and "growing and changing understanding of mindfulness".

It was the most important, comprehensive, and prevalent theme. It included reflecting upon one's intentions of well-being (e.g. what kind of well-being do I want to develop and focus on for myself; what does it mean to care well for oneself and others); learning to mentally and physiologically slow down; and becoming more compassionate towards oneself and others.

Many participants found the concept of compassion difficult to conceptualise without adequate training and experience:

"Difficult to conceptually understand what compassion was" (Sarah – W1).

This also draws to the fact that compassion is a skill that requires much effort and courage:

"Compassion is not easy" (Fiona – W1).

And is clearly seen as a much-needed resource:

"...feelings of compassion in myself..., would like to do more on compassion to self." (Fiona – W1).

Over the 8 weeks of the course, participants were able to experience their intentions of well-being:

"A sense of calm of endings. More mindful of the world, people, myself" (Kate – W1),

Participants were able to come to terms with life events that relate to the idea that compassion is a tool that helps people face various adverse situations:

> *"I feel I have gained a renewed ability to be compassionate towards myself + others, and this helps deal with difficult aspects of my life"* (Fiona – W2), *"Perspective, skills, resources*" (Sarah – W). *"Felt like I could end things. Wish people well"* (Kate – W1).

Yet compassion-based training not only aims to alleviate difficult thoughts, emotions and teach participants to cope with physical difficulties (regulation of difficult mental states), it also focuses on the cultivation of positive emotions of contentment, soothing and safeness or in other words, generating positive mental states (Gilbert, 2010a):

"Feeling of letting go some difficult past experiences. Relaxation. A tool to allow me to feel in control" (a34 – W1),

"Finding safeness within oneself. The compassionate self – very moving, safe place" (Alison – W1).

Compassion is the helpful and wise proximity, what can be called optimal closeness, with the feelings of others or oneself. It is when we do not avoid the pain (whether physical or emotional), and at the same time kindly and actively respond to whatever suffering arises (Neff & Pommier, 2013). This helps create a safe emotional space within oneself. Thus, one can use it as a resource for all appropriate situations (including difficult ones). Working with or on compassion starts with reflecting on intentions; the issues, the values that one wants to focus on in life, and thus activating motivation that ultimately changes behavioural, mental, and affective responses (Jinpa, 2015).

a) Reflecting on intentions.

Focusing on intentions of well-being was a useful reminder of what participants were doing on the course in the first place. For example, what their needs were, their future hopes and what they wanted to cultivate:

"Found it helpful to be asked to look at intention" (Alison – W1).

It also allowed participants to get back on the right track if doubt or simple forgetfulness occurs, and was a reminder that the compassion practice not only aims to self-regulate and self-explore (as is the case of mindfulness) (Kabat-Zinn, 1996), but also helps to generate positive feelings of safeness, connectedness, contentment, and soothing that set the scene for feeling, thinking and acting compassionately.

b) Growing and changing understanding of mindfulness.

This subtheme concerns the way mindfulness is understood from the perspective of compassion practice. One of the issues that arose during the course was the difference between mindfulness and compassion approaches. Both emphasise metacognitive awareness (also known as *decentring, cognitive distancing, diffusion* in cognitive-behavioural therapy terms; or *observing self* , using the psychoanalytic term) (Keng, Smoski, & Robins, 2011). They also incorporate elements of both loving kindness and compassion approaches and exercises. In CforC kindness and compassion are the qualities expressed as being with difficulties, the way one behaves, holds their bodies, speaks (tone of voice) and the actions (or lack of actions) one chooses to take when faced with difficulties.

These are implicit in mindfulness-based interventions and explicit in compassion-based interventions (Germer & Neff, 2013). Thus, mindfulness is seen as a foundational skill for the practices of compassion as it helps participants learn to focus, slow down (enabling access to the soothing system), cope with internal turmoil, and see where one can emotionally place themselves:

> *"Emptying my mind just being rather than rushing on to the next thing"* (Stacey – W1),
>
> *"It has made me think about the things I pay attention to and the things I don't, and whether that should change"* (Liz – F).

Based on the feedback received from participants, the distinction between different emotion regulation tools was clear and appreciated, *i.e.* attention, mindfulness and the three flows of compassion:

> *"Liked the link drawn between awareness, mindfulness and compassion"* (Alison – W1).

The understanding between various tools is even more crucial when one is faced with distress beyond everyday stressors.

Theme 4: Practical considerations.

This last theme included issues such as the setting for the course, format of practices, home assignments, order of exercises, session themes, and therapeutic alliance. The first practical issue referred to the training setting and had a significant role in the delivery of the training programme. A university environment, when one sits in a class (e.g. classroom and the ethos of academia), can not only affect participants' psyche but can also result in physical discomfort. For example, the chairs were not comfortable and there was not enough space. A warm and casual setting for the training would be a better option for future training programmes:

> *"…Yes, somewhere where, what I would call, a little bit more casual. Less formal"* (Kate – F).

There were also two areas of practice difficulties, home assignments and systematic practice:

> *"…the frustration in myself not finding the time to do the home practices. So really, you're asking me to find 10 minutes. 2.5 hr and I can't find it"* (Sarah – F),

For the purpose of better cultivation and learning, there should be more written practices (as is the case in mindfulness-based cognitive therapy):

> *"So that after every couple of exercises to have just five minutes where you write your own thoughts because that helps me"* (Alison - F).

There were only two comments about the order of specific exercises:

> *"I would do the pain meditation earlier in the session. More able to focus"* (Alison– W1)

"Found it difficult to focus on a strength after completing the pain/suffering task" (Eve – W1)

These illustrated the importance of first establishing a secure physical and emotional base before embarking on working with difficult sensations, thoughts and emotions.

Participants' feedback also suggested that participants would not change things in terms of the structure and pace of sessions. The chosen weekly topics were reported to be helpful and the step by step approach was appreciated:

"the pace + content was good" (Ann – W1)

"session seemed to pass quickly" (Liz – W1)

In terms of the order of particular themes, whilst for participants the content was suitable, it was noted by the trainer that the first session should focus on compassion rather than mindfulness because this sets up specific expectations and intentions right from the very beginning. Mindfulness and compassion focus on different motivations. Mindfulness primarily focuses on maintaining one's attention and then the ability to expand it and stay with whatever phenomena arises (for instance by the means of what one may call the observing breath), while compassion focuses on providing one with comfort when confronted with different experiences (for instance by the means of the soothing breath) (Gilbert, 2013, personal communication).

Throughout the training, and based on participants' evaluations, it was evident that there was a need to repeat the exercises, especially the ones referring to various aspects of compassion:

"Do the exercises/discuss them do it again to get a real feel for it to create less wandering after you have discussed it" (Kate – W1),

"*it would've been good to revisit some of the stuff, so do it each week*" (208 – F).

Good personal connection between the trainer and participants was also highlighted. It aided recruitment and helped participants to stay on the course:

"I suppose for me there was something about meeting you" (Sarah – F),

"I met you and become aware of the research you were doing" (Sarah – F);

"…it was strange doing with somebody else, similar but also different" (Kate – F).

To summarise, the final theme demonstrates that a good curriculum is not enough. Most importantly the therapist and the qualities they embody and demonstrate in their practice play an essential role in the therapeutic process. In line with this, individual differences in therapeutic style (e.g. due to temperament, body language, systems of belief) have been found to be more influential to therapeutic outcomes than any therapeutic orientation or technique (Lambert, 1992; Luborsky et al., 1997). This highlights the importance of building a safe personal relationship.

4.4. Discussion.

The current pilot study aimed to evaluate the structure of the CforC curriculum and any potential benefits of participation in it. Four themes (beneficial processes) were identified that were based on: i) evaluations after each session; ii) an evaluation after the whole training programme; and iii) a post-CforC focus group. Two themes referred to regulatory processes (cognitive, emotional and physiological), namely "gaining mental awareness" (theme 1) and "gaining bodily awareness" (theme 2), and the further two themes concerned "slowly growing in compassion" (theme 3) and 'practical considerations' (theme 4). Of note, the first three themes highlight the many benefits of participating in the training programme.

The first theme, “gaining mental awareness”, illustrates how participants were able to learn to cognitively (attention regulation), emotionally self-regulate (emotion-regulation), and to see the patterns of their own thoughts and emotions, i.e. meta-awareness. The latter, meta-awareness focus, describes the cognitive ability to be aware of the processes of consciousness and is a pre-requisite for further meditative abilities such as self-regulation (Dahl et al., 2016). The former, enhancement of emotional self-regulation, is at the core of contemplative practices; but most importantly, also includes introspective metacognition (Dorjee, 2016), or what one can call “knowing of the knower”. Thus, this alludes to the possibility of compassion training courses to equip participants with the skill of self-regulation.

The second theme, “gaining bodily awareness”, describes how participants gained more insight into physical sensations and how they were able to learn how to regulate their physicality better. This includes insight into symptoms of pain, which is crucial when working with somatic patients (Hansen & Streltzer, 2005). Self-compassion is associated with greater pain acceptance (Costa & Pinto-Gouveia, 2011), and specific types of compassion-based interventions, such as loving-kindness (Sansk. *maitri*, Pali *metta*) meditation, have positive effects on pain (Carson et al., 2005). Thus, participants were also able to change the way they related to pain, gain acceptance of that experience, and learn to differentiate between pain and suffering.

Another benefit included finding stability in the body, improving the “felt sense” (Gendlin, 1998) of one’s body and integrating the body with the cognitive and affective parts of the brain. It also included a stronger sense of self. This sense of self constantly changes, depending on how one feels and what one is preoccupied with (subtheme “discovering strength”). This demonstrates that contemplative interventions may attenuate symptoms of pain (Hölzel et al., 2007). Specifically, it shows that compassion-based practices can directly help reduce the

intensity of pain, serve as a buffer against various types of suffering (including physical setbacks), as well as teach participants to respond to these with compassion (Chapin et al., 2014). Combined, these may result in better coping strategies.

The third theme, "slowly growing compassion", refers to participants being able to experience the benefit of unblocking compassion towards themselves and others, which was the main focus and purpose of the intervention. Dahl et al. (2016) point out that one of the essential aims of contemplative practices is to de-construct concepts about self and reality, change maladaptive self-schema towards more helpful content and concept of self, restructure priorities and values, and nurture pro-social qualities. These factors all have an impact on well-being. Compassion-based practices are constructivist in nature and involve two mechanisms that enable change; cognitive reappraisal (changing the way one responds to events) and perspective taking (imagining how one would feel differently in different circumstances) (Dahl et al., 2016).

According to Dahl et al. (2016), training in compassion involves three stages: The generation of compassion; the extension of compassion; and the globalization and stabilization of compassion. In other words, generating compassion for oneself, being able to receive compassion, and gradually extending compassion to all beings. Participants also described cultivating positive emotions of contentment, soothing and safeness, learning to mentally and physiologically slow down (thus experiencing relaxation). This indicates that self-compassion not only helps regulate difficult internal experiences, but also encourages warmth and self-care through activating specific physiological systems (Finlay-Jones, Rees, & Kane, 2015). Fostering their intentions of well-being was yet another result of the training programme which points to the outcome mechanism of motivational and affective states (Dahl et al., 2016). Finally, participants gained understanding of the difference between the tools of

mindfulness and compassion, or in other words, attentional versus constructive practices (Dahl et al., 2016). This enabled them to be able to choose appropriate practices when necessary.

The final theme, "practical considerations", referred to the format of practices, home assignments, order of exercises, session themes, and therapeutic alliance; all of which were found to be adequate and beneficial. In particular, participants found the home practices, including systematic formal practice, to be good reinforcers between the sessions (Angiola & Bowen, 2012). Some participants reported needing more written practices that would enable the consolidation of their experience. They also reported the need to have a comfortable environment (not formal, equipped with all supporting materials). A good personal connection also helped support the learning and therapeutic process, which cements the importance of a good therapeutic "container" (Finlay-Jones et al., 2015) which refers to a holding environment

My own clinical observations included noticing the group and individual processes during formal sessions. Two recommendations stem from this. Firstly, a limited number of participants should be included in the programme. Secondly, sometimes changes in order of session content should be applied if the trainer feels that there is an abundance or lack of something (e.g. physical movement needed after too many sitting practices). Importantly, the curriculum serves as a map, as one can never completely adhere to a restrictive protocol. Of note, the example of cognitive-behavioural therapy (CBT) has shown that most CBT therapists seldom follow assigned scripts, as this approach does not work with most patients. Restrictive models or perspectives should be abandoned (Norcross & Goldfried, 2005). It is the group process that should be followed and therefore appropriate changes applied where necessary (J. Kabat-Zinn, personal communication, 2011).

Considering the emerging themes from the pilot study data and clinical observations, it is apparent that two areas should be focused upon in terms of future development. These are content and practical issues. In terms of content, the pace of the training and subsequent introduction of topics and practices should ensure there is a balance between the three affective systems (drive, threat and soothing-affiliative), with the emphasis on the soothing-affiliative system (Gilbert, 2009). This is evident from informal comments made by the participants. Also in terms of the content, the curriculum should include a substantial number of body-related practices, helping participants manage their bodily responses more easily (e.g. compassion of touch, compassionate movement). This was clearly an important focus for participants, as demonstrated through written and focus-group feedback. These practices should be repeated throughout the course of the training programme, especially for courses specifically aimed at cancer patients or other groups of somatic patients who often suffer from pain conditions.

Furthermore, reflecting on intentions of well-being (what is needed, what is helpful), throughout the whole courses should be another constant ingredient of the curriculum and each session. Helping participants practise systematically builds their motivation. This helps maintain a disciplined and committed practice (Kabat-Zinn, 2011), that eventually produces behavioural and emotional changes (Jinpa, 2015). As Kabat-Zinn (1996) states when referring to another contemplative practice (i.e. mindfulness), what motivates people to practise further is their experience of relaxation and calmness. Indeed, reinforcement and inspiration may help ensure that long-term benefits are maintained and consolidated.

Practical issues also need to be considered and, importantly, include the use of systematic practice, which includes ways of inspiring and supporting it. It is important to know how to ask a lot from the participants (in terms of practice time challenging bodily, affective, and

mental schemas), and adequately support them not only during each session, but between the sessions, and after the conclusion of the whole course (Angiola & Bowen, 2012). Follow-up days for course graduates may serve as a booster to enable self-practice (Hopkins & Kuyken, 2012).

Additionally, participating in talks, classes and group sittings can further cultivate the habit of practising (Kabat-Zinn, 1996). Facilitation of systematic practice might be further supported by reflecting on intentions (i.e. how can I take better care of myself and others, what is beneficial). More written practices are also recommended since it activates a new pathway to experience compassion, helping organise thoughts, increasing insight and self-reflection (Smyth, Hockemeyer, & Tulloch, 2008). A second practical issue, raised by participants, concerns the nature of a contemplative training environment: participants emphasized the need of a warmer and more casual setting. Thus, a warm and casual setting for the training would be the best option for future training programmes in order to create a comfortable and safe place (Aherne et al., 2016).

In summary, based on the described benefits and recommendations, compassion practice may help individuals not only cope better with thoughts, emotions, and physical circumstances, but may also warm up their emotional (internal) tone (i.e. voice, physical posture, movement). The CforC described here combines both attentional and constructive types of practice, which lead to the deconstructive exercises. Furthermore, appropriate psychological interventions, such as CforC, might improve outcomes in cancer care and potentially be of benefit in terms of post-traumatic growth. Patients might not only cope better with their illness and treatment procedures, but also gain emotional resilience. When referring to MBSR, Santorelli (1999) called it “a new collaborative, participatory medicine”; CforC also falls into this category. In continued research and practice, changes to the curriculum will be introduced to ensure it is

more comprehensive. Since the current training programme did not include a clinical population (i.e. cancer patients or survivors), future research is necessary to examine the benefits of the CforC programme regarding the emotional and physical outcomes in cancer patients and survivors, and possible further populations of chronically ill patients. Such studies should also involve a two-step process measuring both the feasibility of running the course, as well as its effectiveness.

In conclusion, it was found that the CforC course provided initial evidence of psychological benefits for participants in terms of changing their relationship to body, mental and affective processes. CforC is a contemplative course, with the aims of teaching how to cope with stress, including guided discovery of potentially radical changes to a person's life and awareness of mortality (such as with a cancer-diagnosis and treatment). It also supports regulating psychological and physical difficulties, and bolsters self-care and prosocial emotions. This initial evidence will be further examined in the next studies. These are described in the next sections but extend the trial of the CforC curriculum with cancer patients and survivors. In these chapters it will also be demonstrated how the weekly themes and exercises have been amended and refined based on the trainer's expertise and participant feedback, with full description of the practices, the processes behind them and their rationale in Chapter 5.

In order to gain in-depth understanding of how compassion works, in terms of applying a formal compassion training programme (CforC) for specifically cancer patients and survivors, three clinical groups were recruited in Poland: in Żagań and Warsaw.

As explained in Chapter 1, compassion plays a role in a variety of mental health conditions and can result in affective changes (Kirby, 2016). Then, the pilot study described in Chapter 2 had looked at the benefits of CforC for a non-clinical population (participants not directly

affected by cancer). The primary objectives of this study, therefore, were (a) to investigate if an 8-week training programme based on compassion is associated with changes in mindful states, stress, satisfaction, emotion regulation, post-traumatic growth (as assessed by appropriate questionnaires) for cancer patients and survivors; and (b) to confirm the appropriate weekly themes and format, ordering and balancing themes and exercises accordingly.

Certain changes were made to the curriculum and its practices before (described in this chapter) and certain practices were to be more emphasised after the training programme with clinical populations based on the participants' comments, trainers' evaluation (Małgorzata Wawrzynkowska and Magdalena Mazurkiewicz) and supervisor's reflections (Julia E. Wahl).

The next chapter (Chapter 5) will reflect on the key features of the current training programme (CforC) such as the importance of various processes: motivational processes, cultivation of courage, group shared experiences, and specific practices directed at compassion. Additionally, qualitative results based on running groups with clinical populations will be presented in Chapter 6. The hermeneutics of results is often a gargantuan and subjective task, even when quantitative measures are being employed as science is the art of approximation (Kuhn, 1962). Therefore, qualitative approaches have also been applied.

Chapter 5. Processing Compassion: Key Conceptual, Practical Features and Processes.

"Compassion is an unstable emotion. It needs to be translated into action, or it withers. The question of what to do with the feelings that have been aroused, the knowledge that has been communicated. If one feels that there is nothing 'we' can do -- but who is that 'we'? -- and nothing 'they' can do either -- and who are 'they' -- then one starts to get bored, cynical, apathetic."

— Susan Sontag (2003, p. 101)

Sontag (2003) very precisely addressed three crucial issues for the current training programme: the question of how to train in compassion; the importance of relationships in the training; and the possible obstacles that one is faced with when cultivating compassionate qualities. To start the whole training process, one needs to first cultivate appropriate motivations which will be looked at in the first place. It also needs to be stated that CFT is seen by some as being process-driven versus protocol-driven (Russell Kolts, 2020, personal communication).

This chapter describes specific processes behind all the formal and informal practices and the philosophical underpinnings that affect the design of the CforC training programme, and ultimately its effects (including describing processes of motivational change and courage).

5.2. Inspiring Motivation as the Core of Practice.

"Never allow yourself externally to portray anything that you have not inwardly experienced"

– Konstantin Stanislavski (1936, p. 28)

Inspiring appropriate motivation is one of the pivotal elements of the CforC training as it is about activating innate motivational circuits that regulate human behaviour (Lang & Bradley, 2010) and in this case, specifically, compassionate behaviours. In the training session this is done through a variety of means. For instance, one of the ways of resolving motivational issues is through "disinterested" thinking (The New Encylopædia Britannica, Volume 28, Macropædia. Knowledge in Depth, 1993). This way of practising is when one is asked to reflect on an issue and then stay with it without having to resolve it immediately. In this way, it is the discovery of an answer that is initiating the motivational and thinking processes and not focusing on the answer itself.

A different way of activating appropriate motivational circuits is done through sensory experience and association so that sensation would change into perception (Locke, 2000). Thus, participants are asked to recall and/or imagine various sensory qualities that are combined with specific psychological qualities, e.g. recalling a pleasant place when one felt the warmth of sun and felt safe, welcomed and accepted. The last way of initiating motivational processes which are inherently unconscious is through focusing on intention (object of internal inquiry) as mediated by thoughts or images (this refers to intentionalism or representationalism). This is a conscious (intentional) process: focusing on the question of *kusala*, the activities, qualities, behaviours that are helpful, skilful, wholesome, salutary, or valuable for oneself and others. The content of one's intentions can be either conceptual or

non-conceptual (Crane, 2001). Thus, one first consciously focuses on an intention which then becomes an unconscious motivation and ultimately affects (changes) behaviour, including approaching oneself, one's internal content, and others in a changed way. This understanding of various functions and processes of meditative and contemplative practices is important when creating and applying specific formal exercises (e.g. types of meditation).

The need to activate appropriate motivational processes is not only based on neurophysiological research but also on self-determination theory (SDT). In SDT, Deci and Ryan (1991) refer to specific psychological innate and instinctive needs that determine an individual's behaviour: competence, autonomy, and relatedness. In this conceptualisation, competence concerns a person's ability to be in control of an outcome; relatedness refers to the will to be connected, being able to experience care; the last aspect, autonomy, is to be responsible for oneself and be in harmony with oneself. It is important to note that the autonomy aspect does mean being able to relate to and rely on others (Deci & Vansteenkiste, 2004). Furthermore, SDT includes both intrinsic (inherent drives) and extrinsic motivations (from external sources).

What is important is the fact that concepts of SDT seem to be consistent with the concepts of healthy attachment patterns which the theory of CFT is based upon. One of the ways to raise motivation is to raise courage which is the first and most important quality of compassion (Gilbert, 2014).

5.1.2. Courage.

"*Then, Laches, suppose that we first set about determining the nature of courage... Tell me, if you can, what is courage*."

– Socrates (Plato, trans. 1987)

As Putman (2001, p. 469) writes "courage lies in the interface where the limit of our confidence meets the reality of a feared situation". Therefore, courage does not signify the lack of fear but, on the contrary, when faced with fear, one's willingness to work through it. Courage therefore would signify Hemingway's description, "grace under pressure''[13], or as Shelp (1984) described it being "the disposition to voluntarily act, perhaps fearfully, in a dangerous circumstance, where the relevant risks are reasonably appraised, in an effort to obtain or preserve some perceived good for oneself or others recognizing that the desired perceived good may not be realized'' (p. 354).

That is, in the way that courage is being explained to CforC participants: as a way of doing rather than having to feel it. For further understanding, it is relevant to describe this specific mindset: according to Hannah, Sweeney and Lester (2007) the process of courage constitutes of being able to increase "personal resources to reduce fear" and overcome "residual fear to promote courageous action", which is also one of the ways to work with blocks towards courage. Training in the attitude of courage may also prevent the narrowing of attention which often occurs in situations when one experiences fear, threat or stress (Fredrickson, Tugade, Waugh, & Larkin, 2003; Hannah, Sweeney, & Lester, 2007). Furthermore, some authors claim

[13] Ernest Hemingway used it in a profile piece written by Dorothy Parker.

that courage may be inspired through positive interactions, relationships with others, and relatedness as courage is associated with prosocial behaviours (Yalçındağ, 2009).

5.1.3. Shared Experiences and Relatedness.

One of the main features of the compassion training is that it is a *com*munal process. Whilst the results (and benefits) of the training in large part depend on the individual's discipline in formal and informal practices, the practices cannot be uncoupled from the training group, and the social environment and intimate relationships one is embedded in, and ultimately how the training in compassion then influences the intimate and social environments back. Self-other relatedness has long been discussed in psychology, especially developmental psychology where, for instance, social imprints in the neural structures are based on relational experiences (Jonsen et al., 2002; Samaritter & Payne, 2013). Moreover, relatedness (alongside autonomy) is seen as one of the basic human needs in various psychological and philosophical schools of thought (Kagitcibasi, 2011). It is also of key importance to refer to self-other similarity as a recognition that we share certain features/attributes with others (this is related to the concept of common humanity – the perception of shared community) which facilitates altruistic behaviour and compassion-related responses to others (Oveis, Horber, & Keltner, 2010; Monroe, 1996).

This need to share experiences and oneself is similar to the experiences in various training settings, and to refer specifically to a contemplative training, of participants of the MBSR groups, with participants saying that among components of particular importance were group process and sharing experiences with patients (this included patients with cancer) (Kvillemo & Bränström, 2011). This sharing is vital as one can both gain agency when self-narrating to others and learn from what others are sharing.

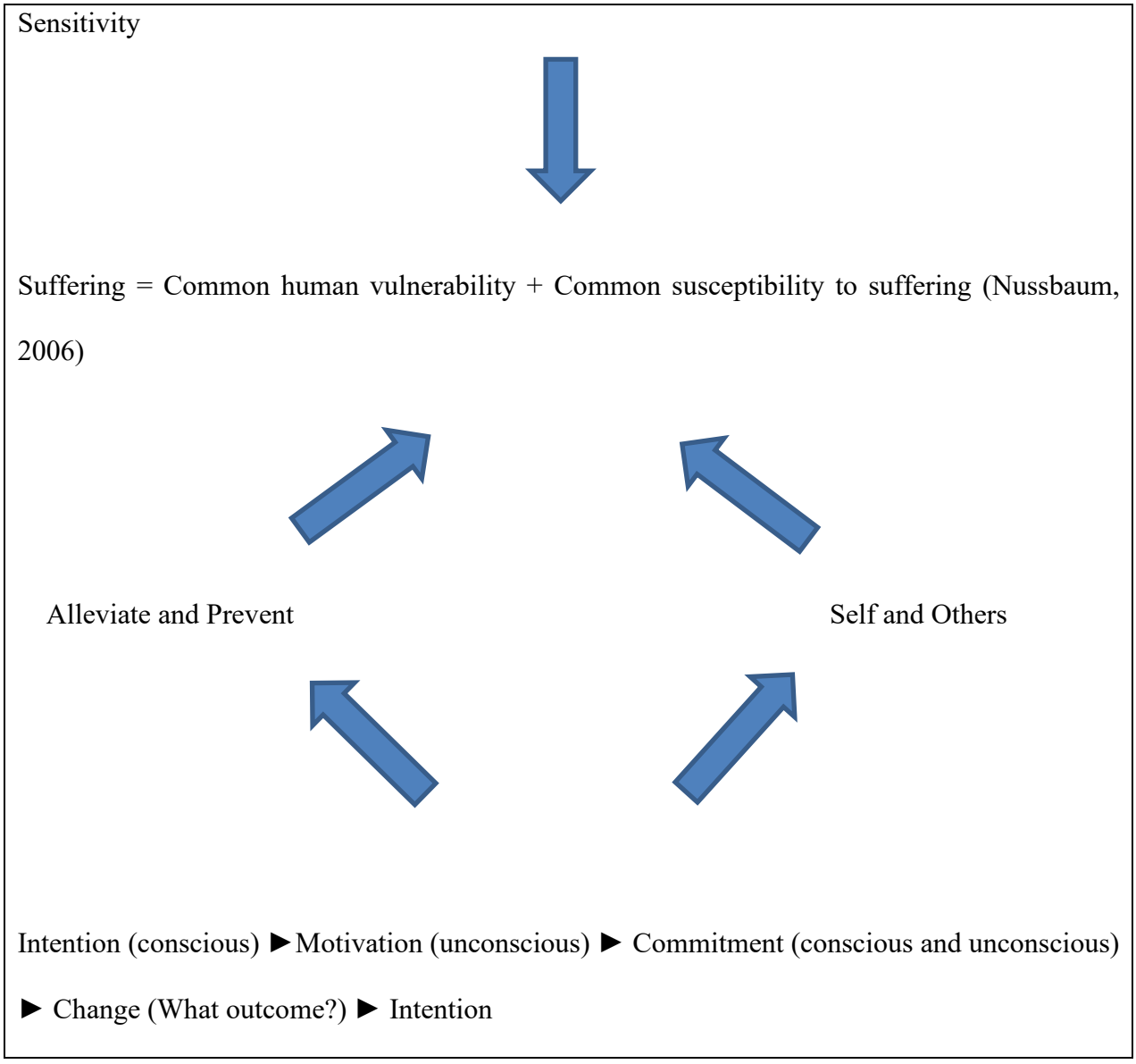
5.1.4. The Process and its Tools.

In the current paradigm compassion is seen as a process and the individual cultivating it seen more as 'self-as-process' than 'self-as-object' which refers to the ability to be constantly "moulding" oneself in the compassionate direction through being sensitive to the suffering of oneself and others, and through employing compassionate skills to alleviate and prevent the suffering (see Figure 6.). This self-as-process also refers to the Buddhist notion that personality is a dynamic aggregate is constantly changing (changeable).

The training can first be explained by referring to the Plato's Allegory of the Cave when one is deeply hidden and cannot yet see the sky, slowly emerging from one's cocoon. One also starts "work[ing] with the greatest defilements first" (McLeod, 1987) but not as a way of blaming oneself or others, but rather as seeing what one's specific behaviours, ways of approaching thoughts and emotions about oneself and others are, learning to understand the evolutionary processes behind it, and finally taking responsibility for it.

Figure 6.

Compassion-as-process (partially based on Steindl, personal communication, 2018)



In the training process of CforC, teachers (trainers) first work on inspiring students' motivation, later help them maintain stability in the formal and informal practices, and finally accompany them in the cultivation period.

5.2. Description of Particular Issues and Practices.

To enable the process, the following three formal parts have been included: (1) meditation/contemplation as cultivating appropriate attention and/or qualities combined with role-playing/method acting, body work/touch, imagery work; (2) psychoeducation; (3) the shared (communal) experience (external and internal narratives). Meditation in this context (Sansk. *dhyana* and *hāgâ* - הגה in Hebrew) is essentially a practice of calm abiding (e.g. Sanskr. *shamatha)* by first focusing attention on one object and later systematically expanding and extending to other objects until there are none (for instance in the Tibetan Buddhist tradition of *Madhyamaka*) which leads to "awareness". Awareness is a "sort of knowing" (Pardy, 2016) without any object of focus. Meditation is not a homogeneous phenomenon and can therefore be divided into different categories, for instance: into focused attention, open monitoring practices. It is also a "type of mental task and training, mental effort and physiological arousal" (Lumma, Kok, & Singer, 2015) aimed at training cognitive skills (Wallace, 1999) and affective qualities (Davidson, 2010) which are both aims of compassion-based training courses. As in many other contemplative practices learning and understanding therefore is realised through meditative insight, study, and reflection (Armstrong, 2016). This meditative insight is often mediated through various breathing exercises and strategies.

5.2.1. Rhythm of Breathing.

Breathing has long been used in various psychological interventions and contemplative traditions for a variety of reasons, ranging from easing one's tensions through resolving interpersonal issues, working with trauma, to experiencing mental equilibrium. Additionally, its physiological effects on the body and emotions have also been studied (Caldwell &

Victoria, 2011). In the CforC training programme, a specific way of breathing (soothing-rhythmic breathing) is a prelude to most other forms of formal practices (e.g. imagery work).

In the current training curriculum, the focus is to teach practitioners how to breathe in an optimal way, depending on the situation in which they find themselves. What is the main aid in the process is the right rhythm of breathing or "rhythmic flow inside the body" (Conger, 1988). Further, what Caldwell and Victoria (2011) mention is the "three-dimensionality" of breathing: being able not only to breathe from top to bottom and the reverse, but from left to right and the reverse (as it is done in the vase breathing exercise or *tummo* meditation). Caldwell and Victoria (2011) also highlights the interpersonal or social patterns of breathing as one learns to follow what is the trend in one's family (co-regulation).

Adequate breathing is first thought as consciously paying attention, and then ultimately becoming effortless: slowing moving the breathing from the upper thorax (upper thoracic breathing), which is often a sign of dysfunctional breathing, to the abdomen (Peper & Tibbetts, 2008). Peper and Tibbetts (2008) advise teaching people to learn how to completely exhale (expiration) and thus teach them to breathe effortlessly. Watkins (2016) refers to twelve dimensions of breathing that we can learn and that can affect us physiologically and affectively but emphasises the importance of the first three: rhythmicity, smoothness, and location of attention which is usually suggested to be the heart. The other dimensions are: speed, pattern, volume, depth, entrainment/synchronization, resistance, mechanics, flower patterns, and special techniques. This way of looking at breathing patterns draws on the coherence models of heart-brain and psychophysiological coherence and its relevance to emotional and cognitive functions (McCraty, Atkinson, Tomasino, & Bradley, 2009).

It is crucial to comprehensively describe these processes and aspects of breathing to all the participants of CforC training programme (see Table 11) and in addition, spend an appropriate amount of time teaching how to realise the correct breathing patterns, before introducing other exercises. The correct (soothing) way of breathing will serve as the foundation for such practices as the practice of *tong-len*. This concept is described in the next section.

Table 11. Key features of breathing in CforC.

- Exploring the three-dimensionality of breathing
- Moving the breathing from the upper thorax (upper thoracic breathing) to the abdomen (diaphragmic breathing)
- Focusing on three main qualities of breathing: rhythmicity, smoothness, and location of attention (typically the heart)
- As mediated by post-class explorations

5.2.2. The Taking and Giving (*tong-len*) and the Beneficial Intention Practices.

Tong-len (also written together as *tonglen*) is a traditional practice derived from Tibetan (*Vajrayana*) Buddhism which has been practised for the past 1000 years and is a type of meditation that combines visualisation with breathing. It is sometimes referred to as the practice of "sending and taking" (Chödron, 2001), "giving and receiving" or "exchange self for others". It is often practised coupled with the Buddhist *lo-jong* or mind-training teachings collected by the Indian Buddhist teachers, Atisha. *Tong-len* can also be practised as stand-alone meditation and is recommended for both beginners and advanced practitioners, although there seems to be a disagreement about at what stage it should be first practised (McKnight, 2014; Chödron, 2001).

It can be divided into various stages: working with one's own pain, the pain of others, first starting with our close ones/benefactors, and moving onto strangers and difficult people. Some say that is should be learned in four stages (Chödron, 2001): the first is to cultivate a state of openness (expanded reality), the second is about synchronising one's breath with the visualisation of breathing in and breathing out, extending to the whole body, the third stage refers to choosing a particular object of focus (e.g. oneself or others) and the final stage is about expanding the practices to all beings.

The way it is being taught in CforC differs from most traditional ways (e.g. in Tibetan Buddhism training) in that one first starts by imagining their compassionate self and from that perspective also imagining the ordinary part of self that is suffering in some way (e.g. physically, emotionally), and only then literally (using imagination) or metaphorically (based on the felt sense) breathing the difficult, heavy, and dark cloud and suffering which is being transmuted into a light cloud whilst breathing out the troubled self. This particular approach, identifying with the compassionate self and practising *tong-len* for oneself first, may be a bit more practical as the standard version may be too challenging at first for most practitioners, especially the ones who have no previous practice.

In the current curriculum, this practice helps individuals develop a more compassionate connection with themselves and later with others, becoming more resilient to pain and suffering, and overcoming barriers to certain parts of human nature and/or other human beings. It can also help one work through their avoidance and suppression (C. Germer, personal communication, 2013). Furthermore, it can assist in developing compassion, overcoming one's biases, expanding beyond one's solipsistic perspective or challenging one's self-absorption (Pardy, 2016). Some authors claim that the practice of *tong-len* can even have benefits for patients suffering from anxiety (including social anxiety), depression or certain

types of personality disorder, like the avoidant type of personality as it works with overcoming intimidation (Pardy, 2016).

Unfortunately, the processes and potential benefits of this practice have not been separately and extensively studied, with only three stand-alone *tong-len* studies being reported in psychology: McKnight's studies in 2012 and 2014 and Pardys's qualitative study in 2016. These studies suggest that the practice of *tong-len* may have in fact produced such benefits as becoming aware of one's interconnectedness, encouraging self-reflection (McKnight, 2012; McKnight, 2014), improving interactions with others, and uncovering emotions (Pardy, 2016). There are three other studies and one training description: in one *tong-len* is part of a series of Buddhist practices (Lichty, 2009), in another it is part of a wider mindfulness practice (Lee, Zaharlick, & Akers, 2011), and in another is combined with mindfulness and loving-kindness meditation (LKM) (Orellana-Rios et al., 2018); and in the training examples is taught to university students in a compassion course (Grace, 2009). Therefore, it would be important to analyse the practice both separately and in combination with other practices.

In contrast to the practice of *tong-len*, it is important to mention the loving-kindness meditation (LKM) which has been studied most extensively amidst formal compassion meditation practices, also due to the fact that it is often compared with *tong-len*. McKnight (2014) argues (based on personal observations) that both practices help individuals develop loving-kindness and compassion with loving-kindness sometimes being used as the prelude to the *tong-len* practice (Orellana-Rios et al., 2018), expending beyond the interest of oneself and close ones. The main difference is that LKM focuses only on what is positive: the positive being the focus on supportive phrases (intentions).

In the current training curriculum, there has been no formal practice of LKM – instead what has been employed is choosing one own's words or phrases of helpful intention in order to find one's own genuine meaning. The choice of not including LKM was based on the need to limit the necessary practices employed in the training programme.

5.2.3. Compassionate Touch and Compassion through Other Senses.

"We believe that contact comfort has long served the animal kingdom as a motivating agent for affectional responses."

– *Harry Harlow* (2000 March, Retrieved from https://psychclassics.yorku.ca/Harlow/love.htm)

What additionally has been employed in the current curriculum from the pilot study/intervention, based on trainer's observations, also refers to bottom-up processing in contrast to top-down processing: for instance, compassionate, or in other words, soothing and supportive self-touch and soothing self-massage. This haptic/tactile sense is the largest organ and one that connects us to the external, working alongside the other basic senses (sight, hearing, smell and taste) and extended senses (nociception, equilibrioception, proprioception and kinaesthesia, sense of time, thermoception, magnetoception). Touch is also the first sense to develop, during the 8 to 14 weeks of gestation (Raisa Mo & Raisa Mo, 2011) and can been seen as a non-verbal communication of compassion, NVCC (Kemper & Shaltout, 2011). It influences changes in autonomic nervous systems, greater parasympathetic activity and improved well-being (Shaltout, Tooze, Rosenberger, & Kemper, 2012), can additionally influence (elicit or modulate) affective responses and is a combination of various features such as "responding to touch, pressure, temperature, pain, joint position, muscle sense, and movement" (Gallace & Spence, 2010) – known as somesthesis. Furthermore, Young (2005)

lists what other authors have also referred to the therapeutic qualities of touch: “healing touching” (Brown, 1990), or “listening touch” (Rubenfeld, 2002). Hunter and Struve (1997) go even further than that and propose grouping touch into various categories: “accidental touch, task-oriented touch, attentional touch, celebratory/affectional touch, emotional/expressive touch, aggressive touch, sensual touch, and sexual touch” (p. 115), ultimately grouping touch into intentional and non-intentional. Totton’s classification (2003) lists: touch as comfort (soothing), touch to explore contact, touch as amplification; touch as provocation, and touch a skilled intervention.

The practice of touch in CforC is facilitated by the exploration and enhancement of perceptual information (as described by Lederman & Klatzky, 1987) in the following way: exploring texture, hardness, global shame/volume, temperature, weight and shape. Touch is never facilitated by being touched by others for a variety of potential issues such as experiences of abuse, trauma, and one learns “to be able to use the right touch, in the right place, at the right time, and with the right person” (Young, 2005).

Apart from the sense of touch, compassion can be elicited through other senses, which has been the case in the current curriculum by encouraging participants to engage in informal practices (post-class explorations) such as finding a soothing smell, taste, colours, music and tone of voice in oneself (psychophysics) and to combine it with the “feeling tone” (Pali *vedana)* for an evaluation of internal consistency (pleasant, unpleasant, neutral). Particularly the sense of smell is encouraged as it is closely related to memory.

Finally, a modest part of voice exercises (voicework) has been added to the training curriculum in order to focus more on the appropriate internal and external voice (tone). As noted by Bady (1985) appropriate vocalization can add to the healing process, not only in

terms of speech (words or sentences uttered) but the sounds and mechanism behind it (how to use breathing, one's vocal cords). The main here is to experience certain modes of being (personal qualities) through sounds (how one can do it) and parameters such as one's timbre, accent, rhythm, resonance (prosody) in order to increase vocal coordination for better regulation of emotions.

The phenomenon of voice with all its aforementioned qualities has been studied before, most notably by Jaffe and Feldstein (1970) who focused on vocal rhythm in dyads (mother-baby). Also Rice with her various colleagues (e.g. Rice and Kerr, 1986; Rice and Wagstaff, 1967; Wiseman and Rice, 1989) studied the processes involved in vocalization: vocal quality of therapists. Specific methods for studying the aspects of voice have been developed such as the Vocal Quality Patterns (VQP) system (Tomicic, Martínez, Chacón, Guzmán, & Reinoso, 2011) drawing on the work of Rice and her colleagues. VQP included: Report, Connected, Affirmative, Reflection, Emotional Expressive, and Emotional-Restrained) and two categories of conversational phenomena (Full Pause and Overlapping). The voice has also been studied in terms of its influencing cognitive, emotional and physiological aspects (Moneta, Penna, Lo Yola, Bucheim, & Kázel, 2008). As noted by some scholars, intonation can result in affective significance (Cook, 2002). In the majority of cases it is the voice of the other (e.g. therapist) that is studied in terms of its influence, e.g. Knowlton & Larkin, 2006) voice and progressive relaxation training) but the voice of oneself is overlooked.

The prosodic qualities that have been highlighted in the training course by focusing on the pitch of the voice, loudness timbre (general feeling of intonation), and how all these qualities relate to the experience of compassion. What is important to highlight is that there should be consistency across all the sensory dimensions and experiences (sound of voice, sensation of touch/one's body.

5.2.4. Bodywork, Method Acting and Role Playing: Importance of Kinaesthetic Experiences.

"*Man is least himself when he talks in his own person. Give him a mask and he will tell you the truth*"

– Oscar Wilde (1981, p. 36)

The mask that Wilde (1981) is alluding to may signify conducting specific exercises, such as role playing, in order to explore various versions and modes of oneself but in contrast to what one may think, the mask can in fact reveal what is most beneficial, in terms of intra- and interpersonal benefits and insights. Through movement and becoming more aware of one's embodiment and senses (sensing), one can learn to self-regulate their kinetic qualities (Samaritter & Payne, 2013) which also affects the physiological, affective and cognitive systems. In the current training this is done by the introduction of gentle body movements/body awareness exercises, role playing and method acting. As Noddings points out (1984) "when I am in this sort of relationship with another, when the other's reality becomes a real possibility for me, I care". In the current context this care would signify care for oneself and others, including through various sensory experiences.

The first aspect, body movement, is closely related to the compassionate body-touch described earlier in the chapter: how to learn to be within the body in a compassionate way which entails combining the qualities of strength and tenderness. This is expressed through experiencing through various physical modes: partial stillness (lying down, sitting, standing) and direct movement (walking, running, moving various body parts, facial expressions). Some of the exercises are aimed at, what Reich would call, a "character armour" – in order to ease the "rigidity of skeletal muscles" (Reich, 1972). Additionally, what is employed in CforC is

similar to the preliminary stages of Self-Active Relaxation Therapy (Ohno, 2007) in which trainers ask participants to gentle move their various parts (e.g. by stretching) and releasing tension.

Role-playing is another technique applied in CforC. These types of techniques have been long applied in psychological interventions and reflective work by, for instance, by Adlerians, Rogerians, eclectics, psychoanalysts, and most notably in psychodrama introduced by Moreno: used as a means of diagnosis, instruction, and/or training (Corsini, 1966). Corsini (1966) also mentions three characteristics of effective role playing: simultaneity (of thinking, feeling, acting), spontaneity (individual's creativity in responding to situations), and veridicality (how real is the role playing). As described by Boulet (1975), role playing represents realism due to the fact that it is "playing" and therefore entails freedom of exploration and does not require finding the right answers immediately.

The role-playing techniques presented in the present curriculum involved focusing on various attitudes and exploring various modes and taking on the imaginative roles or attitudes that may be less accessible to one, e.g. being in the three types of affective systems, "being" strength and tenderness.

Certain method acting techniques have also been applied in CforC. Method acting had been first introduced by Konstantin Stanislavski and later proliferated by Lee Strasberg, Stella Adler, Sanford Meisner, Jerzy Grotowski. This type of acting varies from the classical (Shakespearean) style in that it is not action-oriented but rather emotion-oriented: one is trying to feel the character and not only emulate its physical gestures (Lionheart Theatre Company, 2017). This is not to say that one needs to experience (feel) certain feelings all the time – rather the "experiencing of glimpses of feelings" may help instil certain attitudinal changes.

The idea of applying method acting in psychological interventions is not a novel one. For instance, it had been used in cultivating empathy (Verducci, 2000). In CforC, the focus is on cultivating the wholesome identities based on compassionate qualities.

To summarise, this method is like "making the spectator see the optical illusion of an identity." (Barba & Savarese, 2005) or in other words how transitory and changeable it is which is one of the conceptualisations of CFT. One is exploring possibilities of having various identities, modes of being and learning to choose the one that needs to be cultivated.

It also needs to be noted that in Buddhism there are six sense spheres (Sansk. *ayatana*): the main ones have already been described here (eye and visible objects, nose and smell, tongue and taste, ear and sound, body and touch). The sixth sense, mind and mental objects, will also be described here as imagery work, which is one of focal points of CforC work.

5.2.5. Working with Attention and Imagery.

"Attention is vitality. It connects you with others. It makes you eager. Stay eager."

— Susan Sontag (2006, as quoted in the New York Times)

Cognitive or diversion (attentional) strategies were also employed, including working with pain as these have been used in various psychological therapies (e.g. Elomma, De Williams, & Kalso, 2009). Rollman (1992), Turk, Meichenbaum and Genest (1983) classify these attention strategies into: imaginative inattention, imaginative transformation of pain and imaginative transformation of context. This can be either done by diverting or refocusing attention. In the present study, this work has been done by the means of specifically directing attention to various areas of experiences: painful, pleasurable, and neutral.

Imagery work has been employed, e.g. imagining one's compassionate self, ideal compassionate being, by either focusing on fully imaginative explorations or through memory-based imagery (e.g. recalling acts of kindness from and to others). This type has been first described by Pierre Janet in 1889 as "imagery substitution", and later applied for instance by Jung as "active imagination" (1935), by Leuner (1984) as "guided affective imagery", and Frankl (1988) to affect "emotional processing" (term introduced by Foa and Kozak, 1986). It is often also referred to as "imagery rescripting" (Edwards, 2007). For many years this type of work has been mainly practised in hypnotherapy, e.g. Watkins' hypnoanalysis which included imagery work focusing on different parts being with dialogue with another (Watkins, 1992). This type of work is very important as the cognitive and affective parts need to be combined. As noted by Greenberg and Safran (1984): "there is no affect without cognition and no cognition without affect" (p. 569).

Using imagery extends one's semiotics field and various other strategies can be applied here, e.g. metaphors, symbols, analogies, thereby combining the affective system with the cognitive. It has to be noted that when activating the affective system, sadness, grief or other types of negative affect can occur as the attachment systems are being activated (Bowlby, 1980) through certain imagery work exercises in the first stages of compassion practice. At a later stage the positive affect is being experienced (Singer & Klimecki, 2013).

5.3. Conclusion.

This chapter described various processes underlining CforC training programme, beginning with motivational systems, the aspect of courage, and shared experiences. Additionally, it described the processes behind and rationale for specific practices such as soothing-rhythmic

breathing, *tong-len*, compassionate touch and applying other senses, body work, kinaesthetic experiences and finally imagery work.

The reception from the clinical population (cancer patients and survivors) of all of the practices described and the changes made since the pilot study will be fully described in the next Chapter (Chapter 6). The results including quantitative measure will also be described in Chapter 6.

Chapter 6. Results: Clinical Populations.

After the pilot study with the non-clinical population, two studies with three groups (one Żagań and two in Warsaw) with clinical populations of cancer patients and survivors were conducted. The following chapter will present both qualitative and quantitative results.

6.1. Participants.

Thirty-three participants (one male and thirty-two women) aged 28 to 65 years participated in the study. The mean age of the subjects was 48.4 years, with a standard deviation of 11.14.

Gender, age, education and occupation. The majority of the participants (n=19) declared having higher education, eight had secondary education (graduated from secondary school with a baccalaureate) while six participants did not provide their level of education. Fourteen participants declared being professionally active and 14 did not indicate their professional status. The remaining participants declared no job or retirement (pensioner) status (n=5) (see Table 12).

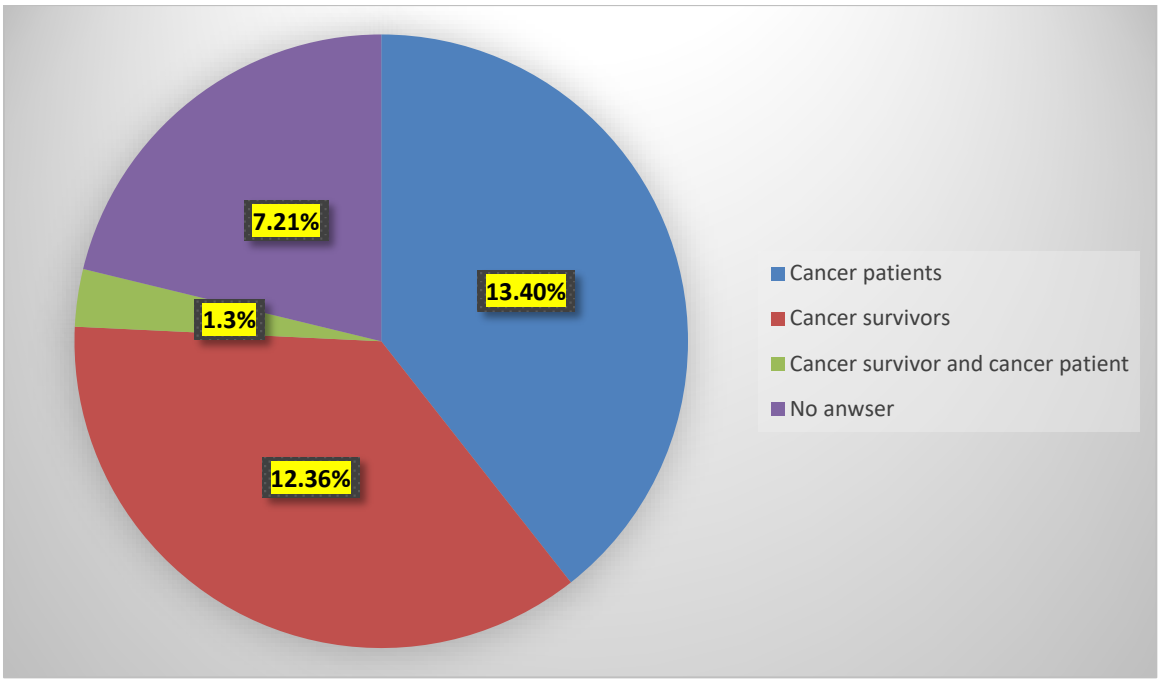
Table 12 – Information on Participants.

Participants	Age	Employment/Occupation/Education
1.	48	Teacher
2.	30	Nutrition technician
3.	54	Economy technician
4.	40	Agriculture technician
5.	30	MA in Gardening & Environmental Protection

6.	65	Secondary education (occupation not specified)
7.	50	Teacher (kindergarten)
8.	37	Environment protection technician
9.	37	Civil engineer
10.	56	Economy technician
11.	64	Civil engineer
12.	40	Saleswoman
13.	45	MA, office work
14.	36	MA (occupation not specified)
15.	38	MA, working as an assistant
16.	56	BA, podologist
17.	62	MA, engineer (retired)
18.	64	MA, economist
19.	48	MA, economist
20.	45	Adragogist
21.	35	Chemistry teacher, therapist
22.	42	Secondary education, office assistant
23.	53	MA in European Studies, previously working in the office, currently not working
24.	51	Manager
25.	65	Journalist
26.	42	Translator, financial controller
27.	35	Higher education, currently retired
		Psychologist, working in HR
		Translator

Health status. Of the 33 participants, 21% of the respondents did not answer the question about health status (see Chart 1), 40% were oncological patients, 36% of participants had completed treatment and one participant was in the course of another cancer.

Chart 1. Health status.



Among 27 participants who answered the question about the type of cancer: 13 participants had breast cancer, two had thyroid cancer, three had Hodgkin's lymphoma, the remaining single participants suffered from tumours: ovary, duct, brain, colorectal, cervical, prostate, skin, myeloma, melanoma and one patient was diagnosed both with breast and duct cancers. In addition to cancer, 15 participants reported recent upsetting life events (apart from their illness), while nine persons negated such experiences and nine omitted answering this question.

Experience in meditation and mindfulness. Over half of the participants (52%) declared no previous experience related to meditation and mindfulness, while some (36%) of the respondents had such experiences before the CforC training.

Reasons for attending (participating in the training programme). Most participants declared participation in training for reasons of willingness to work on emotions and stress, while a few indicated reasons such as quality of life, improvement of relationships (see Chart 2).

Chart 2. Reasons for doing the training programme.

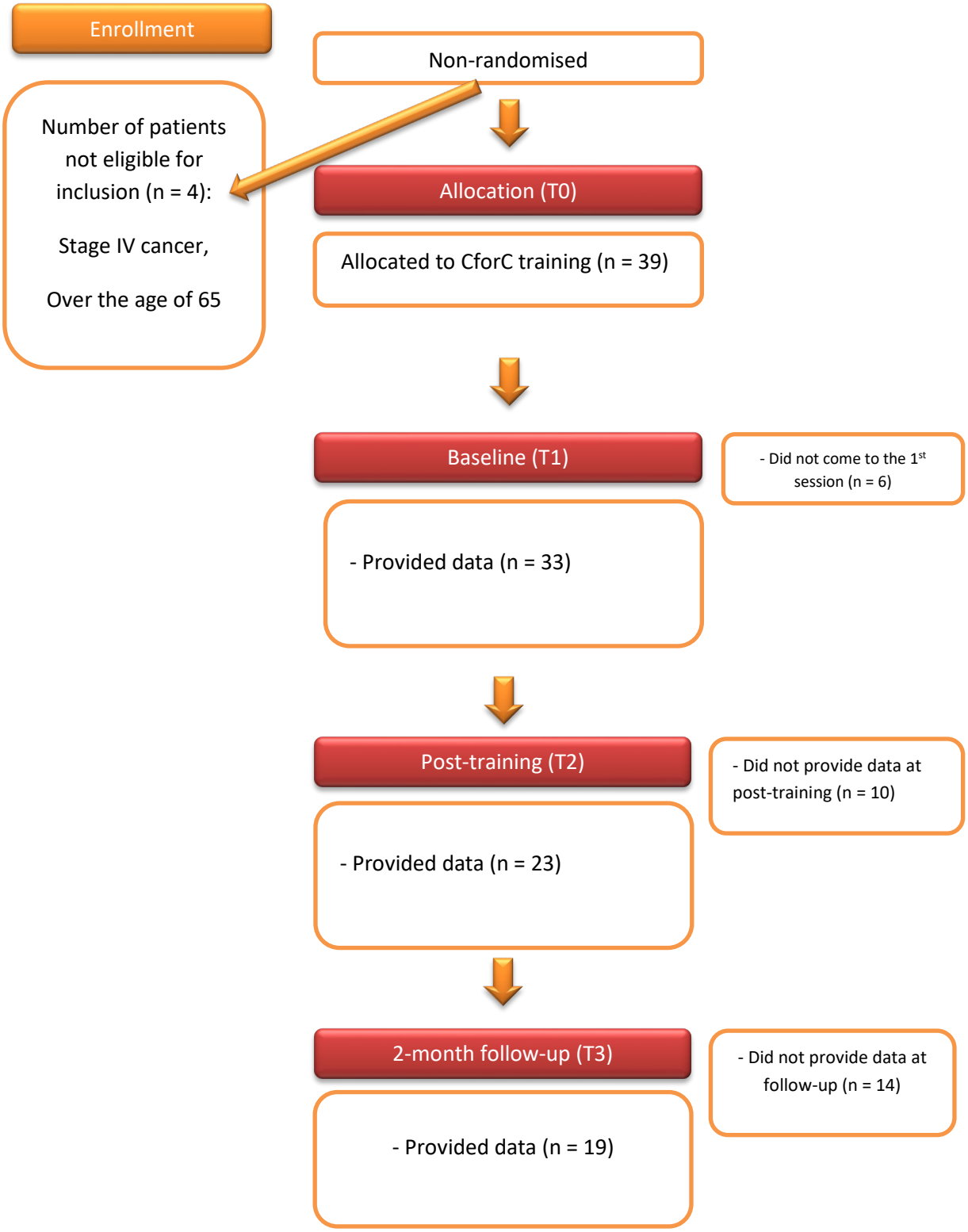
Attendance. Participants took part in an average of 5.79 classes (there were eight during the whole CforC training), with a standard deviation of 2.36 (median= 7); the scope of attendance ranged from participation in one meeting to attending all eight meetings (sessions). The participants completed the training courses in two cities; 19 were in Warsaw and 14 were in Żagań.

Thirty-three participants attended between one and eight sessions. Reasons for reported attrition and non-attendance included side effects of cancer treatment (e.g. feeling too weak to come), lack of transportation and location of training sessions (e.g. too far from home; no car; nobody to drive the participant to the venue), bad weather (e.g. high temperatures that made it difficult to participate), family issues (e.g. illness of a family member), and work overload. These reasons were either reported directly to one of the trainers or described in emails sent to Julia E. Wahl. Nobody reported that the content of the training course had resulted in attrition, but one needs to consider it to be a possibility on top of the reasons mentioned here.

The main limitations of the research are to do with the homogeneity of participants: only one ethnic group and gender being studied, the findings are based on a relatively small sample of a homogeneous ethnic and gender population; all clinical groups were based in Poland with only one male participant. Finally, there was a lack of a control or comparative group (see Figure 7). Nevertheless, a mixed sample of cancer patients and survivors was used (though the sample was representative of the clinical population: cancer patients and survivors), and the current series of studies indicate interesting and important directions for new research into helpful interventions for both cancer patients and survivors and is a novel training model for cancer patients and survivors.

Figure 7.

Participant flow after allocation and dropout throughout the study



In terms of working with cancer patients and survivors it has to be made clear that dropouts happen predominantly due to fatigue, feeling too weak to come to the class, ongoing treatment, problems with transport, and work overload (see Table 13). These factors have to be taken into account, not only in terms of running future studies but also in terms of any training programmes. However, these may be counteracted by introducing on-line training options, e.g. full on-line training programmes using Dropbox and Zoom or partial options to help with on-site absences, which has already been taken into account by including using Dropbox for the course materials, including recordings to be used for participants who could not be present during a specific session. Also, if someone does not attend up to three sessions this still does not constitute a dropout. However, these absences within the training programme (similarly to the MBSR course) are taken into account.

Table 13. Stages of specific studies.

Stages		**Number of participants**	**Number of dropouts**	**Reason given (dropouts or absences)**
Pre-study, Preparatory Stage and Research Design.	Informal interviews with various experts, including Profs Paul Gilbert, Christopher Germer, Eric Cassell, Yori Gidron, Jan Lubiński. Informal interviews with various cancer	N/A	N/A	N/A

	patients and survivors.			
Stage 1. **Pilot Study – Non-clinical group**	Initial recruitment (before the 1st session)	11	2	Personal reasons, not specified
	Pre-training data collection (1st session)	9	-	-
	Post-training data collection (last session): evaluation after the whole training	5	4	Personal reasons, e.g. partner's illness/ill health, too much work at work, family issues, no time to practise.
	Focus group	5	0 since post-training data collection.	All participated.
Stage 2. **Żagań group.**	Initial recruitment (before the 1st session)	14	-	-
	Pre-training data collection (1st session)	13	1	Personal reasons, not specified.
	Post-training data collection	12	1	Treatment.

	2-month follow-up data collection	10	2	Inability to come to the focus group because of treatment.
	Focus group	14	The additional 3 participants were not able to come to the 2-month follow up but were able to come to the focus group.	-
Stage 3. Warsaw 1st group.	Initial recruitment (before the 1st session)	13	-	-
	Pre-training data collection	9	4	Treatment, fatigue, lack of transport.
	Post-training data collection	6	3	Treatment, fatigue, lack of transport.
	2-month follow-up data collection	5	1	Treatment, fatigue, lack of transport.
	Focus group	3	2	Treatment, fatigue, lack of transport.

Stage 4. Warsaw 2nd group	Initial recruitment (before the 1st session)	12	-	-
	Pre-training data collection	10	2	Treatment, fatigue.
	Post-training data collection	4	6	Treatment, fatigue, lack of transport.
	2-month follow-up data collection	4	0	-
	Focus group	4	0	-

Given the small number of participants in one single focus group discussion (single focus group; Morgan, 1996) in the current research, there was not one single focus group but four (including the pilot study with non-clinical participants). The number of focus groups is with accordance with the recommendations that suggest that between three and four focus groups should be conducted for research topics (Burrows & Kendall, 1997). It also needs to be considered that mini focus groups, between two and five participants, are allowed according to research standards (Kamberelis & Dimitriadis, 2005), and may be part of mixed method research. Bigger size focus groups may also be problematic due to time constraints, as it is advised meetings for such groups should last up to two hours. In actuality, the number of participants in the focus groups was not low; as in the 1st focus group (pilot, non-clinical) there were five participants, and moreover, there were three focus groups for the clinical groups themselves: the first consisting of 14 people, the second comprised three people, and the third comprised four people.

6.2. Qualitative Data Analysis Overview.

Thematic analysis was once again employed (previously in the pilot study with non-clinical population) for the sake of verifying and evaluating participants' experiences. The analysis was based on participants' written evaluation after each session (W1: W1A for the group in Żagań, W1B for the 1st group in Warsaw, W1C for the 2nd group in Warsaw) and a focus group two months after the last (eighth) session (F: F1 for the group in Żagań, F2 for the 1st group in Warsaw, F3 for the 2nd group in Warsaw) and employed collectively across questions from forms and focus groups. In the first focus group in Żagań all participants took part. In the first Warsaw study, three (out of nine) participants took part; in the second Warsaw study, four participants (out of ten) (n=21).

As in the non-clinical/pilot study, all phases of analysis have been followed: familiarising with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the results (Braun & Clarke, 2006). Thematic analysis is described in more detail earlier in the chapter.

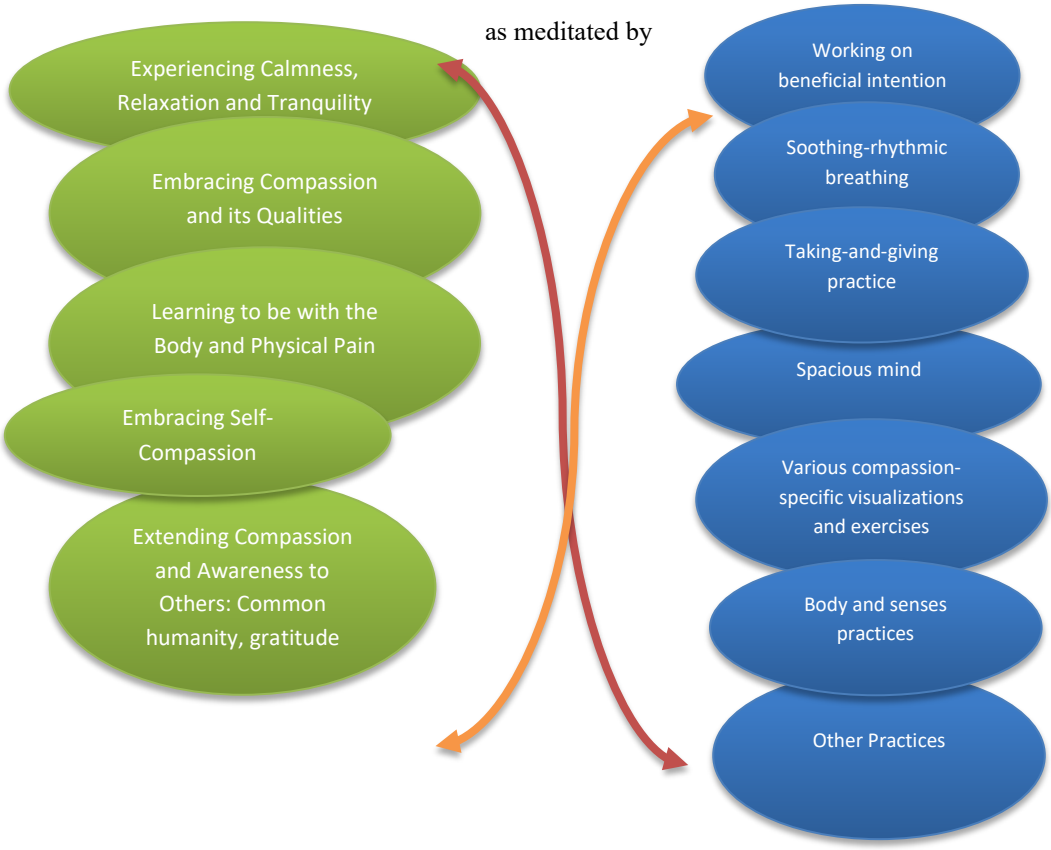
6.2.1. Qualitative Results.

Based on the focus groups and open-ended questionnaires, the following themes have been identified in terms of the beneficial practices as mediated through beneficial processes: "the taking and giving practice", "working on beneficial intention", "the spacious mind practice", "the soothing-rhythmic breathing", "various compassion-specific visualisations and exercises", "body and senses practices" and "other practices" (see Figure 8).

The beneficial processes that mediated it included: “experiencing calmness, relaxation and tranquillity; embracing compassion and its qualities”; “learning to be with the body and physical pain”; “embracing self-compassion”; and finally “extending compassion and awareness to others (common humanity, gratitude)”. It has to be noted that there were changes in terms of the identified themes between the clinical and non-clinical populations (see Chapter 2.)

Figure 8

Thematic map: benefits in terms of beneficial practices and processes



6.2.1. 1. Beneficial Processes.

Theme 1: Experiencing Calmness, Relaxation and Tranquility.

This theme referred to the ability to experience relaxation in terms of both physical and emotional experiences. Indeed, many of the participants reported the benefit of relaxation and calmness after each of the sessions, being able to "put things into perspective":

> *"I'm calming down and trying to forget about my problems that often turn out to be something banal in my life" (W1A, session 5).*

At times participating in the sessions posed a challenge but participants were still able to learn how to relax and be calm:

> *"…Today it was harder for me to focus but being able to participate provided me with tranquillity of body and mind" (W1A, session 6).*

What is important to note is that feelings of calmness went beyond experiencing it during or straight after specific sessions, and extended to general life experiences:

> *"It has tremendously changed my life, my thinking. I really calmed down" (F1 – Lidia)*

The calmness and/or relaxation also included the experiencing of realising some internal tensions:

> *"I let myself be now filled with peacefulness and letting go…" (F3 – Ania)*

The data on the effect of relaxation itself on most specific issues (such as depression) is scarce (Sheard & Maguire, 1999) and yet the issue of not being able to relax and the experience of

emotional and physical tension is often reported to be one of the reasons for engaging in psychological interventions for cancer patients and survivors and it was similar in this case.

Theme 2: Embracing Compassion and its Qualities.

Training in compassion inspired a number of personal qualities (i.e., courage/strength, warmth/kindness, understanding/wisdom, commitment/responsibility) which are included under this theme. These qualities both refer to a feeling, sense of, or an embodiment of a particular quality and being able to experience it in one's own actions.

Among the most important qualities mentioned was wisdom, which was seen by some as inseparable from compassion. This is consistent with the CFT conceptualisation of compassion and wisdom being joined together:

> *"...wisdom with compassion is tightly joined together, because without wisdom it's not there (compassion)" (F1 – Dobrosława).*

What inspired the process of acquiring a sense of wisdom and its direct application was the psychoeducation component:

> *"During this training I've received a tremendous knowledge, and this provided me with wisdom. How to react in stressful situations, how to calm down, how not to react, how to respond towards other people and this is all really connected to compassion" (F1 – Helena).*

It is also important to mention that the quality of wisdom meant gaining an understanding of one's life circumstances (i.e. reasons behind them or acceptance of them):

"For me there is now this reflection that I have understanding for everything, everything that I've been through" (F1 – Kasia)

Commitment (engagement) was also mentioned as one of important qualities of compassion:

"The four qualities… This was quite revealing for me because I thought I had most of these qualities and I felt that I had a very strong personality. And yes, I'm wise… Responsible and tender…. But now I think with this commitment I think I can do so much more" (F2 – Paulina).

This phenomenon can either be understood in terms of commitment as "dedication to completion of a line of action" or in behavioural terms, "factors that constrain one to continue a line of action" (Kiesler, 1971, p. XII), and thus can be cultivated and realised through specific compassion practices as was the case with CforC participants.

There were also comments associated with additional qualities of compassion, such as mindfulness, and the connection not only with other humans, but the general natural world:

"Not thinking about what's going to happen next… And to me it's this compassion that means "feeling". With… nature" (F3 – Gosia).

This shows that training in compassion may inspire feelings of interconnectedness, going beyond feeling connections with fellow human beings, and extending the feeling to other species and the natural world.

Theme 3: Learning to be with the Body and Physical Pain.

This theme referred to participants' ability to stay with one's body and bodily (somatic) experiences, regardless of de facto experience (whether it was neutral, pleasant, or

unpleasant). It also meant learning how other processes, such as one's own thoughts and mental attitudes (tenderness), influence the bodily experiences.

In the first instance, this process translated into noticing what was happening:

> *"They taught me (exercises) to notice and work on the things that I haven't yet resolved and that are difficult" (W1A, session 1).*

What also was revealed is how the CforC training influenced the way participants approached their body. Initially, this was similar to the process occurring in MBSR: participants starting to experience the body and oneself together (as joined entities instead of separated):

> *"In the past I would think that there is me… and (that) the body is separate. As if one had nothing to do with the other. And one can say that because of that lack of contact, things happened the way they did. And now I have a closer connection with it and I approach it with compassion. It's just one that it's a very good relationship" (F1 – Kasia).*

Additionally, the theme involved being able to see how the way of thinking (pattern of thinking and attitude towards one's mental processes) influenced the body and its sensations:

> *"For me it was really important to notice what I was thinking, the way I'm thinking and how this affected my body. Because it did have a big effect on my body" (F1 – Krystyna).*

Most importantly, the attitudinal change involved the body being approached in a tender way:

> *"I've read the autobiography of Marina Abramovic, the performer. She went to see a married couple of Shamans when she was going through a crisis. And she worked with the husband, and then the wife. And one point the wife said "kiss yourself, "your own*

body… So I was reading it and thought 'I'll give it a go" (kissing her hand). And so, I kissed it with so much tenderness. And this is it… and this related to the breath and body scan" (F3 – Agnieszka);

"(Agnieszka) mentioned kissing. After one of the body scans, I went to the bathroom, stood before the mirror and gave myself a kiss…" (F3 – Dorota).

As a means to be able to cope with physical difficulties, bodily sensations, apart from explicit compassion-focused practices, working with one's attention was one of the tools helpful in the process:

"I was travelling to Italy and thinking of my hip that was hurting, and I've shifted my attention to the parts that are healthy, and somehow managed to survive the 24-h trip" (F1 – Ewelina).

It may be postulated that working on managing physical symptoms included not only working on being with challenging sensations but also emotions associated with these sensations, i.e. being with various types of experiences in a new, compassionate and tender way.

Theme 4: Embracing Self-Compassion.

Self-compassion ,being the first flow or skill of compassion was often mentioned and this theme meant being able to notice and accept oneself and all the experiences (pre-, during and post-treatment/illness) in the first place without referring to the strategy of avoidance:

"I've realised I existed, that I problems exists because till now… for a variety of reasons I was avoiding facing myself and didn't have the time to do it" (F1 – Dorota).

The next stage in experiencing self-compassion included approaching oneself with care and tenderness:

> *"The exercises of touching yourself with love. It showed me that it is possible to be warm for oneself and nothing bad happened because of that" (W1A, session 5).*

What also needs to be mentioned are the obstacles encountered at first. These included conceptual assumptions that compassion meant compassion to others but not to oneself:

> *"It was difficult for me. To generate compassion towards myself, towards a person who all their life thought about pleasing others, to be a good wife, mother…, and after the training course I've realised how I was wasting my life, and only then I started thinking about how to show compassion to myself, it was like this opening, so much space that I haven't previously made use of… (F1 – Krystyna).*

Additionally, with more practice self-compassion was cultivated and extended to being more accepting and understanding of one's shortcomings, limitations (including physical ones), feelings, and behaviours:

> *"Surrounding yourself with kindness and love provided me with feeling of soothing and understanding towards my imperfection" (W1A, session 2).*

Other processes involved in becoming more self-compassion included seeing the changes in "experiencing of self" slowly occurring:

> *"Personally, the meetings made me realise that I didn't have any compassion for myself. All my life I've thinking about others. I worked, I raised my children, I ran my house. But in all of this I could not see myself, I did not take of care myself, and finally my body rebelled against me… I've realised that that one needs to… That I am as well. That I too need compassion, not only the others" (F1 – Paulina).*

For practitioners of CforC self-compassion also meant that they were able to learn to accept oneself fully:

> *"After the training with Małgosia… Previously less and now more and more… I'm feeling more accepting towards myself. Self-acceptance but the maximal one" (F1 – Grażyna).*

The experience of self-compassion was also related to the experience of illness and the ability to cope with it better and taking better care of one's body. This included taking care of oneself while receiving (active) treatment:

> *"Previously I would be ashamed to feel self-acceptance and I would behave totally against my body and my beliefs" (F1 – Jagoda) "For instance when I was receiving chemotherapy I was sitting, I was tired but ashamed to close my eyes as someone might think 'she came here and she's sleeping'. I was just imagining things… And now I can easily sit on this chair, the nurse does everything, I close my eyes and fall asleep. I disconnect from everything. I'm no longer afraid that something might fall down (the chemotherapy) and I won't be quick enough to catch it and that the nurse might come and shout at me…" (F1 – Jagoda).*

Experiencing self-compassion also translated into an active way of managing one's being in a more skilful way:

> *"...for me in the past the word compassion had negative connotations… and now I think it's a positive way of thinking because then you start to care about yourself... when there's pain, you have to do something to ease it. Thinking about you need to look after your health, to be in a better mood" (F1 - Krystyna).*

Self-compassion also inspired feelings of calmness and safeness, and the ability to experience other flows of compassion (compassion for others and the ability to receive compassion from others):

> *"There was this exercise in which someone was expressing compassion towards me and this was such an experience to me… A huge experience. I then started feeling that I had some value" (F1 – Dorota).*

Apart from calmness, acceptance and understanding self-compassion also included gentleness:

> *"I have more gentleness towards myself… More space for myself, more acceptance. This way of looking with acceptance, without judgement…" (F1 – Marzena).*

Finally, due to the processes of self-compassion some of the participants were able to gain a more realistic expectation towards themselves:

> *"Now I expect less from myself… Previously even when I let myself relax; I would feel guilty about it. To relax, do nothing. That would bring about a lot of guilt" (F3 – Gosia)*

In summary, it was a very positive experience resulting in mental (attitudinal), affective, relational and behavioural changes:

> *"I've experienced many difficult things… and the same time… my divorce, that is my illness first, and then several months later the split. And this divorce was worse than anything else. But when I came to the classes and listened to compassion, I was almost proud of myself ... after the first classes ... because I often cried, in my past, having had difficult experience, I shouted "how I feel for myself". Only that it was completely different from what I learned here and what I learned straightened to some degree,*

maybe not 180 degrees right away. It straightened my thinking and the way I was reliving the past. Here I grabbed ... I do not know, like this hook, a hint, which automatically appears when needed. Maybe not the word "how I feel for myself", but "I can act, I am strong, I am wise", which I used to be, before classes, my friends or someone close to my family "You are wise, you are strong", do you my sons. I could not hear it. It was quickly moved away. And here at which class I heard a voice flowing towards me, "you are wise, strong, gentle, kind and committed." I will remember this to the end of my days.... There were so many tears that I couldn't stop it..." (F3 – Dorota).

As described above, the experience of self-compassion can have a powerful affective effect on how one is approaching oneself, including the difficult parts, one's life events, and other individuals

Theme 5: Extending Compassion and Awareness to Others: Common humanity, gratitude and understanding.

This theme described the cultivation of compassion as extended to other flows of compassion (ability to receive compassion and give compassion). This included affecting and changes in relationships mediated by common humanity:

"Imagining how I can give compassion to my close ones and the unknown people or the person with whom I have a difficult relationship with. It has showed me that all of us, no matter what our relations are, what our occupation, age is, wishes for happiness and love in our lives. This exercise brings out towards another human being. A wonderful feeling – a feeling of warmth in one's heart" (W1A, session 3).

Experiencing compassion through the practices also helped participants support other people (second flow of compassion: ability to give compassion to others) and understand various expressions of suffering:

> *"…Compassion is an important element of support for the suffering person, whether the suffering is physical or an emotional one" (W1A, session 3).*

Other benefits of extending compassion included gaining a different perspective concerning others which once again may be related to the experience of common humanity

> *"It's an eye-opener in terms of looking at the lives of others. Suffering isn't only my domain, and by giving compassion to others one can feel better" (W1A, session 3).*

Gaining understanding towards others was another issue described by CforC practitioners. This included understanding how other people function, what their difficulties are, becoming less judgemental and critical:

> *"I had too many expectations towards my husband. I made him tired and myself. And then I realised that he's a human being, that he's got his own point of view… Our relationship is much warmer now. We're no longer afraid of each other. He's not afraid that I will say something again and I catch myself wanting to say something and thinking "you don't have to say it" (F3 – Ania).*

Finally, there was a general feeling of gratitude which can be explained as both compassion and gratitude being "mutually and reinforcing emotions", together with awe and joy (Robbins, 2015):

> *"Most importantly, I'd like to thank for being able to participate in these sessions because they were very important to me" (F1 – Dorota).*

Overall, his theme highlights the relationality of compassion, i.e. the practices of compassion not only being directed at oneself and self-regulation of the affective system but expanding to the realm of how one approaches others.

6.2.1.2. Beneficial Practices.

The processes described above were meditated through a variety of specific practices present in the CforC curriculum. The rationale for these specific practices has been described in Chapter 3. What was found in the thematic analyses also included the main practices of benefit to the participants.

Theme 1: The taking and giving practice (tong-len).

The importance and value of the practice of *tong-len* has been discussed in Chapter 3 but it was of interest in the clinical studies to see whether this extended to cancer patients and survivors. As anticipated, this practice caused some difficulties at first, even including experiencing difficult physical sensations:

> *"The practice of giving and taking. This hasn't been easy for me, especially when I was experiencing a constant pain in my hand" (W1A, session 4),*

Various difficulties occurring during the practice also slowly evaporated:

> *"The most beneficial exercise was the one with the dark cloud breathing (taking it in) that caused me some discomfort, feeling of squeeze. This discomfort then disappeared when I was dissolving everything into a bright light, there was tranquillity, feeling of soothing" (W1A, session 4).*

The experience of cancer often left participants feeling powerless. Nussbaum sees being powerless as to surrender omnipotence (Vanden Eynde, 2004). Yet to feel powerless and to surrender one's omnipotence are very distinct actions: to surrender the latter one can actually not only help one be more realistic but be a freeing experience, as it is described in the above quotation. This experience may be facilitated through the practice of *tong-len*.

Even though some participants still experienced difficulties during the practice of *tong-len*, they could see a benefit in it for themselves:

> *"This 'cloud' came when I needed it … I reacted to it very emotionally. I rebelled against because I was afraid of it at first… even the most difficult of things I change through my work. And it's then when I don't run away, I access it and I have enough strength that I'm able to change it" (F2 – Marzena).*

In terms of other benefits of the practice, it also helped participants become aware of various parts (e.g. aspects, expressions of self, modes of being) that they had:

> *"The practice of giving and taking. I've discovered different parts of myself" (W1A, session 4).*

The experience of seeing oneself in different ways may also have a freeing effect as one learns to embrace various aspects of oneself, including seeing illness as only one part of themselves and not the ultimate truth about who one is (i.e. one stable and never changing identity).

The practice of *tong-len* also helped participants be with oneself in a more intimate and deeper way:

> *"Giving and taking - I was able to inspire emotions and visualize the cloud which is cleansing itself in my body. I've entered myself deeply" (W1B, session 4).*

Another value of the practice has been expressed through the experience of calmness, relief, and relaxation:

"The practice of taking and giving towards myself and others. This calms me down and provides me with peace" (W1A, session 8);

"Giving and taking" – feeling of relief and relaxation" (W1B, session 5);

"The practice of giving and taking because afterwards there's a feeling of relief" (W1B, session 5).

The taking and giving practice has also been related to seeing what was important in terms of personal mundane needs and values:

"Tong-len – I've realised what I needed in my daily life" (W1B, session 4).

Most importantly the practice helped teach how to be with difficult aspects of one's life (regardless of its nature):

"The practice of taking and giving because it has opened me to a difficult problem I'm facing in my family" (W1C, session 4).

Another benefit due to the practice of *tong-len* included expanding oneself to others and cementing bonds:

"The practice of taking and giving towards a sick friend – I've realised how deep the fear of illness is, how instinctively the body shrinks in self-defence, how difficult this practice is" (W1C, session 6),

"The practice of giving and taking – I felt the bond with my adult, sick son" (W1C, session 8).

This shows that practising *tong-len* can help overcome fear of one's suffering and the suffering of others (Orellana-Rios et al., 2018) by gradually familiarising oneself with various types of difficulties rather than consciously or unconsciously avoiding them.

Theme 2: Working on beneficial intention (BI).

The second theme in reference to important practices referred to the practice of cultivating conscious intention(s) which is described in full within Chapter 3.

Focusing on one's intention is the very first practice of CforC. Intention is about "deliberateness" or an "articulation of a conscious goal" (Jinpa, 2015). This process (focusing on intention) is helpful in itself as it can result in mental reformulation:

> *"The intention practice – it helps me organise my thinking" (W1B, session 8).*

Another benefit and by-product of this type of practice included new conative discoveries (i.e. finding new meaning in terms of one's life or rediscovering it):

> *"Intention – I've discovered a new, deeper aim that is connected to others and all other exercises" (W1B, session 8).*

This type of practice is both the starting point and one that participants finish with. This can be related to the Vedic term and concept, "that which is remembered" (Sank. स्मृति "smriti") or needs to be remembered. It is not only the act of reminding oneself of what is actually happening (e.g. mindfulness of the present moment), but most importantly what one needs to and wants to cultivate in life (e.g. which affective and mental qualities, activities, behaviours, mindfulness of intention and values):

> *"Realising my most important intention – because there are many" (W1C, session 1).*

This mindfulness of intention lets one remember what is important in both life and death, and what one wants to cherish throughout their lives, and what priorities to focus on.

Theme 3: The spacious mind practice (SMP).

Another practice that was mentioned on many occasions was the spacious mind practice which is based on the *vipaśyanā* or the *śūnyatā* practices and its non-conceptuality (nonconceptual awareness).

This practice is one of the practices that allows practitioners to experience the calming down effect:

> *"Thinking about those good and bad thoughts – spacious mind. It helped me calm down" (W1A, session 5).*

Other benefits of the practice included feeling strength and freedom (resilience):

> *"The expanding mind/spacious mind – among the troubling thoughts appeared some space. I managed to let go of some of them and enjoy the space, the wide perspective, omnipresence" (W1B, session 7),*

Similar to the practice of *tong-len*, a feeling of interconnectedness was experienced:

> *"It allowed me to see how interconnected we all are, how everything has got a meaning (life, the way the world is, intelligence that created us)" (W1, session 5)*

Theme: 4: The soothing-rhythmic breathing (SRB)

Alongside intention, focusing and exploring the breath is the foundation of all other practices (as described in Chapter 3). Firstly, letting practitioners physiologically and mentally slow down:

> *"Mindfulness and the breath are good foundation for calming down – which I liked" (W1C, session 1).*

Breathing can even have an effect on being able to experience gratitude:

> *"The breathing exercises – feeling of gratitude" (W1A, session 6).*

Focusing on a soothing pattern of breathing (as described in Chapter 3) also allows one to understand one's emotions:

> *"The breathing exercise because I'm seeing results in the way I'm feeling and how I understand my emotional moods (modes)" (W1B, session 1).*

Self-regulating through appropriate breathing can be easily applied after the sessions and incorporated into daily life:

> *"…the breathing-soothing… It's now part of my daily routine" (F1 – Lidia).*

Theme 5: Various compassion-specific visualisations and exercises.

Under this theme all of the various practices directly addressing compassion and its qualities are listed. In compassion-focused work, there were practices directed at all three distinct flows of compassion (giving to oneself, giving to others and being able to receive it from other people). Receiving compassion from others was done through either explicitly focusing on

memory or through imagery work (e.g. compassionate being imagery, safe place imagery). The overall experience of imagery work focusing of compassion has been received well:

"Working with imagery is amazing" (F2 – Dorota),

"The practice concerning the compassionate being. It was so pleasant, nice, warm and very vivid" (W1B, session 2).

Giving compassion to oneself and others was also experienced as one of the most important practices during some of the sessions. Among the most important issues raised were the experiences of feeling safeness:

"The visualisation of the safe place because it was the easiest thing for me to visualize. I was able to think of a place, so it was easier to go back to it. Was able to experience the smell and all the senses and so I'll be returning there" (W1B, session 2).

The common humanity exercise was also mentioned as an important exercise in being able to look at other individuals in a changed way:

"Common humanity because it helped me gain a different perspective when it comes to looking at others" (W1B, session 6).

Among the practices helpful in treatment and physical difficulties was the "compassionate colour" imagery", which was also helpful in situations directly involving cancer treatment:

"The compassionate colour – I hope to try it tomorrow during my chemotherapy which I don't cope with well" (W1C, session 2).

The practice of "compassionate being" also provoked changes in emotions and in the body:

"Visualising the compassionate person and working on emotions – I felt the change in emotions through my whole body" (W1C, session 3).

Theme 6: Body and senses practices.

This theme listed the beneficial practices concerned with kinaesthesia, the sense of proprioception and other senses, including the sense of touch. The power of touch (or self-touch) was among the most important practices evoking feelings of tenderness towards oneself:

"Touching myself. An amazing feeling. I've never touched myself with love and compassion. I didn't even know this was possible" (W1A, session 5)".

Working with compassionate movement was also mentioned as a beneficial exercise in terms of being more mindful of the body and additionally experiencing one's body in a different way (e.g. experiencing physical strength):

"Slow walking. It helped me focus on each and every movement of my legs, feet, toes. Helping me cultivate mindfulness" (W1A, session 4).

The compassionate body scan was also reported as beneficial – in terms of being able to relax and be kinder with oneself:

"Body scan because I didn't fall asleep and looked at myself with kindness" (W1B, session 5).

The exercise of shifting attention to various physical experiences helped expand a variety of experiences which can be very helpful when one is only focusing on the painful areas (areas associated with surgery, radiotherapy, etc.):

"Looking for the place of pain without the pain, and the places of pleasure" (W1B, session 5).

Focusing on pain in CforC was similar to "physical *Naikan*" (Miki & Kuroki, 1998; Otani, 2003) in which one focuses on problematical areas or sensations of the body in a reflective way and thus, gradually changes the way one relates to the body and its sensations.

Theme 7: Other practices.

There were also other distinct practices that were mentioned by participants and/or trainers One of them being focusing on the three different affective modes and therefore being more understanding of oneself and others:

"Being able to recognise the three modes: mode of anger, excitement, and being soothed. Realising they're occurring in all humans and what the proportions are" (W1B, session 1).

This particular exercise was additionally mentioned by the trainers (Małgorzata Wawrzynkowska and Magdalena Mazurkiewicz) as one of the important practices in terms of participants realising how they affectively function on a day-to-day basis. Thus, being able to notice various aspects of experience triggering each of the modes of affective functioning.

Focusing on different parts of oneself was also reported as being important:

"Different parts because it helped me see the source of my frustrations and reactions, helped me fully relax my mind" (W1B, session 3)".

The importance of focusing on different parts has been described elsewhere in this chapter - but it is important for cancer patients to be able to experience various parts of oneself; also the parts not associated with illness as it allows patients to expand their emotional topographies beyond the limited and difficult view of illness and treatment.

Working with the experience of anger was another practice that was important to both practitioners and trainers:

> *"The exercise concerning anger because quickly and directly shows the consequences of letting go" (W1B, session 6).*

This particular practice is particularly important as negative affect anger is most detrimental if repressed and the ability to express it is associated with a better quality of life and lower depression in breast cancer patients (Lieberman & Goldstein, 2005; Julkunen, Gustavsson-Liliusa, & Hietanen, 2009). Additionally, anger is often experienced by patients with life-threatening disease (Gerhart, Sanchez Varela, & Burns, 2017).

Gratitude was another experience reported as important. It can be understood as a "*tendency to recognise and respond with grateful emotion to the roles of other people's benevolence in the positive experiences and outcomes that one obtains*" (McCullough et al., 2004, p. 112), and focusing on gratitude was one of the practices being employed in participants' everyday life:

> *"The practice of gratitude – I felt how the empty heart got filled up, how the hungry (internal) infant got fed, how important it is to appreciate the crumbs of everyday goodness in life" (W1C, session 6).*

6.2.1.3. Trainers' Reflections and Intentions.

As stated before, the two trainers have also given their feedback in order to expand on the findings and deepen the understanding of what was beneficial to participants.

It may be useful to use some of the information provided by the two trainers. Once again, it is important to note that the two trainers had different professional and personal backgrounds, lived in two different locations (cities and regions) and had never met one another.

Similar to the participants, it is important to first look at the intentions of the trainers concerning running CforC. Both of the trainers (T) reported personal, professional and communal intentions, with one of the trainers stating that the intention was to:

> *"Educate and experience both at a personal level and for the sake of others. I wanted for the participants to evaluate if the process was beneficial to them or not"* (T1).

The second trainer also mentioned the CforC training programme being a way of directly helping oneself whilst also hoping to help others:

> *"Support oneself in a difficult life situation, to once again find strength, motivation and meaning of life, to do something useful, something that has got a meaning and will help others who are facing difficulties, especially difficulties concerning illness"* (T2).

The two-fold intentions (personal and professional, working for others) seems to be very important as the trainers are advised not to put themselves above the practitioners and practice alongside the whole group, joining the whole community of practitioners for the sake of shared experiences and the aspect of common humanity. Interestingly, in the course of CforC training reciprocity occurred.

The personal benefits the trainers have reported, similarly to the experiences of CforC participants, included feelings of tranquillity:

> *"Being able to participate in the CforC myself apart from just being the trainer and thanks to that I felt more at ease and peace…"* (T1).

The second trainer reported another benefit, namely reciprocity, i.e. the process of not only being able to give but also receive (Sandhu et al., 2015):

> *"joy at being able to give, a feeling of connectedness with others, energy"* (T2).

This once again refers to the need and value (benefit) of the trainer being part of the group and not just the expert delivering the training (i.e. interrelationality).

The obstacles faced by trainers were also reported and included both technical issues as well personal difficulties: "to personalise the way of delivering the exercises" (T1), while the other mentioned working with people who were in active cancer treatment (T2). The former issue refers to being skilful at using one's own style of presenting and not rigidly adhering to the written instructions; the latter points out the importance of enough time being given to psychoeducation and practicalities of the cancer experience to potential trainers who may or may not have the sole theoretical experience of psycho-oncological issues.

6.2.1.4. Summary of Qualitative Results.

This study aimed to evaluate the structure of the CforC curriculum and any potential benefits of participation in it. Five themes (beneficial processes) were identified that were based on: i) evaluations after each session; ii) an evaluation after the whole training programme; and iii) the post-CforC focus groups: "experiencing calmness, relaxation and tranquillity" (theme 1);

"embracing compassion and its qualities" (theme 2); "learning to be with the body and physical pain" (theme 3); "embracing self-compassion" (theme 4); and finally "extending compassion and awareness to others (common humanity, gratitude)" (theme 5). Additionally, seven themes concerning beneficial practices (which have been described in Chapter 3) have been identified: "the taking and giving practice" (theme 1), "working on beneficial intention" (theme 2), "the spacious mind practice" (theme 3), "the soothing-rhythmic breathing" (theme 4), and "various compassion-specific visualisations and exercises" (theme 5), "body and senses practices" (theme 6) and "other practices" (theme 7). It has to be noted that there were differences in terms of the identified themes between the clinical and non-clinical populations (see Chapter 2). The themes "experiencing calmness, relaxation and tranquillity" and "learning to be with the body and physical pain", illustrate how participants were able to learn to self-regulate, including both emotion regulation (as described in Chapter 2) and self-regulation in action. This was achieved through regulatory process of bodily and affective systems (i.e. exercises employing and aimed at the two dimensions, including breathing exercises).

It is important to not only look at these two processes of regulation (emotion and action) distinctively but to evaluate how they are intertwined (Koole, Van Dillen, & Sheppes, 2009). To explain it in more details, self-regulation in action refers to what behavioural strategies one employs, including formal practices used in various training programmes, and how these strategies influence the affective system. One of the practices involved changing how one engages in bodily experiences (e.g. pain) including diverting attention (attentional deployment) to a different object (location, area) and therefore preventing triggering of an emotional dimension of a stimulus to be fully processed (Koole, Van Dillen, & Sheppes, 2009). This also shows how the two types of regulatory processes are interconnected. Another regulatory strategy applied in the CforC training programme involved response modulation,

in other words, learning how to be with a particular experience (e.g. emotional, bodily) in a different way (e.g. by employing breathing exercises) without having to eliminate it. Working with the body can also be done through a variety of kinaesthetic exercises which can not only help one recognise areas of tension but also result in physical relaxation (Kabir et al., 2018) which results in the experience of calmness (Ohno, 2015).

The two themes "embracing compassion and its qualities", "embracing self-compassion" reflect the interconnectedness of all flows of compassion and the value of focusing at all of them in one training paradigm: as participants not only focus on their own well-being but experience the value of common humanity, being part of a larger human family. If the area of interest solely lies in focusing on the self this becomes dangerous as heightened degrees of self-focused attention is associated with various clinical disorders (Ingram, 1990), including social anxiety disorder (Boehme, Miltner, & Straube, 2015). Some researchers claim that it may also exaggerate processes of self-cherishing and traits of self-esteem (narcissism) (see Brummelman, Sander Thomaes, & Sedikides, 2016) or whilst feeling well with oneself (self-compassion) also experiencing isolation or even superiority (J. Kirby, personal communication, 2016). The antidote therefore may be focusing on other beings and the emotional exchanges one has with them in order to avoid fixation on oneself.

In terms of the last theme "extending compassion and awareness to others (common humanity, gratitude)" it is also important to mention that the experiencing of gratitude is very important in terms of being protective against various types of psychopathology and helps to have a more compassionate relationship with oneself and others (Petrocchi & Couyoumdjian, 2015). Additionally, it serves as a buffer from negative affect which may be experienced during the first exposure to compassion-focused techniques (Singer & Klimecki, 2013).

In summary, based on the described benefits and recommendations, it can be concluded that there was value of CforC being delivered to cancer patients and survivors similar to the experiences of the non-clinical group described in Chapter 2. Additionally, for future studies, it would be important to see how the experience(ing) of trainers may affect the experience of participants. In conclusion, both cancer patients and survivors reported various changes, e.g. in the way of approaching oneself (e.g. being able to relax and be more self-compassionate) and various aspects of one's experience (e.g. having more understanding), including differences in relating to one's body, pain, and other people.

The quantitative results will be described in next paragraphs. These include how compassion was associated with changes in mindful states, stress, satisfaction, emotion regulation, post-traumatic growth (as assessed by appropriate questionnaires) for cancer patients and survivors and confirm the appropriate weekly themes and format once again (order and types of themes, exercises).

6.3. Quantitative Results.

In the previous section, qualitative (based on open-ended data) results of the study with a clinical population have been described and five themes (beneficial processes) were identified that were based on: i) evaluations after each session; ii) an evaluation after the whole training programme; and iii) from the post-CforC focus groups. The themes were: "experiencing calmness, relaxation and tranquillity" (theme 1); "embracing compassion and its qualities" (theme 2); "learning to be with the body and physical pain" (theme 3); "embracing self-compassion" (theme 4); and finally, "extending compassion and awareness to others (common humanity, gratitude)" (theme 5). Additionally, seven themes concerning beneficial practices (which have been described in Chapter 3) have been identified: "the taking and giving

practice" (theme 1), "working on beneficial intention" (theme 2), "the spacious mind practice" (theme 3), "the soothing-rhythmic breathing" (theme 4), and "various compassion-specific visualisations and exercises" (theme 5), "body and senses practices" (theme 6) and "other practices" (theme 7).

In this section the quantitative results (based on closed-ended data) will be presented. The rationale for using mixed methods was to make the studies both more flexible and feasible, integrate and synergise the data collected in order to gain a more complex and insightful picture of the benefits, processes and various perspectives concerning CforC training programme. The application of mixed methods can also enrich the understanding of quantitative results and the two sets of results (quantitative and qualitative) can be compared (McKim, 2017).

Seven hypotheses were tested which are described in detail below.

Concerning research problem I.

Participants in compassion-based training (study group) will be characterised by increased frequency of mindful states on a daily basis after the training and in the follow-up.

Concerning research problem II.

Participants in compassion-based training (study group) will be characterised by decreased perceived levels of stress after the training and in the follow-up.

Concerning research problem III.

Participants in compassion-based training (study group) will be characterised by higher levels of life satisfaction after the training and in the follow-up.

Concerning research problem IV.

Participants in compassion-based training (study group) will be characterised by a better sense of meaning in life in two dimensions (presence of meaning and search of meaning) after the training and in the follow-up.

Concerning research problem V.

Participants in compassion-based training (study group) will be characterised by a better emotional regulation in two dimensions (cognitive reappraisal and expressive suppression) after the training and in the follow-up.

Concerning research problem VI.

Participants in compassion-based training (study group) will be characterised be higher levels of being comfortable with closeness, feel they can depend on others, and are less anxious or fearful about such things as being abandoned or unloved - after the training and in the follow-up.

Concerning research problem VII.

Participants in compassion-based training (study group) will be characterised by higher levels of the ability to be successful in reconstructing or strengthening their perception of self, others, and the meaning of events - after the training and in the follow-up.

6.3.2. Analysis.

The assumptions for the use of parametric tests were verified, however, due to the small size of groups, and unequal size of groups, non-parametric tests were used, using a significance level of 0.05. In order to compare the results for all studied scales and subscale between pre-

test, post-test and follow-up, analyses with two-way analysis of Friedman's variance were first made according to the rank for dependent samples, then they were examined using Wilcoxon rank marks tests. In order to investigate the relationship between the results of individual scales and subscales with age and attendance during the classes, Kendall's Tau-b correlation analysis was used. In addition, with the Mann-Whitney test, an in-depth analysis of differences between groups depending on the city, health status, work, level of education, experience of meditation and mindfulness was performed by performing comparisons within the groups. Sten scores were also reported due the adaptation and validation of the questionnaires in Poland. Data analyses were performed using IBM SPSS Statistics 24.

6.3.3. Results.

There were differences reported in all seven questionnaires (see Table 14). The first hypothesis to be tested was "does training in compassion skills impact the frequency of mindful states on a daily basis".

Table 14. Overall results for all measures (median, range and/or interquartile range).

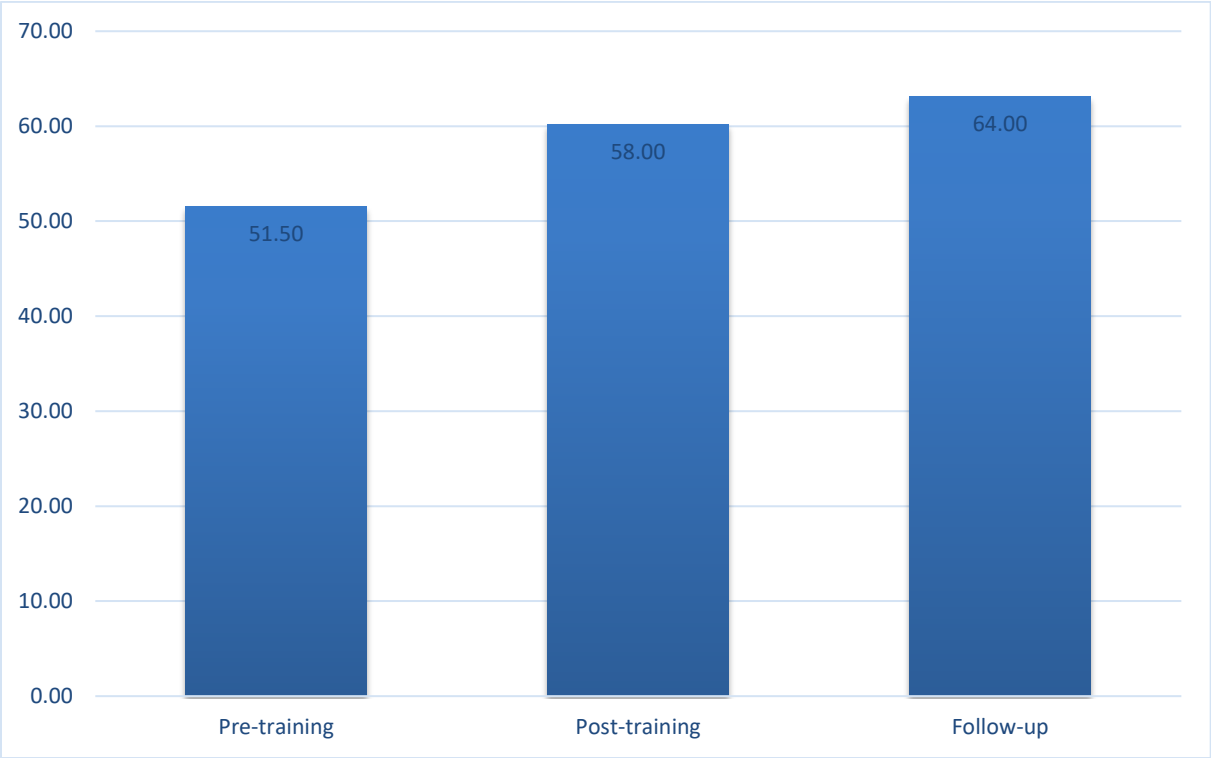
Name of measure		Pre-training (baseline)	Post-training	Two-month follow-up
	Subdimensions, facets or domains of particular measures (if applicable)	Median[a,b] Range and Interquartile Range	Median[a] Range and Interquartile Range	Median[b] Range and Interquartile Range

MAAS		M = 52.50 R = 50.00 IQR = 13.50	M = 62.50 R = 33.00 IQR = 14.25	M = 63.50 R = 31.00 IQR = 20.50
PSS		M = 24.00 R = 15	M = 23.00 R = 15	M = 22.00 R = 12
MLQ	Search of meaning	M = 20.00 R = 19.00 IQR = 5.50	M = 24.00 R = 8.00 IQR = 4.50	M = 24.00 R = 12.00 IQR = 5.50
	Presence of meaning	M = 23.00 R = 19.00 IQR = 9.50	M = 28.00 R = 23.00 IQR = 8.50	M = 27.00 R = 25.00 IQR = 8.50
ERQ	Cognitive Reappraisal	M = 27.50 R = 21.00 IQR = 7.75	M = 35.00 R = 24.00 IQR = 9.25	M = 32.50 R = 15.00 IQR = 11.25
	Expressive Suppression	M = 12.00 R = 17.00 IQR = 7.75	M = 12.00 R = 15.00 IQR = 8.50	M = 9.00 R = 16.00 IQR = 6.25
RAAS	CLOSE	M = 19.00 R = 16.00 IQR = 6.75	M = 20.50 R = 13.00 IQR = 5.75	M = 21.00 R = 16.00 IQR = 8.25
	DEPEND	M = 18.50 R = 12.00 IQR = 3.75	M = 19.50 R = 12.00 IQR = 6.75	M = 19.50 R = 16.00 IQR = 6.25
	ANXIETY	M = 17.00 R = 21.00	M = 16.00 R = 17.00	M = 13.50 R = 18.00

		IQR = 8.75	IQR = 10.75	IQR = 11.75
SWLS		M = 21.00 R = 19.00 IQR = 8.50	M = 24.00 R = 22.00 IQR = 6.00	M = 26.00 R = 18.00 IQR = 7.00
PTGI	Changed perception of self	M = 32.00 R = 38.00 IQR = 9.75	M = 37.50 R = 23.00 IQR = 8.25	M = 38.00 R = 17.00 IQR = 9.50
	Changed interpersonal relationships	M = 24.00 R = 31.00 IQR = 10.50	M = 29.50 R = 19.00 IQR = 5.25	M = 30.00 R = 21.00 IQR = 6.50
	Appreciation of life	M = 12.00 R = 14.00 IQR = 4.00	M = 13.00 R = 7.00 IQR = 3.00	M = 14.00 R = 7.00 IQR = 3.00
	Spiritual change	M = 7.00 R = 7.00 IQR = 3.00	M = 6.50 R = 9.00 IQR = 3.25	M = 7.00 R = 8.00 IQR = 3.25

In terms of MAAS, a two-way analysis of Friedman's variance according to rank for dependent samples showed that there were significant differences between all stages of evaluation (χ^2scores = 10.78, $p < 0.05$). Additionally, detailed analysis carried out with the Wilcoxon rank marks tests showed significant differences between pairs of measurements (i.e. pre-post, post-follow-up) indicating that the average MAAS scores for the pre-test training stage were significantly lower than for the post-training stage ($Z = -3.25$, $p < 0.01$) and follow-up ($Z = -2.94$, $p < 0.05$). However, although the results for the follow-up were higher than the results from the post-training (post-training vs. follow-up), the difference was not significant ($Z = -0.47$, $p = 0.64$)

Chart 3 Median – results for MAAS in three stages of evaluation (pre-training, post-training, and follow-up).



Based on these results it was concluded that MAAS was significantly higher at the post-training and at follow-up stages than at the pre-training stage (baseline) (see Chart 3).

In terms of the second research problem (does training in compassion impact perceived stress) there were also changes. The PSS questionnaire at the pre-training stage was completed by 33 participants, 23 participants at the post-training stage, and 19 at the follow-up stage. For the pre-training stage, stress severity measured in terms of the mean PSS score was $\mu = 24.58$ with a standard deviation of 3.69 ($\mu = 24$) (see Table 13).

Chart 4. Median – results for PSS on three stages of evaluation (pre-training, post-training, and follow-up).

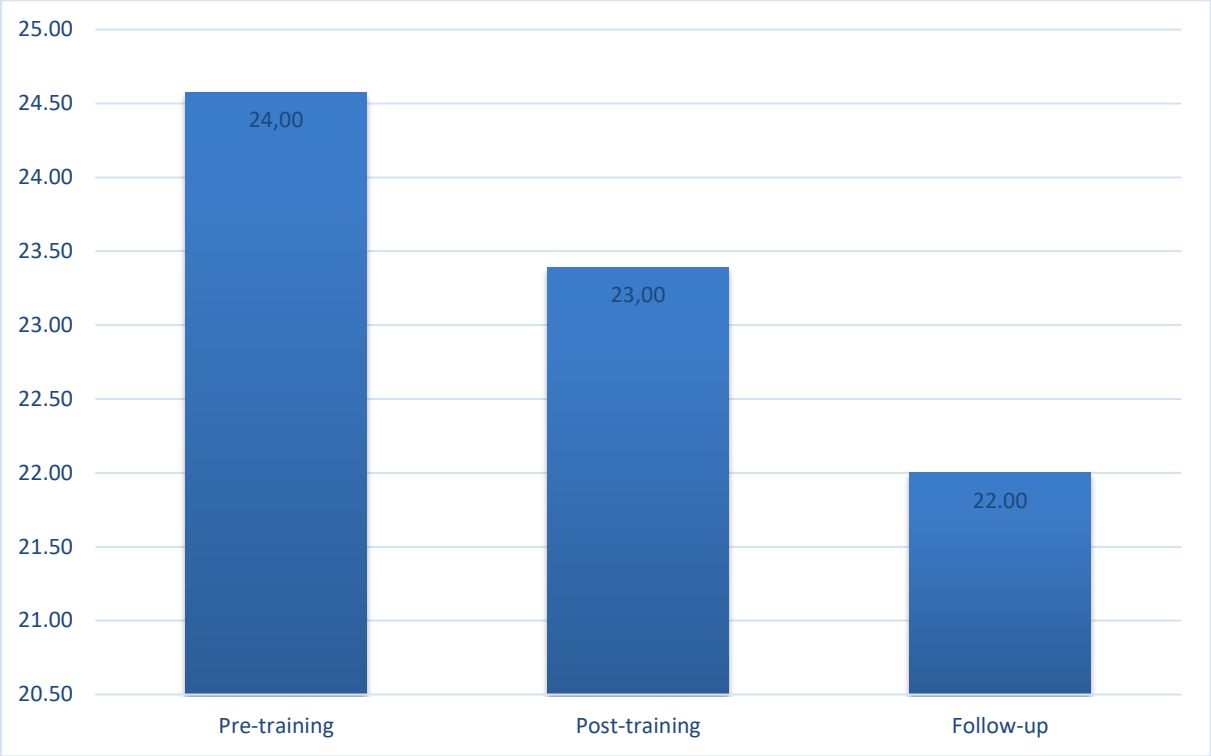
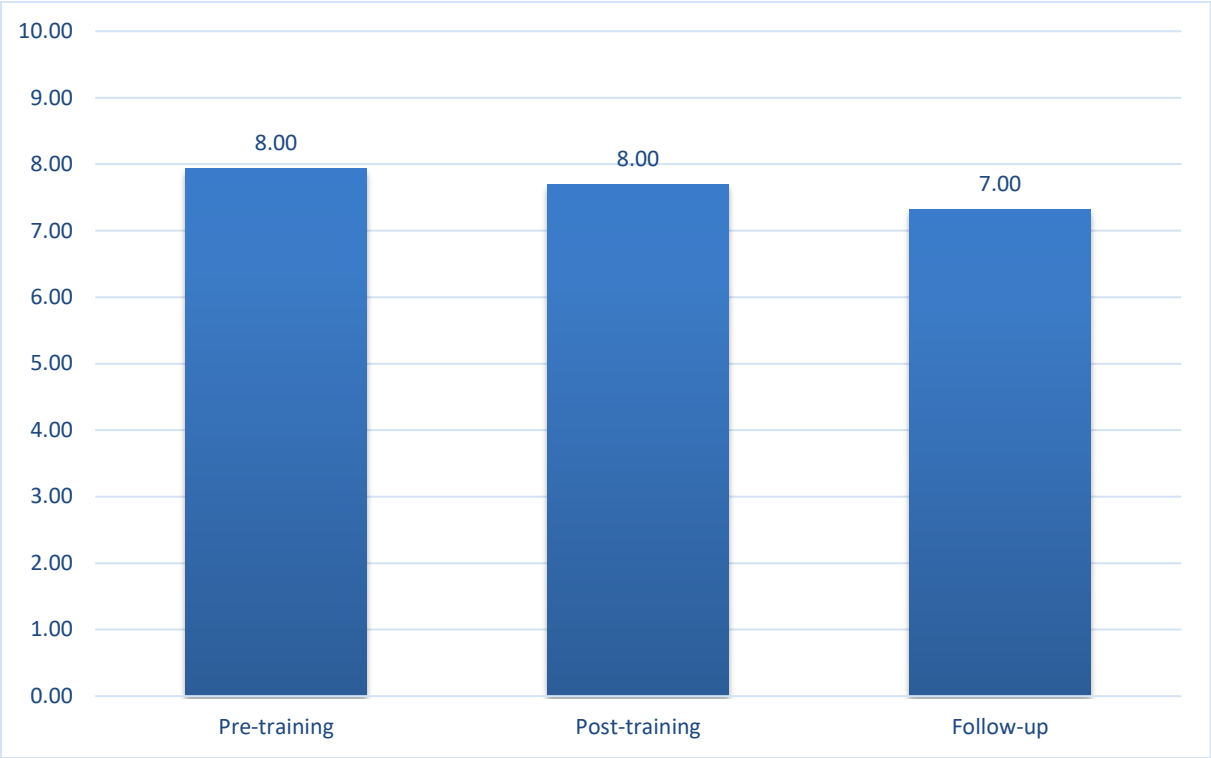


Chart 5. Median – results for PSS on three stages of evaluation (pre-training, post-training, and follow-up) presented on the sten score.



As shown on the chart (see Chart 4 and 5), the average intensity of experienced stress decreased in the study group with subsequent evaluation stages. A two-way analysis of Friedman's variance according to rank for dependent samples showed that, considering all stages of the evaluation, no significant differences were observed between them in terms of overall results ($\chi^2 = 2.63$, $p = 0.27$). Between the pre-training and post-training stages, as well as the post-training and follow-up stages, although the values appeared to decrease, the examined differences turned out to be statistically non-significant ($Z = -1,19$, $p = 0.23$ and $Z = -1.50$, $p = 0.13$). However, the results between pre-training and follow-up stages was significant ($Z=-2.23$, $p<0.05$). Thus, it was concluded that in the follow-up there was a reduction of stress, at the post-training stage the stress was reduced but there was no statistical significance.

In order to test the hypothesis concerning satisfaction with life (does training in compassion relate to greater life satisfaction), the SWLS was completed by 32 participants at the pre-training stage, 21 at the post-training stage, and 19 at the follow-up stage.

Chart 6. Median – results for SWLS on three stages of evaluation (pre-training, post-training, and follow-up).

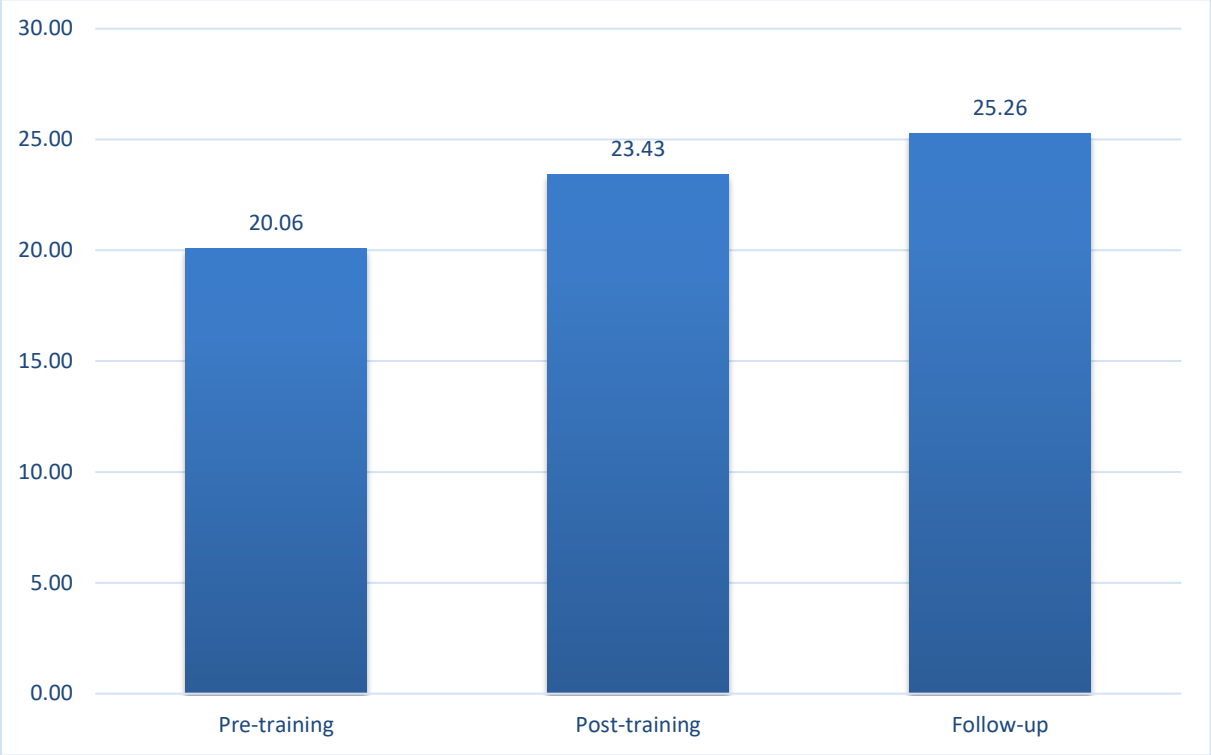
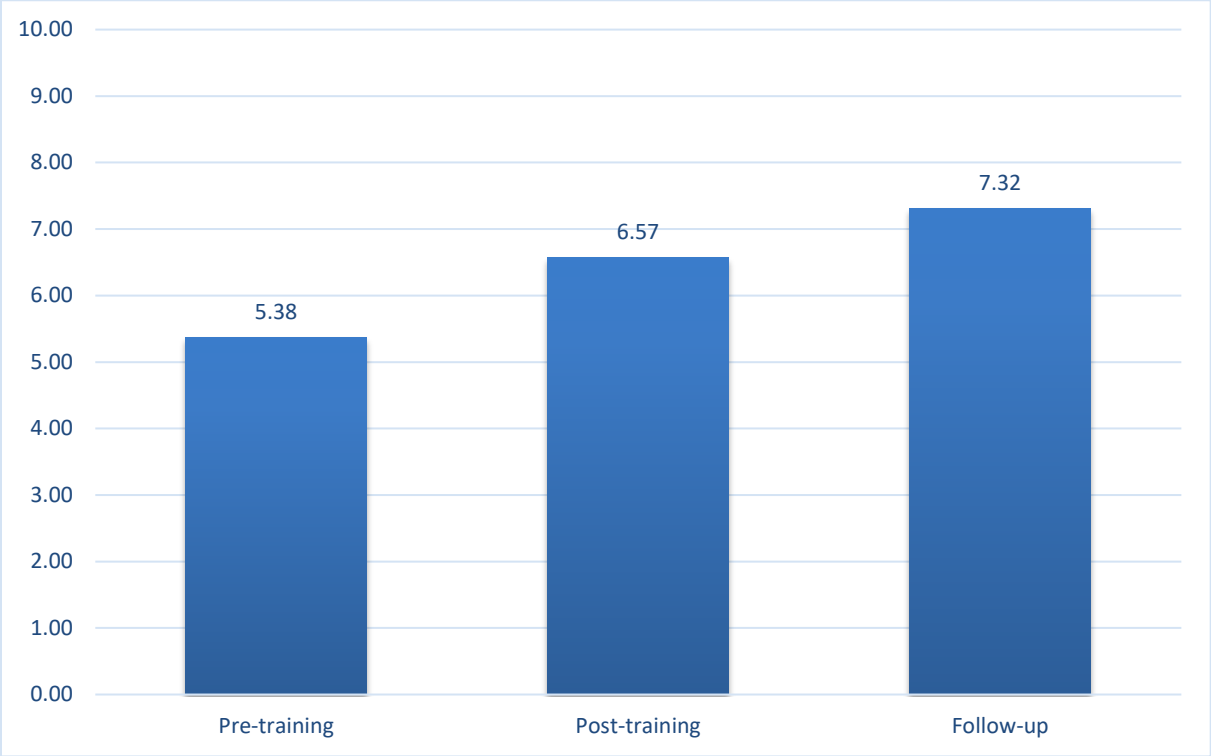


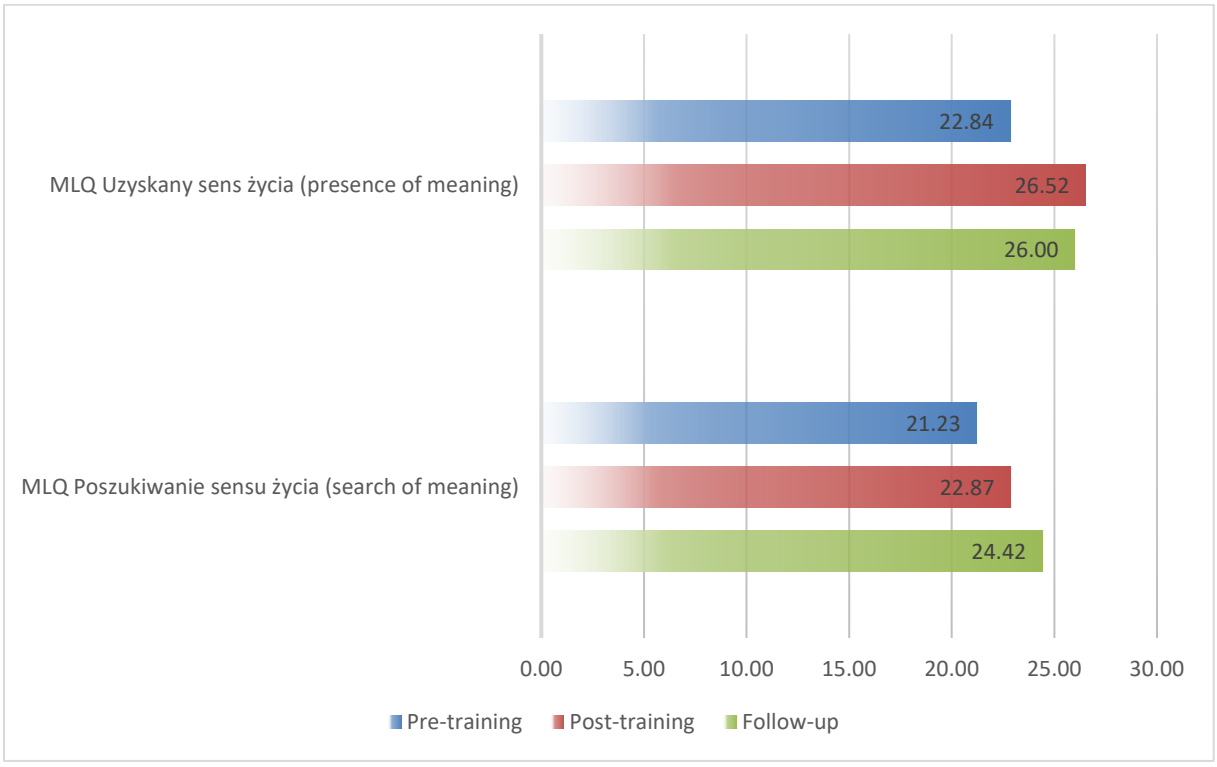
Chart 7. Median – results for SWLS on three stages of evaluation (pre-training, post-training, and follow-up) presented on the sten score.



As shown in the above charts (see Chart 6 and 7), along with the subsequent stages of evaluation, the average intensity of life satisfaction in the surveyed group increased. A two-way analysis of Friedman's variance according to rank for dependent samples showed that there are significant differences between all stages of evaluation ($\chi^2 = 16.09$, $p < 0.01$) in the general test results. In-depth analysis of the Wilcoxon rank tests has shown that a significant increase in life satisfaction measured by the overall score is observed between the pre-training and post-training evaluation stage ($Z = -2.30$, $p < 0.05$) and follow-up ($Z = -3.42$, $p < 0.01$). However, no significant differences were observed between post-training and follow-up evaluation ($Z = -1.86$, $p > 0.05$). In conclusion, the results were higher between post-training and follow-up stages (in comparison to the pre-training stage) but there was no significant growth between the post-training and follow-up.

In order to test the hypothesis concerning meaning of life (does training in compassion relate to greater meaning in life), at the pre-training stage, the MLQ was completed by 31 participants, 23 participants at the post-training stage, and 19 at the follow-up stage.

Chart 8. Median – results for the MLQ on three stages of evaluation (pre-training, post-training, and follow-up).

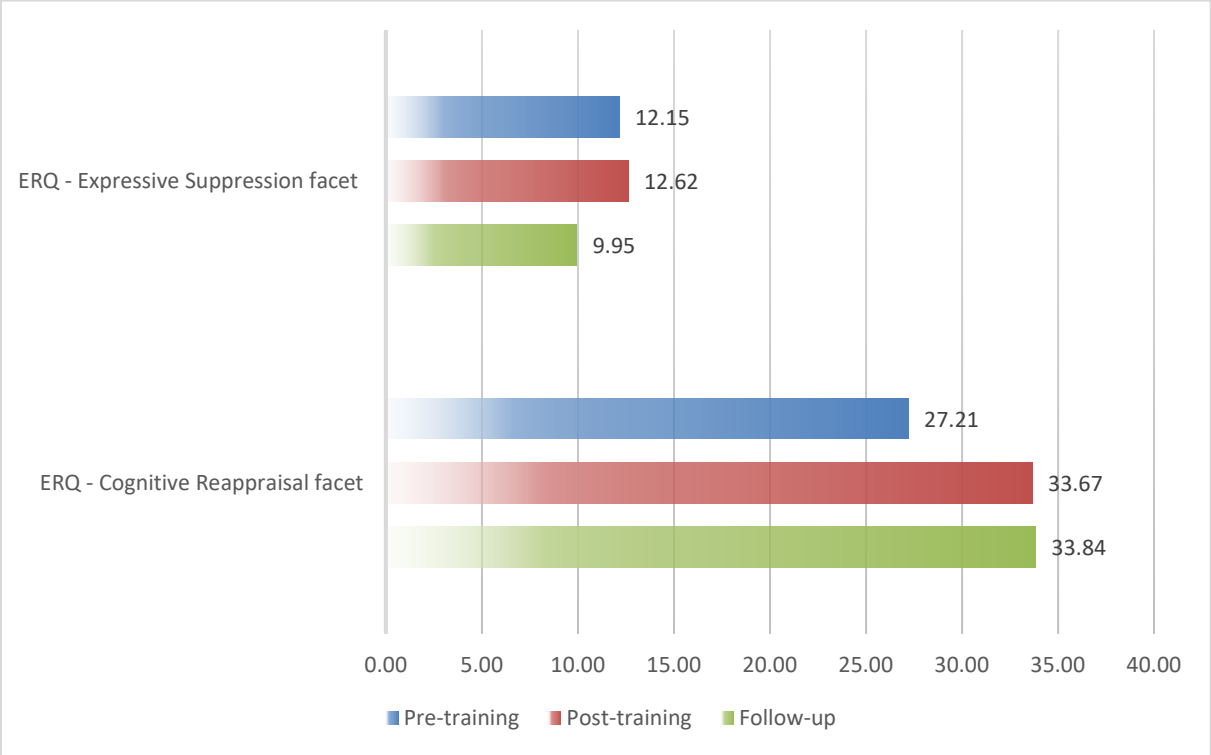


As shown in the chart above, along with the subsequent stages of evaluation, the average intensity of search of meaning in the studied group increased. A two-way analysis of Friedman's variance according to rank for dependent samples showed that there are significant differences between all stages of the evaluation ($\chi^2 = 17.56$, $p < 0.01$) in the scope of results for the search of meaning scale. In-depth analysis of the Wilcoxon rank tests has shown that a significant increase in this scale is observed between the pre-training and post-training evaluation phase ($\chi^2 = 2.12$, $p < 0.05$) and follow-up ($\chi^2 = -3.12$, $p < 0\ 05$). However, no significant differences were observed between the post-training and follow-up evaluation

stages (χ^2 = -1.69, p> 0.05), although these results increased as mentioned above. Also, a two-way analysis of Friedman's variance according to rank for dependent samples showed that there are significant differences between all stages of evaluation (χ^2 = 13.50, p <0.01) in the Presence of Meaning range. In-depth analysis of the Wilcoxon rank tests has shown that a significant increase in Presence of Meaning is observed between the pre-training and post-training evaluation stage (Z = -3.36, p <0.01) and follow-up (Z = -2.33, p < 0.05). No significant differences were observed between post-training and follow-up evaluation (Z = -1.33, p> 0.05). In conclusion, search of meaning in life increased with subsequent stages of CforC but there was no significance between the post-training and 2-month follow-up stages; presence in meaning increased till until the post-training stage and then decreased but was still significantly higher than at the beginning (baseline – pre-training stage).

In order to test the hypothesis concerning the emotion regulation (does training in compassion relates to greater emotion regulation), the ERQ was completed by 33 participants at the pre-training stage, 21 at the post-training stage, and 19 at the follow-up stage.

Chart 9. Average results for ERQ scales on three stages of evaluation



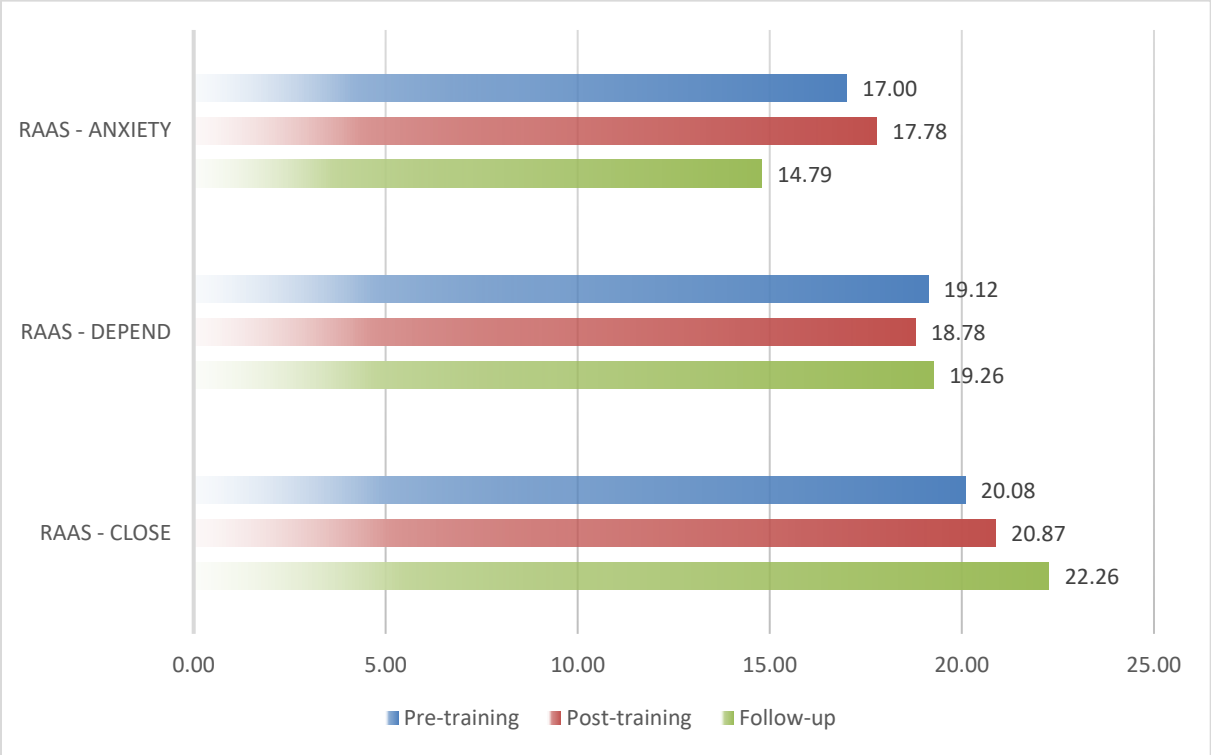
As shown in the chart above (Chart 9), the average intensity of the Cognitive reappraisal facet in the study group increases with subsequent stages of evaluation. A two-way analysis of Friedman's variance according to rank for dependent samples showed that there were significant differences between all stages of the evaluation ($\chi^2 = 11.43$, $p < 0.01$) in the range of Cognitive reappraisal facet results. In-depth analysis of the Wilcoxon rank tests has shown that a significant increase in this scale is observed between the pre-training and post-training evaluation stage ($Z = -3.07$, $p < 0.05$) and follow-up ($Z = -2.91$, $p < 0.05$). However, no significant differences were observed between post-training and follow-up stages ($Z = -0.91$, $p > 0.05$), although results were observed to increase. Additionally, the two-way analysis of Friedman's variance according to rank for dependent samples did not show significant differences between all stages of evaluation in terms of Suppression facet ($\chi^2 = 3.90$, $p > 0.05$). However, in-depth analyses of Wilcoxon's rank tests resulted in significant decrease in the Suppression facet observed between the pre-training and follow-up evaluation stages (Z =-

2.4, p <0.01). There were no significant differences between the pre-training and post-training evaluation stages (Z = -412, p> 0.05), and post-training and follow-up stages (Z = -1.22, p> 0.05).

In conclusion, there were significant differences between the analysed stages for the ERQ's dimension of the cognitive reappraisal facet, but not for the expressive suppression dimension. In further exploration there were significant differences between pre- and post- training stages (ERQ Cognitive reappraisal facet), pre-training and 2-month follow-up stages (ERQ Cognitive reappraisal facet and ERQ expressive suppression) (Wilcoxon), and 2 and 3 have no significant differences in both dimensions, and between pre-training and post-training stages in the dimension of ERQ expressive suppression. Additionally, the cognitive reappraisal facet increased with each stage, but irrelevant between the post-training and follow-up stages, and ERQ expressive suppression increased the post-training stage, then decreased and was significantly lower than at the at the pre-training stage.

As for the hypothesis **"**does training in compassion relate to better attachment styles"*,* the RAAS was completed by 25 participants at the pre-training stage, 23 at the post-training stage, and 19 at the follow-up stage.

Chart 10. Median results for RAAS on three stages of evaluation.

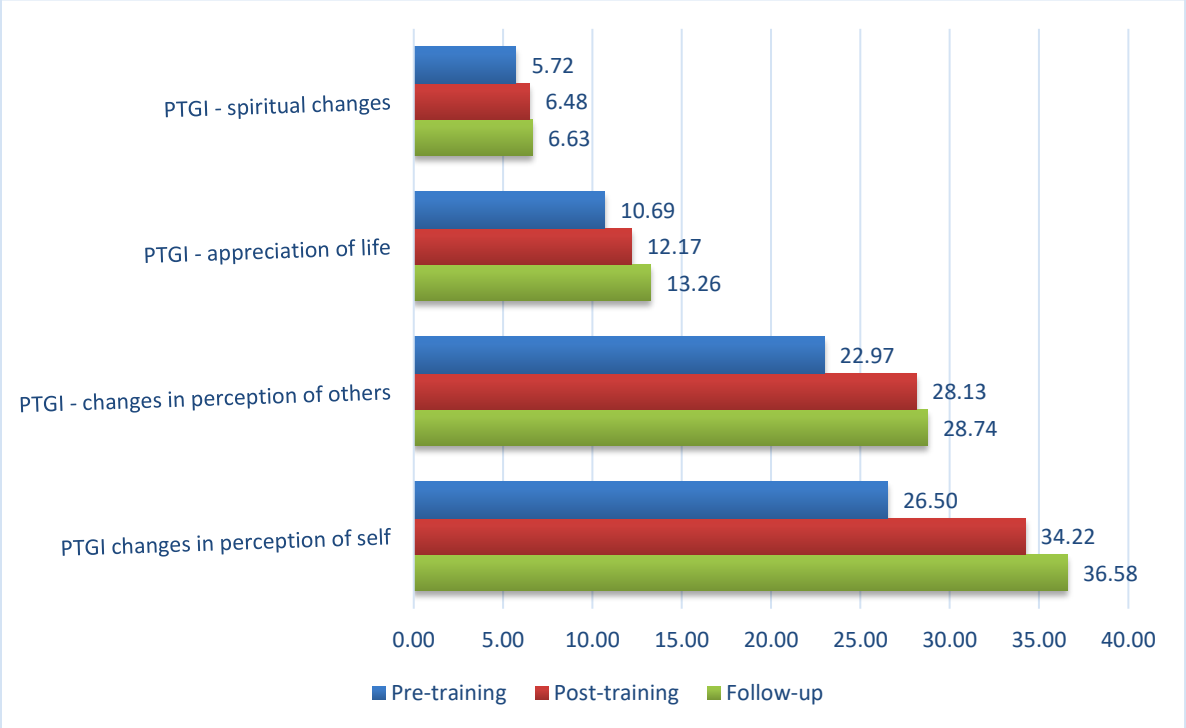


As shown on the above chart, the average RAAS-CLOSE intensity increased along with subsequent stages. In the case of RAAS-DEPEND, the U-shaped curve is observed, while the RAAS-ANXIETY curve is a reversed U-shaped curve. A two-way analysis of Friedman's variance according to rank for dependent samples showed that there were significant differences between all stages in the RAAS CLOSE scale ($\chi^2 = 7.96$, $p < 0.01$) and RAAS-ANXIETY ($\chi^2 = 10.43$, $p < 0,01$), while at the RAAS-DEPEND scale, these differences were statistically insignificant ($\chi^2 = 1.21$, $p > 0.05$). In-depth analyses of Wilcoxon's rank marks showed that a significant increase was observed on the RAAS CLOSE scale between the pre-training and follow-up stages ($Z = -2.60$, $p<0.01$). However, no significant differences were observed between the post-training and pre-training stages ($Z = -1,92$, $p > 0.05$) and post-training and follow-up ($Z = -1.55$, $p > 0.05$), although these results had an upward trend. At the same time, in-depth analyses of Wilcoxon rank tests in the case of the RAAS - DEPEND scale confirmed the lack of significant differences between pairs of stages.

In conclusion, RAAS CLOSE increased with stages and there was a statistically significant difference between pre-training and follow-up stages. RAAS DEPEND increased until the post-training stage and at the follow-up stage returned to the same level. In terms of the anxiety dimension the results grew until the post-training, and decreased at the follow-up stage.

As for the last hypothesis (does training in compassion relate to higher levels of post-traumatic growth), at the pre-training stage the PTGI was completed by 32 participants, 23 at the post-training stage and 19 at the follow-up stage.

Chart 11. Median – results for the PTGI on three stages of evaluation (pre-training, post-training, and follow-up).



As shown in the Chart 11, along with the subsequent stages of evaluation, the average intensity of changed perception of self, changed interpersonal relationships, greater appreciation of life

and spiritual change increased. A two-way analysis of Friedman's variance according to rank for dependent samples showed that there were significant differences between all stages of evaluation in terms of results on the scale: Changed perception of self ($\chi^2 = 13.65$, $p = 0.01$), changed interpersonal relationships ($\chi^2 = 11.12$, $p < 0.01$) and Greater appreciation of life ($\chi^2 = 11.68$, $p < 0.05$). In terms of the spiritual Change dimension, these differences proved to be insignificant ($\chi^2 = 0.43$, $p > 0.05$). In-depth analyses of Wilcoxon's rank tests showed that a significant increase was observed in the dimension of changed perception of self between the stage of pre-training and post-training stages ($Z = -3,49$, $p < 0.01$), and at pre-training and follow-up stages ($Z = -3.49$, $p < 0.01$). However, no significant differences were observed between post-training and follow-up stages ($Z = -0.13$, $p > 0.05$), although these results increased.

In-depth analysis of the Wilcoxon rank tests showed that a significant increase was observed in the dimension of changed interpersonal relationships between the pre-training and post-training stages ($Z = -2.91$, $p < 0.05$), and pre-training and follow-up stages ($Z = -3.42$, $p < 0.01$). However, no significant differences were observed between the post-training and follow-up stages ($Z = -0.05$, $p > 0.05$), although an increase was observed. In-depth analyses of the Wilcoxon rank tests showed that a significant increase was observed on the scale appreciation of life only between the stage of pre-training and follow-up ($Z = -3.07$, $p < 0.01$). There were differences between pre-training (baseline) and post-training stages ($Z = -1.11$, $p > 0.05$ and post-training and follow-up stages ($Z = -1.83$, $p > 0.05$) turned out to be statistically insignificant, although these results as mentioned tend to increase.

Based on the results it has been found that changes in the perception of self increased with each stage: (statistically) significant beyond the short (post-training) and long term (follow-up). Changes in the perception of self also increased with stages: significantly statistically

beyond the short (post-training) and long term (follow-up), whereas greater appreciation of life increased with the stages significantly between the baseline (pre-training) and follow-up, and finally no significant differences were reported in terms of spiritual changes, although there was a pattern of change with each stage.

In order to check whether high-frequency attendees differ from low-frequency attendees on baseline characteristics, the Mann-Whitney test, the nonparametric test equivalent of the two-sample t-test was carried out. Although the differences were not significant (there's one p-value lower than .1), it can be seen that the results obtained at the baseline stage by low-frequency attendees on all scales (except for the Spiritual change) consistently point towards better mental health / condition compared to high-frequency attendees (see Table 15).

Table 15. Differences in results between high-frequency and low-frequency attendees.

Name of measure				
	Subdimensions, facets or domains of particular measures (if applicable)	High (N= 22) Mean (rank)	Low (N= 11) Mean (rank)	Significance p
MAAS		M = 14.73	M = 20.40	n.s.; p = 0.11
PSS		M = 16.84	M = 17.64	n.s.; p = 0.78
MLQ	Search of meaning	M = 21	M = 10	n.s.; p = 21

	Presence of meaning	M = 14.05	M = 20.10	n.s.; p = 0.08
ERQ	Cognitive Reappraisal	M = 14.91	M = 21.18	n.s.; p = 0.78
	Expressive Suppression	M = 17.59	M = 15.82	n.s.; p = 0.62
RAAS	CLOSE	M = 12.68	M = 14	n.s.; p = 0.70
	DEPEND	M = 12.16	M = 15.67	n.s.; p = 0.30
	ANXIETY	M = 12.63	M = 14.17	n.s.; p = 0.65
SWLS		M = 15.68	M = 18.30	n.s.; p = 0,46
PTGI	Changed perception of self	M = 17.16	M = 15.05	n.s.; p = 0.55
	Changed interpersonal relationships	M = 15.41	M = 18.90	n.s.; p = 0.33
	Appreciation of life	M = 17.23	M = 14.90	n.s.; p = 0.51
	Spiritual change	M = 16.39	M= 16.75	n.s.; p = 0.92

6.3.4. Summary of Quantitative Results.

Based on these results it was concluded that MAAS results were significantly higher at the post-training and at follow-up stages than at the pre-training stage (baseline). In terms of the PSS (reduction of stress) at the follow-up there was a reduction of stress, at the post-training stage the stress was reduced but there was no statistical significance. For the MLQ, search of meaning in life increased with subsequent stages of CforC but there was no significance between the post-training and 2-month follow-up stages; presence in meaning increased until the post-training stage and then decreased but was still significantly higher than at the beginning (baseline – pre-training stage). For the ERQ, there were significant differences between the analysed stages for the ERQ's dimension of the cognitive reappraisal facet, but not for the expressive suppression dimension. Further exploration indicated significant differences between pre- and post- training stages (ERQ Cognitive reappraisal facet), pre-training and 2-month follow-up stages (ERQ Cognitive reappraisal facet and ERQ expressive suppression) (Wilcoxon), and at the post-training and follow-up stage there were no significant differences in both dimensions, and between pre-training and post-training stages in the dimension of ERQ expressive suppression. Additionally, the cognitive reappraisal facet increased with the stages of the, but irrelevant between the post-training and follow-up stages, and ERQ expressive suppression increased the post-training stage, then decreased and was significantly lower than at the pre-training stage. For the RAAS, the RAAS CLOSE dimension increased with stages and there was a statistically significant difference between pre-training and follow-up stages. RAAS DEPEND increased until the post-training stage and at the follow-up stage returned to the same level. In terms of the anxiety dimension the results grew until the post-training and decreased at the follow-up stage. For the SWLS, the results were higher between post-training and follow-up stages (in comparison to the pre-training stage) but there was no significant growth between the post-training and follow-up. For the PTGI

the results showed that changes in the perception of self increased with each stage: (statistically) significant beyond the short (post-training) and long term (follow-up). Changes in the perception of self also increased with stages: significantly statistically beyond the short (post-training) and long term (follow-up), whereas greater appreciation of life increased with the stages significantly between the baseline (pre-training) and follow-up, and finally no significant differences were reported in terms of spiritual changes, although there was a pattern of change with each stage.

Chapter 7. Discussion of Results and Conclusions.

7.1. Overview of Specific Results.

The main intention and goal of the PhD was to skilfully design and evaluate a novel, effective, evidence-based and practical psychological management training programme for both cancer patients and cancer survivors (in stage 0-IIIC) based on predominantly, but not solely, CFT conceptualisation. Thus, the pilot study and subsequent studies (initial and main study combined) aimed to evaluate the structure, specific themes and tools of the CforC curriculum, and any potential benefits for participation (usability), together with its feasibility. Additionally, specific objectives included testing and implementing compassion-based interventions (CBIs) as a means to greater mindfulness, meaning of life, satisfaction with life, emotion regulation, attachment styles, and post-traumatic growth (PTG) improvement by facilitating coping with a range of stressors associated with cancer and developing capacities for self-regulation and self-soothing. Another objective involved determining whether there were differences between the levels of mindfulness, PTG, meaning of life, satisfaction with life, emotion regulation, attachment styles before taking part in a compassion-based programme, after the last session, and two months later (follow-up). All of these aims and objectives were met, including the implementation of CforC (main objective); subsequently resulting in changes in all dimensions of psychometric and qualitative measures.

In the first (pilot study) with the non-clinical group, qualitative measures were employed and four themes (beneficial processes) were identified based on: i) evaluations after each session; ii) an evaluation after the whole training programme (open-ended questionnaires); and iii) a post-CforC focus group. Two themes referred to regulatory processes (cognitive, emotional and physiological), namely ‘gaining mental awareness’ (theme 1) and ‘gaining bodily awareness’ (theme 2), and the further two themes concerned “slowly growing in compassion”

(theme 3) and 'practical considerations' (theme 4). Based on clinical observations by the trainer (Julia E. Wahl) and conversations with the participants (focus group, and informal conversations during and after specific sessions) the CforC was amended, e.g. in order to ensure the two distinctive processes and tools (mindfulness and compassion respectively) were not misunderstood as being the same process and skill. Other changes involved adding specific practices like the practice of *tong-len*, changing them (e.g. the contemplation practice was exchanged for the spacious mind practice) and simplifying instructions to make them clearer for both the participants to receive and trainers to deliver. Last but not least, more home assignments of a reflective nature were added to facilitate the process of change i.e. growing in compassion. For example, asking participants to reflect on how they experience receiving and giving kindness and compassion, what blocks them from these experiences and what are the sources of difficulty in their lives.

Similarly, in the study with the clinical populations of both cancer patients and survivors reported various changes, e.g. in the way of approaching oneself (mentally and physically). In this study five themes concerning benefits were identified: "experiencing calmness, relaxation and tranquillity; "embracing compassion and its qualities"; "learning to be with the body and physical pain"; "embracing self-compassion"; and finally, "extending compassion and awareness to others (common humanity, gratitude)". The differences concerning the themes between the non-clinical and clinical groups may be due to a number of issues; changed curriculum since the pilot study (order, emphasis, additional exercises added such as *tong-len*, exercises that focus on management of pain and bodily symptoms), and the variety of symptoms experienced due to various treatments and the illness itself (differences between healthy and clinical populations). Additionally, the following themes were identified with the clinical population in terms of the beneficial practices as mediated through beneficial processes: "the taking and giving practice", "working on beneficial intention", "the spacious

mind practice", "the soothing-rhythmic breathing", and "various compassion-specific visualisations and exercises", "body and senses practices" and "other practices". These qualitative changes were discussed in Chapter 4 and Chapter 6.

Apart from using qualitative measures, quantitative measures have been employed to further explore the benefits of a CBI for cancer patients and survivors, and specifically CforC. The questionnaires used, the statistical methods and results have been described in detail in the previous chapters (Chapter 4 and 5). Increases in the dimensions of PTG, attachment styles, ER, meaning of life, perceived stress and mindful attention were found.

To start with, one of the purposes of CforC and the current thesis was to focus on possible changes it may cause in terms of attachment patterns, and in the study with clinical populations (cancer patients and survivors). The results showed that there were differences in the dimension of closeness in the R-AAS with CforC participants experiencing more closeness in the two-month follow-up (as compared to baseline measures: pre-training). The results suggest that CforC training and CBIs can trigger processes associated with safeness, including feeling safer in relationships and being able to feel a bond with fellow beings. These findings are important in terms of cancer always being a relational phenomenon; as it not only influences the individual but their close and distant surroundings (relationships) and the general relational dynamics (i.e. in terms of intimate relationships, family, friends, co-workers, and organisations). As stated by the (US) Committee on Cancer Survivorship (2006), cancer survivors may experience "legacy of physical, psychological, social, vocational, spiritual, and economic consequences" and long-lasting effects may appear many years later. CforC may therefore facilitate stable attachment patterns as a means, not only for the sake of survival, but a better quality of life. Thus, attachment patterns were studied in the current thesis as they may be explained as "behavioural control systems rooted in neuropsychological

systems" (Giuliani, 2003) and can be activated in times of stress and other difficulties (Bowlby, 1988). It was also relevant to focus on attachment patterns as they have often been ascribed to being able to influence the way one can cope with stressful events and have usually been used for predicting the development of potential mental health issues (Bartholomew, Kwong, & Hart, 2001), including PTSD; individuals are less likely to develop PTSD if they possess a secure attachment style (Dekel, Solomon, Ginzburg, & Neria, 2004). The development of disease and chronic illnesses is also predicted by insecure attachment styles (McWilliams and Bailey, 2010), and there is also a study of particular relevance to this thesis: Tacón, Caldera and Bell (2001) found that cancer groups score higher on avoidant attachment styles than comparison group. Better coping for cancer patients was also associated with more secure attachment patterns (Drageset & Lindstrøm, 2004) and generally fewer chronic diseases (Schmidt et al., 2002).

Apart from attachment styles, another noticeable change connected to CforC, has been reported in the dimension of emotion regulation (ER), and which is also one of the most frequently mentioned benefits of contemplative training courses such as MBSR. Interestingly, the expressive suppression facet increased at first (after the eighth session), and then decreased significantly below the baseline level (two-month follow-up). In terms of the cognitive reappraisal facet it increased between the pre-training (before the first session) and post-training period (after the eighth session). There was also an increase in cognitive reappraisal facet between the last (eighth) session and the two-month follow-up, but this was not statistically significant. These results were also reflected in the thematic analysis of the clinical group as it was revealed that participants were able to learn to self-regulate, including both emotion regulation (described in detail in Chapter 1) and self-regulation in action. In terms of the initial increase in ERQ (quantitative measure) may be explained in terms of various factors: contemplative practices at first serving as a safety buffer against emotions due to

previous experiences, blocking convictions one may have, the phenomenon of sensual romanticism (e.g. thinking that compassion is all about feeling love and kindness). Other factors include the cult of positive thinking ("I need to feel good emotions"), "cruel optimism" (the thing that should be helpful becomes an obstacle in itself; Berlant, 2006), e.g. in the form of empathy, or even fears of compassion (towards yourself, others, receiving) (Gilbert et al., 2012), and for example it is not safe to feel safe; feelings of compassion associated with convictions such as being compassionate is a form of weakness, indulgence, giving up; and criticism that "does good" and motivates.

In terms of post-traumatic growth (PTG), participants experienced significant improvements from pre-training to post-training in all dimensions (changes in perception, relationships, appreciation) except for the spiritual dimension (even though it increased with the stages of CforC training, it was not statistically significant). Post-traumatic growth can be described as interaction with life wisdom and life narrative (Tedeschi & Calhoun, 2004) and this interaction can be reached through employing appropriate CBIs. The lack of statistically significant changes in the religiosity dimension of PTGI may be explained in terms of the association that occurs in Poland; being religious is associated with being Catholic (Zarzycka, 2009) and that association may not suit all people. Interestingly, once again changes were also found in qualitative measures (described in detail in Chapter 4) with participants seeing themselves differently and approaching their relationships differently and having great appreciation for life in general.

Another issue that was looked at concerned the flows of compassion (participants were asked about this in the open-ended questionnaires after each session and during focus groups). According to Scoglio et al. (2017) the first flow of compassion, self-compassion, may be a meaningful issue in terms of recovery, trauma, and even PTSD with self-compassion serving

a buffer against symptom severity and supporting resilience which is related to PTG and helpful in healthy ER strategies.

In terms of another issue that has been investigated psychometrically there was mindfulness (mindful attention) which has increased with each stage of the study (baseline versus post-training and two-month follow-up). Similar results were found in thematic analyses with participants saying that they were experiencing more mindfulness on a daily basis. These results are not surprising as the increase in mindfulness may be explained in terms of mindfulness and compassion "co-creating another" (Tirch, 2010). It is often claimed that mindfulness includes compassion (implicit compassion), or at least self-compassion and/or kindness (Kabat-Zinn, 2003; Birnie, Speca, & Carlson, 2009; Christensen & Marck, 2017), but the reverse in not as obvious for all flows of compassion (all-dimensional compassion including mindfulness). It has also previously been shown how effective mindfulness and MBIs are in terms of helping cancer patients with various type of cancers, stages of illness, and ages in coping with mood disturbances and symptoms of stress (Speca, Carlson, Goodey, & Angen, 2000). Therefore, it was also important in the current study to see if training in compassion can increase instances of mindfulness. To conclude, the results further show the potential of the CforC in its ability not only to increase a compassionate attitude and behaviour but also instances of mindfulness. Another important benefit of experiencing mindfulness is the fact that mindfulness can lead to meaning and positive reappraisal (Garland et al., 2015). As suggested by Tedeschi and Blevind (2015) mindfulness is also similar to PTG in its "metacognitive stance" of being able to observe and engage in thoughts at the same time which leads in changes of experiencing one's present and past events. This is particularly important in terms of cancer patients and survivors absorbing, assimilating, reframing and juxtaposing their experiences.

In terms of meaning of life, in the dimension of search of meaning in life increased with subsequent stages of CforC but there was no significance between the post-training and 2-month follow-up stages; presence in meaning increased until the post-training stage and then decreased but was still significantly higher than at the beginning (baseline pre-training stage).

As the CforC training also increased mindfulness it may be important to describe how these results may be directly connected to meaning. Meaning of life may play a role in survivors' psychological adjustments and is also related to growth (Park, Edmondson, Fenster, & Blank, 2008). It is important to state that meaning can give one motivation which defines "the direction, the intensity and the persistence of behaviour directed towards the attainment of one or more objectives" (Zuccolo, 2006).

In the current thesis there were also significant increases in terms of satisfaction of life between pre-training (before the first session) and post-training (after the last session) (statistically significant difference) and there was also an increase in the post-training and follow-up (although not statistically significant). Satisfaction is a relatively new concept, only established in the 18th Century Age of Enlightenment and it substantially differs from the concept of meaning as it refers to the subjective general evaluation of the quality of one's life (Pavot & Diener, 1993) and is a "cognitive process of judgement" (Vera-Villarroel et al., 2012). The concept of life satisfaction is not necessarily related to health outcomes but is important in terms of how patients and survivors live after the diagnosis and consequent treatment and how it influences their quality of life.

Perceived stress was the last issue to be measured psychometrically as stress is among the most commonly reported issues for cancer patients and survivors. Once again there were significant changes: between the first session and in the two-month follow-up. The results are

consistent with previous findings reporting self-compassion as increasing resilience to stress (MacBeth & Gumley, 2012).

To summarise, there were changes in all psychometric dimensions, with some changes occurring only in the two-month follow-up (see Table 16). CforC can therefore serve as a catalyst for allostasis and provide patients and survivors with cognitive, emotional and relational benefits as was shown in the qualitative results

Table 16. Changes (increase or decrease) in all dimensions and sub-dimensions in various periods (pre-training and post-training, post-training and follow-up).

Name of questionnaire (including its dimensions) and changes between each measurement period	**Pre - post**	**Post – Follow-up**
MAAS	+	+
PSS		
Changed perception of self	+	0
Changed interpersonal relationships	+	0
Appreciation of life	+ (not statistically significant)	+
Spiritual change	+ (not statistically significant)	+ (not statistically significant)
ERQ		
Cognitive reappraisal	+	+ (not statistically significant)

Expressive suppression	+	-
SWLS	+	+ (not statistically significant)
MLQ		
Search for meaning	+	+ (not statistically significant)
Presence of meaning	+	+ (lower than in the post-training but higher than in the pre-training)
RAAS		
Closeness	+ (not statistically significant)	+
Anxiety	+ (not statistically significant)	-
Dependent	+ (not statistically significant)	- (not statistically significant)

7.2. Other Observations and Implications.

I have discussed my general findings and the meaning behind them, but it is also important to discuss some issues such as resilience which is often mentioned in the context of compassion. Resilience was not measured separately in the current series of studies, but it would be important to see how long-term the effects would affect this dimension and how this would be related to PTG and mediated by compassion. Further, it would be interesting to see if compassion was a PTG in itself. Furthermore, past adversities may lead to being more compassionate, perspective-taking and empathetic concern (Lim & DeSteno, 2016) and in cancer treatment it would be important to give patients more agency (Leal et al., 2015),

especially amidst all the changes happening before, during and even long after their cancer treatment this agency being of the expressions of one's resilience and would refer to being able to skilfully navigate through the "meanders" of illness (resilience) and adapt to all the changes (post-traumatic growth). As Fitzhugh Mullan states (1985, p. 271) "the challenge in overcoming cancer is not only to find therapies that will prevent or arrest the disease quickly, but also to map the middle ground of survivorship and minimize its medical and social hazards". Similarly, Epstein (2017) describes resilience as "intention + skills + community". CforC follows the same route as it focuses on cultivating one's intention (of patients and survivors) and skills which are ultimately embedded in the shared communal "experiencing", which should be another aspect studied separately in terms of its benefits.

Meaning was another dimension studied alongside mindfulness. Interestingly, Mindfulness-to-Meaning Theory (MMT) explains "how mindfulness might promote the sense of eudaimonic meaning in the face of adversity" (Garland, Farb, & Goldin, 2015) as mindfulness is not only about enhancing cognitive processes but also specific qualities and focusing on relational aspects. Mindfulness therefore may allow patients and survivors to construct a new perspective on one own's life (Garland, Farb, Goldin, & Frederickson, 2015). The changes may also occur due to the constant focusing on intention(s), during the course of the training, as compassion is a motivation in itself (Hofmann et al., 2011).

Another aspect that was incorporated in the current series of studies involved ER which refers to the "processes by which we influence which emotions we have, when we have them, and how we experience and express them" (Gross, 2002, p. 282); or in other terms, the ability to regulate emotions and emotional responses (Gross, 1998). Gross (2015) also describes the stages of ER as "identification, selection, and implementation". In contrast to ER, emotion dysregulation mediates the relationship between for instance, PTSD and its symptom severity

(Scoglio et al., 2017). Furthermore, self-compassion is one of the emotional regulation strategies (MacBeth & Gumley, 2012) as especially individuals who tend to avoid their experiences learn to notice them, be with them in an accepting way and subsequently be able to modify negative emotions (Inwood & Ferrari, 2018).

Compassion can also activate feelings of sadness and regulate negative emotions but does not necessarily evoke positive ones initially (Gilbert,2012). Another issue that occurred in the training, is the experience of negative affect, which is very common in contemplative practices (Klimecki & Singer, 2014). This is particularly important as the contemplative practices, especially the ones based on compassion, affect the affective processes. Yet when one explores emotions further (with the courage to look deeper into one's emotions) and various parts of themselves, participants may learn to navigate through emotions more skilfully. As the writer Joan Didion (quoted in Zebroski, 1994, p. 55), once said: "I have already lost touch with a couple of people I used to be". Viewing human beings as a conglomerate of different parts is particularly important when patients and survivors overly identify with one emotion, one mode of being, or one identity (e.g. being a cancer patient, being sad). In contrast, in Buddhism, personality is a transitory phenomenon mediated and influenced by the various *skandhas* (of form, perception, mental formations, feeling tone and consciousness) (Armstrong, 2016), and so one is always changing depending on the factors involved. As Massi (2002, p. 158) points out "it is necessary to integrate a differentiated, cohesive self-structure before undertaking rigorous meditation practice to see through the self". The main reason for CforC would be therefore to teach how to ultimately implement healthier patterns of emotion regulation which would mean first acknowledging what is being experienced, then learning to be with it and accept it and ultimately changing negative affect into positive affect e.g. sadness into connectedness, gratitude.

In terms of the dimension of attachment, even though Bowlby once stated that "…attachment behaviour is held to characterise human beings from the cradle to the grave…" (Bowlby, 1979, p. 129) it may be that due to the nature of compassion training one's attachment patterns and behaviours associated with them may be changed, e.g. by the means of patients' and survivors' community of shared experiences (e.g. practice in good social context, relational factors – secure bond, attachment) and the nature of the practices themselves (the focus on relational issues). This claim needs to be investigated in future studies. One other issue that needs to be mentioned here is the fact that meditation with individuals who experience attachment issues or "failures" has been cautioned against (Masis, 2002) but it also needs to be remembered that certain types of contemplative practices may improve attachment patterns or create healthy ones (e.g. compassion-based practices). Interestingly for clinical considerations, there were also increases in the anxiety dimension of attachment with participants experiencing *more* anxiety (anxious style of attachment) after the eighth session (in comparison to baseline measures – before the first session) the increase was large (after the eighth session), and then decreasing (two-month follow-up) below the baseline levels (before the start of the CforC training; statistically significant). This is important to mention as one of the explanations for the experience of anxiety may be that practising compassion may inspire memories and evaluations of past and current relationships and their dynamics which may lead to experiencing more anxiety (negative affect) at first and this negative affect vanishes with time (Klimecki, Leiberg, Richard, & Singer, 2014). The phenomenon of negative affect when first practising compassion and subsequently decreasing negative affect to baseline levels and increasing positive affect is not unheard of as training in compassion activates a network associated with positive affect in terms of affective change in both experiential and neural activity (Klimecki, Leiberg, Richard, & Singer, 2014). In terms of another clinical consideration, the experience of sadness was also verbally reported to the trainers in the initial stages of meditation (and sessions). CforC may serve here as a vehicle to evaluate current

relationships, their patterns and dynamics in a way that ultimately allows individuals to feel more connected to others. Additionally, training in compassion can protect patients from experiencing relational issues due to unhealthy attachment patterns that are prognostic for developing psychiatric disorders (Armour, Elkit, & Shevlin, 2011). “Compassionate reactions are products of what has been called the caregiving behavioural system” (Mikulincer & Shaver, 2005, p. 325) and attachment security can be induced through adequate practices and affiliative emotions such as compassion.

Treatment adherence and attendance (participation) is a topic that has long been studied (Nock & Kazadin, 2005), and one other issue of interest involves the difference between high-frequency attendees and low-frequency attendees in terms of their attendance (see Table 14 in the previous Chapter). In the current body of research there were no significant differences between the two groups (at the baseline) in terms of their well-being (as measured by all the scales and questionnaires).

In the future research it would be important to look at motivation as it may be plausible that participants who already have certain coping skills and mechanisms (e.g. higher levels of mindfulness, lower levels of perceived stress) are less motivated to participate in any training programmes than individuals who may not have certain skills. Therefore, it is likely that there are differences in intrinsic motivation between high-frequency attendees and low-frequency attendees. Similarly to what Møller (2010) is saying, it would be important to specify what is motivating and why this is, rather than how motivated individuals are, including measuring motivation based on the levels of severity of one’s symptoms.

7.3. Limitations of the Current Series of Studies.

7.3.1. Confounding Factors.

Confounding factors may be attributed to such issues as the personality of the trainer (the two groups had two different trainers), community factors (many of the group members in Żagań had known each other before the training whilst none of the participants in Warsaw had met each other before), the venue (setting) and location of the training (a nice refreshed room versus a hot room; a nicely decorated room versus a minimalistic, cold looking room; small versus big city). Other factors include the weather (the first group participated in the training during the warmer season, the second during colder periods, the third one during a very hot season), and even to the regular staccato of political upheavals in Poland if one was politically engaged (e.g. liquidation of the separation of powers, destruction of the Białowieża forest, attempts to further restrict abortion laws, reversing the 1999 education reform). Other confounding factors may be to do with previous experiences in contemplative approaches e.g. mindfulness training, meditation, and/or one participating in psychotherapy. This also alludes to the important question of whether compassion may be employed regardless of context, as we know context changes the way of one's being, presenting oneself and accessibility to certain faculties.

Initially the studies were designed to be conducted in the UK setting. Unfortunately, as neither the researcher nor the university did not have any official association with the NHS, and the fact that recruitment outside of the NHS had failed to provide any results, it was decided to conduct the studies in Poland which substantially stalled the whole research process, apart from the pilot study (non-clinical group) which was organised by the researcher (Julia E. Wahl) in the UK.

Based on all the factors described it would therefore be important to run a series of CforC training programmes that would include appropriate practical changes e.g. inviting participants with no previous experience of contemplative practices, in order to see if these corrections would be reflected in the results.

In terms of running another study, feasibility is a problem as a novel approach is hard to be advertised and recruitment is therefore a problem. In the present studies there were no funds available, other than from the researcher herself, e.g. funding for room hire, translation services, fees for trainers. The application of mixed methods was intentionally considered and introduced to counter a potentially low number of participants in the quantitative part of the research. In actuality, from a total of 33 participants (three groups combined), 23 participants filled in the questionnaire at the post-training stage, and 19 at the follow-up stage which constitutes more than half of the participants. There were no differences between participants who dropped out at the baseline in terms of their well-being as assessed by all the seven questionnaires (see Table 14 in the previous chapter).

According to Hackshaw (2009) some of the strengths concerning small number of subjects is its quick applicability in terms of speed of enrolment, completion of questionnaires, review of data, obtaining ethical approval from various institutions is also easier, especially if studies involve conducting research internationally. Thus, research questions can be addressed quickly. Moreover, Hackshaw (2009) also states that testing a new research hypothesis in a small number of subjects is better at first as it helps avoid spending too many resources e.g. time, financial costs, human resources in order to see if there is an association between specific factors (Hackshaw, 2009; Faber & Martins Fonseca, 2014) . The general opinion is that larger samples are ideal for research or statistical analysis but this is not always true for a reason such as ethics posing the question if a specific study should be performed with more patients

than it is necessary especially when one is introducing a novel approach (Faber & Martins Fonseca, 2014). Faber and Martins Fonesca (2014) also point out the that statistical measures were developed to measure samples not populations (human beings), and therefore one should consider limitations of a quantity focused science and consider the importance and need for a "science of qualities" (D. C. Wahl, personal communication, 2020) and what is called "warm data" which refers to transcontextual information about the interrelationships that integrate a complex system which first looks at qualities rather than quantities (Bateson, 2016). That is why in the current research project it was decided to apply a model based on mixed methods and transcend paradigms (Meadows, 2008). Transcending paradigms refers to being flexible and understanding that there is no such thing as a "true paradigm" and thus intentionally switching between modes and paradigms (Meadows, 2008).

7.3.2. Mixed Methods.

Mixed method research (MMS) is another area that may be criticised for failing to integrate both the quantitative and qualitative methodologies that may lie in their disagreement on their ontology (Wiggins, 2011). These different ontologies may offer different approaches as essentialism, atomism, universalism, sameness, contextualism, and holism, and they may also come from different worldviews so in essence take on different assumptions ("the dilemma of mixed methods"; Wiggins, 2011).

On the other hand, using mixed methods may be of value as for instance, Kelle (2006) claims that qualitative methods are at times better designed for its flexibility to gather more culturally nuanced information than quantitative methods. This stance is in accordance with critical psychology rationale which states that research is for people and not only about them and this is possible if research is conducted from the perspective of the subjects (Holzkamp, 1991).

Further, this also prevents ‘methodolatry’ or ‘methodologism’ in which the method plays the most important role rather than the problem (Teo, 2015).

Quantitative and qualitative data triangulation may also strengthen the validity of results and help measure same concepts (e.g. compassion) by using various instruments (e.g. scales). This may therefore broaden the understanding of what it meant to be compassionate or do compassion in various dimensions and show any potential benefits of such practices and attitudes in one’s life.

7.4. Changes Made after Running the Group.

How research is translated into practice is often the neglected part of describing how certain programmes came about (Cohen et al., 2008). Thus, the current research project aimed at describing these underlying processes and the issue of how successful certain changes to the final curriculum have been. Based on the forms after each session, focus group and conversations with the two trainers, certain subtle changes have been made after the studies. These include both formal and informal practices, and the teaching of theory and how to apply it. The formal practices have been emphasised to focus more specifically on the body and senses aspect (including working with physical pain), voicework through a number of precise explorations during the sessions and afterwards and referencing it to compassionate qualities. Overall, the focus on the body and movement is similar to Serge Peyrot’s Morfoanalitica Therapy and Basic Body Awareness Therapy which include body awareness, massage, various movements and diaphragmic breathing (Mantovani et al., 2015).

In terms of teaching, it must be made clear that in the current version of the curriculum there is less emphasis on mindfulness in order not to confuse the participants as some have already

experienced (practised) or read about mindfulness exercises. Another issue concerns spending a bit more time on theoretically explaining how to breathe in a way to activate the sympathetic part of the nervous system and more broadly explain the whole concept of the process of physiological breathing, as all the other practices are based on the ability of the soothing and slowing down quality of the breath (Gilbert, 2012).

The informal practices (application in real life) and post-class explorations that have been added include: "*tong-len* on the spot" as a regular exercise to contrast in with the "on the cushion experience"; exploring various breathing strategies, e.g. smelling flowers and slowly inhaling the fragrance, loosening constrictive clothing to focus on abdominal breathing, self-observation of breathing patterns – as some of the strategies suggested by Peper & Tibbetts (1997). These changes, additions, or simply changes in emphasis were added based on the observations made by the two trainers, the CforC's supervisor (Julia E. Wahl), and conversation between them. They also reflect participants' verbalised need to be able to apply some of the formal practices in their daily experiences, including those of hospital treatment.

7.5. On Teaching Compassion to Others.

As discussed in Chapter 2, it is the therapist (or trainer) and the qualities they embody and demonstrate in their practice that play an essential role in the therapeutic process. The teacher's role is to inspire and maintain the following aspects of students' practice: motivation, stability, and the cultivation as observed based on the training programme experiences (by the supervisor, Julia E. Wahl, and the two trainers). This is done through introducing and explaining formal and informal exercises, providing psychoeducational information, examples of obstacles in the practice (e.g. blocks to and fears of compassion) and how to overcome them, using metaphors and real-life examples, referring to the application in time

of treatment and post-illness. Education or rather (psycho)educat*ing* in this case is much more than just information schooling but to some degree may refer to the Greek notion of *paideia* (Jaeger, 1944) and the Greek aphorism "*gnothi seauton*" or Latin "*nosce te ipsum*" (know thyself) which in CforC would be associated with refinement of psychological qualities and skills and would be interested in focusing on the whole person rather than separated aspects of a person. It is also of vital importance to say that one does not train compassion *per se* but rather the qualities that incline one towards it (Feldman, 2005).

Formally and for pedagogical reasons, and based on the comments made by participants, trainers should repeat a previous session's theme, main practices, and remind participants of the post-class explorations, not to shame in case of being forgotten but as a kind reminder. Discipline in this conceptualisation is understood as (self-) kindness or compassionate *askesis* (self-discipline). This means that participants are not forced to do anything but invited, reminded and encouraged to engage in formal and informal practices.

In terms of using the curriculum or its manual, one needs to remember to have a certain flexibility and creativity (Kendall, Chu, Gifford, Hayes, & Nauta, 1998). The guidelines described in the curriculum give a general framework, a point of reference, its basic theoretical underpinnings and practical application. They also help maintain appropriate scientific evaluation. Having said that, a teacher needs not be rigid and at times be able to shift or move certain practices depending on the processes occurring during the session whilst remembering the overall theme and rationale e.g. knowing what movable and unmovable parts of the training are, what can be left out if necessary. A manual is ultimately a guide that depends on the skill and creativity of the trainer (Kendall, Chu, Gifford, Hayes, & Nauta, 1998). Kendall, Chu, Gifford, Hayes, & Nauta (1998) also refer to this process as "breathing life into manuals" and also highlight the importance of writing them in a way to be understandable to most. They

call it either “communication pain” or “communication pleasure”. It is therefore very important than trainers never follow the practices sequaciously or in a manner that is too rigid. In other words, CforC training needs to follow a particular structure but within that structure specific processes need to be followed and respected (process-oriented work), e.g. what participants bring to the sessions and relating it to specific themes of CforC. In terms of the final curriculum and how it should be used, both critical, non-movable and movable and changeable parts are described in Chapter 2.

Although CFT (on which CforC is based to some degree as described in Chapter 2) is part of CBT (Third Wave CBT) it is a sensorimotor approach and not a cognitive one: first focusing on the experience (senses) and then being able to create a mental representation (Gilbert, 2018, personal communication). This is therefore similar to the concept of “embodied cognition” (Mahon, 2015). According to Mahon (2015, p. 420) in this particular conceptualisation “cognition is mediated by representations expressed in the vocabulary and format of sensory and motor representations” which corresponds to CforC conceptualisation. To describe it further, among other features of embodied cognition, cognitive processes are influenced by the body and its processes and cognition may be influenced without internal representations (Goldinger, Papesh, Barnhart, Hansen, & Hout, 2016) which would be helpful in the case of aphantasia (inability to voluntarily visualise imagery; Zeman et al., 2010). People afflicted with it can still practise imagery work but rather than visualising they may benefit from focusing on the felt experience. This sensorimotor approach may also have a positive effect on practitioners who are more analytical and who struggle whilst visualising. As E.E. Cummings (‘since feeling first’, n.d.) points out:

“since feeling is first

who pays any attention

to the syntax of things

will never wholly kiss you…"

7.5. On Supervising.

Since manuals cannot provide all the answers and teach all the necessary skills, supervision is crucial to skilfully implement certain elements and through that benefits of a manual/curriculum (Kendall, Chu, Gifford, Hayes & Nauta, 1998). The personality of the trainer and style and skill of teaching/presenting material has always been considered the most important factor in therapeutic interventions and contemplative training courses and can be further cultivated through appropriate supervision.

During this process, it is also important to stress the reciprocity occurring in CforC which can be conceptualised into having four dimensions: dynamic equilibrium; shared affect; asymmetric alliance; and recognition as a fellow human being (Sandhu et al., 2015). Dynamic equilibrium refers to interactions being equal, both parties being engaged, and the mutual awareness of one another, whilst the concept of shared affect describes all sides being emotionally involved (Sandhu et al., 2015).

To summarise, the person of the trainer needs to take into account both the phenomenon of asymmetric alliance and recognising all as fellow human beings (Sandhu et al., 2015) and common humanity.

7.6. Fidelity of the Intervention, Supervision, and Model.

The two trainers have both participated in multiple workshops on professional compassion-based interventions, including CFT-oriented and MSC professional workshops (e.g. with

Christopher Germer) (trainers' experience, qualifications are described in detail in Chapter 2). Additionally, they both were using the same curriculum, training materials, and recordings, and where advised about the movable and non-movable elements (in terms of both theory and practice). These elements (core and changeable) are described earlier in the Chapter 2. They were also supervised on a regular (weekly) basis by Julia E. Wahl, specifically in regard to CforC and compassion-based approach, apart from receiving their usual clinical supervision.

The reasons for choosing the two specific trainers included not only their availability, willingness to learn more about CforC, but also their professional and personal experiences and background. Namely, both are experienced in running training courses, working with somatic patients, and are somatic patients themselves (cancer and multiple sclerosis) – which they also disclose to their patients and clients. They both have been practising clinically i.e. working with various clinical populations for many years and have a history of formally practising contemplative approaches e.g. mindfulness and compassion, secular and Buddhist.

Moreover, it needs to be stated that since there was no formal teacher competence in CFT/CMT at the time of creating CforC similar to the Mindfulness-Based Intervention Teacher Competence (MBI-TAC, Crane et al., 2012) created for MBSR/MBCT curricula. Thus, MBIs played a reference point and a similar approach was followed to the one present in MBIs before the creation of MBI-TAC. Namely, it was assumed that in order to deliver good and efficient quality of training, all trainers should have: i) general clinical skills, ii) ample theoretical understanding of the model, iii) good experience in terms of one's own personal (formal) practice (Wielgosz et al., 2019). Thus, each of the trainers was asked to describe to Julia E. Wahl the theory for each of the sessions in their own words and the function of each of the practices. This was to demonstrate their appropriate knowledge, training/clinical skills, and to ensure the fidelity of the whole process of training and research.

Additionally, there is the issue of tension between fidelity of implementation and program adaption (Gonzalez Castro, Barrera, & Martinez, 2004); how programmes are delivered as prescribed by their developers and how to modify, accommodate them depending on the receivers. As suggested by Gonzalez Castro, Barrera, and Martinez (2004), the best way would be to create an in-build "hybrid prevention programme". This approach was also incorporated in the current training programme.

It is clear that for future development and adherence specific measures should be developed for CBIs (e.g. fidelity assessments tools), including CforC. Additionally, what is highlighted by Wielgosz et al. (2019) is "teachers' behaviours and characteristics that go beyond adherence and competence" (p. 19) and highlighting the inconsistence link between adherence and competence with therapeutic outcome.

7.6.1. Practising Inside Out and Personal Self-advice.

It needs to be once again highlighted that the person of the creator of a specific approach plays a huge role in the overall philosophy and execution or genuineness of that approach (Crews, 2017). In truth, the whole approach may as well be informed by these specifications (R. Erskine, personal communication, 2013; C. Germer, personal communication, 2014; W. Wood, personal communication, 2019). Any type of psychotherapeutic intervention is not only a pure technique but in reality, an art as well (Richard Erskine, 2013, personal communication). The person of the therapist or trainer and the qualities they embody and demonstrate in their practice, play an essential role in the therapy/training process. Individual differences between therapists have been found to be more influential to therapeutic outcomes than any particular therapeutic orientation or technique (Lambert, 1992; Shapiro & Shapiro, 1982; Luborsky, McLellen, Diguer, Woody, & Seligman, 1997). Whilst such bold statements

need to be looked into and studied in depth, it may be important to describe the experience (both professional and personal dimensions) of the CforC creator (Julia E. Wahl), and what informed the work as described in detail in Chapter 2.

The axiological perspective is included in the current research strategy as it refers to the issues of values, including one's own values (e.g. the researcher's values) and what ensues, the influence on the research process and its results. What was valued by the researcher (Julia E. Wahl) involved the understanding of what constitutes a helpful tool (e.g. specific exercise), what is the process behind such methods, and how one should train the trainers (TTT) in such approaches (trainers) for the benefit of their patients/course participants. Questions concerning policies were not part of the concern but may be part of a future area of interest as in the researcher's opinion, research should not only distance itself from the practical implications (outside the academic realm), but be directly focused on that aspect of pragmatism, feasibility and applicability.

7.7. Future Directions and Final Words.

The aims of the thesis were to, most importantly, design the training programme and subsequently, evaluate its structure, tools, feasibility, and any potential benefits of the participants. As described in previous paragraphs and chapters, all of these aims and objectives were met, including the feasibility and implementation of CforC (main premise), and subsequently resulting in the changes in all dimensions of psychometric and qualitative measures. It also once again needs to be noted that CforC is at its early stages and future modifications are likely to be introduced, similarly to the history of other contemplative approaches such as MBSR and in fact CFT/CMT.

In terms of future directions two aspects need to be mentioned separately: clinical and research implications. When it comes to the former, in terms of the four stages of clinical trials, phase 1 was included and involved healthy individuals, phase 2 involved testing the effects (both positive and negative) of CforC with the clinical population and also looking at the issue of feasibility and implementation. Thus, what still needs to be done (next stage) is to set-up a randomized control trial to compare any differences between the effects of CforC and treatment as usual, possibly also other psychological interventions such as MBCR/MBSR. It may also be important to distinguish between various stages and types of cancer to see if CforC is more or less beneficial among certain clinical populations. In further studies it would also be interesting to see how physiological aspects are influenced, including HRV, specific hormones like oxytocin, and also astrocytes which may have an effect on human breathing since they actively help control the rhythm of breathing (Sheikhbahaei et al., 2018) and telomeres which affect longevity (Epel et al., 2004).

In terms of clinical implications, it is important to remember that there are many emotional and physical consequences of cancer that go way beyond the time of treatment and thus need to be the focus of further model of care, including social issues (Fenlon et al., 2012) as cancer is not considered to be a chronic disease by many (Blank, 2009). Compassion-focused interventions can therefore not only help people in active treatment but also the ones who are still experiencing the effects of their diagnosis long after, helping to navigate them in the cancer experience trajectory as a preventive, supportive and rehabilitative tool. In terms of practical and applicable issues, survivorship follow-up clinics would be a good place to offer CforC and similar training modules. A further study has been approved by the East Midlands NHS ethics committee for breast cancer patients. Currently CforC has only been tested in a stationary format but for a variety of reasons (e.g. feasibility in terms of side effects of cancer treatment, lack of transportation) an online version should be offered. Already an on-line

version has been designed and approved by the Ethics Committee at the University of Derby. This on-line version would involve all materials, including audio and video recordings available on-line, weekly or bi-weekly on-line meetings (ZOOM or other available on-line platform), weekly reminders (emails), email support if needed. It is important to mention the need for on-line meetings of more than one person as the shared experience is one of the most important components of the experience and benefits of CforC.

Some of the studies that can be conducted in the future include the exploration of appearance-related issues for cancer patients and survivors in terms of their sense of self and social functioning as this has been indicated to be an overlooked issue (Preston, 2010). Another area that still needs to be investigated further is how CforC can help with managing pain as self-compassion may be important in pain adjustment (Wren et al., 2012) and better management was reported as one of the benefits in both clinical and non-clinical groups in open-ended questionnaires, focus groups and conversation with the trainers and Julia E. Wahl.

Apart from the physiological dimension it would be also important to look in more detail at certain dimensions such as common humanity, e.g. developing a Common Humanity Scale would be helpful in order to see how common humanity relates to the concept of Nussbaum's human capabilities and in addition, how this concept relates to health and relational benefits. This also points out to the importance of applying CforC to various cultural and linguistic groups and evaluating if any changes should be made based on the place, culture and language spoken.

Similar to mindfulness, compassion and CBIs can also be studied in terms of the process of making meaning and its relation to health benefits for the individual and its proximate surroundings. This would include the meaning of the illness and general directions of life one

wants to focus on. Additionally, it would be valuable to compare the differences between emotion regulation in the two distinctive processes: of mindfulness and compassion.

Finally, another issue involves the nature of the compassion training itself. As Kevin Knox (personal communication, 2018) reports:

> "*I did a retreat with Alan Wallace a few years back where he asked us all to imagine living in a world where everyone fully practiced the 5 precepts*[14]*, but none did mindfulness meditation, vs. one (like our modern Western world) where the opposite was true. Which would we rather live in*?".

What Knox highlights are the specific qualities that one should focus on rather than just the enhancement of cognitive skills. Interestingly, these qualities not only help the individual in a variety of ways, such as the diagnosis, treatment and post-cancer life, but the whole system in which one lives. Contemplative practices are not only about consciousness and heightening it, they are predominantly about the ethics of consciousness. Thomas Metzinger (2006) described this as having three conditions: minimising the suffering in humans and all other beings capable of suffering, possessing an epistemic potential (component of insight and expanding knowledge), and finally having behavioural consequences that increase the probability of the occurrence of such experiences. Metzinger (2006) refers here to the phenomenal self-model (PMS) which is consistent with the conceptualisation of all-dimensional compassion seeing one and others as a whole which is in opposition to modern-day individualisation which may produce feelings of being disconnected, separated, loneliness or even oneness narcissistic uniqueness. Thus, compassion should penetrate and be applied to both the individual (how one can cope on an individual level) and their surroundings,

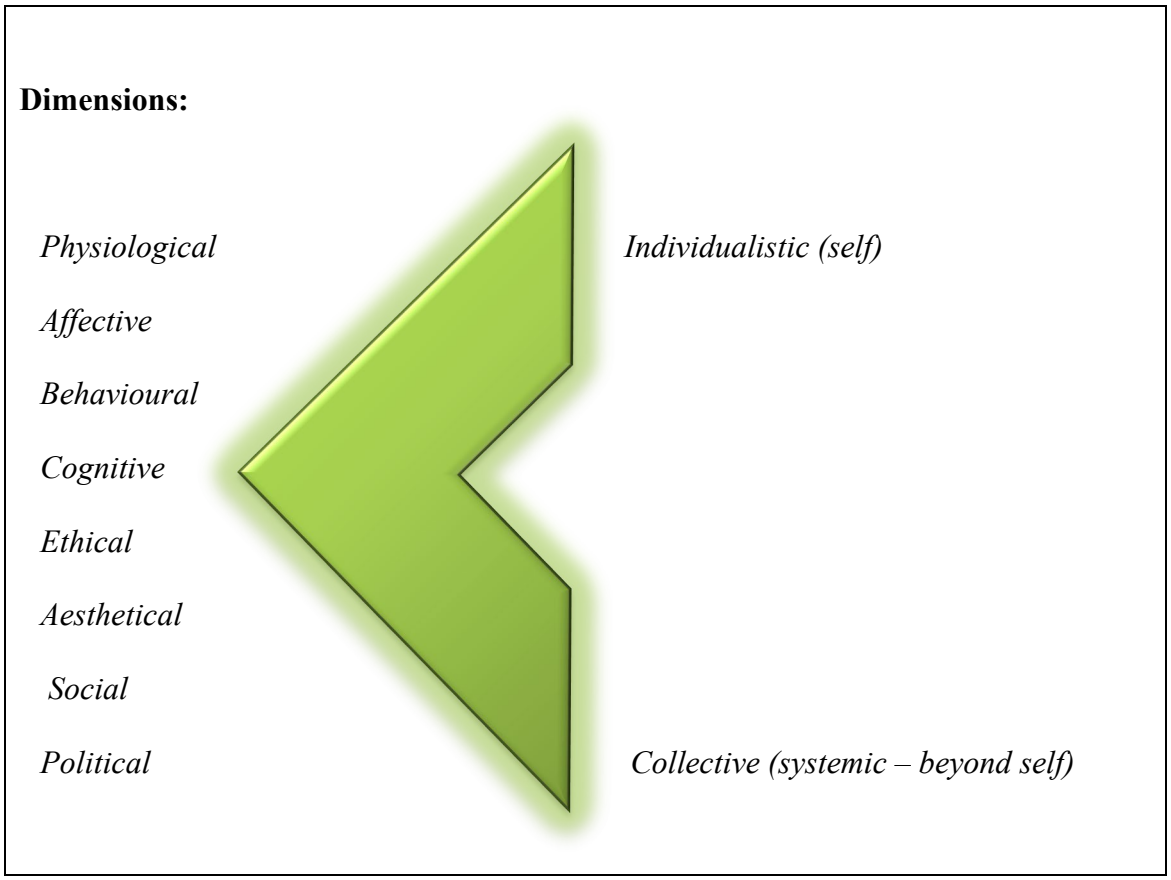
[14] "Five moral precepts" focus on morality and refer to harming living things, taking what is not given. sexual misconduct, lying or gossip, taking intoxicating substances e.g. drugs or drink.

including family, various communities (how one can relate to other people and groups) in various dimensions (see Figure 9) going beyond the general solipsistic view of most therapeutic interventions, including the Westernised type of mindfulness (Joiner, 2017).

In conclusion, even though no adverse side effects were reported in the occurrence of the three eight-week training programmes, it is noteworthy to include some precautions for the future, based both on the limited existing research and one's personal experience

Figure 9

Dimensions and processes of compassion



Thus, training in compassion can help oneself "transcend" the side effects of illness, pain and even oneself. As described by the poet Marilyn Hacker (1994/2012, p. 494) in her "Cancer Winter" poem:

"I woke up, and the surgeon said, 'You're cured.' Strapped to the gurney, in the cotton gown and pants I was wearing when they slid me down onto the table, made news straps secure while I stared at the hydra-headed O.R. lamp, I took in the tall, confident, brown-skinned man, and the ache I couldn't quite call pain from where my right breast wasn't anymore to my armpit. A not-yet-talking head, I bit my dry lips. What else could he have said? And then my love was there in a hospital coat; then my old love, still young and very scared. Then I, alone, graphed clock hands' asymptote to noon, when I would be wheeled back upstairs."

There is physical pain, there is emotional pain, there is change and what is important in the process is the presence of a close person to cope better with all of the difficulties, in the absence of a close person being able to generate such an image. Being able to communicate not only with the otherness of other people but also with the unfamiliarity of oneself and one own's various experiences. As Ferrell (2005) states that in order to be a full human one also needs to be fully compassionate, and yet at times this ability is being forgotten. The experience of the CforC training has proved that one needs to deliberately train in compassion and to quote Pablo Casals (Blum, 1977, p. 4): *"Real understanding does not come from what we learn in books; it comes from what we learn from love of nature, of music, of man. For only what is learned in that way is truly understood."*

References

Aaronson, N. K., Mattioli, V., Minton, O., Weis, J., Johansen, C., Dalton, S. O., & Van de Poll-Franse, L. V. (2014). Beyond treatment – Psychosocial and behavioural issues in cancer survivorship research and practice. *European Journal of Cancer Supplements*, *12*(1), 54–64. http://doi.org/10.1016/j.ejcsup.2014.03.005

Adamczyk, K. (2012). Właściwości psychometryczne polskiej wersji językowej skali do pomiaru stylu przywiązania w dorosłości the Revised Adult Attachment Scale (RAAS). *Przegląd Psychologiczny, 55*(3), 253-269.

Aherne, D., Farrant, K., Hickey, L., Hickey, E., Mcgrath, L., & Mcgrath, D. (2016). Mindfulness based stress reduction for medical students: optimising student satisfaction and engagement. *BMC Medical Education*, 1–11. http://doi.org/10.1186/s12909-016-0728-8

Ahles, T. A., Root, J. C., & Ryan, E. L. (2012). Cancer- and cancer treatment-associated cognitive change: An update on the state of the science. *Journal of Clinical Oncology*, *30*(30), 3675–3686. http://doi.org/10.1200/JCO.2012.43.0116

Ainsworth, M. D., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*(1), 49–67. https://doi.org/10.2307/1127388

Alter, C.L., Pelcovitz, D., Axelrod A, Goldenberg B., Harris H., Meyers B, Grobois, B., Mandel F., Septimus, A., & Kaplan, S. (1996). The identification of PTSD in cancer survivors. *Psychosomatics 37*, 137–143.

Angiola, J. E., & Bowen, M. (2012). Quality of Life in Advanced Cancer: An Acceptance and Commitment Therapy View. *The Counseling Psychologist*, *41*(2), 313–335. http://doi.org/10.1177/0011000012461955

Armour, C., Elklit, A., & Shevlin, M. (2011). Attachment typologies and posttraumatic stress disorder (PTSD), depression and anxiety: a latent profile analysis approach. *European Journal of Psychotraumatology*, *2*, 6018.

Armstrong, G. (2016). *Emptiness*: *A Practical Guide for Meditators.* Somerville, MA: Wisdom Publications.

Arnaboldi, P., Lucchiari, C., Santoro, L., Sangalli, C., Luini, A., & Pravettoni, G. (2014). PTSD symptoms as a consequence of breast cancer diagnosis: clinical implications. *Springerplus, 3*(1), 392.

Ashworth, F., Gracey, F., & Gilbert, P. (2011). Compassion focused therapy after traumatic brain injury: Theoretical foundations and a case illustration. *Brain Impairment, 12*, 128–139.

Atkins, L. & Goodhart, F. (2013). *The Cancer Survivor's Companion: Practical ways to cope with your feelings after cancer.* London: Piatkus.

Au, T. M., Sauer-Zavala, S., King, M. W., Petrocchi, N., Barlow, D. H., & Litz, B. T. (2017). Compassion-Based Therapy for Trauma-Related Shame and Posttraumatic Stress: Initial Evaluation Using a Multiple Baseline Design. *Behavior Therapy*, *48*(2), 207–221. http://doi.org/10.1016/j.beth.2016.11.012

Aurelius, M. (1989). *The meditations of Marcus Aurelius Antoninus.* Oxford: Oxford University Press.

Bady, S. L. (1985). The voice as a curative factor in psychotherapy. *Psychoanalytic Review, 72*(3), 479–490.

Barba, E., & Savarese, N. (2005). *The secret art of the performer: A dictionary of theatre anthropology.* London: Routledge.

Bartholomew, K., Kwong, M. J., & Hart, S. D. (2001). Attachment. In W. J. Livesley (Ed.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 196-230). New York, NY: Guilford Press.

Bateson, N. (2016). *Small Arcs of Larger Circles. Framing Through other Patterns.* Axminster, England: Triarchy Press.

Baumeister, R. F., Campbell, J. D., Krueger, J.I., & Vohs, K.D. (2003).

Does high self-esteem cause better performance, interpersonal success, or healthier lifestyles? *Psychological Science in the Public Interest, 4* (1), 1-44.

Bazeley, P. (2010). Computer-assisted integration of mixed methods data sources and analyses. In Tashakkori, A. & Teddlie, C. (Eds), *The Sage Handbook of Mixed Methods in Social & Behavioral Research* (pp. 431-467). Sage, California.

Bergomi, C., Tschacher, W., & Kupper, Z. (2013). Measuring mindfulness: First steps towards the development of a comprehensive mindfulness scale. *Mindfulness, 4*(1), 18-32.

Berlant, L. G. (2006). *Compassion: the culture and politics of an emotion*. New York: Routledge.

Biegler, K.A., Chaoul, M.A., & Cohen, L. (2009). Cancer, cognitive impairment, and meditation. *Acta Oncologica, 48*(1), 18–26.

Birnie, K., Speca, M., & Carlson, L. E. (2010). Exploring Self Compassion and Empathy in the Context of Mindfulness-Based Stress Reduction (MBSR). *Stress and Health, 26,* 359-371.

Birren, J. E., & Fisher, L. M. (1990). The elements of wisdom: Overview and integration. In R. Sternberg (Ed.), *Wisdom: Its nature, origins, and development* (pp. 317–332). New York: Cambridge University Press.

Blank, T.O. (2009). Cancer from Both Sides Now: Combining Personal and Research Perspectives on Survivorship. *Journal of General Internal Medicine*, *24*(2)*,* 425–428.

Bleiker, E.M..A, Pouwer, F., Van der Ploeg, H.M., Leer, J.W.H., & Ader, H.J. (2000). Psychological distress two years after diagnosis of breast cancer: frequency and prediction. *Patient Education and Counseling, 40,* 209–217.

Bloom, J.R., Cook, M., Fotopoulos, S., Flamer, D., Gates, C., Holland, J.C., Muenz, L.R., Murawski, B., Penman, D., & Ross, R.D. (1987). Psychological response to mastectomy: A prospective comparison study. *Cancer, 59,* 189–196.

Bloom, P. (2016). *Against Empathy. The Case for Rational Compassion.* New York: HarperCollins.

Blum, D. (1977). *Casals and the Art of Interpretation.* Berkeley: University of California Press.

Boehme, S., Miltner, W. H. R., & Straube, T. (2015). Neural correlates of self-focused attention in social anxiety. *Social Cognitive and Affective Neuroscience, 10*(6), 856-862.

Bogaarts, M.P.J., Den Oudsten, B.L., Roukema, Van Riel, J.M.G.H., Beerepoot, L.V., & De Vries, J. (2012). The Psychosocial Distress Questionnaire-Breast Cancer (PDQ-BC) is a useful instrument to screen psychosocial problems. *Support Care Cancer 20*(8)*,* 1659–1665.

Bonanno, G. A., Romero, S. A., & Klein, S. I. (2015). The temporal elements of psychological resilience: An integrative framework for the study of individuals, families, and communities. *Psychological Inquiry, 26*(2), 139-169.

Boulet, D.B. (1975). A comparison of two training approaches, role playing and audio training, on the communication of empathic understanding (Doctoral dissertation). Retrieved from https://ruor.uottawa.ca/bitstream/10393/21268/1/DC53750.PDF

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Bowlby, J. (I980). *Attachment and loss, Vol. 3: Loss, sadness and depression*. New York: Basic Books.

Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds*. London: Tavistock.

Brandberg, Y., Sandelin, K., Erikson, S., & Arver, B. (2008). Psychological Reactions, Quality of Life, and Body Image After Bilateral Prophylactic Mastectomy in Women

at High Risk for Breast Cancer: A Prospective 1-Year Follow-Up Study. *Journal of Clinical Oncology 26*(24), 3943-9.

Brandsma, R. (2017). *The mindfulness teaching guide: Essential skills & competencies for teaching mindfulness-based interventions.* Oakland, CA: New Harbinger.

Brannen, J. (2005). Mixed Methods research: A discussion paper. *ESRC National Centre for Research Methods NCRM Methods Review papers, NCRM/005.*

Braun, E. (2013). *The Birth of Insight: Meditation, Modern Buddhism, and the Burmese Monk Ledi Sayadaw.* Chicago: University of Chicago Press.

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brazier, D. (2013). Mindfulness reconsidered. *European Journal of Psychotherapy and Counseling, 15*(2), 116–126.

Breines, J. G., & Chen, S. (2012). Self-compassion increases self-improvement motivation. *Personality and Social Psychology Bulletin, 26,* 1151-1164.

Britton, W. (2017). Meditation-related difficulties: Building competency. In Mindfulness in Society Conference. Centre for Mindfulness Research and Practice. Bangor University: Chester, UK. Powerpoint, not available online.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84*(4), 822-848.

Brown, M. (1990). *The healing touch. An Introduction to Organismic Psychotherapy.* Mendocino, CA: LifeRhythm.

Brummelman, E., Thomaes, S., & Sedikides, C. (2016). Separating narcissism from self-esteem. *Current Directions in Psychological Science, 25,* 8–13. https://doi.org/10.1177/0963721415619737

Burnett, D. (2012). Inscribing knowledge: Writing research in social work. In W. Green & B.

L. Simon (Eds.), *The Columbia guide to social work writing* (pp. 65-82). New York, NY: Columbia University Press.

Buswell, R. E., & Lopez, D. S. (2013). *The Princeton Dictionary of Buddhism*. Princeton: Princeton University Press.

Caldwell, C., & Victoria, H. K. (2011). Breathwork in body psychotherapy: Towards a more unified theory and practice. *Body, Movement and Dance in Psychotherapy, 6,* 89–101.

Calhoun, L. G., & Tedeschi, R. G. (2006). *Handbook of posttraumatic growth*. Mahwah, NJ: Erlbaum.

Cambridge International Dictionary of English (1995). Cambridge: Cambridge University Press.

Cameron, R, (2011). Mixed methods in business and management: A call to the 'first generation". *Journal of Management and Organisation, 17* (2), 245-267

Carlson, L. E. (2012). Mindfulness-based interventions for physical conditions: a narrative review evaluating levels of evidence. *ISRN Psychiatry*, 651583. http://doi.org/10.5402/2012/651583

Carlson, L. E., & Brown, K.W. (2005). Validation of the Mindful Attention Awareness Scale in a cancer population. *Journal of Psychosomatic Research, 58*, 29-33.

Carlson, L. E., & Speca, M. P. (2010). *Mindfulness-based cancer recovery: a step-by-step MBSR approach to help you cope with treatment.* Oakland, CA: New Harbinger Publications.

Carriere, J.S, Cheyne, J.A, & Smilek, D., (2008). Everyday attention lapses and memory failures: The affective consequences of mindlessness. *Consciousness and Cognition 17*, 835 –47.

Carvalho, S., Martins, C.P., Almeida, H.S., & Silva, F. (2017). The evolution of cognitive behavioural therapy – The third generation and its effectiveness. *European Psychiatry, 41,* S773-S774.

Cassell, E. J. (2004). *The nature of suffering and the goals of medicine*. New York: Oxford University Press.

Chan, C.M.H., Ng, C.G., Taib, N.A., Wee, L.H., Krupat, E., & Meyer, F. (2017). Course and Predictors of Post-Traumatic Stress Disorder in a Cohort of Psychologically Distressed Patients with Cancer: A Four-Year Follow-Up Study. *Cancer, 124*(2), 406 – 416.

Chapin, H. L., Darnall, B. D., Seppala, E. M., Doty, J. R., Hah, J. M., & Mackey, S. C. (2014). Pilot study of a compassion meditation intervention in chronic pain. *Journal of Compassionate Health Care*, *1*(1), 4. http://doi.org/10.1186/s40639-014-0004-x

Checkland, P., and Holwell, S. (1993). Information management and organisational processes: An approach through soft systems methodology. Journal of Information Systems 3, 3-16.

Chismar, D. (1988). Empathy and sympathy: The important difference. *Journal of Value Inquiry, 22*(4), 257-266.

Chödrön, P. (2001). *Tonglen: The Path of Transformation.* Halifax: Vajradhatu Publications.

Christensen, H. J., & Marck, D. E. (2017). The Efficacy of Mindfulness Based Stress Reduction (MBSR) for Decreasing Anxiety and Depression among Breast Cancer Survivors. *School of Physician Assistant Studies*, 613.

Cohen, D. J., Crabtree, B. F., Etz, R. S., Balasubramanian, B. A., Donahue, K. E., Leviton, L. C., Green, L. W. (2008). Fidelity versus flexibility: Translating evidence-based research into practice. American Journal of Preventive Medicine, 35, S381–S389.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385-396.

Collins, N. L., & Read, S. J. (1990). Adult attachment, working models, and relationship quality in dating couples. *Journal of Personality and Social Psychology, 58*, 644-663.

Collins, N.L. (1996). Working models of attachment: Implications for explanation, emotion, and behavior. *Journal of Personality and Social Psychology, 71*(4), 810-832.

Conger, J.A., & Kanungo, R.N. (1988) The Empowerment Process Integrating Theory and Practice. *Academy of Management Review, 13,* 471-48.

Cook, N.D. (2002). *Tone of voice and mind: The connections between intonation, emotion, cognition and consciousness*. Amsterdam, Netherlands: John Benjamins Publishing Company.

Corsini, R. (1966). *Roleplaying* in psychotherapy. Chicago: Aldine.

Costa, J., & Pinto-Gouveia, J. (2011). Acceptance of pain, self-compassion and psychopathology: using the chronic pain acceptance questionnaire to identify patients' subgroups. *Clinical Psychology & Psychotherapy*, *18*(4), 292–302. http://doi.org/10.1002/cpp.718

Crane, R. S., Soulsby, J. G., Kuyken, W., Williams, J. M. G., & Eames, C. (2012). The Bangor, Exeter & Oxford MindfulnessBased Interventions: Teaching Assessment Criteria (MBITAC) for assessing the competence and adherence of mindfulness-based class-based teaching. Retrieved from http://www.bangor.ac.uk/mindfulness/documents/MBITACJune2012.pdf

Crane, T. (2001). *Elements of Mind*. Oxford: Oxford University Press.

Crawford, P., Brown, B., & Kvangarsnes, M. (2014) The design of compassionate care. *Journal of Clinical Nursing 23*(23–24), 3589–3599.

Creswell, J. W. (2009). Research Design: Qualitative, Quantitative, and Mixed Methods Approach. Thousand Oaks: Sage.

Creswell, J.W. & Plano Clark, V.L. (2007). Designing and Conducting Mixed Methods Research. Sage, Thousand Oaks, California.

Crocker, J., & Canevello, A. (2012). Consequences of self-image and compassionate goals. In P. G. Devine & A. Plant (Eds.), *Advances in Experimental Social Psychology, 45* (p. 229–277). New York: Elsevier.

Csikszentmihalyi, M., & Rathunde, K. (1990). The psychology of wisdom: an evolutionary interpretation. In R. J. Sternberg (Ed.), *Wisdom: its nature, origins, and development.* Cambridge: Cambridge University Press.

Curran, L., Sharpe, L., & Butow, P. (2017). Anxiety in the context of cancer: A systematic review and development of an integrated model. *Clinical Psychology Review, 56*, 40-54. doi: 10.1016/j.cpr.2017.06.003

Dąbrowski, K. (1979). *Dezintegracja pozytywna*. Państwowy Instytut Wydawniczy.

Dahl, C. J., Lutz, A., & Davidson, R. J. (2016). Cognitive Processes Are Central in Compassion Meditation Forum Cognetics : Robotic Interfaces for the Conscious Mind. *Trends in Cognitive Sciences*, *20*(3), 161–162. http://doi.org/10.1016/j.tics.2015.12.005

Dane, A. V., & Schneider, B. H. (1998). Program integrity in primary and early secondary prevention: are implementation effects out of control? Clinical Psychology Review, 18(1), 23–45.

Danhauer, C.S., Case, D.L., Tedeschi, R., Russell, G., Vishnevsky, T., Triplett, K, Ip, E.H., & Avis, N.E. (2013). Predictors of posttraumatic growth in women with breast cancer. *Psychooncology, 22*(12), 2676–2683.

Davidson, R. J. (2010). Empirical explorations of mindfulness: Conceptual and methodological conundrums. *Emotion, 10*, 8 –11. http://dx.doi .org/10.1037/a0018480

Davidson, R., Kabat-Zinn. J., Schumacher, J., Rosenkranz, M., Muller, D, Santorelli, S., Urbanowski, F., Harrington, A., Bonus, K., & Sheridan, J. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine, 65,* 564-570.

Davies, J. (2012). *The importance of suffering: the value and meaning of emotional discontent*. London: Routledge.

De Couck, M., Nijs, J., & Gidron, Y. (2014) You may need a nerve to treat pain: the neurobiological rationale for vagal nerve activation in pain management. *Clinical Journal of Pain, 30*(12), 1099-1105.

Debes, R., (2015). From Einfühlung to Empathy: Sympathy in Early Phenomenology and Psychology. In E. Schliesser (Ed.), *Sympathy; a History* (pp. 286 – 332). New York: Oxford University Press.

Deci, E. L., & Ryan, R. M. (1991). A motivational approach to self: Integration in personality. In R. Dienstbier (Ed.), *Nebraska symposium on motivation: Vol. 38, Perspectives on motivation* (pp. 237-288). Lincoln: University of Nebraska Press.

Deci, E. L., & Vansteenkiste, M. (2004). Self-determination theory and basic need satisfaction: Understanding human development in positive psychology. *Ricerche di Psicologia, 27*(1), 23-40.

Dekel, R., Solomon, Z., Ginzburg, K., & Neria, Y. (2004). Long-term adjustment among Israeli war veterans: The role of attachment style. *Anxiety, Stress & Coping: An International Journal, 17*(2), 141-152.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The Discipline and Practice of Qualitative Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (p. 1–32). Thousand Oaks, CA: Sage.

Desbordes, G., Gard, T., Hoge, E. A., Hoge, E.A., Hölzel, B. K., Kerr, C., Lazar, S. W., Olendzki, A., & Vago, D. R. (2015). Moving Beyond Mindfulness: Defining Equanimity as an Outcome Measure in Meditation and Contemplative Research. *Mindfulness, 6(*2) 356–372. http://doi.org/10.1007/s12671-013-0269-8

Desbordes, G., Negi, L.T., Pace, T.W.W., Wallace, B.A., Raison, C.L., & Schwartz, E.L. (2012). Effects of Mindful-attention and Compassion Meditation Training on Amygdala Response to Emotional Stimuli in an Ordinary, Non-meditative State. *Frontiers in Human Neuroscience, 6*, 292.

Diedrich, A., Grant, M., Hofmann, S., Hiller, W., & Berking, M. (2014). Self-compassion as an emotion regulation strategy in major depressive disorder. *Behaviour Research and Therapy, 58*, 43–51. https://doi.org/10.1016/j.brat.2014.05.066.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment, 49*(1), 71-75

Dinger, U., Zilcha-Mano, S., Dillon, J., & Barber, J. P. (2015) Therapist Adherence and Competence in Psychotherapy Research. In R. Cautin & S. Lilienfeld (Eds) The Encyclopedia of Clinical Psychology. New York: John Wiley & Sons.

Dodds, S. E., Pace, T. W. W., Bell, M. L., Fiero, M., Negi, L. T., Raison, C. L., & Weihs, K. L. (2015). Feasibility of Cognitively-Based Compassion Training (CBCT) for breast cancer survivors: a randomized, wait list controlled pilot study. *Supportive Care in Cancer*, *23*(12), 3599–3608. http://doi.org/10.1007/s00520-015-2888-1

Dorjee, D. (2016). Defining Contemplative Science: The Metacognitive Self-Regulatory Capacity of the Mind, Context of Meditation Practice and Modes of Existential Awareness. *Frontiers in Psychology, 7,* 1788. http://doi.org/10.3389/fpsyg.2016.01788

Drageset, S., Lindstrom, T.C., Giske, T., & Underlid, K. (2012). "The support I need": Women's experiences of social support after having received breast cancer diagnosis and awaiting surgery. *Cancer nursing, 35*(6), E39-E47.

Dreyfus, G. (2002). Is compassion an emotion? A cross-cultural exploration of mental typologies. In R. J. Davidson & A. Harrington (Eds.), *Visions of compassion: Western scientists and Tibetan Buddhists examine human nature* (pp. 31-45). New York, NY: Oxford University Press.

Duarte, J.O., Cruz, F.C., Leão, R.M., Planeta, C.S., & Crestani C.C. (2015). Stress vulnerability during adolescence: comparison of chronic stressors in adolescent and adult rats. *Psychosomatic Medicine 77*(2), 186-99.

Durkheim, E. (1897/1997). *Suicide.* New York: The Free Press.

Dusenbury, L., Brannigan, R., Falco, M., & Hansen, W. B. (2003). A review of research on fidelity of implementation: Implications for drug abuse prevention in school settings. *Health Education Research, 18*(2), 237–256.

Edwards, R.B. (1984). Pain and the ethics of pain management. *Social Science and Medicine, 18,* 515-523.

Edwards, D. J. A. (2007). Restructuring implicational meaning through memory based imagery: Some historical notes. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 306-316.

Eisenberg, N., & Strayer, J. (1987). *Empathy and its development.* New York: Cambridge University Press.

Ekman, P. (2010). Darwin's Compassionate View of Human Nature. *Journal of the American Medical Association, 303(*6), 557-558.

Elomaa, M. M., Williams, A. C. C., & Kalso, E. A. (2009). Attention management as a treatment for chronic pain. *European Journal of Pain*, *13,* 1062–1067.

Emler, N. (2001). *Self Esteem: The Costs and Consequences of low self-worth.* York: York Publishing Services.

Eng, W., Heimberg, R. G., Hart, T. A., Schneier, F. R., & Liebowitz, M. R. (2001). Attachment in individuals with social anxiety disorder: The relationship among adult attachment styles, social anxiety, and depression. *Emotion, 1*(4), 365-380.

Epel, E.S., Blackburn, E.H., Lin, J., Dhabhar, F.S., Adler, N.E., Morrow, J.D., & Cawthon, R.M. (2004). Accelerated telomere shortening in response to life stress. *Proceedings of the National Academy of Sciences of the United States of America 101*(49), 17312–17315.

Epstein, R.M. (2017). *Attending: Medicine, Mindfulness, and Humanity.* New York: Scribner.

Feldman C. (2005). *Compassion: Listening to the cries of the world*. Berkeley CA: Rodnell Press.

Ferrell, B. (2005). Ethical perspectives on pain and suffering. *Pain Management Nursing 6*(3), 83-90.

Feuerstein, M. (2007). Defining cancer survivorship. *Journal of Cancer Survivorship, 1*, 5–7.

Figley, C. R. (Ed.). (1995). *Brunner/Mazel psychological stress series, No. 23. Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* Philadelphia, PA: Brunner/Mazel.

Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-compassion, emotion regulation and stress among Australian psychologists: Testing an emotion regulation model of selfcompassion using structural equation modeling. *Plos One, 10*(7), e0133481. http://doi.org/10.1371/journal.pone.0133481

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*(1), 20-35.

Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48*(1), 150-170.

Fox, K.M., Brooks, J.M., Gandra, S.R., Markus, R., & Chiou C.F. (2009). Estimation of Cachexia among Cancer Patients Based on Four Definitions. *Journal of Oncology,* 693458.

Frankl, V. E. (1988). *The will to meaning: Foundations and applications of logotherapy*.

Frankl, V. (1946/2004). *Man's Search* for *Meaning*. New York: Rider.

Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. R. (2003). What good are positive emotions in crisis? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal of Personality and Social Psychology, 84*(2), 365-376.

Gallace, A., & Spence, C. (2010). The science of interpersonal touch: An overview. *Neuroscience and Biobehavioural Reviews, 34,* 246–259.

Ganz, P. (2011). The 'three Ps' of cancer survivorship care. *BMC Medicine 9*(2), 14.

Garland, E. L., Farb, N. A., R. Goldin, P., & Fredrickson, B. L. (2015). Mindfulness Broadens Awareness and Builds Eudaimonic Meaning: A Process Model of Mindful Positive Emotion Regulation. *Psychological Inquiry*, *26*(4), 293-314.

Gendlin, E. T. (1998). *Focusing-oriented Psychotherapy: a manual of the experimental method*. New York: Guilford Press.

Gerhart, J.I., Sanchez Varela, V., & Burns, J.W. (2017). Brief training on patient anger increases oncology providers' self-efficacy in communicating with angry patients. *Journal of Pain Symptom Management, 54*(3), 355- 360.e2.

Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology*, *69*(8), 856–67. http://doi.org/10.1002/jclp.22021

Gilbert, P & Mascaro, J. (2017). Compassion: Fears, blocks, and resistances: An evolutionary investigation. In, Seppälä, E.M., Simon-Thomas, S., Brown, S.L., Worline, M.C., Cameron, C.D & Doty, J.R. (eds). The Oxford handbook of compassion science. (p.388- 418). New York: Oxford University Press.

Gilbert, P. & Mascaro, J. (2017). Compassion, fears, blocks and resistances: An evolutionary investigation. In Seppälä, E. M. et al. (eds.) *The Oxford Handbook of Compassion Science, Oxford, Oxford University Press*.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208. http://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010a). *Compassion focused therapy: distinctive features*. London: Routledge.

Gilbert, P. (2010b). *The compassionate mind: a new approach to life's challenges*. London: Constable.

Gilbert, P. (2012). Compassion focused therapy. In W. Dryden (Ed.), *Cognitive behaviour therapy* (pp. 140–165). London, UK: Sage.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. British Journal of *Clinical Psychology, 53*, 6–41.

Girdon, Y., De Couck, M., & De Greve, J. (2014). If you have an active vagal nerve, cancer stage may no longer be important. *Journal of Biologic and Regulatory Homeostatic Agents, 28*(2), 195-201.

Giuliani, M. V. (2003). Theory of attachment and place attachment. In M. Bonnes, T. Lee, & M. Bonaiuto (Eds.), *Psychological theories for environmental issues* (pp. 137–170). Hants: Ashgate.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin, 136,* 351-374.

Gonzalez, F., Barrera, M., & Martinez, C.R. (2004). The Cultural Adaptation of Prevention Interventions: Resolving Tensions between Fidelity and Fit. *Prevention Science, 5*(1), 41-45.

Goldberg, J.A., Scott, R.N., & Davidson, P.M. (1992). Psychological morbidity in the first year after breast surgery. *European Journal of Surgical Oncology, 18*(4)*,* 327–31.

Goldinger, S. D., Papesh, M. H., Barnhart, A. B., Hansen, W. A., & Hout, M. C. (2016). The poverty of embodied cognition. *Psychonomic Bulletin & Review, 23*(4), 959-978.

Gozum, S. & Akcay, D. (2005). Response to the needs of Turkish chemotherapy patients and their families. *Cancer Nursing 28*(6), 469–475.

Greenberg, L. S., & Safran, J. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research, 8*(6), 591-598.

Greene, J., Caracelli, V. (2003) "Making Paradigmatic Sense of Mixed Methos Inquiry", in Handbook of Mixed Methods in Social & Behavioral Research, Tashakkori, A & Teddlie, C. (Eds) 2003, Sage, California.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271-299.

Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*(3), 281-291.

Gross, J. J. (2015). Emotion regulation: Current status and future prospects. *Psychological Inquiry, 26*(1), 1-26.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*(2), 348-362.

Grossman, P. (2008). On measuring mindfulness in psychosomatic and psychological research. *Journal of Psychosomatic Research, 64,* 405 –8.

Gyatso, T. & Thupten Jinpa. (1995). *The power of compassion: a collection of lectures by His Holiness the XIV Dalai Lama: translated by Geshe Thupten Jinpa.* New York: Thorsons.

Hacker, M. (1994). *Winter Numbers.* New York: W.W.Norton.

Haidt, J. (2003). Elevation and the positive psychology of morality. In C. L. M. Keyes & J. Haidt (Eds.), *Flourishing: Positive psychology and the life well-lived* (pp. 275-289). Washington DC: American Psychological Association.

Haller, H., Winkler, M. M., Klose, P., Dobos, G., Kümmel, S., & Cramer, H. (2017). Mindfulness-based interventions for women with breast cancer: an updated systematic review and meta-analysis. *Acta Oncologica, 56*(12), 1665-1676.

Hanley, A. W., Peterson, G. W., Canto, A. I., & Garland, E. L. (2015). The Relationship Between Mindfulness and Posttraumatic Growth with Respect to Contemplative Practice Engagement. *Mindfulness*, *6*(3), 654–662. http://doi.org/10.1007/s12671-014-0302-6

Hannah S.T., Sweeney P.J., & Lester P.B. (2007). Toward a courageous mindset: The subjective act and experience of courage. *Journal of Positive Psychology, 2,* 129–135.

Hansen, G. R., & Streltzer, J. (2005). *The Psychology of Pain, 23*, 339–348. http://doi.org/10.1016/j.emc.2004.12.005

Harcourt, D. (2010). Body image and appearance. *Breast Cancer Care Secondary Breast Cancer Support Day, Bristol.* Retrieved from http://eprints.uwe.ac.uk/27193/

Harlow, H. (2000, March). *The Nature of Love*. Retrieved from https://psychclassics.yorku.ca/Harlow/love.htm

Harrington, C.B., Hansen, J.A., Moskowitz, M., Todd, B.L., & Feuerstein, M. (2010). It's not over when it's over: long-term symptoms in cancer survivors – A Systematic review. *International Journal of Psychiatry in Medicine, 40*(2), 163-181.

Havel, V. (1994). *The need for transcendence in the postmodern world. Liberty Medal acceptance speech*, Philadelphia. Retrieved from http://www.worldtrans .org/whole/havelspeech.html

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2011). *Acceptance and Commitment Therapy: an Experiential Approach to Behavior Change.* New York: Guilford Press.

Herold A.H, & Roetzheim, R.G. (1992). Cancer survivors. *Primary Care* 19(4), 779–791.

Hewitt, M. E., Greenfield, S., & Stovall, E. (2006). *Cancer Policy Board (US) Committee on Cancer Survivorship Improving Care and Quality of Life. From cancer patient to cancer survivor: lost in transition, National.* Washington, DC: The National Academies Press.

Hicks, D. (2013). *Dignity: The essential role it plays in resolving conflict*. New Haven: Yale University Press.

Hofmann, S. G., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review, 31,* 1126-1132.

Holland, J. C., & Alici, Y. (2010). Management of distress in cancer patients. *The Journal of Supportive Oncology, 8*, 4-12.

Hölzel, B.K., Ott, U., Hempel, H., Hackl, A., Wolf, K., Stark, R., & Vaitl, D. (2007). Differential engagement of anterior cingulate and adjacent medial frontal cortex in adept meditators and non-meditators. *Neuroscience Letters, 421*(1), 16–21.

Holzkamp, K. (1991). Experience of self and scientific objectivity. In C. W. Tolman, & W. Maiers (Eds.), *Critical psychology: Contributions to an historical science of the subject* (pp. 65–80). Cambridge, MA: Cambridge University Press. (Original work published 1985).

Hopkins, J. & Napper, E. (1996). *Meditation on Emptiness*. London: Wisdom Publications.

Hopkins, V., & Kuyken, W. (2012). Benefits and Barriers to Attending MBCT Reunion Meetings: An Insider Perspective. *Mindfulness*, *3*(2), 139–150. http://doi.org/10.1007/s12671-012-0088-3

Hopwood, P., Fletcher, I., Lee, A., & Al Ghazal, S. (2001). A body image scale for use with cancer patients. *European Journal of Cancer*, *37*(2), 189–197.

Huang, H.P., He M., Wang, H.Y., & Zhou, M. (2016). A meta-analysis of the benefits of mindfulness-based stress reduction (MBSR) on psychological function among breast cancer (BC) survivors. *Breast cancer, 23,* 568-576.

Hume, D. (1978). *A Treatise of Human Nature.* Oxford: Oxford University Press.

Hunter, M. & Struve, J. (1997). *The ethical use of touch in Psychotherapy*. New York: Thompson Publishing.

Ingram, R. E. (1990). Self-focused attention in clinical disorders: review and a conceptual model. *Psychological Bulletin, 107*(2), 156-76.

Inhestern, L., Beierlein, V., Krauth, K.A., Rolfes, U., Schulte, T., & Berger, D., (2017). Belastungen bei Eltern krebskranker Kinder in der familienorientierten Rehabilitation [Burden of parents of pediatric cancer patients in pediatric-oncological rehabilitation]. *Praxis Kinderpsychologie und Kinderpsychiatrie 66*(3), 179–93

Ioannidis, C., & Siegling, A.B (2015). Criterion and incremental validity of the emotion regulation questionnaire. *Frontiers in Psychology, 6,* 247.

Jablonka, E., & Lamb, M.J. (2014). *Evolution in four dimensions: Genetic, epigenetic, behavioural, and symbolic variation in the history of life (2nd ed.).* Cambridge: Cambridge University Press.

Jaeger, W. (1944). *Paideia: The Ideals of Greek Culture*. New York: Oxford University Press.

Jaffe, J., & Feldstein, S. (1970). *Rhythms of dialogue*. New York: Academic Press.

Janet, P. (1889). *L'Automatisme psychologique*. Felix Alcan: Paris. (Reprint: Société Pierre Janet, Paris, 1973).

Jazaieri, H., Jinpa, G., McGonigal, K., Rosenberg, E., Finkelstein, J., Simon-Thomas, E., Cullen, M., Doty, J., Gross, J., & Goldin, P. (2012). Enhancing compassion: A randomized controlled trial of a Compassion Cultivation Training program. *Journal of Happiness Studies, 14,* 1113-1126. http://doi.org/10.1007/s10902-012-9373-z

Jeffrey, D. (2016). Empathy, sympathy and compassion in healthcare: Is there a problem? Is there a difference? Does it matter? *Journal of the Royal Society of Medicine, 109*(12).

Jia, Y., Li, F., Liu, Y.F., Zhao, J.P, Leng, M.M., & Chen L. (2017) Depression and cancer risk: a systematic review and meta-analysis. *Public Health, 149*, 138-148.

Jinpa, T. (2015). *Fearless heart.* London: Piatkus Books.

Johnson, R.B., & Onwuegbuzie, A.J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researchers, 33,* 7, 14-26.

Johnson, S. & Walker, J. (1828). *A Dictionary of the English Language (Second Edition).* London: William Pickering.

Joiner, T. (2017). *Mindlessness: The Corruption of Mindfulness in a Culture of Narcissism*. Oxford: Oxford University Press.

Jonsen, A.R., Churchland, P.S., Damasio, A.R., Moreno,J., Schaffner,K.F., & Mobley, W. (2002). Brain science and the self. *Cerebrum, 4*(3), 56–58.

Juczyński Z. (2001). *Narzędzia pomiaru w promocji i psychologii zdrowia.* Warszawa: PTP.

Juczyński, Z., Ogińska-Bulik, N. (2009). Pomiar zaburzeń po stresie traumatycznym – polska wersja zrewidowanej Skali Wpływu Zdarzeń. *Psychiatria, 6*(1), 15-25.

Julkunen J., Gustavsson-Lilius M., & Hietanen P. (2009). Anger expression, partner support, and quality of life in cancer patients. *Journal of Psychosomatic Research, 66*, 235-244.

Jung, C.G. (1935). The Tavistock lectures. In J. Chodorow (Ed,), *Encountering Jung: Jung on active imagination*. Princeton, NJ: Princeton.

Kabat-Zinn, J. (1990). *Full catastrophe living: how to cope with stress, pain and illness using mindfulness meditation*. New York: Dell Publishing.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144-156. http://doi.org/10.1093/clipsy/bpg016

Kabat-Zinn, J. (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism*, *12*(1), 281–306. http://doi.org/10.1080/14639947.2011.564844

Kabir, R.S., Haramaki, Y., Ki, H., & Ohno, H. (2018). Self-Active Relaxation Therapy (SART) and Self-Regulation: A Comprehensive Review and Comparison of the Japanese Body Movement Approach. *Frontiers in Human Neuroscience, 12,* 21.

Kagitcibasi, C. (2011). Socio-cultural change and integrative syntheses in Human development: Autonomous related self and socio-cognitive competence. *Child Development Perspectives, 5*(3), 1-7.

Kang, J., Lee, S.I., Lim, D.H., Park, K.W., Oh, S.Y., Kwon, H.C., Hwang. I.G., Lee, S.C., Nam E., Shin, D.B., Lee, J., Park, J.O., Park, Y.S., Lim, H.Y., Kang, W.K, & Park, S.H. (2012). Salvage chemotherapy for pretreated gastric cancer: a randomized phase III trial comparing chemotherapy plus best supportive care with best supportive care alone. *Journal of Clinical Oncology, 30*(13), 1513-8.

Kanov, J. (2005). *Re-envisioning feeling and relating at work: An inductive study of interpersonal disconnection in organizational life* (Doctoral dissertation). Retrieved from https://deepblue.lib.umich.edu/handle/2027.42/125396

Kaushik, V., Walsh, C. A. (2019). Pragmatism as a Research Paradigm and Its Implications for Social Work Research. *Social Sciences, 8* (9), 255.

Kelle, U. (2006). Combining qualitative and quantitative methods in research practice: Purposes and advantages. *Qualitative Research in Psychology, 3*(4), 293–311.

Keltner, D. (2009). *Darwin's Touch: Survival of the Kindest.* Retrieved from https://greatergood.berkeley.edu/article/item/darwins_touch_survival_of_the_kindest

Kemper, K. J., & Shaltout, H. A. (2011). Non-verbal communication of compassion: Measuring psychophysiologic effects. *BMC Complementary & Alternative Medicine, 11*(132), 1-9.

Kendall, P. C., Chu, B., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing life into a manual: Flexibility and creativity with manual-based treatments. *Cognitive and Behavioral Practice*, *5*(2), 177-198.

Keng, S. L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*, *31*(6), 1041–1056. http://doi.org/10.1016/j.cpr.2011.04.006

Kennifer, S. L., Alexander, S. C., Pollak, K. I., Jeffreys, A. S., Olsen, M. K., Rodriguez, K. L., Arnold, R.M, & Tulsky, J. A. (2009). Negative emotions in cancer care: Do oncologists' responses depend on severity and type of emotion? *Patient Education and Counseling*, *76*(1), 51–56. http://doi.org/10.1016/j.pec.2008.10.003

Kever, A., Pollatos, O., Vermeulen, N., & Grynberg, D. (2015). Interoceptive sensitivity facilitates both antecedent- and response-focused emotion regulation strategies. *Personality and Individual Differences, 87,* 20-23.

Khyentse, D. (2007). *The Heart of Compassion*. Boston: Shambhala.

Kiesler, C. (1971). *The Psychology of Commitment.* New York: Academic Press.

Kimber, M., Barac, R., & Barwick, M. (2019). Monitoring fidelity to an evidence-based treatment: Practitioner perspectives. *Clinical Social Work Journal, 47*(2), 207–221.

Kirby, J. N. (2016). Compassion interventions: The programs, the evidence, and implications for research and practice. *Psychology and Psychotherapy: Theory, Research and Practice, 90*(3), 432–455.

Kitajima, N., Watanabe, K., Morimoto, S., Sato, Y., Kiyonaka, S., Hoshijima, M., Ikeda, Y., Nakaya, M., Ide, T., Mori, Y., Kurose, H., & Nishida, M. (2011). TRPC3-mediated Ca^{2+} influx contributes to Rac1-mediated production of reactive oxygen species in MLP-deficient mouse hearts. *Biochemical and Biophysical Research Communities, 409*(1), 108–113. doi: 10.1016/j.bbrc.2011.04.124

Kleinman, A. (1992). Local worlds of suffering: An interpersonal focus for ethnographies of illness experience. *Qualitative Health Research, 2*(2), 127-134.

Knowlton, G. E., & Larkin, K. T. (2006). The influence of voice volume, pitch, and speech rate on progressive relaxation training: Application of methods from speech pathology and audiology. *Applied Psychophysiology and Biofeedback, 31*(2), 173–185.

Kobylińska, D. (2015). *Kwestionariusz regulacji emocji.* Retrieved from: http://spl.stanford.edu/ pdfs/ERQ/Polish.pdf

Koole, S.L., Van Dillen, L.F., & Sheppes, G. (2009). Self-regulation in Vohs, K. D., & Baumeister, R. F. (Eds.). *Handbook of Self-Regulation. Research, theory, and applications* (p. 22-40). New York: Guilford Press.

Kornfield, J. (2002). *The art of forgiveness, loving kindness, and peace.* New York, NY: Bantam Dell.

Korzybski, A. (1933). *Science and sanity. An introduction to non-Aristotelian systems and general semantics.* Oxford, England: International Non-Aristotelian Library.

Kossakowska, M., Kwiatek, P., & Stefaniak, T. (2013). Sens w życiu. Polska wersja kwestionariusza MLQ (Meaning in Life Questionnaire). *Psychologia Jakości Życia, 12*(2), 111-131.

Koutrouli, N., Anagnostopoulos, F., & Potamianos, G. (2012). Posttraumatic stress disorder and posttraumatic growth in breast cancer patients. *Women's Health, 52*, 503–516. doi: 10.1080/03630242.2012.679337.

Kramer, D.A. (1990). Conceptualizing wisdom: the primacy of affect - cognition relations. In R. Sternberg (Ed.), *Wisdom: Its nature, origins and development* (pp. 279- 309). Cambridge: Cambridge University Press.

Krippner, S. (2014). The mind-body-spirit paradigm: Crisis or opportunity? *American Journal of Clinical Hypnosis, 56,* 210-215.

Lang, P., & Bradley, M. (2010). Emotion and the motivational brain. *Biological Psychology, 84*(3), 437-450.

Laranjeira, C., Ponce Leão, P., & Leal, I. (2014). We look beyond the cancer to see the person: the healing path of female cancer survivor. *Procedia – Social and Behavioral Sciences, 114,* 538–542.

Lazarus, R. S. (1991). *Emotion and Adaptation.* New York: Oxford University Press.

Leal, I., Engebretson, J., Cohen, L., Rodriguez, A., Wangyal, T., Lopez, G., & Chaoul, A. (2015). Experiences of paradox: A qualitative analysis of living with cancer using a framework approach. *Psychooncology, 24*(2), 138-46.

Lederman, S.J., & Klatzky, R.L. (1987). Hand movements: A window into haptic object recognition. *Cognitive Psychology, 19*(3), 342-368.

Ledesma, D., & Kumano, H. (2009). Mindfulness-based stress reduction and cancer: A meta-analysis. *Psycho-Oncology, 18*(6), 571-579.

Lee, E.H. (2012). Review of the psychometric evidence of the perceived stress scale. *Asian Nursing Research, 6(*4), 121–127.

Lee, M. Y., Zaharlick, A., & Akers, D. (2011). Meditation and Treatment of Female Trauma Survivors of Interpersonal Abuses: Utilizing Clients' Strengths. *Families in Society, 92*(1), 41-49.

Lerman R., Jarski R., Rea H., Gellish R., & Vicini F. (2012). Improving symptoms and quality of life of female cancer survivors: A randomized controlled study. *Annals of Surgical Oncology,* 19(2), 373-8.

Leuner, H. (1984). *Guided Affective Imagery*: *Mental Imagery in Short-Term Psychotherapy*, *The Basic Course*. New York: Thieme Medical Publications.

Lewin, K. (1935). *A dynamic theory of personality.* New York, NY: McGraw-Hill.

Lichty, S. (2009). *The air that I breathe: How Buddhist practice supports psychotherapists in the midst of vicarious trauma and burnout* (Master's Thesis). Retrieved from http://dspace.nitle.org/bitstream/handle/10090/9902/SimoneLichty%20final%20THESIS.pdf?sequen ce=1

Lieberman, M. A, & Goldstein, B. A. (2005). Self-help on-line: An outcome evaluation of breast cancer bulletin boards. *Journal of Health Psychology, 10*(6), 855–62.

Lim, D., & DeSteno, D. (2016) Suffering and Compassion: The Links Among Adverse Life Experiences, Empathy, Compassion, and Prosocial Behavior. *Emotion, 16*(2), 175.

Lindahl, J. R., Fisher, N. E., Cooper, D. J., Rosen, R. K., & Britton, W. B. (2017). The varieties of contemplative experience: A mixed-methods study of meditation-related challenges in Western Buddhists. *PLoS ONE, 12*(5), Article e0176239.

Locke, E. A. (2000). Motivation, cognition, and action: An analysis of studies of task goals and knowledge. *Applied Psychology: An International Review, 49,* 408–429.

Lucey, J. (2017). *The Life Well Lived.* Dublin, Ireland: Transworld Ireland Publishers.

Lumma, A., Kok, B. E., & Singer, T. (2015). Is meditation always relaxing? Investigating heart rate, heart rate variability, experienced effort and likeability during training of three types of meditation. *International Journal of Psychophysiology, 97,* 38-45

Lykins, E.L., & Baer, R.A. (2009). Psychological functioning in a sample of long-term practitioners of mindfulness meditation. *Journal of Cognitive Psychotherapy, 23,* 226–241.

Lynd, H. M. (1958). *On shame and the search for identity.* Oxford, England: Harcourt, Brace.

Maass, S.W.M.C., Roorda, C., Berendsen, A.J., Verhaak, P.F.M., & de Bock, G.H. (2015). The prevalence of long-term symptoms of depression and anxiety after breast cancer treatment: A systematic review. *Maturitas, 82,* 100–8.

Macbeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*(6)*,* 545– 552.

Mahon, B. Z. (2015). What is embodied about cognition. *Language, Cognition, and Neuroscience*, *30,* 420–429.

Makransky, J. & Lavelle, B.D. (2016, February 1). *Sustainable Compassion for Those Who Serve.* Retrieved from https://tricycle.org/trikedaily/sustainable-compassion-for-those-who-serve

Manczak, E. M., DeLongis, A., & Chen, E. (2016). Does Empathy Have a Cost? Diverging Psychological and Physiological Effects within Families. *Health Psychology, 35,* 211-218.

Mantovani, A.M., Fregonesi, C.E.P.T., Lorençon,i R.M.R, Savian, N.U., Palma, M.R., Salgado A.S.I., de Oliveira, L.V., & Parreira, R.B. (2016). Immediate Effect of Basic Body Awareness Therapy on Heart Rate Variability. *Complementary Therapies in Clinical Practice, 22*, 8-11.

Maratos, F., Montague, J., Ashra, H., Welford, M., Wood, W., Barnes, C., Sheffield., & Gilbert, P. (2019) Evaluation of a Compassionate Mind Training Intervention with School Teachers and Support Staff. Mindfulness. *Mindfulness, 24*(2), 241-52

Marx, K. (1867/1990). *Capital: Critique of Political Economy.* London: Penguin Classics.

Masis, K. V. (2002). American Zen and psychotherapy: An ongoing dialogue. In P. Young-Eisendrath & S. Muramoto (Eds.), *Awakening and insight: Zen Buddhism and psychotherapy* (pp. 149-171). New York: Brunner/Routledge.

Massion, A. O., Teas, J., Hebert, J. R., Wertheimer, M. D., & Kabat-Zinn, J. (1995). Meditation, melatonin and breast/prostate cancer: hypothesis and preliminary data. *Medical Hypothesis, 44,* 39-46.

Matos, M., Duarte, C., Duarte, J., Pinto-Gouveia, J., Petrocchi, N., Basran, J., & Gilbert, P. (2017). Psychological and physiological effects of compassionate mind training: A pilot randomised controlled study. *Mindfulness, 8*(6), 1699–1712.

Matos, M., Duarte, J., & Pinto-Gouveia, J. (2017). The origins of fears of compassion: Shame and lack of safeness memories, fears of compassion and psychopathology. *The Journal of Psychology, 151*, 804–819.

McCraty, R., Atkinson, M., Tomasino, D., & Bradley, R. T. (2009b). The coherent heart: heart-brain interactions, psychophysiological coherence, and the emergence of system-wide order. *Integral Review, 5*(2)*,* 10–115.

McCullough, M. E., Emmons, R. A., & Tsang, J.-A. (2002). The grateful disposition: A conceptual and empirical topography. *Journal of Personality and Social Psychology, 82*(1), 112–127.

McFarland, S., Brown, D., & Webb, M. (2013). Identification with all humanity as a moral concept and psychological construct. *Current Directions in Psychological Science, 22,* 194–198. https://doi.org/10.1177/0963721412471346

McGrew, J. H., Bond, G. R., Dietzen, L., & Salyers, M. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting and Clinical Psychology, 62*(4), 670–678.

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments. *American Psychologist, 65,* 73-84.

McKim, C.A. (2017). The Value of Mixed Methods Research: A Mixed Methods Study. *Journal of Mixed Methods Research, 11*(2) 202–222.

McKnight D.E. (2012). *Tonglen Meditation's effect on levels of compassion and self-compassion: a proof of concept study and instructional guide. Thesis completed as part of the Upaya Buddhist chaplaincy training program* (Thesis). Retrieved from https://upaya.org/uploads/pdfs/McKnightTonglenThesis.pdf

McKnight. D.E. (2014). *Tonglen Meditation's Effects on Compassion in Novice Meditators* (Doctoral Dissertation). Retrieved from https://pqdtopen.proquest.com/doc/1564777536.html?FMT=ABS

McLeod, K. (Trans.). (1987). *The great path of awakening: The classic guide to using the Mahayana Buddhist slogans to tame the mind and awaken the heart.* Boston: Shambhala Publications.

McWilliams, L. A., & Bailey, S. J. (2010). Associations between adult attachment ratings and health conditions: Evidence from the National Comorbidity Survey Replication. *Health Psychology, 29*(4), 446-453.

Meadows, D. (2008). *Thinking in Systems. A Primer.* White River Junction, Vermont: Chelsea Green Publishing.

Mehta, R.D., & Roth, A.J. (2015). Psychiatric considerations in the oncology setting. *CA: a Cancer Journal for Clinicians, 65*(4), 300-314.

Mentzer, J.T., & Kahn, K.B. (1995). A framework of logistics research. Journal of Business Logistics, 16 (1), 231-50.

Mermelstein, H.T., & Lesko, L. (1992). Depression in patients with cancer. *Psycho-oncology, 1*(4), 199–215.

Merriam-Webster Dictionary (n.d). Retrieved from https://www.merriam-webster.com/dictionary/compassion

Mersky, H. (1979). Pain terms: a list with definitions and notes on usage. *Pain 6,* 249-252.

Metzinger, T. (2006). Different conceptions of embodiment. *Psyche, 12*(4), 1–7.

Miki, Y., & Kuroki, K. (1998). Dialogue: On psychotherapy practice in Japan. In Y. Miki & K. Kuroki (Eds.), *Nihon no Shinri-ryoho* [Japanese psychotherapies] (pp. 273–297). Tokyo: Tokishobo.

Moneta, M.E., Penna, M., Loyola, H., Kächele, H., & Buchheim, A. (2008) Measuring emotion in the voice during psychotherapy: A pilot study. *Biological Reseach, 41*(4), 389-395.

Monroe, K.R. (1996). *The Heart of Altruism: Perceptions of a Common Humanity.* Princeton, NJ: Princeton University Press.

Moore, J. (1991). *Gurdjieff: The Anatomy of a Myth.* Shaftesbury: Element Books.

Moye, J., June, A., Martin, L.A., Gosian, J., Herman, L., & Naik, A.D. (2014). Pain is prevalent and persisting in cancer survivors: Differential factors across age groups. *Journal of Geriatric Oncology, 5*(2):190–196.

Mravec, B., Gidron, Y., Kukanova, B., Bizik, J., Kiss, A., & Hulin, I. (2006). Neural–endocrine–immune complex in the central modulation of tumorigenesis: facts, assumptions, and hypotheses. *Journal of Neuroimmunology, 180*(1-2)*,* 104–16.

Mrazek, M. D., Franklin, M. S., Tarchin, D., Baird, B., & Schooler, J. W. (2013). Mindfulness Training Improves Working Memory Capacity and GRE Performance While Reducing Mind Wandering. *Psychological Science, 24*(5), 776-81 http://doi.org/10.1177/0956797612459659

Mullan, F. (1985). Seasons of survival: reflections of a physician with cancer. *New England Journal of Medicine, 313*, 270–273.

Nakatani,Y., Iwamitsu, Y., Kuranami, M., Okazaki, S., Yamamoto, K., Watanabe., M, & Miyaoka, H. (2013). Predictors of psychological distress in breast cancer patients after surgery. *Kitasato Medical Journal*, 43, 49-56.

Neff, K. D., & Pommier, E. (2013). The Relationship between Self-compassion and Other-

focused Concern among College Undergraduates, Community Adults, and Practicing Meditators. *Self and Identity*, *12*(2), 160–176. http://doi.org/10.1080/15298868.2011.649546

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-Compassion and Adaptive Psychological Functioning. *Journal of Research in Personality, 41,* 139-154.

Neff, K. D., Rude, S. S., & Kirkpatrick, K. L. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality*, *41*(4), 908–916. http://doi.org/10.1016/j.jrp.2006.08.002

Neff, K.D., & Pommier, E. (2012). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity, 12*, 1–17.

Nersesyan, H., & Slavin, K. (2007). Current aproach to cancer pain management: Availability and implications of different treatment options. *Therapeutics and Clinical Risk Management*, *3*(3), 381-400.

Nock, M. K., & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73*(5), 872–879.

Noddings, N. (1984). *Caring, a feminine approach to ethics & moral education*. Berkeley: University of California Press.

Norcross, J. C., & Goldfried, M. R. (2005). *Handbook of psychotherapy integration*. New York: Oxford University Press.

Nussbaum, M. C. (1990). Aristotelian Social Democracy. In B. B. Douglass et al. (Eds) *Liberalism and the Good* (pp. 203-252). New York: Routledge.

Nussbaum, M. C. (2001). *Upheavals of thought: the intelligence of emotions*. Cambridge: Cambridge University Press.

Ogińska-Bulik, N., Juczyński. Z. (2010). Rozwój potraumatyczny - charakterystyka i pomiar. *Psychiatria, 7*(4), 129-142.

Ohira, H., Matsunaga, M., Osumi, T., Fukuyama, S., Shinoda, J., Yamada, J., & Gidron, Y. (2013). Vagal nerve activity as a moderator of brain-immune relationships. *Journal of Neuroimmunology, 260*, 28-36.

Ohno, H. (2007). Basic SART Techniques with Q&A. Fukuoka: NPO Psychological Rehabilitation Center. [In Japanese].

Ohno, H. (2015). Applications of relaxation to stress management I: principles of self-active relaxation therapy. *Hiroshima Psychological Research Bulletin 14*, 3–11. [In Japanese with English abstract]. doi: 10.15027/39583

Online Etymology Dictionary (n.d). Retrieved from https://www.etymonline.com/word/sympathy#etymonline_v_22516

Orellana-Rios, C.L., Radbruch, L., Kern, M., Regel, Y.U., Anton, A., Sinclair. S, & Schmidt, S. (2018). Mindfulness and compassion-oriented practices at work reduce distress and enhance self-care of palliative care teams: a mixed-method evaluation of an "on the job" program. *BMC Palliative Care, 17*(1), 3.

Orwoll, L., & Perlmutter, M. (1990). The study of wise persons: Integrating a personality perspective. In J. Sternberg (Ed.), *Wisdom: Its nature, origins, and development* (pp. 160- 177). New York: Cambridge University Press.

Osei-Bonsu, P. E., Weaver, T. L., Eisen, S. V., & Wal, J. S. V. (2012). Posttraumatic growth inventory: Factor structure in the context of DSM-IV traumatic events. *International Scholarly Research Network, 2012*. Retrieved from http://downloads.hindawi.com/journals/isrn.psychiatry/2012/937582.pdf.

Otani, A. (2003). Eastern Meditative Techniques and Hypnosis: A New Synthesis. American *Journal of Clinical Hypnosis, 46*(2), 97 – 108.

Oudenhove, L. Van, & Cuypers, S. (2014). The relevance of the philosophical ' mind – body

problem ' for the status of psychosomatic medicine: a conceptual analysis of the biopsychosocial model. *Medicine, health care, and philosophy, 17*(2), 201–213. http://doi.org/10.1007/s11019-013-9521-1

Oveis, C., Horberg, E. J., & Keltner, D. (2010). Compassion, pride, and social intuitions of self-other similarity. *Journal of Personality and Social Psychology, 98,* 618–630.

Pace, T. W. W., Negi, L. T., Adame, D. D., Cole, S. P., Sivilli, T. I., Brown, T. D., Issa, M.J, & Raison, C. L. (2009). Effect of compassion meditation on neuroendocrine, innate immune and behavioral responses to psychosocial stress. *Psychoneuroendocrinology*, *34*(1), 87–98. http://doi.org/10.1016/j.psyneuen.2008.08.011

Panksepp, J. (1998). *Series in affective science. Affective neuroscience: The foundations of human and animal emotions.* New York, NY: Oxford University Press.

Pardy, J. (2016). *The tonglen experiences of individuals with established sitting meditation practices: a grounded theory study (*Masters thesis). Retrieved from https://research.library.mun.ca/11893/

Park, C. L., Edmondson, D., Fenster, J. R., & Blank, T. O. (2008). Meaning making and psychological adjustment following cancer: The mediating roles of growth, life meaning, and restored just-world beliefs. *Journal of Consulting and Clinical Psychology, 76,* 863–875.

Parry, S. L., & Malpus, Z. (2017). Reconnecting the mind and body: a pilot study of developing compassion for persistent pain. *Patient Experience Journal 4*(1), 145-153.

Pascual-Leone, J. (1990). An essay on wisdom: Toward organismic processes that make it possible. In R. J. Sternberg (Ed.), *Wisdom: Its nature, origins, and development* (pp. 244–278). New York: Cambridge University Press.

Patterson, R.E., Neuhouser, M.L., Hedderson, M.M., Schwartz, S.M., Standish, L.J., Bowen, D.J. (2003). Changes in diet, physical activity, and supplement use among adults diagnosed with cancer. *Journal of the American Dietetic Association, 103*(3), 323–328.

Paul, R., & Elder, L. (2006). *The thinker's guide to understanding the foundations of ethical reasoning.* Dillon Beach, CA: Foundation for Critical Thinking.

Pavot, W., & Diener, E. (1993). Review of the Satisfaction With Life Scale. *Psychological Assessment, 5*(2), 164-172.

Penman, D.T., Bloom, J.R., Fotopoulos, S., Cook, M.R., Holland, J.C., Flamer, D., Murawski, B., Ross, R., Brandt, U., Muenz, L.R., & Pee, D. (1987). The impact of mastectomy on self-concept and social function: A combined cross-sectional and longitudinal study with comparison groups. *Women and Health, 11,* 101–130.

Peper, E. & Tibbetts, V. (1994). Effortless diaphragmatic breathing. *Physical Therapy Products, 6*(2), 67-71.

Peper, E., & Tibbetts V. (1997). Changes in breathing patterns by meadow and concrete implications for health. *Biological psychology, 46*(1). 8-8.

Peters, D., & Calvo, R. (2014). Compassion vs. Empathy: Designing for Resilience. *Interactions, 21*(5), 48–53.

Pinto-Gouveia, J., Duarte, C., Matos, M., & Fráguas, S. (n.d.). The protective role of self-compassion in relation to psychopathology symptoms and quality of life in chronic and in cancer patients. *Clinical Psychology & Psychotherapy*, *21*(4), 311–23. http://doi.org/10.1002/cpp.1838

Piot-Ziegler, C., Sassi, M. L., Raffoul, W., & Delaloye, J. F. (2010). Mastectomy, body deconstruction, and impact on identity: a qualitative study. *British Journal of Health Psychology, 15*(3), 479-510.

Planck, M. (1932). *Where is Science Going?* New York, NY: Norton.

Plato. (1987). *The Republic*. New York: Penguin.

Pollak, S. M., Pedulla, T., & Siegel, R. D. (2014). *Sitting together: Essential skills for mindfulness-based psychotherapy.* Guilford Press.

Post, L. F., Blustein, J., Gordon, E., & Dubler, N. N. (1996). Pain: Ethics, Culture, and

Informed Consent to Relief. *The Journal of Law, Medicine & Ethics 24*, 348–359.

Preston, M.M. (2010). *An Exploration of Appearance-Related Issues of Breast Cancer Treatment on Sense of Self, Self-Esteem, and Social Functioning in Women with Breast Cancer* (Doctoral Dissertation). Retrieved from https://repository.upenn.edu/cgi/viewcontent.cgi?article=1012&context=edissertations_sp2

Priestman. T.J. (2005). *Coping with Chemotherapy*. London: Sheldon Press.

Przezdziecki, A., Sherman, K. A., Baillie, A., Taylor, A., Foley, E., & Stalgis-Bilinski, K. (2013). My changed body: Breast cancer, body image, distress and self-compassion. *Psycho-Oncology, 22,* 1872–1879.

Purser, R., & Loy, D. (2013). *Beyond McMindfulness.* The Huffington Post.

Purser, R., & Milillo, J. (2015). Mindfulness revisited: A Buddhist-based conceptualization. *Journal of Management Inquiry, 24*(1), 3-24.

Putman, D. (2001). The emotions of courage. *Journal of Social Philosophy, 32,* 463–470.

Quigley, K.M. (1989). The adult cancer survivor: Psychosocial consequences of cure. *Seminars in Oncology Nursing, 5,* 63–69.

Quintner, J. L., Bs, M. B., Cohen, M. L., Buchanan, D., Katz, J. D., Williamson, O. D., & Bs, M. B. (2010). Pain Medicine and Its Models: Helping or Hindering ? *Pain Medicine 9*(7), 824–835. http://doi.org/10.1111/j.1526-4637.2007.00391.x

Radoń, S. (2014). Validation of the Polish adaptation of the Five Facet Mindfulness Questionnaire. *Annals of Psychology, 17*(4), 737-760.

Reich, M., Lesur, A., & Perdrizet-Chevallier, C. (2008). Depression, quality of life and breast cancer: a review of the literature. *Breast Cancer Research Treatment, 110*, 9-17.

Reich, Wilhelm (1972). *Character Analysis.* New York: Simon and Schuster.

Retzinger, S., & Scheff T. (2000). Emotion, alienation, and narratives: resolving intractable conflict. *Mediation Quarterly, 8* (1), 71–85.

Rice, L. N., & Kerr, G. (1986). Measures of client and therapist vocal quality. In L. Greenberg & W. Pinsoff (Eds.), *The psychotherapeutic process: A research handbook* (pp. 73–105). New York, NY: Guilford Press.

Rice, L. N., & Wagstaff, A. K. (1967). Client voice quality and expressive style as indexes of productive psychotherapy. *Journal of Consulting Psychology, 31*(6), 557–563.

Roache, R. (2007). Should we enhance self-esteem? *Philosophica 79*, 71-91.

Rockliff, H., Karl, A., McEwan, K., Gilbert, J., Matos, M., & Gilbert, P. (2011). Effects of intranasal oxytocin on "compassion focused imagery". *Emotion*, *11*(6), 1388–96. http://doi.org/10.1037/a0023861

Rollman, G.B. (1992). Cognitive variables in pain and pain judgments. In Algom, D. (Ed.), *Psychophysical Approaches to Cognition* (pp. 515 – 574). Amsterdam: Elsevier.

Roscoe, J.A., Kaufman, M.E., Matteson-Rusby, S.E., Palesh, O.G., Ryan, J.L., Kohli, S., Perlis M.L., & Morrow, G.R. (2007). Cancer-related fatigue and sleep disorders. *Oncologist 12*, 35 – 42.

Rosenbaum, E., & Kabat-Zinn, J. (2012). *Being well (even when you're sick): mindfulness practices for people with cancer and other serious illnesses*. Boston: Shambhala.

Rousseau, J.-J. (1979). *Emile: Or, On education*. New York: Basic Books.

Rowland, J.H., & Massie, M.J. (2010). Breast Cancer. In Holland, J., Breitbart, W., Jacobsen, P., Lederberg, M., Loscalzo, M., & McCorkle, R. (Eds.), *PsychoOncology* (pp. 177-186). New York: Oxford University Press.

Rubenfeld, I. (2002). *The listening hand.* New York, NY: Bantam Books.

Sale, J. E. M., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-method research. *Quality and Quantity, 36*, 43–53.

Samaritter, R., & Payne, H. (2013). Kinaesthetic intersubjectivity: A dance informed contribution to self-other relatedness and shared experience in non-verbal psychotherapy with an example from autism. *The Arts in Psychotherapy, 40,* 143–150.

Sammut, G., Foster, J., Salvatore, S., & Andrisano-Ruggieri, R. (2016). *Methods of psychological intervention. Yearbook of idiographic science (Vol. VII).* Charlotte, NC, USA: Information Age.

Sandhu, S., Arcidiacono, E., Aguglia, E., & Priebe, S. (2015). Reciprocity in therapeutic relationships: a conceptual review. *International Journal* of *Mental Health Nursing*, *24*(6), 460-470.

Santorelli, S. (1999). *Heal thy self: lessons on mindfulness in medicine*. London: Bell Tower.

Santos, J. L. G. dos, Lorenzini Erdmann, A., Meirelles, Hörner Schlindwein, B., Lanzoni, Marcellino de Melo, G., Cunha, Pecini da Cunha, V. & Ross, R. (2017). Integrating quantitative and qualitative data in mixed method research. *Texto & Contexto - Enfermagem, 26*(3), e1590016.

Schellekens, M.P.J., Jansen, E.T.M., Willemse, H.H.M.A., van Laarhoven, H.W.M., Prins, J.B., & Speckens, A.E.M. (2016). A qualitative study on Mindfulness-Based Stress Reduction for breast cancer patients: How women experience participating with fellow patients. *Supportive Care in Cancer, 24*, 1813–1820.

Schlosser, M., Sparby, T., Vörös, S., Jones, R., & Marchant, N. L. (2019). Unpleasant meditation-related experiences in regular meditators: Prevalence, predictors, and conceptual considerations. *PloS one, 14*(5), e0216643.

Schmidt, S., Nachtigall, C., Wuethrich-Martone, O., & Strauss, B. (2002). Attachment and coping with chronic disease. *Journal of Psychosomatic Research, 53*(3), 763–773.

Schnell, T. (2009). The Sources of Meaning and Meaning in Life Questionnaire (SoMe): Relations to demographics and well-being. *Journal of Positive Psychology, 4,* 483-499.

Schou, I., Ekeberg, O., Ruland, C. M., Sandvik, L., & Karesen, R. (2004). Pessimism as a predictor of emotional morbidity one year following breast cancer surgery. *Psycho-Oncology, 13*(5), 309- 320.

Scoglio, A.A.J., Rudat, D.A., Garvert, D., Jarmolowski, M., Jackson, C., & Herman, J.L. (2015). Self-compassion and responses to trauma: The role of emotion regulation. *Journal of Interpersonal Violence, 33*(13), 2016-2036 . https://doi.org/10.1177/0886260515622296

Sears, S. R., Stanton, A. L., & Danoff-Burg, S. (2003). The yellow brick road and the emerald city: benefit finding, positive reappraisal coping and posttraumatic growth in women with early-stage breast cancer. *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*, *22*(5), 487–497. http://doi.org/10.1037/0278-6133.22.5.487

Shaltout, H. A., Tooze, J. A., Rosenberger, E., & Kemper, K. J. (2012). Time, touch, and compassion: Effects on autonomic nervous system and well-being. *Explore, 8,* 177–184.

Shaver, P. R., & Mikulincer, M. (2005). Attachment theory and research: Resurrection of the psychodynamic approach to personality. *Journal of Research in Personality, 39*(1), 22-45.

Sheard, T., & Maguire, P. (1999). The effect of psychological interventions on anxiety and depression in cancer patients: results of two meta-analyses. *British Journal of Cancer, 80*(11), 1770-80.

Sheikhbahaei, S., Turovsky, E.A., Hosford, P.S., Hadjihambi, A., Theparambil, S.M., Liu, B., Marina, N., Teschemacher, A.G., Kasparov, S., Smith, J.C., & Gourine, A.V. (2018). Astrocytes modulate brainstem respiratory rhythm-generating circuits and determine exercise capacity. *Nature Communications 9,* 370.

Shelp, E. E. (1984). Courage: A neglected virtue in the patient-physician relationship. *Social Science & Medicine, 18,* 351-360. doi:10.1016/0277-9536(84)90125-4

Simard, S., Thewes, B., Humphris, G., Dixon, M., Hayden, C., Mireskandari, S., & Ozakinci, G. (2013). Fear of cancer recurrence in adult cancer survivors: A systematic review of quantitative studies. *Journal of Cancer Survivorship, 7*(3), 300-322.

Since feeling first. (20 April 2017). Retrieved from http://www.math.rug.nl/~ernst/poetry/analysis_feeling.html

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology, 24*(18), R875-R878.

Smith, H.S., & Wu, S.X. (2012). Persistent pain after breast cancer treatment. *Annals of Palliative Medicine, 1*(3).

Smith, M.Y., Redd W.H., Peyser, C., & Vogl, D. (1999). Post-traumatic stress disorder in cancer: a review. *Psycho-oncology 8,* 521–537.

Smith, R. (2010). *Stepping out of self-deception: the Buddha's liberating teaching of no-self*. Boston: Shambhala.

Smith, K., & Lesko, L.A. (1988). Psychosocial problems in cancer survivors. *Oncology, 2*(1), 33-44.

Smyth, J. M., Hockemeyer, J. R., & Tulloch, H. (2008). Expressive writing and post-traumatic stress disorder: effects on trauma symptoms, mood states, and cortisol reactivity. *British Journal of Health Psychology*, *13*(1), 85–93. http://doi.org/10.1348/135910707X250866

Speca, M., Carlson, L.E., Goodey, E., & Angen, M. (2000). A randomized, wait-list controlled clinical trial: The effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. *Psychosomatic Medicine, 62*, 613-622.

Spelten, E. R., Sprangers, M. A. G., & Verbeek, J. H. A. M. (2002). Factors reported to influence the return to work of cancer survivors: A literature review. *Psycho-Oncology, 11*(2), 124-131.

Sprecher, S. & Fehr, B. (2005). Compassionate love for close others and humanity. *Journal of Social and Personal Relationships, 22*, 629-651.

Srinivasan, A. (2014). Aptness of Anger. *The Journal of Political Philosophy, 00*(00), 00–00.

Stanislavski. K. (1936). *An actor prepares.* New York: Theatre Arts Books/Methuen.

Stanton, A. L., Rowland, J. H., & Ganz, P. A. (2015). Life after diagnosis and treatment of cancer in adulthood: Contributions from psychosocial oncology research. *American Psychologist, 70*(2), 159-174.

Steger, M. F., Frazier, P., Oishi, S., & Kaler, M. (2006). The meaning in life questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counseling Psychology, 53,* 80-93.

Strauss, C., Lever Taylor, B., Gu, J., Kuyken, W., Baer, R., Jones, F. W., & Cavanagh, K. (2016) What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review, 47,* 15-27.

Syrjala, K. L., Sutton, S. K., Jim, H. S. L., Knight, J. M., Wood, W. A., Lee, S. J., & Yi, J. C. (2017). Cancer and treatment distress psychometric evaluation over time: A BMT CTN 0902 secondary analysis. *Cancer*, *123*(8), 1416-1423.

Tacón A.M., Caldera Y.M., Bell N.J. (2001). Attachment style, emotional control, and breast cancer. *Families, Systems & Health, 19* (3), 319–326.

Tangney, J. P., & Fischer, K. W. (1995). *Self-conscious emotions: The psychology of shame and guilt.* New York: Guilford Press.

Teddlie, C., & Tashakkori, A. (2010). Overview of contemporary issues in mixed methods research". In Tashakkori, A. and Teddlie, C. (Eds), *The Sage Handbook of Mixed Methods in Social & Behavioral Research* (pp 1-41). Sage, California.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-472.

Tedeschi, R. G., & Calhoun, L. G. (2004). Target Article: Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry, 15*(1), 1-18.

Tedeschi, R. G., & Blevins, C. L. (2015). From Mindfulness to Meaning Implications for the Theory of Posttraumatic Growth. *Psychological Inquiry, 26,* 373-376.

Teo, T. (2005). *The Critique of Psychology. From Kant to Postcolonial Theory.* New York: Springer.

The New Encylopædia Britannica, Volume 28, Macropædia. Knowledge in Depth (1993). Chicago: Encyclopaedia Britannica.

Thomas, Y., & Menage, D. (2016). Reclaiming Compassion as a Core Value in Occupational Therapy. *British Journal of Occupational Therapy, 79*(1), 3-4.

Tirch, D.D. (2010). Mindfulness as a Context for the Cultivation of Compassion. *International Journal of Cognitive Therapy, 3,* Special Section.

Tomicic, A., Chacón, L., Martínez, C., Guzmán, M., & Reinoso, A. (2011). Patrones de Cualidad Vocal en Psicoterapia: Desarrollo y Estudio de Confiabilidad de un Sistema de Codificación. *Psykhe, 20*(1).

Totton, N. (2003). *Body Pychotherapy: An Introduction.* Maidenhead: Open University Press.

Treleaven, D. (2010). Meditation, trauma, and contemplative dissociation. *Somatics, 16*(2), 20-22.

Treleaven, D. (2018). Trauma-sensitive mindfulness: Practices for safe and transformative healing. New York, NY: Norton.

Trowbridge, R., & Ferrari, M. (2011). Special Issue: Sophia and phronesis in psychology, philosophy, and traditional wisdom. *Research in Human Development, 8*(2).

Trungpa, C., Baker, J., & Casper, M. (2002). *The myth of freedom and the way of meditation*. Boston: Shambhala.

Turk, D. C, Meichenbaum, D, & Genest, M. (1983). *Pain and behavioral medicine: A cognitive-behavioral perspective.* New York: Guilford Press.

Ury, W. (1999). *Getting to Peace: Transforming Conflict at Home, at Work, and in the World*. New York: Viking.

Vahdaninia, M., Omidvari, S., & Montazeri, A. (2010). What do predict anxiety and depression in breast cancer patients? A follow-up study. *Social Psychiatry and Psychiatric Epidemiology, 45*, 355-61.

Van Dam, N. T., Earleywine, M., & Borders, A. (2010). Measuring mindfulness? An item response theory analysis of the Mindful Attention Awareness Scale. *Personality and Individual Differences, 49*(7), 805-810.

Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2011). Self-Compassion Is a Better Predictor Than Mindfulness of Symptom Severity and Quality of Life in Mixed Anxiety and Depression. *Journal of Anxiety Disorders, 25,* 123-130.

Van den Beuken-van Everdingen, M.H.J., De Rijke, J.M., Kessels, A.G., Schouten, H.C., Van Kleef, M., & Patijn, J. (2007). Prevalence of pain in patients with cancer: a systematic review of the past 40 years. *Annals of Oncology, 18*, 1437-49.

Van Norden, B.W. (2017). *Tacking back philosophy: a multicultural manifesto.* New York: Columbia University Press.

Vanden Eynde, M. (2004). Reflection on Martha Nussbaum's Work on Compassion from a Buddhist Perspective. *Journal of Buddhist Ethics, 11,* 46-67.

Vera-Villarroel, P., Urzúa, A., Pavez, P., Celis-Atenas, K., & Silva, J. (2012). Evaluation of subjective well-being: Analysis of the Satisfaction with Life Scale in the Chilean population. *Universitas Psychologica, 11*(3), 719 -727.

Verducci, S. (2000). A conceptual history of empathy and a question it raises for moral education. *Educational Theory, 50*(1), 63–71.

Walkington, L. & Coleman, R.E. (2011) Advances in Management of Bone Disease in Breast Cancer. *Bone, 48*, 80-87.

Wallace, B. A. (2006). *The Attention Revolution: Unlocking the Power of the Focused Mind*. Wisdom Publications.

Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. Journal of Consulting and Clinical Psychology, 61(4), 620–630.

Watkins, A. (2014). *Coherence: The Secret Science of Brilliant Leadership*. London, Philadelphia, New Delhi: Kogan Page.

Watkins, J. G. (1992). *Hypnoanalytic Techniques: The Practice of Clinical Hypnosis (Vol. II).* New York: Irvington Publishers.

Weber, M. (1948). Religious Rejections of the World and Their Directions, in Gerth, H.H. and Mills, C.W. (Eds), *From Max Weber* (pp. 323–359). London: Routledge.

Wegela, K. K. (2016). Nurturing the seeds of sanity: a Buddhist approach to psychotherapy. In S. G. Mijares (Ed.), *Modern Psychology and Ancient Wisdom. Psychological Healing Practices from the World's Religious Traditions* (p. 3-25). New York, NY: Routledge.

Weiss, E.M., Singewald, E., Baldus, C., Hofer, E., Marksteiner, J., Nasrouei, S., Ruepp, B., Kapfhammer, H.P., Fitz, W., Mai, C., Bauer, A., Papousek, I., & Holzer, P. (2017). Differences in psychological and somatic symptom cluster score profiles between subjects with Idiopathic environmental intolerance, major depression and schizophrenia. *Psychiatry Research, 249*(8), 187-194.

Welwood, J. (1984). Principles of inner work: Psychological and spiritual. *The Journal of Transpersonal Psychology, 16*(1), 63-73.

Werdel, M. B., & Wicks, R. J. (2012*). Primer on posttraumatic growth: An introduction and guide.* Hoboken, NJ: John Wiley & Sons Inc.

Wielgosz, J., Goldberg, S. B., Kral, T. R. A., Dunne, J. D., & Davidson, R. J. (2019). Mindfulness meditation and psychopathology. *Annual Review of Clinical Psychology, 15,* 1-32.

Wiggins, B. J. (2010). The Dilemma of Mixed Methods. *Theses and Dissertations*, 2810. Retrieved from https://scholarsarchive.byu.edu/etd/2810.

Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2015). Six steps in quality intervention development (6SQuID). *Journal of Epidemiology & Community Health*. https://doi.org/10.1136/jech-2015-205952

Wilde, O. (1981). *The Portable Oscar Wilde*. New York: Viking Penguin.

Wilkinson, I. (2005) *Suffering: A Sociological Introduction*, Cambridge: Polity Press.

Williams, J. M. G. (2010). Mindfulness and psychological process. *Emotion, 10*(1), 1–7.

Williams, P. (2009). *Mahāyāna Buddhism: The Doctrinal Foundations (2d ed).* New York: Routledge.

Wiseman, H., & Rice, L. N. (1989). Sequential analyses of therapist–client interaction during change events: A task-focused approach. *Journal of Consulting and Clinical Psychology, 57*(2), 281–286.

Wittman, L., & Sensky, T. (2009). Suffering and Posttraumatic Growth in Women with Systemic Lupus Erythematosus (SLE): A Qualitative/Quantitative Case Study. *Psychosomatics, 50*(4), 362-74.

Wolf, C., & Serpa, J. G. (2015). A clinician's guide to teaching mindfulness. Oakland, CA: New Harbinger.

Wong, P. T. P. (2012c). Introduction: A roadmap for meaning research and applications. In P. T. P. Wong (Ed.), *The human quest for meaning: Theories, research, and applications* (2nd ed., pp. xxvii-xliv). New York, NY: Routledge.

Wong, P. T. P. (2014). Meaning in life. In A. C. Michalos (Ed.), *Encyclopedia of quality of life and well-being research* (pp. 3894-3898). New York, NY: Springer.

Wren Y. E., Roulstone S. E., & Miller L. L. (2012). Distinguishing groups of children with persistent speech disorder: Findings from a prospective population study. *Logopedics, Phoniatrics and Vocology, 37(*1), 1–10.

Yalçındağ, B. (2009). *Relationships between courage, self-construals and other associated variables* (Master's Thesis). Retrieved from http://etd.lib.metu.edu.tr/upload/3/12611072/index.pdf

Yeager, D. S., Romero, C., Paunesku, D., Hulleman, C. S., Schneider, B., Hinojosa, C., Lee, H. Y., O'Brien, J., Flint, K., Roberts, A., Trott, J., Greene, D., Walton, G. M., & Dweck, C. S. (2016). Using design thinking to improve psychological interventions: The case of the growth mindset during the transition to high school. *Journal of Educational Psychology, 108*(3), 374–391. https://doi.org/10.1037/edu0000098

Young S. (2004). *Break through pain: a step-by-step mindfulness meditation program for transforming chronic and acute pain*. Boulder, CO: Sounds True.

Young, C. (2005). *About the ethics of professional touch*. Retrieved, Oct 21, 2006, from www.laurasteckler.pwp.blueyonder.co.uk/courtenay/articles/The%20Ethics%20of%20Touch.pdfg

Zarzycka, B. (2009). Tradition oder Charisma? Religiosität in Polen. In Bertelsmann Stiftung (Ed.), *Woran glaubt die Welt? Analysen und Kommentare zum Religionsmonitor 2008* (p. 205-228). Gütersloh: Verlag Bertelsmann Stiftung.

Zebroski, J.T. (1994). *Thinking Through Theory: Vygotskian Perspectives on the Teaching of Writing.* Portsmouth, NH: Boytnon Cook Heinemann.

Zeman, A.Z., Della Sala, S., Torrens, L.A., Gountouna, V.E., McGonigle, D.J., & Logie, R.H. (2010). Loss of imagery phenomenology with intact visuo-spatial task performance: A case of 'blind imagination'. *Neuropsychologia, 48*(1):145-55.

Zuccolo, M.R. (2006). *Meaning and motivation.* Retrieved November 13, 2009 from http://www.laviecounseling.org/Resources/ZuccoloMR_MeaningMotivation.pdf

Zuidhof, P. W. (2012). Ayn Rand: Fountainhead of Neoliberalism? Review of H. Achterhuis (2010) - De utopie van de vrije markt. *Krisis, 2012*(1), 84-89.

APPENDICES – LIST OF:

All documents have been translated into Polish and verified by a native speaker. All questionnaires and scales have been previously adapted and normalised for the Polish population by other researchers. Additionally, the forms have been read by Małgorzata Wawrzynkowska (psychooncologist, Poradnia Profil – Profil Clinic) and Magdalena Mazurkiewcz (psychologist, mindfulness trainer). This section presents the original versions in English.

APPENDIX 1. ADVERTISEMENT FOR POSTERS, BLOGS and FACEBOOK PAGES.

I would like to invite you to participate in an 8-week Compassion-Focused Training Programme. This training is part of my PhD study and aims to explore the effects of mindfulness and compassion on well-being (including stress reduction).

I am looking to recruit female cancer patients and survivors (stages I-IIIC), people who have recently finished their cancer treatment and breast cancer survivors, between the ages of 30 and 65 in good mental health.

I am a qualified psychologist and mindfulness teacher and have conducted over 30 8-week MBSR courses and many mindfulness and compassion workshops. I have also worked with various clinical populations.

Inclusion in the programme will be based on answers given by you in the registration form and if in doubt, by additional interviews. Previous experience of mindfulness/compassion or other contemplative practices is not an exclusion criterion. Exclusion criteria from the programme include: acute depression, organic brain damage, PTSD (post-traumatic stress disorder), physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as DID – dissociative identity disorder), anti-social behaviour, suicide risk, LD (learning disability), criteria for PD (personality disorder), and severe social anxiety.

You are excluded if you have received a formal diagnosis of the named conditions (by an appropriate professional). *In case of doubt, please feel free to contact the researcher.*

If you are interested and you would like to learn more about the training and what it entails, please do not hesitate to contact me.

I would be happy to answer all of your questions and send you an invitation/information letter.

Best regards,

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 2:

INVITATION TO PARTICIPATE (E-MAIL).

Email Title:

8-week Compassion-Focused Training Pilot for Cancer Patients and Survivors: Invitation to participate

Dear Potential Participant,

I would like to invite you to participate in a study exploring a compassion-based intervention based for cancer patients and survivors (stages I-IIIC) exploring an 8-week Compassion-Focused Training. I will be looking at changes in self-reported stress, compassion, mindful states, life satisfaction, self-criticism/self-reassurance, emotion regulation.

Compassion is the ability to recognise our own or others' discomfort, difficulty or pain (emotional or physical) in order to work with that and ease our difficulty. Paul Gilbert (2009) describes compassion as "behaviour that aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging in order to benefit another person".

The compassion-based training is an 8-week training and similarly to Mindfulness-Based Stress Reduction (MBSR) classes are delivered on a weekly basis. Each class may consist of lead (sometimes guided) meditations, gentle movement exercises (such as mindful yoga), didactic lecture. Group discussion/inquiry (this is part of the experiential learning/psychological debriefing process exercise) will also be part of each class on a weekly basis. Between weekly classes, students deepen their participation by practising 10-30 minutes a day with meditation recordings and have daily home assignments (described in their Home Practice Manual). An intensive teacher-participant relationship helps the participant integrate the teaching into their specific life situations and make the practice their own

The study will involve:

- Participating in 8 training sessions,
- Completing 8 questionnaires before and after the 8 sessions, and after the whole training (two months after the training),
- Completing programme evaluations sheets after each session and after the whole training programme (8^{th} session)

It is possible to complete the training if one misses no more than 3 training sessions.

If you choose to participate, you will be sent further details.

To withdraw from the study all you need do is contact the researchers and provide your name and date of birth. The research team will then locate your informed consent sheet to access your unique ID code. In the case of withdrawal from the study, all collected data will be destroyed (computer data). The data can be destroyed no longer than four weeks after the last training session.

All the information you provide will remain confidential and will be used only for the purpose of the present study. If you choose to participate you are still free to cease participation at any time or to ask for your data to be withdrawn.

The inclusion criteria are: mentally healthy, stages I-IIIC, between 30 and 65 of age.

The exclusion criteria are: acute depression, organic brain damage, bipolar disorder, PTSD (post-traumatic stress disorder), physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as DID – dissociative identity disorder), anti-social behaviour, suicide risk, LD (learning disability), criteria for PD (personality disorder), and severe social anxiety. *In case of doubt, please feel free to contact the researcher.*

You are excluded if you have received a formal diagnosis of the named conditions (by an appropriate professional). *In case of doubt, please feel free to contact the researcher.*

The researcher who is also a psychologist/mindfulness teacher will always take reasonable steps to identify and minimize any harm to participants. Risks include: opening to difficult memories, emotions, bodily sensations.

For further reading I recommend the following websites:

The Compassionate Mind Foundation - http://www.compassionatemind.co.uk/

Mindful Self-Compassion (Christopher Germer, PhD) - http://www.mindfulselfcompassion.org/

I look forward to hearing from you and hope that you will consider this training opportunity for the benefit of yourself and other people.

Please feel free to contact me if you require any more information.

Best regards,

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 3. PARTICIPANT INFORMATION SHEET

Compassion-Focused Training

Participant Information Sheet – Study Group

Introduction

You are invited to take part in a study which aims to explore the content and effectiveness of a newly designed 8-week compassion training based on Compassion-Focused Therapy (CFT) for cancers' patients and survivors (stages I-IIIC) and any potential impact it can have on the levels of stress, emotion regulation, compassion, mindful states, satisfaction, emotion regulation, post-traumatic growth, meaning of life.

For further reading I recommend the following websites:

The Compassionate Mind Foundation - http://www.compassionatemind.co.uk/

Mindful Self-Compassion (Christopher Germer, PhD) - http://www.mindfulselfcompassion.org/

Who is doing this research?

The research is being undertaken by Ms Julia E. Wahl, MA, a PhD Student at the University of Derby and her supervisors: Professor David Sheffield, Dr Frances Maratos, and Dr Stephanie Archer.

Why have you been invited to participate?

Recruitment for this project has been conducted through various cancer organisations and social media.

You have been invited to take part in the research as you have been identified by the research team as someone who meets all of the inclusion criteria and would be suitable to take part in the study. If you have any questions about the inclusion and/or exclusion criteria, please let us know. You are excluded if you have received a formal diagnosis of the named conditions (by an appropriate professional). *In case of doubt, please feel free to contact the researcher.*

What does taking part in this research involve?

The aim of the research is to evaluate and determine the application and order of particular interventions (practices and exercises) chosen for the training, the training structure and to determine any potential obstacles. Finally, the aim is to investigate if an 8-week training programme based on compassion is associated with changes in self-compassion, mindful states, stress, satisfaction, emotion regulation, post-traumatic growth and meaning of life as assessed by questionnaires.

After consenting to take part in the research you will be asked to complete a questionnaire pack which includes mindful states, self-compassion, meaning of life, stress measures among others. The participants will be invited to take part in an 8-week course of compassion. It may take up to 30 mins to complete all of the questionnaires.

Two months after the last session all participants will be asked to complete another questionnaire pack. This will allow researchers to identify if there have been any changes during the 8-week study.

What are the inclusion and exclusion criteria?

The inclusion criteria are: mentally healthy cancers' patients and survivors, stages I-IIIC, between 30 and 65 of age.

The exclusion criteria are: acute depression, organic brain damage, bipolar disorder, PTSD (post-traumatic stress disorder), physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as DID – dissociative identity disorder), anti-social behaviour, suicide risk, LD (learning disability), criteria for PD (personality disorder), and severe social anxiety.

You are excluded if you have received a formal diagnosis of the named conditions (by an appropriate professional). *In case of doubt, please feel free to contact the researcher.*

What if I don't know if meet the exclusion criteria?

Please feel free to contact the researcher.

What are the side effects of taking part?

Currently, there are no side effects reported in terms of compassion-based interventions. You will be encouraged to listen to your own body and emotions.

What are the possible benefits of taking part?

We are testing the hypothesis that practicing compassion can bring benefits in terms of reducing levels of stress, increasing levels of life satisfaction, helping regulate emotions better. We cannot promise that this study will help you, but the information we get from this study could help to improve the care of other groups of participants and/or clinical groups (such as female breast cancer patients).

What if something goes wrong?

We do not believe that participation in this study will harm you in any way. However, if you are harmed by taking part in this research project, there are no special compensation arrangements. If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, contact Professor David Sheffield (translation will be provided).

In case the questionnaires or intervention raise physical or psychological health concerns, please contact appropriate trainers.

Who is organizing and funding the research?

The materials are funded by the researcher (Julia E. Wahl).

Who has reviewed the study?

The study has been approved by the Psychology Research Ethics Committee (PREC) at the University of Derby. If you have any questions or concerns about this study, you should discuss them with the researcher. If you have any concerns about the way in which this study is being conducted, you are welcome to contact the Chair of the Psychology Research Ethics Committee, Dr Frances Maratos.

What do I do if I am interested in taking part in the research?

If you would like to take part in the research, please contact Julia E. Wahl by email (you can find it at the bottom of this sheet). At this point we will be able to explain the study in more detail and answer any questions you might have.

What happens if you change your mind?

Although your input to this research will be extremely valuable, participation is entirely voluntary, and should you decide you no longer want to take part you are free to withdraw from the study at any time, before, during or after you have completed ANY part of the study. The researcher (who is also a psychologist) might ask for the reason due to clinical responsibility in order to ensure participants are leaving the study in a similar state to entering it. In the case of withdrawal from the study, all collected data will be destroyed (computer data, paper transcripts). The data can be destroyed no longer than four weeks after the last training session.

What happens if you decide not to take part?

It is your choice whether you take part in the research or not. Participation is entirely voluntary.

What will happen to the information that you give?

The information will be stored securely at the University of Derby and only the researchers will have access to it. All of your data will be anonymised. A summary of the data and the overall findings will be used in research papers and be submitted to the University of Derby as part of a PhD thesis.

Where can I get more information about this research?

If you would like more information about this research please contact Julia E. Wahl.

Best regards,

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 4. INFORMED AGREEMENT

This training includes skill training in contemplative methods of mindfulness and compassion as well as gentle stretching/mindful yoga exercises.

The inclusion criteria are: mentally healthy female and male participants who suffer or suffered from cancer (stages I-IIIC), between 30 and 65 of age.

The exclusion criteria are: acute depression, organic brain damage, bipolar disorder, PTSD (post-traumatic stress disorder), physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as DID – dissociative identity disorder), anti-social behaviour, suicide risk, LD (learning disability), criteria for PD (personality disorder), and severe social anxiety. You are excluded if you have received a formal diagnosis of the named conditions (by an appropriate professional). *In case of doubt, please feel free to contact the researcher.*

I agree to respect the privacy and confidentiality of fellow group participants both in and out of the group setting.

The training instructor has my permission to contact me via e-mail regarding class business (for instance when a participant misses more than two sessions). I also have the right to contact the training instructor in case of any questions, worries or difficulties via email address.

I can decide to withdraw my participation and subsequently my data at any time of the training*.

To withdraw from the study all you need do is contact the researchers and provide your name and date of birth. The research team will then locate your informed consent sheet to access your unique ID code. In the case of withdrawal from the study, all collected data will be destroyed (computer data, paper transcripts). The data can be destroyed no longer than four weeks after the last training session.

**All participants are free to leave the study at any time without giving any reason, but the researcher (who is also a psychologist) might ask for the reason due to clinical responsibility in order to ensure participants are leaving the study in a similar state to entering it. In the case of withdrawal from the study, all collected data will be destroyed (computer data, paper transcripts). The data can be destroyed no longer than four weeks after the last training session.*

Information was given to me on (please tick):

Mindful yoga/Mindful movement, Sitting meditation, Group discussion/Inquiry, Group activities, Home practice, Confidentiality _____

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this training and pilot study.

Print Name of Participant _____

Signature of Participant _____

Date _____

day / month / year

APPENDIX 5. REGISTRATION FORM (INCLUDES MEDICAL AND MENTAL HEALTH SCREENING).

We want to learn more about your motivation and experience to shape our training around it. We also want to make sure that this training is safe for you. That is why we ask you to answer the questions below. This form is confidential. If we have any concerns in terms of your participation, we will inform you about it. If you have any questions, please do not hesitate to ask them.

The inclusion criteria are: mentally healthy female and male participants - cancers' patients and survivors (stages I-IIIC), between 30 and 65 of age.

The exclusion criteria are: acute depression, organic brain damage, bipolar disorder, PTSD (post-traumatic stress disorder), physical addiction to alcohol and/or drugs, current or past psychosis/dissociative disorders (such as DID – dissociative identity disorder), anti-social behaviour, suicide risk, LD (learning disability), criteria for PD (personality disorder), and severe social anxiety. You are excluded if you have received a formal diagnosis of the named

conditions (by an appropriate professional). *In case of doubt, please feel free to contact the researcher.*

ID CODE _____ __

DATE OF BIRTH (DOB) _____

DATE_____

AGE _____

EDUCATION AND OCCUPATION _____

MOTIVATION/INTENTION

What brings you to this training? What would you like to achieve?

_____

_____

_____

_____

EXPERIENCE AND BACKGROUND

Do you have any experience in terms of mindfulness or compassion practices? Have you meditated before? Please describe.

_____

_____

_____

_____

CANCER

What type of cancer/stage/treatment have you received/you are currently receiving.

_____

_____

_____

_____

PHYSICAL AND MENTAL HEALTH (APART from CANCER)

Do you suffer from any illnesses, allergies, diabetes, high/low blood pressure? Do you think that your health (i.e., pain,) will influence your ability to participate in the training? Please state any concerns.

_____

_____

_____

_____

Some practices involve gentle movement and stretches. Do you have any physical conditions that you think we should be aware of?

_____

_____

_____

_____

Have you had any mental ill-health within the last few years, such as anxiety or depression? If yes, please tell us about it here:

_____

_____

_____

_____

If you are taking any medication at present (other than to do with cancer), please say what it is and what it is for:

_____

_____

_____

_____

Have you had any disturbing life event in the last year (apart from cancer), or is there anything going on for you in your life right now that you would like us to be aware of?

_____

_____

_____

_____

APPENDIX 6. DEBRIEFING INFORMATION AND THANK YOU LETTER.

Dear _____

Thank you for taking part in the 8-week compassion-based training. Your participation is much appreciated. We would like to thank you for participating.

The aim of this study is to explore the use of compassion-based interventions as a means to improve better coping with stress and anxiety, enhance levels of self-compassion, mindfulness, satisfaction, post-traumatic growth, and meaning of life.

Contemplative practices such as mindfulness and compassion have been used to lower levels of stress, improve coping strategies and learning to be with both difficult and positive emotions and emotional states.

The results of this study will determine the structure and application of particular interventions for future programmes with clinical populations.

Please remember your participation in this research is voluntary. If you change your mind about having taken part, please let me know.

To withdraw from the study all you need do is contact the researchers and provide your name and date of birth. The research team will then locate your informed consent sheet to access your unique ID code. In the case of withdrawal from the study, all collected data will be destroyed (computer data, paper transcripts). The data can be destroyed no longer than four weeks after the last training session.

Once again, thank you for your participation in this research. You will be contacted in 2 months to complete a follow up questionnaires. Your participation in this follow up would also be much appreciated and will help identify some of the potential long term benefits of participation in compassion-based training.

Yours Sincerely

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 7. EVALUATION FORM AFTER EACH SESSION

As part of this compassion course we are carrying out an evaluation. We would like to ask you if would be willing to help us by taking part in this evaluation.

- Which exercise was the most beneficial for you and why?

_____

_____

_____

_____

- Would you change anything about the exercises? Why and what?

_____

_____

_____

_____

- Would you change anything in terms of the structure of this session? Why and what?

_____

_____

_____

_____

- What do you think about the theme of this session?

_____

_____

_____

_____

- Was there anything missing for you during this session? If yes, please explain what was it.

_____

_____

_____

_____

APPENDIX 8. EVALUATION FORM (AFTER THE WHOLE TRAINING) AND COURSE FEEDBACK FORM

- What brought you to this training? What were your expectations of it? Why have you stayed?

_____

_____

_____

_____

- Tell me about what you thought of the overall presentation of the course? Things like the length, the format, the facilitation, and the materials.

_____

_____

_____

_____

- Is there anything else that you think could be improved for future courses? Any expectations that you had that weren't met? What would you see as the ideal course?

_____

_____

_____

_____

- How important has this course been to you and why?

_____

_____

_____

_____

- What have you gained from the course?

_____

_____

_____

_____

- What aspects of the overall course did you specially enjoy?

_____

_____

_____

_____

- What aspects do you think you will take into your everyday life?

_____

_____

_____

_____

- What aspects challenged you (if any)?

_____

_____

_____

_____

- Anything else you would like us to know?

_____

_____

_____

_____

APPENDIX 9. QUESTIONNAIRES.

9.1. Mindful Attention Awareness Scale (NOTE: no title will be included in the materials given to the participants, all questionnaires)

day-to-day experiences

Below is a collection of statements about your everyday experience. Using the 1–6 scale below, please indicate, in the box to the right of each statement, how frequently or infrequently you have had each experience in the last week (or other agreed time period). Please answer according to what really reflects your experience rather than what you think your experience should be.

almost always	*very frequently*	*somewhat frequently*	*somewhat infrequently*	*very infrequently*	*almost never*
1	*2*	*3*	*4*	*5*	*6*

1	I could be experiencing some emotion and not be conscious of it until some time later	
2	I break or spill things because of carelessness, not paying attention, or thinking of something else	
3	I find it difficult to stay focused on what's happening in the present	
4	I tend to walk quickly to get where I'm going without paying attention to what I experience along the way	
5	I tend not to notice feelings of physical tension or discomfort	

	until they really grab my attention	
6	I forget a person's name almost as soon as I've been told it for the first time	
7	It seems I am "running on automatic" without much awareness of what I'm doing	
8	I rush through activities without being really attentive to them	
9	I get so focused on the goal I want to achieve that I lose touch with what I am doing right now to get there	
10	I do jobs or tasks automatically, without being aware of what I'm doing	
11	I find myself listening to someone with one ear, while doing something else at the same time	
12	I drive places on "automatic pilot" and then wonder why I went there	
13	I find myself preoccupied with the future or the past	
14	I find myself doing things without paying attention	
15	I snack without being aware that I'm eating	

total score = ***average statement score =***

9.2. Perceived Stress Scale <u>(NOTE: no title will be included in the materials given to the participants)</u>

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.

1. In the last month, how often have you been upset because of something that happened unexpectedly?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

2. In the last month, how often have you felt that you were unable to control the important things in your life?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

3. In the last month, how often have you felt nervous and "stressed"?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

5. In the last month, how often have you felt that things were going your way?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

7. In the last month, how often have you been able to control irritations in your life?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

8. In the last month, how often have you felt that you were on top of things?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

9. In the last month, how often have you been angered because of things that were outside of your control?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

___0=never___1=almost never___2=sometimes___3=fairly often___4=very often

9.3. The Satisfaction with Life Scale (NOTE: no title will be included in the materials given to the participants)

DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Neither Agree or Disagree

5 = Slightly Agree

6 = Agree

7 = Strongly Agree

_____1. In most ways my life is close to my ideal.

_____2. The conditions of my life are excellent.

_____3. I am satisfied with life.

_____4. So far I have gotten the important things I want in life.

_____5. If I could live my life over, I would change almost nothing.

9.4. Meaning of Life Questionnaire <u>(NOTE: no title will be included in the materials given to the participants)</u>

Please take a moment to think about what makes your life and existence feel important and significant to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Please answer according to the scale below:

Absolutely Untrue	Mostly Untrue	Somewhat Untrue	Can't Say True or False	Somewhat True	Mostly True	Absolutely True
1	2	3	4	5	6	7

1. I understand my life's meaning.

2. I am looking for something that makes my life feel meaningful.

3. I am always looking to find my life's purpose.

4. My life has a clear sense of purpose.

5. I have a good sense of what makes my life meaningful.

6. I have discovered a satisfying life purpose.

7. I am always searching for something that makes my life feel significant.

8. I am seeking a purpose or mission for my life.

9. My life has no clear purpose.

10. I am searching for meaning in my life.

9.5. Emotion Regulation Questionnaire (ERQ) <u>(NOTE: no title will be included in the materials given to the participants)</u>

Instructions and Items:

We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your emotional experience, or what you feel like inside. The other is your emotional expression, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

1 2 3 4 5 6 7

strongly disagree neutral strongly agree

1. ____ When I want to feel more positive emotion (such as joy or amusement), I change what I'm thinking about.
2. ____ I keep my emotions to myself.
3. ____ When I want to feel less negative emotion (such as sadness or anger), I change what I'm thinking about.
4. ____When I am feeling positive emotions, I am careful not to express them.
5. ____When I'm faced with a stressful situation, I make myself think about it in a way that helps me stay calm.

6. ____ I control my emotions by not expressing them.

7. ____When I want to feel more positive emotion, I change the way I'm thinking about the situation.

8. ____ I control my emotions by changing the way I think about the situation I'm in.

9. ____When I am feeling negative emotions, I make sure not to express them.

10. ____When I want to feel less negative emotion, I change the way I'm thinking about the situation.

9.6. ***Revised Adult Attachment Scale (RAAS) (Collins, 1996)***

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5

Not at all characteristic of me — **Very characteristic of me**

1) I find it relatively easy to get close to people. _____

2) I find it difficult to allow myself to depend on others. _____

3) I often worry that romantic partners don't really love me. _____

4) I find that others are reluctant to get as close as I would like. _____

5) I am comfortable depending on others. _____

6) I don't worry about people getting too close to me. _____

7) I find that people are never there when you need them. _____

8) I am somewhat uncomfortable being close to others. _____

9) I often worry that romantic partners won't want to stay with me. _____

10) When I show my feelings for others, I'm afraid they will not feel the same about me. _____

11) I often wonder whether romantic partners really care about me. _____

12) I am comfortable developing close relationships with others. _____

13) I am uncomfortable when anyone gets too emotionally close to me. _____

14) I know that people will be there when I need them. _____

15) I want to get close to people, but I worry about being hurt. _____

16) I find it difficult to trust others completely. _____

17) Romantic partners often want me to be emotionally closer than I feel comfortable being. _____

18) I am not sure that I can always depend on people to be there when I need them. _____

9.7. ***Post-traumatic growth inventory***

Listed below are 21 areas that are sometimes reported to have changed after traumatic events. Please mark the appropriate box beside each description indicating how much you feel you have experienced change in the area described. The 0 to 5 scale is as follows:

0 = I did not experience this change as a result of my crisis

1 = I experienced this change to a very small degree

2 = a small degree

3 = a moderate degree

4 = a great degree

5 = a very great degree as a result of my crisis

	possible areas of growth and change	*0*	*1*	*2*	*3*	*4*	*5*
a.	my priorities about what is important in life						
b.	an appreciation for the value of my own life						
c.	I developed new interests						
d.	a feeling of self-reliance						
e.	a better understanding of spiritual matters						
f.	knowing that I can count on people in times of trouble						
g.	I established a new path for my life						
h.	a sense of closeness with others						
i.	a willingness to express my emotions						
j.	knowing I can handle difficulties						
k.	I'm able to do better things with my life						

l.	being able to accept the way things work out						
m.	appreciating each day						
n.	new opportunities are available which wouldn't have been otherwise						
o.	having compassion for others						
p.	putting effort into my relationships						
q.	I'm more likely to try to change things which need changing						
r.	I have a stronger religious faith						
s.	I discovered that I am stronger than I thought I was						
t.	I learned a great deal about how wonderful people are						
u.	I accept needing others						

APPENDIX 10. FOLLOW-UP LETTER.

Dear _____

Once again thank you for taking part in the 8-week compassion-based training programme.

The aim of this study was to explore the use of compassion-based interventions as a means to improve better coping with stress and anxiety, enhance levels of self-compassion, mindfulness, satisfaction and meaning of life for cancer patients and survivors.

Two months ago you have completed the training. Therefore, I would like you to complete the seven questionnaires again.

If you have any questions, please contact the researcher on the details below.

I am happy to provide you with appropriate feedback about the results if you wish to receive it.

Yours sincerely,

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 11. Participant Information Sheet – Focus Group

Compassion-Focused Training

Participant Information Sheet – Focus Group

What is a focus group?

A focus group is a discussion group in which people share their experiences, views and ideas about a particular topic.

What is the purpose of this focus group?

The purpose of this focus group is to explore your thoughts and feelings about providing compassion and mindfulness-based interventions to cancer patients. This will include discussing the any positives and negatives you may have experienced during the course. Participation is entirely voluntary.

Who will be hosting this focus group?

The focus group will be hosted by Julia E. Wahl.

How long will the discussion last?

The discussion should last approximately 90 minutes.

What will happen on the day?

Before the focus group starts Julia E. Wahl will check with each person that they have completed an informed consent sheet to say that they have understood what the focus

group is about and how the information will be used. Help will be provided to complete this form if required.

During the discussion people will be asked to share their thoughts about taking part in the compassion-based course. We will discuss both the positives and negatives of the study and try to identify and areas for improvement.

After the discussion Julia will summarise what has been discussed and you will be given the opportunity to comment.

Will other people know what I have said?

The other people in the group will know what you have said during the discussion, but everyone who takes part in the focus group has an obligation to keep the information that is shared in the group to themselves. This is one of the 'ground rules' for taking part in a focus group and these 'ground rules' will be discussed before the focus group starts. Outside of the focus group no one will have access to any information you provide. If we do include specific quotes or experiences in our written reports you will not be identified by name. All information is kept confidential.

What happens after the focus group?

At the end of the discussion you will be thanked for your participation. The recordings from the sessions will be written up and analysed to identify themes that will provide points for discussion. Information from the focus groups may be incorporated into academic papers which may be published and transcript materials may be used subsequently for teaching purposes, which would enable the materials to be used to support teaching of research methods. Results from the focus group will also form part of

a PhD thesis which will be submitted to the University of Derby. Information will be stored at the University of Derby for the duration of 7 years.

What happens if you change your mind?

Although your input to this research will be extremely valuable, participation is entirely voluntary and should you decide you no longer want to take part you are free to withdraw from the focus group at any time, before, during or after you have completed the focus group. Although we cannot withdraw your information as such as it forms part of an interaction with a larger group, the information you give will not be used for quotations and will not be referred to in any published work. If you change your mind about having taken part in this focus group you will have up to two weeks from the date of the focus group to withdraw, after which time your data will have been incorporated into the analysis.

If you require any further information please feel free to talk to Julia E. Wahl before the session starts.

Yours sincerely,

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 12. CONSENT FORM (FOCUS GROUPS).

Compassion-Focused Training

Statement of Informed Consent – Focus Group

I …….. understand that I have agreed to participate in a focus group exploring the impact of an 8-week compassion course for cancers' patients and survivors (stages I-IIIC).

I have received a copy of the focus group information sheet and have been given an opportunity to ask any questions about the focus group.

I understand that my participation in the focus group is voluntary, and that if I wish to leave the focus group at any time I may do so at any point, and that I do not have to give any reasons or explanations for doing so. I have also been provided with details of who I should contact if I wish to withdraw my information from the focus group.

I understand that although any information I disclose during the focus group will be kept anonymous for the purposes of the research and associated publications, I acknowledge that any information I disclose is not confidential with other members of the focus group.

I also understand that anonymous extracts from the discussion may also be used in research and associated publications.

I understand all information collected for the research will be stored securely at the University of Derby on a password protected database. Any paperwork you complete including your consent forms and questionnaire measures will be stored in a locked filing cabinet. Only the research team have access to this.

I understand that these results may be disseminated through conferences and/or published articles, and that transcript materials may be used subsequently for teaching purposes, which would enable the materials to be used to support teaching of research methods. I understand that my data will remain anonymous at all times. I understand that the results of this research study will be written up as part of a PhD thesis and submitted to the University of Derby. Information will be stored at the University of Derby for the duration of 7 years.

I have read and understood this information and consent to take part in the focus group.

Signed …… (Participant)

Date ……

Yours sincerely,

Julia E. Wahl, MA (Researcher)

608 079 909

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 13. POTENTIAL QUESTIONS FOR THE FOCUS GROUP.

Focus group questions

Julia (Wahl) to introduce the session and how it fits into the overall intervention.

Note any behavioural, non-verbal observations, cues.

Me to introduce myself and outline my interests in terms of the project.

Set out the ground-rules: confidentiality, anonymity, honesty and openness, valuing opinions, no right or wrong answers, one person at a time. All responses equally useful for the project team in developing the processes, improving the curriculum.

Ask people to give answers as full as possible and to value everyone's contribution. If there's something they're reminded of when someone's speaking make a note of it or keep it in mind to add in at the next available point.

Check nobody has any questions before we begin.

(Overall experience)

1. The first aspect I'd like to explore today is your overall experience of the curriculum/training programme.

o So, first of all, what was your overall impression of the compassion focused approach?

o Were there any exercises or practices which you thought should have had more time devoted to them?

o Were there particular sessions that the team delivered that you found more challenging to engage with?

 If yes: Why was that?

(Specific exercises)

2. The second area I'd like to explore with you relates in a bit more depth to the specific exercises and practices that you learnt about and have been working with across the past few weeks.

o Can you describe for me any of them that you found particularly beneficial?

o What was it that you felt positive about? (if not described)

o What was it about that particular exercise or practice (whichever is described) that you feel has benefitted you?

o Has it affected your day to day interactions/practice? If yes: In what way? (Probe for descriptions)

o Has anyone had any differing experience with that exercise/practice? (Probe for descriptions)

o Now I'd like you to think about any of them that were less easy to work with for you. Can you describe anything that you found particularly challenging to engage with?

o What was it that you felt was challenging in terms of (whichever practice/exercise is described)?

o Has anyone had any differing experience with that exercise/practice? (Probe for descriptions)

o Did you find it easier to engage with the exercises or practices as the intervention progressed?

 If yes: Which ones in particular? What was it that made them easier?

 If no: Can you describe any that posed a challenge for you. How did you deal with those?

(Application/relevance to life)

3. One area that we're really interested in as a project team is how well you feel the intervention addressed issues that you encounter in your personal life and illness/treatment related issues?

o To begin to address this I wonder if any of you can describe anything within the sessions or the exercises that you felt we might have covered in more depth? How would that have helped?

 For example, was there anything you thought was missing from the training programme that would have aided your understanding or engagement with the compassion focused approach?

o Was there anything you feel the team focused on too much?

o Can compassion-based exercise help you with anything in particular? (probe for descriptions: pain management, body)

o Do any of you feel a follow up would be useful for you?

 If yes/maybe: So if we were to follow this up with you in a few months' time what would be the aspect/s that you'd most like to revisit?

 Is there anything you feel would be less helpful to revisit?

(Specific themes)

4. Since the training programme focused on compassion, we're interested in how your understanding of compassion has changed or expanded.

o How do you understand compassion now that the training is over?

o What does it mean to compassionate to yourself?

o What does it mean to be compassionate towards others?

o How can you apply compassion in your daily life? (examples of application)

o How do you understand the quality of wisdom within the compassion training?

- What does it mean to feel safe and connected? Can you give an example?
- How important touch is?

(Conclusions)

5. In the final part of this discussion I have one or two more general areas for us to consider and would really welcome your feedback on.
   - Can you please describe for me anything you learned about within the sessions or exercises that surprised you? In what ways was it a surprise?
   - Do you feel you have been able to adapt what you learned, or the practices, and apply them in your daily working and personal life? Please describe some examples of this.
   - Can the practices help with your illness, treatment or post-illness/treatment experience?

6. Before we finish, and as you're now may be experts in integrating compassion into your practice/life, is there anything else that you would like to add that we have not covered in our discussion?
   - What advice would you give me now, if any? To the trainer and/or participants?

Thank participants for time and contributions.

APPENDIX 14. Focus Group Debrief Sheet.

Compassion-Focused Training

Focus Group Debrief Sheet

Once again thank you for taking part in the 8-week compassion-based training programme for cancers' patients and survivors. Your participation is much appreciated. We hope that you have enjoyed taking part in the programme.

The aim of this initial pilot study was to explore the use of compassion-based interventions as a means to improve better coping with stress and anxiety, enhance levels of self-compassion, mindfulness, satisfaction and meaning of life. The purpose of today's focus group was to further explore your thoughts and feelings about the use of contemplative practices and get some more in depth information about the classes and how they have impacted on your quality of life both positively and negatively . This information will help us decide whether offering this specific modality is suitable for cancer patients and what should be changed.

Please remember your participation in this research is voluntary. If you change your mind about having taken part in this focus group you will have up to two weeks from the date of this letter to withdraw, after which time your data will have been incorporated into the analysis.

If you do choose to withdraw your data, we will not use any of the information you have provided as direct quotes, but we will use information gathered in the main body of the focus group from other participants. To withdraw from the study all you need do is contact one of the research team and provide your name and date of birth.

Yours sincerely,

Julia E. Wahl, MA (Researcher)

Professor David Sheffield, Director of Studies (Main supervisor)

APPENDIX 15. FIRST CURRICULUM.

(PRELIMINARY) SHORT GUIDE TO

8-WEEK COMPASSION-BASED TRAINING PROGRAMME

FOR cancers' patients and survivors (stages 0.-III.):

CURRICULUM / CONTENT DESCRIPTION – May 2014

INCORPORATING COMPASSIONATE MIND TRAINING (CMT) and MINDFULNESS PRACTICES

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Photo: Julia E. Wahl

This curriculum is for trainers only.

Overview

This is the curriculum of an 8-week training programme (9-session curriculum = 2.5 h sessions + 1 half-day practice), based on Compassionate-Mind Training (CMT) which derives from Compassion-Focused Therapy (CFT). Similarly to Mindfulness-Based Stress Reduction (MBSR), this current training uses both formal and informal practices. This intervention is based on systematic training in mindfulness and compassion meditation (contemplative practices).

The difference between the current training and MBSR is that MBSR emphasizes more the body at the outset. While our training recognises the importance of working with the body, it initially focuses on the cognitive and emotional aspects of human functioning. The rationale behind is the fact that often it is very threatening for breast cancer patients to focus on their bodies. This topic and subsequent practices have to be introduced gently (our motto is: *Langsam aber sicher* – Slowly but surely).

This training supports the skill of self-regulation and mind-body connection through both "formal" and "informal" practices based on the principles of mindfulness and compassion. It aims to help patients cope with both physical and emotional pain of their condition and equip them with experiences and skills that can be used long after the completion of the training.

Important notes

This is not group therapy although it is therapeutic in its nature and should be conducted by an experienced, qualified psychologist or psychotherapist in case of unforeseen difficulties participants might experience. Optionally the training can be led by a trainer who is clinically trained and supervised on a regular (weekly) basis.

Definitions:

Compassion *– has two components: (1) common (shared) feeling with the world, (2) a way of communicating with the phenomenal world, and responsiveness by skilful means (wisdom) to alleviate the suffering (discomfort, fear, doubt, stress, pain) of both the other and oneself (definition by Julia E. Wahl) (working definition).*

Biggest compassion trap: intellectualisation (over-thinking)/non-action.

Mindfulness – means **paying attention** in a particular way; **on purpose**, in the **present moment**, and **non judgmentally, as if your life depended on it (**Jon Kabat-Zinn, 1994/2011).

Biggest mindfulness trap: lack of discipline, not paying attention, no compassion in action.

BRIEF OUTLINE OF WEEKLY SESSIONS

Training Format: 8 meetings (sessions) of the core programme + 1 pre-orientation session + 1 post-training session + 1 half-day practice (in the middle of the training, preferably after session 5 or 6);

1 meeting (session) = 2.5 hr = 150 minutes (15 min break included);

1 half-day practice = 4 hr = 240 minutes (breaks included).

–

ORIENTATION SESSION (0)

This session is about explaining the philosophy, structure and methods involved in the training. It is to emphasize the importance of regular practice and our commitment to it. Participants have the opportunity to ask any questions they might have (includes Q & A). It is important to understand that in order to benefit from the training one has to devote between 10 and 50 minutes each day to formal practice + Home Practice Manual.

During this session it is also important to explain what happens if participants do not come to any of the training sessions: all materials are available on Dropbox (Home Practice Manual + appropriate recordings). It is also possible to call (telephone/Skype or Google Hangout) the teacher and inquire about the training sessions and practice (by appointment). If one misses more than three sessions, it is advised that this person participates in the next edition of the training.

Also explain what happens if participants do not do their home assignments (including different logs: pain, practice)

Important note:

Before the training participants are asked to submit registration forms. Registration forms include questions about personal physical and mental health, motives for participation to determine whether or not the training is suitable for each person who is willing to participate. It is also to ensure that the training will do no harm and possibly enhance physical and mental functioning.

**If in doubt participation will be assessed on an individual basis.*

Duration of Orientation Session: up to 2 hours.

CLASS ONE (1)

INTRODUCTION TO THE PROGRAMME;

WHAT IS ATTENTION and MINDFULNESS?

"Mindfulness practice means that we commit fully in each moment to be present; inviting ourselves to interface with this moment in full awareness, with the intention to embody as best we can an orientation of calmness, mindfulness, and equanimity right here and right

now."

— Jon Kabat-Zinn

"Attention is vitality. It connects you with others. It makes you eager. Stay eager."

— Susan Sontag

Overview: This 2.5-hour session focuses on experiential attention and mindfulness practices. It might be confusing for participants to start the compassion training with mindfulness practices but it is important to first establish attention and mindfulness before working with/using a more 'emotionally challenging' practice of compassion. We first have to stabilise and prepare our mind to gain security and confidence in terms of our own practice, and most importantly, ourselves. Through different practices we learn about innate potential: the ability to be focused and mindful, even if it is only for a few seconds that we can experience it. In moments of difficulty with compassion practices we can always retreat to mindfulness practices that enable us to be anchored in the present moment rather than in the world of our fantasies, ruminations, hopes or fears.

Theme: What is attention, mindfulness and why these are important. We experience how it feels to be attentive and mindful and what are some of the obstacles we experience when trying to go back to this (attentive/mindful) mode. **Explanation of why it is important to start with mindfulness first.**

Typical Class Sequence:

Grounding: 1-minute meditation.

Welcome and brief introduction of programme by the teacher (includes: explaining why we first start with mindfulness practices rather than with compassion ones).

Opening meditation: brief meditation of attention (initially guided by the teacher) – paying attention to body sensations, thoughts and emotions.

Class responses to opening mediation. Additional explanations by the teacher: Explaining the first emotion-regulation tool and its importance: **attention**.

Guidelines for participation (personal and practical/technical): confidentiality, no-advice giving, self-care (gentleness) – includes taking care of one's body, freedom to speak/not to speak, turning off mobile phones, breaks, informing the teacher about difficulties experienced during one's practice (publicly or in private).

Guided internal reflection (guided by the teacher): my intention/motivation/needs. Possible formats: asking inquiring questions or suitable intention imagery (example of intention imagery: throwing a stone into a well).

Group go around: participants have the opportunity to introduce themselves – who they are, what brought them here, their expectations, and understanding of the training. The teacher may respond, comment from time to time (**instructive comments, no-advice giving**).

Guided mindfulness meditation of breathing (MOB): using one's natural breathing as an anchor that takes us back from ruminations, judgements and fantasies back to the present moment. Labelling thoughts and returning to the natural flow of breathing. Additional explanations by the teacher: Explaining the second emotion-regulation tool and its importance - **mindfulness**. Explaining the 'monkey mind' phenomena ('wandering mind', 'conceptual proliferation').

Class response to MOB.

Role Playing: Touch & Go Exercise (T&G) (author: Karen Kissel Wegela, revised by Julia E. Wahl): demonstrate with a volunteer (choose carefully based on your clinical intuition) the three different attitudes – (1) touch and go, (2) touch and grab, (3) go and go. This exercise is about experiencing three different attitudes by introducing ourselves to other group participants in three different ways (shaking hands) and therefore seeing

(experiencing) how each different attitude changes the way we experience ourselves and the world outside of ourselves.

Class response to Touch & Go Exercise.

Mindfulness Meditation of Breathing with Touch & Go: starting with MOB and then in one's mind saying 'touch & go' to the passing phenomena of thoughts, emotions and bodily sensations.

Class response to MOB with T&G .

Short Intention Contemplation and Writing down: My intention after the first class.

Goodbyes and Home Assignment.

Home Practice Assignment:

- Recording: MOB (10 minutes per day).
- Informal practice: Mindful activity (here labelled: MINDFUL COMPASSION PAUSE) – choose one activity (eating, brushing teeth, taking a shower, walking etc.). Does not have to be long, can only last up to 5 minutes. Introduce the notion of 'cooking with gentleness' (use quote by Shantideva).
- Practice Log & Pain Log (Record Sheets) – **explain what these are about and why they are important**.
- Read Home Practice Manual (each time included: booklet of poems).

CLASS TWO (2)

WHAT IS COMPASSION? The challenge and courage of compassion.

"Alteri vivas oportet, si vis tibi vivere."

"Compassion is an unstable emotion. It needs to be translated into action, or it withers. The question of what to do with the feelings that have been aroused, the knowledge that has been communicated. If one feels that there is nothing 'we' can do -- but who is that 'we'? -- and nothing 'they' can do either -- and who are 'they' -- then one starts to get bored, cynical, apathetic."

— Susan Sontag

Overview: This 2.5-hour session includes one hour of focused dialogue and reflection concerning the meaning and importance of compassion in the context of evolution and suffering experienced by human beings. It also includes one hour of experiential mindfulness and compassion.

Theme: What is compassion? Why is it important? Full spectrum of human suffering (stress, discomfort, pain, fear, doubt, illness).

Typical class sequence:

Grounding: Introductory, short guided attention mindfulness meditation. Reminder: guidance on stable, dignified and comfortable sitting posture. Dignified but gentle (self-care).

Take attendance & Large Group Discussion: Discuss the home practice – particular tasks from last week, problems, obstacles, what are you learning about yourself. Go over the Pain log.

Large Group Discussion/ **In**quiry* (or optionally small group/dyad sharing – might be better if the group is a little bit shy): What is compassion? Why do we need it? Fear of compassion?

** **In**quiry – **in**ternal exploration during Large Group Discussion. It is about asking participants about their internal experience (body sensations, emotions, thoughts, attitudes, intentions, and difficulties). It is not to theoretically analyse the practice but refer to it based on our own (practical) experience of it.*

Soothing Rhythm Breathing Meditation (SRBM) - guided: helping us focus on a sense of slowing down. Engaging our parasympathetic system. Lays the foundation for feeling compassion and focusing on our compassion.

SRBM + Using facial expressions and voice tones of compassion exercise.

SRBM + Guided reflection: Focusing on the compassionate qualities. Compassionate qualities guided reflection: wisdom, authority and strength, commitment. How does it feel to have those qualities? How does our body posture, tone of voice, facial expression, emotions and thoughts change when we have them.

Imagining Compassionate Self Imagery (CSI) + Large Group Discussion.

Didactic time (psychoeducation) or actually better to do through guided inquiry: Interconnectedness and common humanity, 'why zebras don't get ulcers', individual selves, primary and secondary suffering + Q & A, compassion & courage.

Body postures role playing: experiencing how different postures change the way we feel (physically, cognitively and affectively) through three different postures – tensed, relaxed and mindful.

Assign home practice.

Home Practice Assignment:

- Alternate: MOB & SRBM. **Emphasize the importance of discipline and gentleness**.
- Practice Log & Pain Log – **remind**.
- Home Practice Manual: My emotions and their functions.

- Read Home Practice Manual.

CLASS THREE (3)

Emotions and Different Selves

"...feelings like disappointment, embarrassment, irritation, resentment, anger, jealousy, and fear, instead of being bad news, are actually very clear moments that teach us where it is that we're holding back. They teach us to perk up and lean in when we feel we'd rather collapse and back away. They're like messengers that show us, with terrifying clarity, exactly where we're stuck. This very moment is the perfect teacher, and, lucky for us, it's with us wherever we are."

— Pema Chödrön

"I discovered that I am tired of being a person. Not just tired of being the person I was, but any person at all"

— Susan Sontag

Overview: In this 2.5-hour session, participants learn about their different emotions and their functions, various selves through formal practices and thereby gain greater control over them. This session also includes experiential compassion.

Theme: The three types of emotions (three circles) as referred to our personal experience. Exploring different selves and their potential.

Typical class sequence:

Grounding: Introductory, short guided mindfulness meditation + soothing rhythm breathing mediation. Remind that when in distress we can always go back to these practices (which helps better and when). Emphasis on emotions rather than thoughts.

Take attendance & Large Group Discussion: Discuss the home practice.

Three Types of Emotion Exercise: (1) Driven, excited, vitality, (2) Content, safe, connected, (3) Anger, anxiety, disgust. Remember to stabilise participants by finishing with a neutral visualisation or MOB. Additional explanations by the teacher: Explaining the three types of emotion. Includes Large Group Discussion/Inquiry.

Different Selves Exercise/Imagery: contemplation on different selves (sad, angry, anxious and compassionate self) and writing it down. Additional explanations by the teacher: Explaining that we are just one version of many potential selves and that we have many different mini-selves within us. Includes Large Group Discussion/Inquiry.

Contemplative Meditation (CM) (Sakyong Mipham Rinpoche, revised by JEW): starting with MOB and then slowly use the word 'water' as the object of meditation, think of its meaning, images and ideas associated with it, let it go. Includes Large Group Discussion/Inquiry.

Re-Inhibiting your Body Meditation (Levine & Phillips): exploring areas of the body that are free of pain and the areas that are painful. Includes Large Group Discussion/Inquiry.

Introducing Mindful Yoga (MY): simple postures as a means to enhance vitality and re-connecting with the body. Includes Inquiry.

Optional (can be presented later in the programme): Meditation on Courage (MOC) (by JEW). Includes Large Group Discussion/Inquiry.

Assign home practice.

Conclude class with SRBM.

Home Practice Assignment:

- Alternate: MOB, SRBM and CM
- Practice Log & Pain Log – remind.
- Read Home Practice Manual.

CLASS FOUR (4)

Pain and Suffering

"Illness is the night side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place."

— Susan Sontag

"Don't grieve. Anything you lose comes round in another form."

— Rumi

"This being human is a guest house. Every morning is a new arrival. A joy, a depression, a meanness, some momentary awareness comes as an unexpected visitor...Welcome and entertain them all. Treat each guest honourably. The dark thought, the shame, the malice, meet them at the door laughing, and invite them in. Be grateful for whoever comes, because each has been sent as a guide from beyond."

— Rumi

Overview: During this 2.5-hour session participants learn different techniques to better cope with emotional and physical pain. This session also includes experiential compassion.

Theme: Learning to cope with physical and emotional pain, learning to distinguish between primary and secondary suffering.

Typical class sequence:

Opening meditation (grounding): SRBM.

Take attendance & Large Group Discussion: Discuss the home practice.

Didactic: Types of pain – physical, emotional and post-traumatic (Levine & Phillips, 2012). Includes Large Group Discussion/Inquiry.

Cultivating our Compassionate Self Imagery (CSI).

Soothing rhythm breathing (SRBM).

Mindfulness of Pain Relief Meditation (MPR) (by Levine & Philips): any comfortable position applicable (does not have to be sitting), starting with MOB and then slowly moving to painful areas. Includes Large Group Discussion/Inquiry.

Cancer and Healthy Self Imagery: Explore the cancer and healthy self. Includes Large Group Discussion/Inquiry.

Conclude class with MOB or SRBM (what is most suitable for the whole group – use clinical intuition).

Home Practice Assignment:

- Alternate SRBM recording with CM and MY
- Practice Log & Pain Log.
- Read Home Practice Manual.

CLASS FIVE (5)

Compassion for Others. Embracing our Common Humanity.

"None of us can live our lives independently, without depending on others at all. None of us have complete control over what will happen in our lives because everything is interdependent upon everything else."

- Ogyen Trinley Dorje

"My humanity is bound up in yours, for we can only be human together."

- Desmond Tutu

"I like to feel dumb. That's how I know there's more in the world than me."

— Susan Sontag

"One of the major key realizations over the last few years in science has been to understand that you cannot have anything close to a mind or a mental capacity without it being completely embodied, enfolded with the world. It arises through an immediate coping, inextricably bound in a body that is active, moving and coping with the world. This might sound obvious but it is not so within the world of research where other ideas have been predominant especially the computational idea."

—Francisco Varela

Overview: In this 2.5-hour session, experiential training continues.

Theme: Why is compassion for others also good for us? Explaining the notion of common humanity – possibly refer to the ideas of Raimond Gaita or Kristen Monroe.

Typical class sequence:

Opening, guided meditation (grounding): MOB or SRBM.

Take attendance & Large Group Discussion: Discuss the home practice.

SRB + Guided reflection: Focusing on the compassionate qualities.

Mindful emphatic reflection - Thinking of a person who is in distress: What might be going through their minds? Why might they be thinking or feeling that? Which mini-self might be active in them right now and why? What might be a helpful way for me to think about this or to help them? Emphasize the idea of 'curiosity without judgement'. Includes: Large Group Discussion/Inquiry.

Mindfulness with the Other Exercise: in pairs meditating in front of each other. Includes: Large Group Discussion/Inquiry.

Compassion receiving exercise (Gratitude) – guided. Includes Large Group Discussion/Inquiry.

Discuss the intention of the upcoming half-day session. Describe the structure of this day.

Conclude class with MOB or SRBM.

Home Practice Assignment:

- Alternate SRBM recording with CM and MY
- Practice Log & Pain Log.
- Home Practice Manual: Interpersonal Events Calendar.
- Read Home Practice Manual.

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Half-Day of Practice

After Class Six Day of Practice, usually on a Saturday between 10:00 – 15:00

Typical Schedule:

10:00 – 10:20 Introduction to Half-Day of Practice: rules and schedule.

10:30 – 14:00 Practice time: various mindfulness and compassion practices (e.g. MOB, SRBM, MY, CS).

14:00 – 15:00 Large Group Discussion (Inquiry): Experience of the Day of Practice, difficulties and obstacles, what have we learnt. End with a large group meditation.

CLASS SIX (6)

Cultivating our Compassionate Self

"Being cut off from our own natural self-compassion is one of the greatest impairments we can suffer. Along with our ability to feel our own pain go our best hopes for healing, dignity and love. What seems nonadaptive and self-harming in the present was, at some point in our lives, an adaptation to help us endure what we then had to go through. If people are addicted to self-soothing behaviours, it's only because in their formative years they did not receive the soothing they needed. Such understanding helps delete toxic self-judgment on the past and supports responsibility for the now. Hence the need for compassionate self-inquiry."

— Gabor Maté

Overview: In this 2.5-hour session, participants engage in experiential compassion.

Theme: Working on our compassionate qualities and working through obstacles preventing us to receive and give compassion.

Typical class sequence:

Opening guided meditation (grounding): MOB or SRBM.

Take attendance & Large Group Discussion: Discuss the home practice.

SRBM + Guided reflection: Memories of being compassionate. Includes Large Group Discussion/Inquiry.

SRBM + Guided reflection: Focusing on the compassionate qualities.

Compassionate Self in Action Exercise: contemplation, writing down + Large Group Discussion/Inquiry.

Loving kindness meditation (LKM).

Conclude class with MOB or SRBM.

Home Practice Assignment:

- Practice Log & Pain Log – remind.
- Read Home Practice Manual.
- Home Pratice Manual: Compassionate Self in Action form.

CLASS SEVEN (7)

Openness to compassion & Spaciousness

"Above all, be at ease, be as natural and spacious as possible. Slip quietly out of the noose of your habitual anxious self, release all grasping, and relax into your true nature. Think of your ordinary emotional, thought-ridden self as a block of ice or a slab of butter left out in the sun. If you are feeling hard and cold, let this aggression melt away in the sunlight of your meditation. Let peace work on you and enable you to gather your scattered mind into the mindfulness of Calm Abiding, and awaken in you the awareness and insight of Clear Seeing. And you will find all your negativity disarmed, your aggression dissolved, and your

confusion evaporating slowly like mist into the vast and stainless sky of your absolute nature."

— Sogyal Rinpoche

"Forget safety.

Live where you fear to live.

Destroy your reputation.

Be notorious."

— Rumi

Overview: In this 2.5 hour session, participants practice working with resistance in terms of compassion and further expand their feeling of compassion towards themselves and other human beings. This session includes experiential compassion.

Theme: Expanding our compassion and interconnectedness.

Typical class sequence:

Opening, guided meditation (grounding): MOB or SRBM.

Take attendance & Large Group Discussion: Discuss the home practice.

Appreciation guided exercise: appreciating the ability to experience yourself and the world through your different senses.

Vase breathing meditation (VBM), guided. Includes Large Group Discussion/Inquiry.

Ideal Compassionate Imagery Exercise.

Optional: Glimpses of Wisdom Meditation (GWW) (by JEW). Includes Large Group Discussion/Inquiry.

Contemplative Meditation (CM) – change the words from neutral to difficult (but note that they need to be moderately difficult not extremely difficult – participants safety).

Conclude class with MOB or SRB.

Home Practice Assignment:

- Alternate SRB recording with CM and MY
- Practice Log & Pain Log – remind.
- Read Home Practice Manual.
- Practice Manual: Day-to-day gratitude exercise: choose a day where you deliberately pay attention to anybody who is helpful and/or kind to you. Write it down.
- Practice Manual: Compassionate lifestyle choices form (by JEW).

CLASS EIGHT (8)

Cultivation

"The really important thing is not to reject anything."

— Susan Sontag

"The human heart is basically very compassionate, but without wisdom, compassion will not work. Wisdom is the openness that lets us see what is essential and most effective. "

– Khandro Rinpoche

"Real understanding does not come from what we learn in books; it comes from what we learn from love of nature, of music, of man. For only what is learned in that way is truly understood."

— Pablo Casals

"All of us yearn for the highest wisdom, but we have to rely on ourselves in the end."

— Czesław Miłosz

Overview: This 2.5 hour session includes a review of the programme by means of further practices and dialogue.

Theme: Integrating mindfulness and compassion practice into daily life. What is beneficial in our life, what is maladaptive (compassionate lifestyle choices).

Typical class sequence:

Opening, guided meditation (grounding): SRBM.

Mindful Yoga, emphasis on gentleness.

Compassionate Letter Writing Exercise: writing a letter to oneself from a compassionate person perspective.

Guided reflection + writing it down: what have you learned about yourself? What do you want to remember? What are your goals after the training (short- and long-term)?

Group go around: each participant shares their experience of the training, what they have learned, obstacles and benefits.

Final meditation (MOB + meditation on intention: what is my intention, what do I need) and goodbyes.

Post-Training Session (Optional)

This session usually takes place up to a month after the final (8th) session. Its aim is to further establish our strength in compassion practices (both formal and informal). It is also about addressing any obstacles or difficulties and providing necessary assistance.

ADDITIONAL INFORMATION:

Attendance: If a participant does not come to the next session their teacher calls them.

Setting (Training Venue): preferably non-clinical setting: lack of medical associations (participants might prefer not to associate the training with their treatment process). Participants might choose to sit on meditation cushions or chairs (depending on their physical limitations). It is advised to choose the best option for oneself and this will be checked throughout the training.

Materials for each session = Home Practice Manual + Recordings (not every session/class)

Recordings given to the participants (produced by the teacher):

1. Mindfulness of Breathing (MOB)
2. Contemplative Meditation (CM)
3. Compassionate Self (CS)
4. Mindful Yoga (MY)
5. Soothing Rhythm Breathing Meditation (SRBM)
6. Loving Kindness Meditation (LKM)

This list is not complete. Note: Not all practices will be recorded and given to participants.

APPENDIX 16. Evaluation of sessions – Groups in Żagań and Warsaw I & II.

Group in Żagań

1st session

1. A. Good and revitalizing. The practice of intention.

   B. No because they were important.

   C. They helped me see things.

   D. Good.

   E. No.

2. A. Only becoming familiar with the training so for a beginning I'm not feeling bad.

   B. All was just right.

   C. No.

   D. I think I'll be content later. Now I'm curious.

   E. No.

3. A. All was good. They taught me to notice and work on compassion.

   B. No.

   C. They taught to notice and work on the things that I haven't yet resolved and that are difficult.

   D. Very good theme.

   E. No.

4. A. Imagery work.

   B. It could've lasted longer.

   C. I could've practiced for 30 minutes extra.

   D. They're very moving and after each exercise I'm feeling calmer.

   E. No.

5. A. All.

   B. No.

   C. No.

   D. Very good.

   E. No.

6. A. All.

   B. I liked it all.

   C. No.

   D. Helpful.

   E. No.

7. A. All exercises are good for me.

   B. Nothing.

   C. No.

   D. A very good topic.

   E. Nothing.

8. A. Breathing.

   B. Nothing. Everything’s fantastic.

   C. Nothing.

   D. Ideal.

   E. No.

9. A. All.

   B. No.

   C. Nothing.

D. Very good.

E. I liked everything.

10. A. Compassion for one's family is very important.

    B. Everything is very helpful.

    C. The way it's being conducted is really good.

    D. It's supportive and helpful.

    E. Nothing.

11. A. Each and every one because it was nice to be able to focus on myself.

    B. No.

    C. No.

    D. It's great, relaxation.

    E. No.

12. A. Thinking about family and compassion.

    B. No.

    C. Nothing.

    D. I liked it.

    E. No.

13. A. Working on intention.

    B. No.

    C. No.

    D. Very interesting. It inspires my imagination.

    E. No.

2nd session

1. A. Surrounding yourself with kindness and love provided me with feeling of soothing and understanding towards my imperfection.

   B. No.

   C. No.

   D. It helps me understand that there are many parts of ourselves – and we're not aware of that.

   E. Nothing.

2. A. I didn't know about intention. This is a very good exercise. Till now I haven't thought about it.

   B. No.

   C. No.

   D. It made me calm.

   E. Just right.

3. A. The mindfulness exercise – it helped me focus on myself and think about myself in a compassionate way.

   B. No, they're very good for me. They let me realise what my body needs.

   C. I liked it very much.

   D. On the right track.

   E. All has been covered.

4. A. Working on intention has been very helpful and educational.

   B. I'm not changing anything because everything is conducted in a beautiful way.

   C. No.

   D. I've learned a lot about compassion, myself and others.

   E. Nothing.

5. A. I liked everything. Intention is new.

   B. No.

   C. No.

   D. I need this very much.

   E. No.

6. A. This is all new to me. I'm learning.

   B. I think no.

   C. Nothing.

   D. Very good.

   E. I have no comments.

7. A. The exercise where I visualized the person who was kind to me. I felt tranquility, warmth and safeness.

   B. No.

   C. No.

   D. In my opinion this was right on topic.

   E. No.

8. A. Imagining the person.

   B. No.

   C. No.

   D. The topics are well-fitted and they let me reflect on myself and go deeper.

   E. No.

9. A. All are good.

   B. No.

   C. No.

D. Very good.

E. No.

10. A. Giving compassion. I feel good in this.

    B. No, nothing.

    C. As above.

    D. It's being presented to me in a new way.

    E. No, nothing was missing.

11. A. Working on intention. Good thoughts (kindness, goodness) make me a better person.

    B. No.

    C. No.

    D. Very interesting.

    E. No, nothing was missing.

12. A. I've learned to think with intention. This is new to me. I'd like to learn to think that way.

    B. No.

    C. No.

    D. I'm calmer.

    E. No.

3rd session

1. A. None because I realised I've been pushing my pain away.

   B. Don't think so.

   C. I have no suggestions.

   D. Hard to implement.

   E. I don't think there was anything missing.

2. A. The exercise concerning compassion, pain and suffering.

   B. The exercises are teaching us to be more patient. They're very helpful and good.

   C. It's very educational and helpful in life.

   D. Very good and helpful.

   E. Nothing. It's very practical and helpful.

3. A. Imagining how I can give compassion to my close one and the unknown person or the person with whom I have a difficult relationship. It has showed me that all of us, no matter what our relations are, occupation, age, wishes for happiness and love in our lives. This exercise brings out love towards another human being. A wonderful feeling – a feeling of warmth in one's heart.

   B. No.

   C. No.

   D. Making other closer to us.

   E. No.

4. A. The one concerning compassion. Compassion is an important element of support for the suffering person, whether this is physical or emotional.

   B. No.

   C. No.

   D. An interesting approach towards another person.

   E. Nothing was missing.

5. A. The one concerning compassion for the close one. It has provoked a lot of emotions within me.

   B. No.

   C. No.

D. It’s very educational, it gives me a lot to think about, how to be compassionate towards others.

E. Nothing was missing.

6. A. The one in which I imagined the person to whom I was giving compassion. I’ve realised that others suffer too and deserve my attention.

   B. No.

   C. No.

   D. It’s an eye-opener in terms of looking at the lives of others. Suffering isn’t only my domain, and by giving compassion to other one can feel better.

   E. No.

7. A. It’s easier for me to feel compassion towards a close person because I’m emotionally closer to them.

   B. I don’t want to change anything.

   C. No.

   D. This session is helping me in terms of understanding my feelings and behaviours.

   E. Nothing was missing. I’ve gained a lot from it.

8. A. The exercise of doing good for oneself, looking after oneself, imagining the compassionate carer.

   B. No.

   C. No.

   D. It has been a different perspective on compassion towards oneself.

   E. No.

9. A. Compassion towards my close one is very tender and emotional.

   B. All exercises are very helpful in life.

C. I'm nothing changing anything. Nothing.

D. The topic is about the rest of my life.

E. It was wonderful.

10. A. Concerning compassion for oneself and others.

    B. I'm not changing anything. I'm very satisfied.

    C. I liked it very much.

    D. It's very important in my life.

    E. Nothing, it's very helpful in my illness.

11. A. The one in which I had to focus on the ill, angry and compassionate selves.

    B. No.

    C. No.

    D. It helps be mindful of my body and thoughts.

    E. No.

12. A. Imagining the cloud.

    B. No.

    C. No.

    D. Beneficial.

    E. No.

4th session

1. A. The most beneficial exercise was the one with the dark cloud breathing (taking it in) (the practice of taking and giving) that cause some sort of discomfort, feeling of squeeze. This discomfort then disappeared when I was dissolving everything into bright light, there was tranquillity and feeling of soothing.

   B. Nothing.

   C. Nothing.

D. I think that all topics were adequate and helpful.

E. Nothing.

2. A. Working with imagery is amazing. I like it a lot. Looking at yourself hasn't been easy.

   B. Nothing.

   C. Nothing.

   D. I'm very satisfied.

   E. Nothing.

3. A. The practice of giving and taking. I've discovered different parts of myself.

   B. No.

   C. No.

   D. I liked it.

   E. Just right.

4. A. Thinking about myself in a compassionate way is difficult for me. I've never worked with myself in this way before. This has been difficult but also calming.

   B. No, wouldn't change it.

   C. As above.

   D. It's helpful. I'm feeling more at calm.

   E. All is very good.

5. A. The practice of giving and taking. This hasn't been easy for me, especially when I was experiencing the constant pain in my hand.

   B. No.

   C. No.

   D. Very educational. This will help me in my healing.

   E. All was just right.

6. A. Imagining the dark cloud.

   B. No. There's full comfort.

   C. No.

   D. Familiarising and being with pain and suffering gives me strength so it's ok.

   E. Nothing.

7. A. Slow walking. It helped me focus on each and every movement of my legs, feet, toes. Helping cultivate mindfulness.

   B. Nothing.

   C. Rather not.

   D. I think it's part of a bigger puzzle so it's needed.

   E. Nothing was missing.

8. A. The conversation the healthy part had with ill one, and looking at self in a compassionate way.

   B. No.

   C. No.

   D. I've cried because of emotion.

   E. It was beautiful.

9. A. Random walking and focusing on the body and breath.

   B. The exercises are relaxing, I'm calming down, experiencing tranquility.

   C. Nothing.

   D. I've been feeling very well during this session. Very educational.

   E. Nothing was missing.

10. A. The exercise of compassion towards myself because I can't do it.

B. Nothing.

C. No.

D. Is very important and needed. This topic is very much for me.

E. I don't have any suggestions.

11. A. Looking at myself in a kind way. Never have done this before. It has been very helpful.

    B. No.

    C. No.

    D. I Iiked it very much.

    E. Nothing.

12. A. Being aware of this place in my body that's in pain.

    B. No.

    C. No.

    D. Helpful. I'm more at calm.

    E. Not enough time.

5th session

1. A. Thinking about those good and bad thoughts – spacious mind. It helped calm down.

   B. I would've changed a thing.

   C. Nothing.

   D. I'm calming down and trying to forget about my problems that often turn out to be something banal in my life.

   E. Nothing was missing.

2. A. Working on myself. Touching myself. An amazing feeling. I've never touched myself, with love and compassion. I didn't even know this was possible.

   B. Nothing.

   C. Nothing.

D. Very helpful. Another lesson about myself.

E. All was just right.

3. A. All was helpful but the last practice was the most helpful – the spacious mind. It was giving me strength and freedom. I felt stronger.

   B. No.

   C. No.

   D. All were great, very good topics.

   E. No.

4. A. The exercises of touching yourself with love. It showed me that it possible to be warm for oneself and nothing bad happened because of that.

   B. No.

   C. Also, no changes.

   D. I think it's very needed because I'm opening up to myself. In the past this would not be acceptable (selfishness).

   E. Time. Could've lasted longer.

5. A. Giving and taking – because I have a problem with it.

   B. I would've changed a thing. In my opinion they were fantastic.

   C. This session provided me with a lot to think about: myself and my feelings. I've learned to distinguish and observe them.

   D. I'm very content. Nothing was missing.

6. A. Moving in the space amidst the clouds. Imagining the dark cloud and imagining that I'm giving understanding, compassion and love towards a close one.

   B. No.

   C. No but I'd like to practice the flying amidst the clouds for a bit longer.

D. It’s very good.

E. Nothing.

7. A. Meditation – spacious mind. It allowed me to see how interconnected we all are, how’s everything got a meaning (life, the way the world is, intelligence that created us).

   B. No.

   C. No.

   D. Cultivation – is important for me in terms of giving birth to feeling (compassion) one’s emotions and approaching myself with love and respect.

   E. No.

8. A. Imagining a difficult situation. The practice of taking and giving.

   B. Nothing.

   C. Nothing.

   D. Difficult but beneficial.

   E. Nothing.

6th session

1. A. I have no objections.

   B. I would’ve made any changes.

   C. No, nothing.

   D. I think it has given me a lot of good today.

   E. Nothing was missing.

2. A. The exercise of compassion towards the other person.

   B. I would’ve made any changes.

   C. As above.

   D. It will surely allow me to look at others in a different way.

   E. Nothing was missing.

3. A. I think all exercises were helpful.

   B. No.

   C. No.

   D. I think this is a very important topic. Compassion towards yourself gives you a feeling of tranquillity, balance and safeness. And also, it allows to be compassionate towards others and receive compassion from others.

   E. No.

4. A. Each and every exercise is a source of taking care of myself.

   B. No need to change anything.

   C. No need to change anything.

   D. Very important information concerning compassion.

   E. Nothing was missing.

5. A. The breathing exercises, feeling of gratitude.

   B. No.

   C. No.

   D. A needed topic.

   E. Nothing.

6. A. It's hard for me to tell. Today it was harder for me to focus but being able to participate provided me with tranquility of body and mind.

   B. No.

   C. No.

   D. It was cool.

   E. No.

7. A. The exercise of compassion towards others.

   B. No changes.

   C. I would've changed a thing.

   D. Perfectly matched with my needs.

   E. I'm fully satisfied.

8. A. All are good.

   B. Nothing.

   C. Nothing.

   D. I liked it.

   E. No.

9. A. I liked all of them.

   B. Nothing.

   C. Nothing.

   D. Very beneficial.

   E. No.

10. A. Compassion towards myself and others.

    B. All is good.

    C. Nothing.

    D. It's something I need.

    E. Nothing.

7th session

1. A. Looking at my friend with compassion.

   B. No.

   C. No.

   D. Topic very important for self-development.

E. No.

2. A. The exercise of receiving compassion from others was a very advancing experience.

   B. Would've changed a thing.

   C. No.

   D. Another interesting and valuable practice.

   E. Nothing was missing.

3. A. Compassion in pairs because I felt understanding and warmth.

   B. Nothing.

   C. Nothing.

   D. Something I needed.

   E. Nothing – this session helped me – helpful.

4. A. The exercise about giving compassion to the other person.

   B. Each meeting and exercise (in the group) is very helpful in my experience.

   C. Nothing. All is well thought out and conducted.

   D. Wonderful.

   E. Nothing. Is wonderful.

5. A. Compassion letter to yourself because I've gained this insight that in order to have my own sense of happiness and peace I don't need acceptance from others.

   B. No. They're very well conducted. The trainer has got great knowledge and is conducting the sessions in a compassionate, empathetic.

   C. No.

   D. Very helpful in everyday life, especially in terms of working on yourself and relationships with others.

   E. Too short :).

6. A. The exercise in pairs has provided me with an understanding on how to be compassionate through body posture.

   B. Nothing.

   C. Nothing.

   D. Very interesting topic.

   E. Nothing.

7. A. Writing the compassion letter allowed me to become aware of the fact that I don't know enough about this topic.

   B. Nothing.

   C. Nothing

   D. Received it with a great kindness.

   E. Nothing.

8. A. Giving compassion to the other person – imagining this person, taking the dark cloud and giving the luminous one.

   B. Nothing.

   C. Nothing.

   D. It helps me understand that giving compassion is good for us. "The good returns"

   E. Nothing.

9. A. Writing the letter and pair work. I was really touched. A beautiful experience.

   B. More time dedicated to the letter.

   C. Nothing.

   D. It helped me very much – let me think about myself and others in a different way.

   E. All was just right. The trainer is great!

8th session

1. A. All exercises were beneficial for me. Learned about new methods of compassion.

   B. I belief the exercises were prepared in a professional way.

   C. Would've changed anything – all was prepared in an adequate order.

   D. This topic was really interesting for me.

   E. Not missing anything.

2. A. All exercise were helpful.

   B. No

   C. No.

   D. Very important topic.

   E. No.

3. A. The practice of taking and giving towards myself and others. This calms me down and provides with peace.

   B. No.

   C. No.

   D. Topics that are very helpful.

   E. All was ideal.

4. A. The most beneficial for me is the tender touch and I have problems with this. Work with intention too.

   B. I liked it very much.

   C. No

   D. Very helpful. I'm feeling calmer.

   E. It's a shame it's over.

5. A. Imagery work. I've learned new things. I've calmed down and gained self-trust.

   B. All was ideal.

C. I liked it.

D. All is very helpful for me.

E. Thank you.

6. A. Working on intention and the practice of taking and giving. I think I'm more gentle towards myself.

   B. All was just right.

   C. No.

   D. No.

   E. I'm very happy that I was able to participate.

7. A. Working on intention and spacious mind. Touching myself isn't easy for myself.

   B. No.

   C. No.

   D. I liked all very much.

   E. Nothing was missing.

8. A. The most helpful exercise? It's hard to pick one. Each had some meaning for me.

   B. No.

   C. No.

   D. Like all others – needed, helpful.

   E. No.

Group in Warsaw

1st session

1. A. The intention practice.

   B. Nothing.

C. Nothing.

D. It was really interesting. I hope to gain a lot for myself.

E. All was good.

2. A. Intention.

   B. Nothing.

   C. Nothing but I really liked the medical, scientific explanations of what is happening to our organisms in terms of cortisol, oxytocin, etc.

   D. Very interesting. New to me.

   E. Nothing, alternatively a chat concerning science, medicine.

3. A. Looking for intention. It was interesting – the direction thoughts have taken, the thoughts that resulted in a conclusion. At first it was difficult to pinpoint it but at last there was a direction.

   B. I would make the time to end an exercise a bit longer, e.g. 3 long breaths before opening our eyes, something helping me get back to reality.

   C. I would make the breathing session longer – with the soothing rhythmic breathing. It would be best to have all the information about the exercise and breathing before it.

   D. I liked it.

   E. I wasn't able to 'achieve' all of the exercises.

4. A. The meditation on the three modes because it made me realise how often I feel threatened.

   B. Nothing. The amount of information and practices is enough for the first session.

   C. I would've turned up punctually.

   D. Very interesting and expanding one's horizons.

   E. It was all very good for me. I felt safe.

5. A. The breath at end of session – was able to calm down and relax.

   B. Nothing. The only thing that distracted me were the trainer's hands during meditation i.e. her caressing her legs.

   C. Good structure is ok: introduction, followed by practice.

   D. Logical, practical.

   E. It was ok. I like the relaxed way of conducting meditation – the voice, the way it's being narrated.

6. A. All of them – each had a distinct meaning.

   B. Don't think so.

   C. Don't know.

   D. I liked it. It's something completely new to me.

   E. More explanations.

7. A. Being to recognise the three modes: mode of anger, excitement, and being soothed. Realising that they're occurring in all humans and that influences proportions.

   B. I didn't know about comfortable attire. It would be great to conduct meditations in lying position.

   C. No.

   D. Inspiring but it demands consistency in practicing.

   E. No.

8. A. 3 modes. Intention (difficult).

   B. I don't think so.

   C. No.

   D. Very important. Meeting my needs.

   E. No.

9. A. The breathing exercise because I'm seeing results in the way I'm feeling and how I understand my emotional moods (modes).

   B. Comfortable sits because our chairs are not and the cushions aren't high enough.

   C. No. It's my first time so I have no comparison.

   D. Very interesting, especially since it's all new and fascinating to me.

   E. Time. I think we could be practicing for longer.

2nd session

1. A. Visualising the compassionate being because it helped me open a certain period from the past.

   B. No.

   C. No.

   D. Compassion towards myself is difficult for me.

   E. Nothing.

2. A. Compassionate being and the opening grounding with thinking about intention.

   B. No.

   C. No.

   D. Interesting.

   E. My mindfulness – felt asleep during two of the practices.

3. A. All but the most difficult one was the one with a compassionate being (image).

   B. Nothing.

   C. Nothing.

   D. I liked it.

   E. Nothing.

4. A. Rhythmic breath.

   B. A lot of meditations, practices. It's hard to focus, implement.

C. More discussions because that all is clear.

D. Less helpful in understanding self.

E. As above.

5. A. Safe place – soothing activity. Compassionate self – feeling of safeness.

   B. No.

   C. Don't think so.

   D. Interesting, needed.

   E. No.

6. A. Compassionate being.

   B. No.

   C. No.

   D. I really felt relaxed and supported.

   E. No.

7. A. Compassionate being (image) because it was difficult for me to feel safe so I see the purpose of this practice.

   B. No.

   C. No.

   D. Very interesting.

   E. Nothing!

8. A. Meeting the compassionate being.

   B. Nothing.

   C. Nothing.

   D. Can't say because I was late.

   E. As above.

I'm grateful for the meetings because they allow me to slow down and return to myself.

9. A. The practice concerning the compassionate being: it was so pleasant, nice, warm and very vivid.

   B. Maybe I would've added a chimney with aromatherapy because there was an unpleasant scent in the room.

   C. There were a lot of exercises today. Last time there was a lot of theory and that was a nice introduction to the practices.

   D. Very interesting, especially the colour and compassionate being exercises.

   E. Nothing comes to mind.

10. A. The visualization of safe place because it was the easiest thing for me to visualize. I was able to think of a place so it was easier to go back to it. Was able to experience the smell and all senses and so I'll be returning there.

    B. Not today.

    C. No.

    D. I had problems visualizing things that aren't there. I had more associations, thoughts.

    E. No.

3rd session

1. A. Compassionate self.

   B. No.

   C. No.

   D. Essential perhaps.

   E. No.

2. A. The visualization with the sad self, fearful self and angry self.

   B. More theory.

   C. No.

D. Very useful.

E. No.

3. A. Compassionate self.

   B. No.

   C. No.

   D. A very difficult session.

   E. No.

4. A. The ideal self exercise because it was nice, warm and kind.

   B. Maybe the level of difficulty. It was hard today.

   C. Nothing.

   D. The practices were difficult today.

   E. Nothing.

5. A. The ideal compassionate self – I have the greatest resistance towards this but I also feel this is the most important for me.

   B. Nothing.

   C. Nothing.

   D. Very, very important.

   E. Nothing.

6. A. Left blank.

   B. I don't know.

   C. Nothing.

   D. ?

   E. Left blank.

7. A. Different parts of self because it helped me see the source of my frustrations and reactions, helped me fully relax my mind.

   B. I would make the intro time longer.

   C. No.

   D. Difficult but important.

   E. Nothing.

8. A. Compassionate self because I'm trying to find (search for) traits of a compassionate person.

   B. Nothing.

   C. Nothing.

   D. Ok.

   E. I don't know yet.

4th session

1. A. Tonglen – I've realised what I needed in my daily life.

   B. No.

   C. I would've made the session longer because we exchange experiences at the beginning, but that's good. It would be good to make enough time to have comfort in sharing.

   D. Needed.

   E. Cold room – I was missing warmth :).

2. A. Giving and taking – I was able to inspire emotions and visualize the cloud which is cleansing itself in my body. I've entered myself deeply. The body scan which preceded helped me with this.

   B. No.

   C. No, there was time for discussion, exercises.

   D. It was really good for me and I discovered practices for myself.

   E. No.

3. A. Body scan.

   B. No.

   C. No.

   D. Fantastic.

   E. Exercises to do with integration – could be part of 1st or 2nd session, movement exercises.

4. A. Movement exercises because it helps me localize my strength. Integration within myself.

   B. Nothing. All ok.

   C. Noting. All ok.

   D. Ok.

   E. There was everything that was needed. I thank to thank the trainer for saying that the practices are building up our strength.

5. A. Giving and taking.

   B. No. Maybe body scan could be done not lying because I fell asleep :).

   C. No.

   D. As always interesting and important. Emotions – very important.

   E. No.

5th session

1. A. Body scan – afterwards I felt soothing relaxation.

   B. Today I decided to make use of the cushions but it was difficult for me to find a comfortable position.

   C. No.

   D. I'm approaching it with curiosity.

   E. No.

2. A. Body scan because I was really tired.

B. No.

C. No.

D. It's a repetition to some degree – in part unreadable - it answers doubts.

E. No.

3. A. The practice of giving and taking because afterwards there's a feeling of relief.

   B. Nothing.

   C. Nothing.

   D. No emotions. I'm feeling it's like a repetition.

   E. I'd like a little bit of scientific theory.

4. A. Giving and taking – feeling of relief and relaxation.

   B. I was a bit confused about the instructions in terms of what the black cloud was – was concerning my emotions, my self (ordinary self).

   C. Nothing.

   D. Ok.

   E. Nothing. All was needed.

5. A. Looking for the places of pain without pain, and the places of pleasure.

   B. No.

   C. No.

   D. Good.

   E. Good.

6. A. Body scan because I didn't fall asleep and I looked at myself with kindness.

   B. Nothing.

   C. No.

   D. Super.

E. No.

7. A. Giving – taking.

   B. No.

   C. No.

   D. I'm feeling it's taking me to the source of change.

   E. No.

6th session

1. A. The exercise of "anger" emotion – feeling of letting go.

   B. No.

   C. No.

   D. The conversation help bring order to internal reflections.

   E. No.

2. A. Concerning anger. I need to practice how to be in contact with it and just be in it.

   B. No.

   C. No. I liked that there was time to for discussion at the beginning.

   D. Super.

   E. Nothing.

3. A. Common humanity because it helped me gain a different way of looking at the other.

   B. No.

   C. No.

   D. Very important.

   E. Don't think so.

4. A. Common humanity.

   B. No.

C. No.

D. Useful.

E. No.

5. A. Common humanity.

   B. Nothing.

   C. Nothing.

   D. Brilliant.

   E. Nothing.

6. A. The exercise concerning anger because quickly and directly shows the consequences and benefits of “letting go”.

   B. Unreadable.

   C. Nothing.

   D. Ok.

   E. Ok.

7. A. The last practice of placing in front of us the close person, the neutral person and the negative person.

   B. No.

   C. No.

   D. It’s letting me open up to others.

   E. No.

7th session

1. A. The spacious mind and appreciating oneself. Because this is difficult and I’m practicing this on a daily basis.

   B. No.

   C. A movement interval between the sitting practices.

D. Brilliant. Very important.

E. After two practices I'm so "stuck" – I would benefit from some movement so wouldn't fall asleep at the end.

2. A. The expanding mind/spacious mind – among the troubling thoughts appeared some space. I managed to let go of some of them and enjoy the space, the wide perspective, omnipresence.

   B. No.

   C. No.

   D. I liked the exercise concerning… unreadable …. gratitude.

   E. No.

3. A. The practice of "space" – opening of the mind after a difficult day at work.

   B. No.

   C. No.

   D. It was hard to open up to other because I came after a difficult day at work.

   E. No.

4. A. Taking and giving.

   B. No.

   C. No.

   D. Good.

   E. No.

5. A. The practice of spaciousness because it makes breathe easier, it makes the feeling of decisiveness stronger.

   B. No.

   C. No.

D. Interesting as all of the meetings.

E. No.

8th session

1. A. It was hard for me to focus today.

   B. Left blank.

   C. Left blank.

   D. Left blank.

   E. Left blank.

2. A. The intention practice – it helps organise my thinking.

   B. For me the practice of taking and giving was too long for me today. I wasn't able to focus, I become impatient.

   C. No.

   D. Fantastic, especially the extra information concerning the critic.

   E. No.

3. A. Walking meditation/contemplation because I'm perceiving myself in movement very differently. It triggers new reflections.

   B. No.

   C. No.

   D. Valuable summary. Conducted in a great way by Magda.

   E. No.

4. A. Soothing-rhythmic breathing.

   B. No.

   C. No.

   D. Summary is important and it happened so it's ok.

   E. No.

5. A. Intention – I've discovered a new, deeper aim that is connected to all others and other exercises.

   B. No.

   C. No.

   D. It was nice to hear what other participants gained from the meetings and how different practices may be adequate depending on the situation we're in.

   E. Nothing.

6. A. Compassionate self in movement.

   B. No.

   C. No.

   D. Very useful.

   E. No.

7. A. Walking and integration with the parts of the compassionate being.

   B. Nothing.

   C. Nothing.

   D. Ok.

   E. Nothing.

Evaluation of sessions – Group in Warsaw II

1st session

1. A. Recognising intention because it's important to know one's motivations.

   B. I have no opinion.

   C. I have no opinion.

   D. The proportions between various modes were interesting.

   E. Don't this so.

2. A. Breaths.

   B. No.

   C. No.

   D. This was interesting.

   E. There was no such thing.

3. A. Breathing combined with the sound of gong and the trainer's voice.

   B. Don't think so.

   C. No.

   D. Mindfulness and breath are good foundations for calming down – which I liked. I'll be happy to practice.

   E. For me all was in order.

4. A. Learning to breath.

   B. Nothing.

   C. Nothing.

   D. It got me interested.

   E. Nothing was missing for me.

5. A. The practice – calming down.

   B. No.

   C. No.

   D. Interesting.

   E. No.

6. A. Realising my most important intention – because there are many.

   B. For now – no.

C. For now – no.

D. It got me seriously interested.

E. Opening the windows but I realised it would too loud then.

7. A. The breath – it has caused peace.

   B. Nothing that I can think of.

   C. The window not being open.

   D. It was needed so I could lose the weight of my emotions (too much), so I could to something about it.

   E. Specific examples in daily life.

8. A. Visualising the safe place.

   B. No.

   C. No.

   D. Interesting relaxation techniques.

   E. No.

9. A. Visualising the place, people.

   B. No.

   C. No.

   D. I liked it.

   E. No.

10. A. Imagining the place.

    B. No.

    C. No.

    D. Useful visualization techniques but it's hard to calm one's thoughts.

    E. Thank you!

2nd session

1. A. The exercise of compassionate colour – I hope to try it tomorrow during my chemotherapy which I don't take well.

   B. Left blank.

   C. I'd like for us to fit it all in the 2h slot. I leave being tired and I'm home late.

   D. Interesting.

   E. Left blank

2. A. Finding the safe place, colour.

   B. No.

   C. No.

   D. Useful, interesting.

   E. No.

3. A. Colour – it made me calm down and my joints stop hurting.

   B. No – I liked it.

   C. No.

   D. Personally – very helpful.

   E. No.

4. A. Imagining the colour.

   B. No.

   C. No.

   D. This has been interesting.

   E. No.

5. A. The place of “soothing” – I was able to relax then the most and felt the most pleasure.

   B. So the window would be open but I know this is not possible because of the noise.

   C. No.

   D. I haven’t noticed that there was talk about mindfulness – I’m mindless.

   E. More fresh air.

6. A. Visualising the safe place because I was able to relax.

   B. Between the visualization – discussion in dyads.

   C. Visualisations – beautiful.

   D. I liked it very much as an introduction to my personal practice.

   E. The group being more active.

7. A. Visualising the place – feeling of safeness.

   B. No (but I think I felt during the compassion exercise and this was important).

   C. No.

   D. Was useful.

   E. Because I missed the compassion exercise – for this to be repeated.

3rd session

1. A. The ideal compassion – it helped me relax, I felt light and safe.

   B. I liked everything.

   C. No, all was cool.

   D. I have to think about it more but I was able to look at my emotions and I saw them in colours – I don’t know if that’s good.

   E. Nothing was missing for me.

2. A. Maybe myself.

   B. Not all spoke to me. Instead of sadness I remembered other unpleasant feelings.

   C. Maybe better explain some experiences.

D. I haven't caught the one topic – rather a selection of experiences.

E. Maybe a short intro to the third experience.

3. A. The ideal compassionate.

   B. Nothing.

   C. Nothing.

   D. Moving, useful, "it has started in me".

   E. No.

4. A. Visualising the compassionate person and working on emotions – I felt the changing of emotions through my whole body.

   B. No, it was fine.

   C. I liked the order of visualisations – thanks to that I was able to engage more in the work with emotions so for me the structure was ok.

   D. Left blank.

   E. A few people were missing – a pity.

5. A. All.

   B. No.

   C. No.

   D. It was ok.

   E. Nothing.

4th session

1. A. The practice of taking and giving because it has opened me to a difficult problem I'm facing in family relationships.

   B. More practices, less explanations. Intellectualisations are a waste of time.

   C. OK.

D. The compassionate self – is difficult for me. I hope that slowly I'll get deeper into this practice.

E. It's a shame that a few people were not there.

2. A. The imagining of being wise, strong…

   B. No

   C. Nothing

   D. Very interesting

   E. It's bad that the session exceeded the expected time

3. A. I can't judge so quickly but perhaps the compassionate being.

   B. Questionnaires at home.

   C. So it would be possible to fill out the forms with reflection and not so quickly.

   D. Difficult.

   E. Fresh air, light.

4. A. The compassionate self (unreadable).

   B. I would respond more to my body's movement but during the exercises I haven't been aware of that.

   C. I don't think so.

   D. I have to practice because I didn't feel much.

   E. Left blank

5. A. "You're wise, strong, kind, warm-hearted and committed"

   B. No

   C. No.

   D. Very helpful in my everyday life.

   E. Thank you very much, nothing was missing for me.

5th session

1. A. Focusing attention on the regions of pain and no pain.

   B. More fresh air.

   C. Have no idea.

   D. I would like for this to be really helping others.

   E. Knowledge on how to help others with words.

2. A. The exercise with pain made it possible to feel less pain after the exercise.

   B. No, all is fine.

   C. No.

   D. Interesting, especially the body scan.

   E. No.

3. A. The body scan – it made it possible for me to fully relax.

   B. The trainer's diction.

   C. Nothing.

   D. This has been insightful and inspiring.

   E. Nothing.

4. A. Taking and giving, with the "white" goose bumps – pleasant, warm.

   B. No.

   C. No.

   D. Very important – I felt myself – pain – release.

   E. No. Thank you very much.

5. A. Realising how to breathe – longer to breathe

   B. No.

   C. No.

D. Very useful.

E. No.

6. A. The taking and giving exercise – I feel that I have more access into this experience. The body scan exercise made me realise my muscles tensions.

   B. Ok

   C. First the body scan, later mindfulness of pain and relaxation

   D. It's very hard for me to breathe into the place that's painful but I think it's important to practice it.

   E. Left blank

6th session

1. A. Taking and giving

   B. Left blank

   C. Left blank

   D. Left blank

   E. Compassion

2. A. The practice of gratitude – I felt how the empty heart got filled, how the hungry infant gets fed, how important it is to appreciate the crumbs of everyday goodness in life; the practice of taking and giving towards a sick friend – I've realised how deep the fear of illness is, how instinctively the body shrinks in self-defence, how difficult this practice is.

   B. No

   C. I can't exactly remember the order of exercises, for me personally the best order would be: 1 breath, 2 scan, 3 spaciousness of mind, 4 the practice of self-compassion, 5 taking and giving practice, 6 gratitude practice, 7 compassion towards others

   D. The practice of gratitude helps feel the social network, the flow of good feelings, intention, it heals from alienation, being worse, different due to illness (or due to any other reasons).

E. I missed Roma – the group without her was not full. I missed being more focused during the practices. I missed the silence and mindful yoga – even just a few asanas.

3. A. The practice of gratitude for others – it helps me experience a better mood – when I realised how many people are helping me.

   B. I'd like to better trained in good, effective breathing.

   C. No.

   D. "Spaciousness" is something new for me and it seems that this practice makes me feel better.

   E. More "cannons" against my fear and tension.

4. A. Taking and giving, compassion, transformation.

   B. Nothing.

   C. Nothing.

   D. Thank you for the hope of being able to experience my daily life in a better way.

   E. Nothing, thank you.

7th session

1. A. Spacious mind

   B. No

   C. No.

   D. Interesting topic and it concerns everybody.

   E. No.

2. A. The spacious mind exercise.

   B. All is good.

   C. I like today's meditations. They trigger positive feelings.

   D. I liked it.

   E. All was good.

3. A. Spaciousness and common humanity, the explanation how to act in anger.

   B. Left blank.

   C. Left blank.

   D. Ok. Useful.

   E. Left blank.

4. A. Spaciousness.

   B. No.

   C. The distraction concerning anger – too many individual examples.

   D. Expected. Thank you.

   E. The discipline of topics.

5. A. Gratitude for others.

   B. Left blank.

   C. Left blank.

   D. Left blank.

6. A. The exercise of tightening the fists – I've realised how much anger was there in my jaws, mouth. The soothing-rhythmic breathing – the feeling of how I can effectively affect (lessening) negative emotions. Compassion towards myself – changes how I do hatha yoga.

   B. I'd add a few hatha yoga bits – a few gentle asanas, maybe this would help lessen the tensions. Too many discussions didn't help.

   C. Common humanity, the topic of our previous session – our mutual, in the group, fear, anger, the integration that's being created…and compassion for one another. This all demands time. The cultivation has been lost in all the chaos of chatters concerning our daily problems.

   D. Silence (this also includes myself – I talk too much.

8th session

1. A. Concerning space – it let me gain some distance towards the world.

   B. I'd like more knowledge how to make use of it in daily life – more examples for people living with cancer.

   C. It's ok.

   D. I took part in it with pleasure.

   E. Thank you for the fans!

2. A. Walking and focusing on the compassion qualities – I was able to embody it more and felt more connected towards the people in the group. The practice of giving and taking (I felt the bond with my adult, sick son).

B. No.

C. It was ok, first the practice and then the discussion – summarizing the whole cycle of training.

D. What was important for me was the differentiation between concentration and mindfulness in "cultivation" – I was able to organise the order in which I'll be able to overcome the resistance towards visualizing compassion for myself.

E. The last exercise – concentration on the breath as coming in full circle.

3. A. Giving and taking to others because there are people in my life who need this.

   B. I'd like to focus more on learning how to breath in a good way.

   C. No.

   D. It's very hard to inspire in oneself the feelings of wisdom and strength.

   E. Missing more references to the fact that I'm an oncological patients – to what extent (and if that's the case) this situation differs from a normal human.

4. A. Focusing on change.

   B. No.

C. No.

D. The topic has deepen my feeling and understanding of compassion (acting – commitment).

E. No.

[1] All of the names have been changed

APPENDIX 17. Tables for Wilcoxon rank markers.

Wilcoxon rank marker test for comparisons of pairs of evaluation stages for the MAAS.

	MAAS pre-training	MAAS post-training	MAAS follow-up
From	-3.25	-3.25	-2,94
Asymptotic significance (2-sided)	p>.001	p<.001	**p<.003**

Wilcoxon rank marker test for comparisons of pairs of evaluation stages with the PSS questionnaire on a sten score.

	Sten score PSS post-training - Sten PSS pre-training	Sten score PSS follow-up - Sten PSS post-training	Sten score PSS pre-training - Sten PSS follow-up
From	-,816	-1,026	-2,147
Asymptotic significance (2-sided)	p>0,05	p>0,05	**p<0,05**

Wilcoxon rank marker test for comparisons of pairs of evaluation stages with the SWLS questionnaire on a sten score.

	Sten SWLS post-training - sten SWLS pre-training	Sten SWLS follow-up - sten SWLS post-training	Sten SWLS pre-training - sten SWLS follow-up
From	-2,087	-1,674	-3,178
Asymptotic significance (2-sided)	**p<0,05**	p>0,05	**p<0,001**

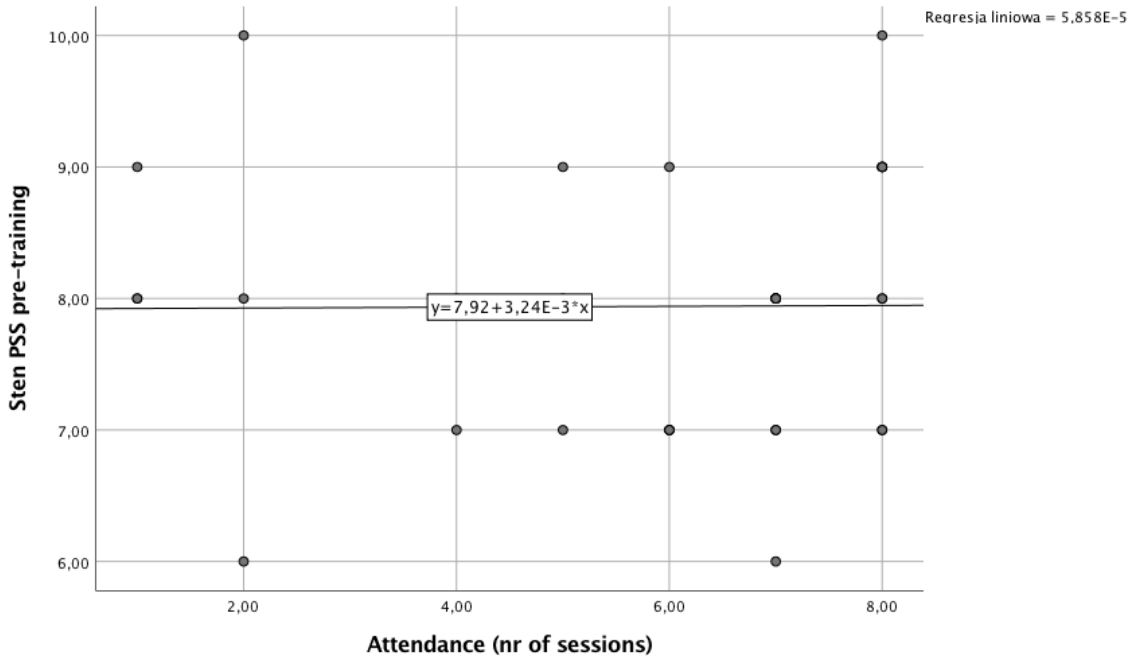
Wilcoxon rank marker test for comparisons of pairs of evaluation steps with the RAAS questionnaire on the DEPEND scale.

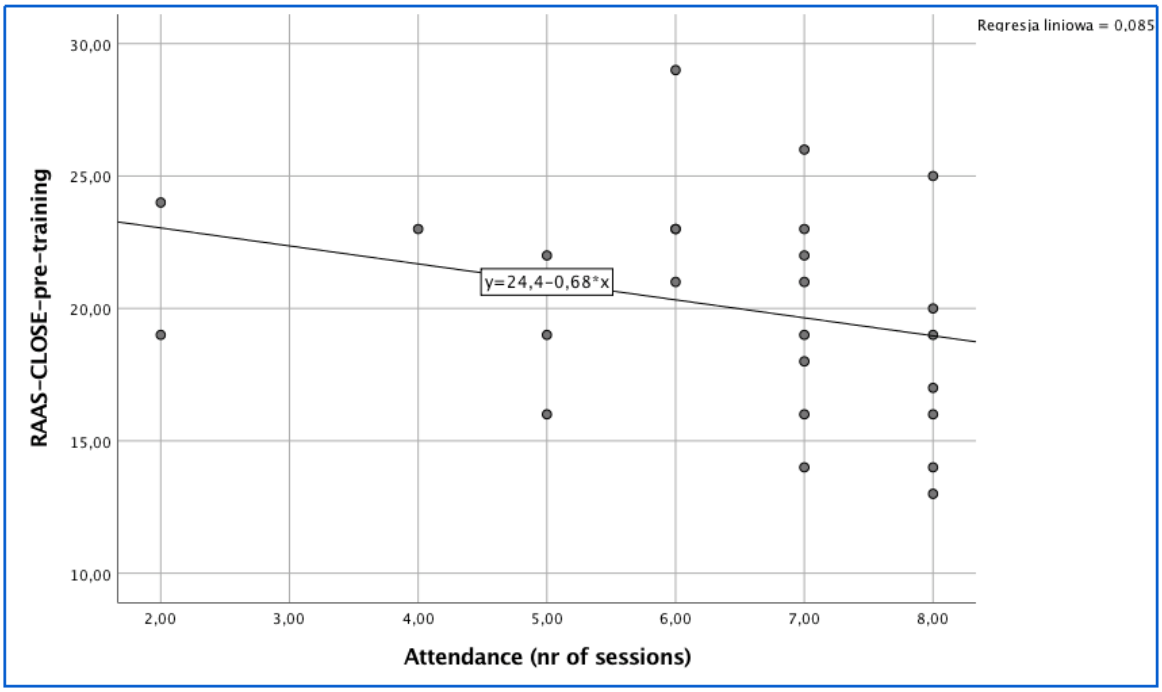
	RAAS-DEPEND-post-training - RAAS-DEPEND-pre-training	RAAS-DEPEND-follow-up - RAAS-DEPEND-post-training	RAAS-DEPEND-pre-training - RAAS-DEPEND-follow-up
From	-,506	-,416	-,623
Asymptotic significance (2-sided)	p>0,05	p>0,05	p>0,05

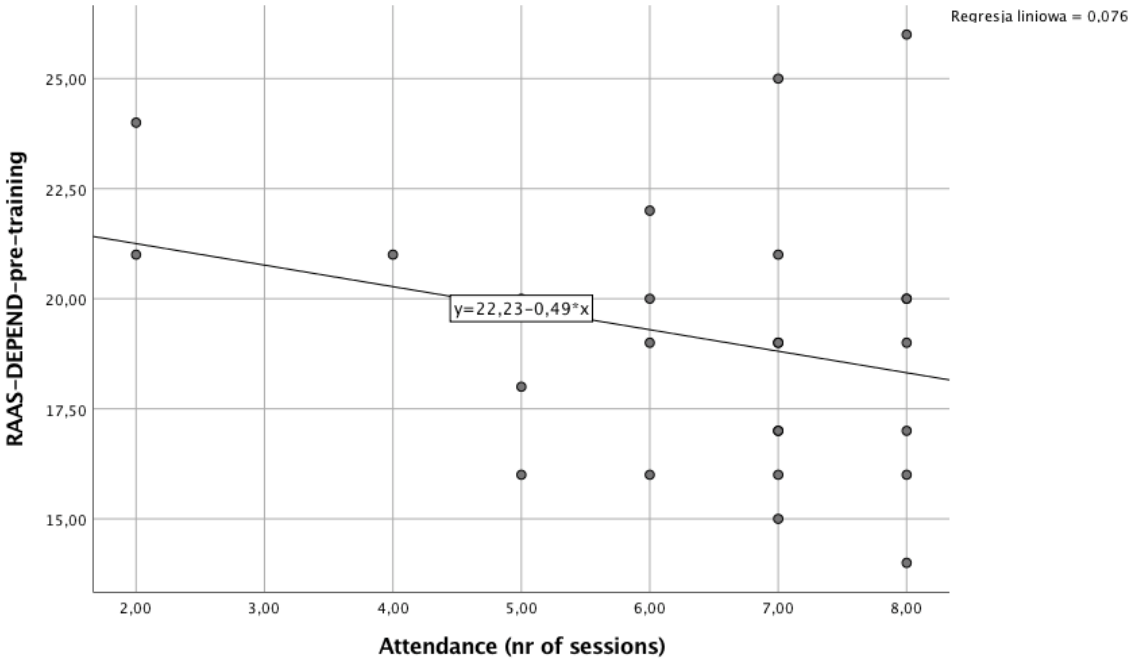
Wilcoxon rank marker test for comparisons of pairs of evaluation stages for PTGI e, dimension of: spiritual change.

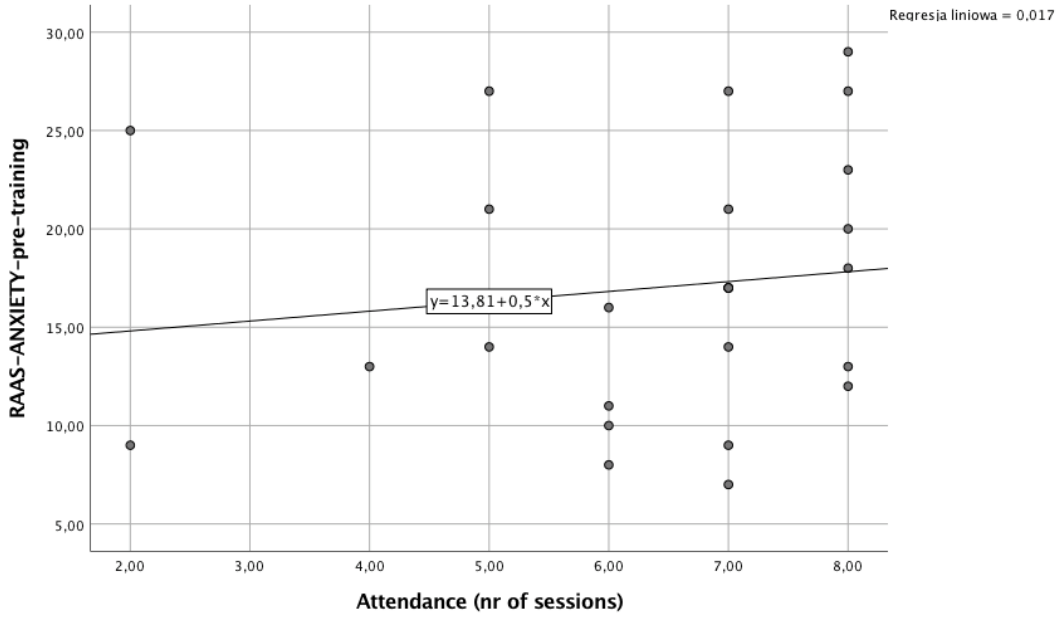
	PTGI Spiritual change - post-training - PTGI Spiritual change - pre-training	PTGI Spiritual change - follow-up-training - PTGI Spiritual change - post-training	PTGI Spiritual change - pre-training - PTGI Spiritual change - follow-up-training
From	-,646	-,287	-,967
Asymptotic significance (2-sided)	p>0,05	p>0,05	p>0,05

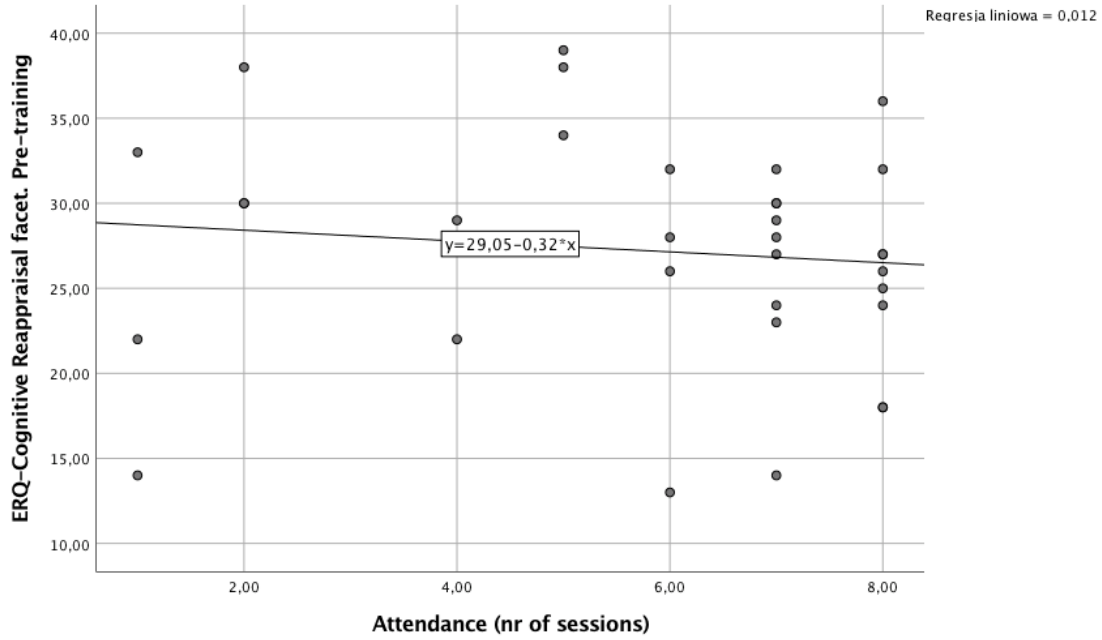
APPENDIX 18. Tables of Correlations: well-being as measured by all the questionnaires (baseline data).

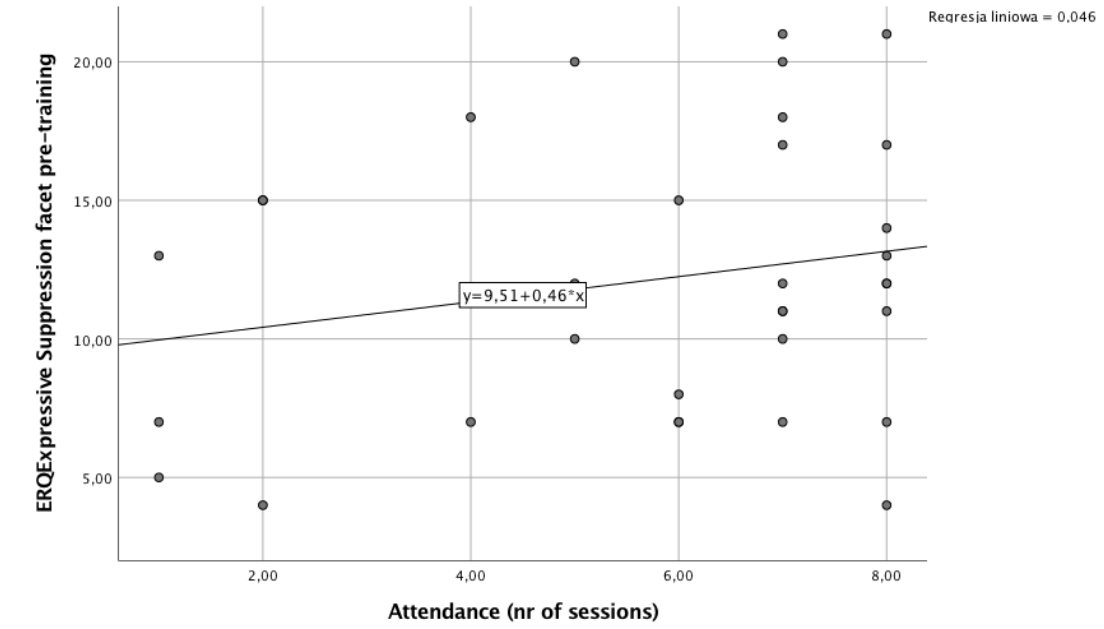


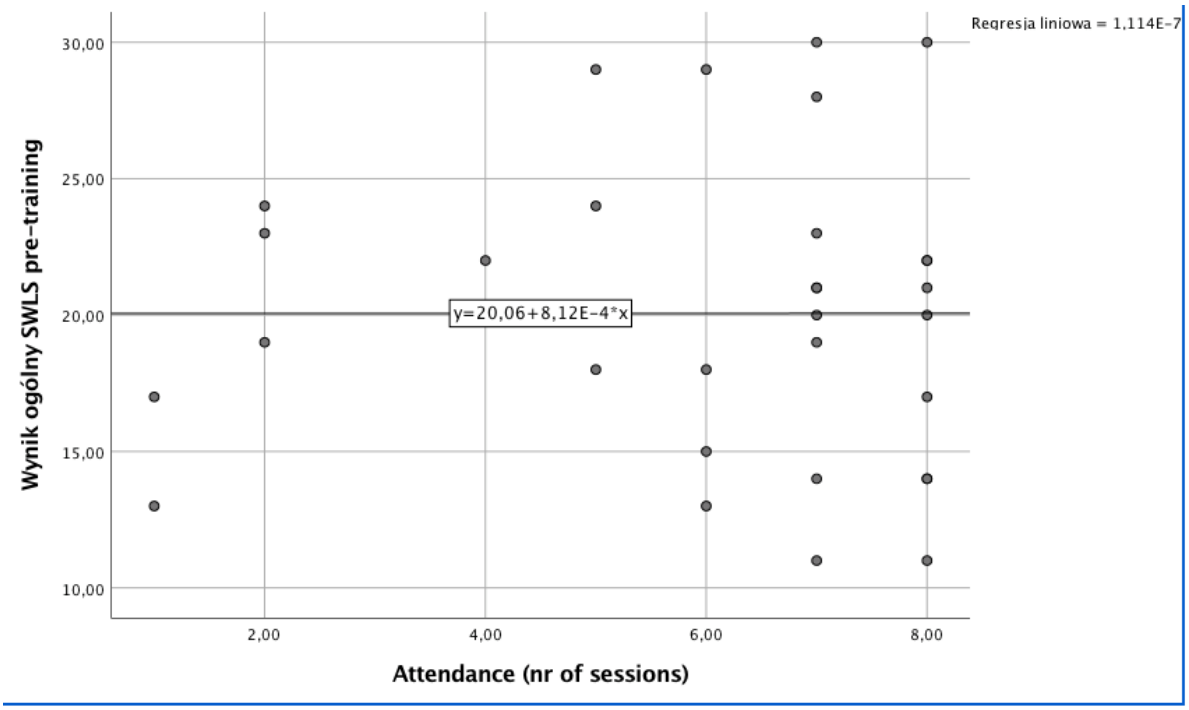

Regresja liniowa = 0,085
RAAS-CLOSE-pre-training
30,00
25,00
20,00
15,00
10,00
y=24,4-0,68*x
2,00
3,00
4,00
5,00
6,00
7,00
8,00
Attendance (nr of sessions)

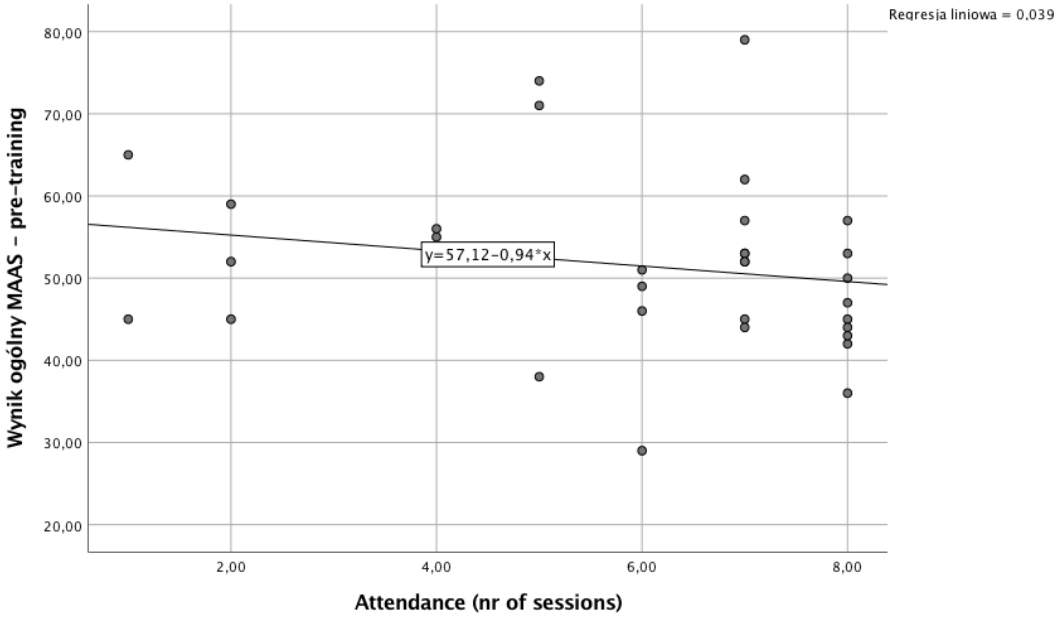

Regresja liniowa = 0,076
RAAS-DEPEND-pre-training
25,00
22,50
20,00
17,50
15,00
y=22,23-0,49*x
2,00
3,00
4,00
5,00
6,00
7,00
8,00
Attendance (nr of sessions)

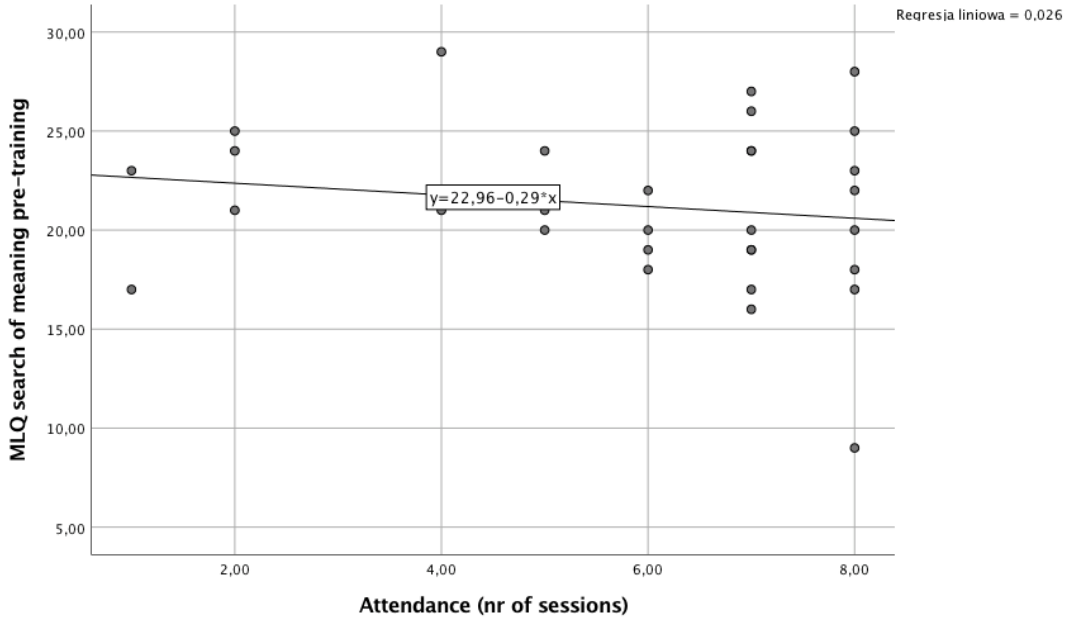

Regresja liniowa = 0,017
RAAS-ANXIETY-pre-training
30,00
25,00
20,00
15,00
10,00
5,00
y=13,81+0,5*x
2,00
3,00
4,00
5,00
6,00
7,00
8,00
Attendance (nr of sessions)

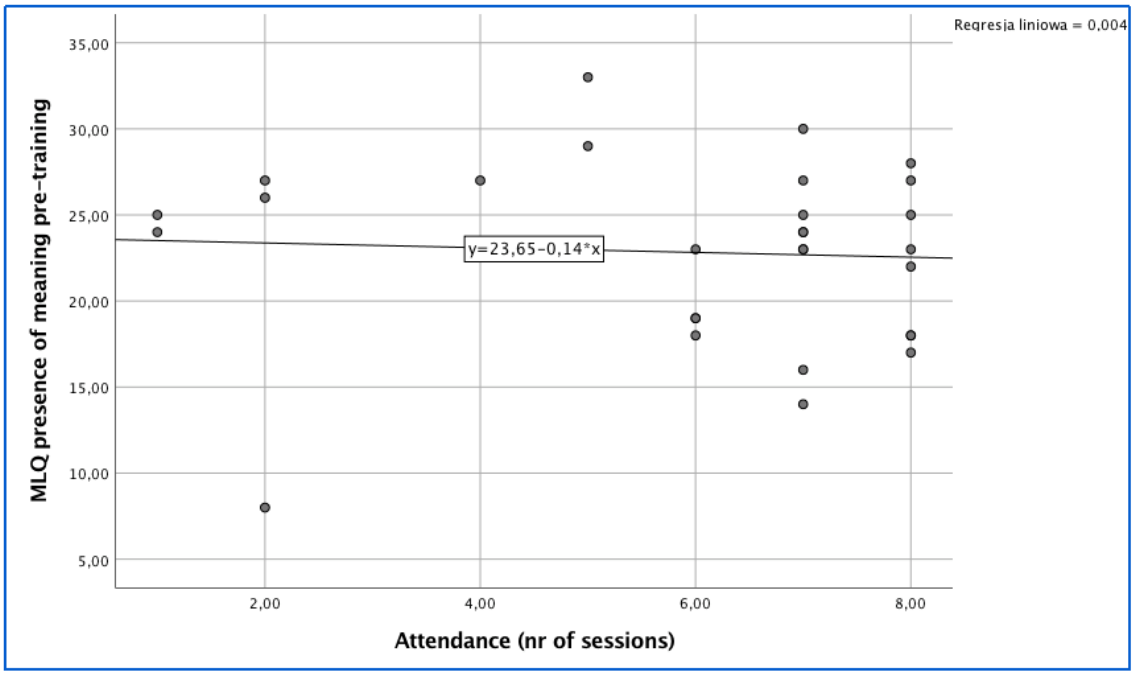

Regresja liniowa = 0,012
ERQ-Cognitive Reappraisal facet. Pre-training
40,00
35,00
30,00
25,00
20,00
15,00
10,00
y=29,05-0,32*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)

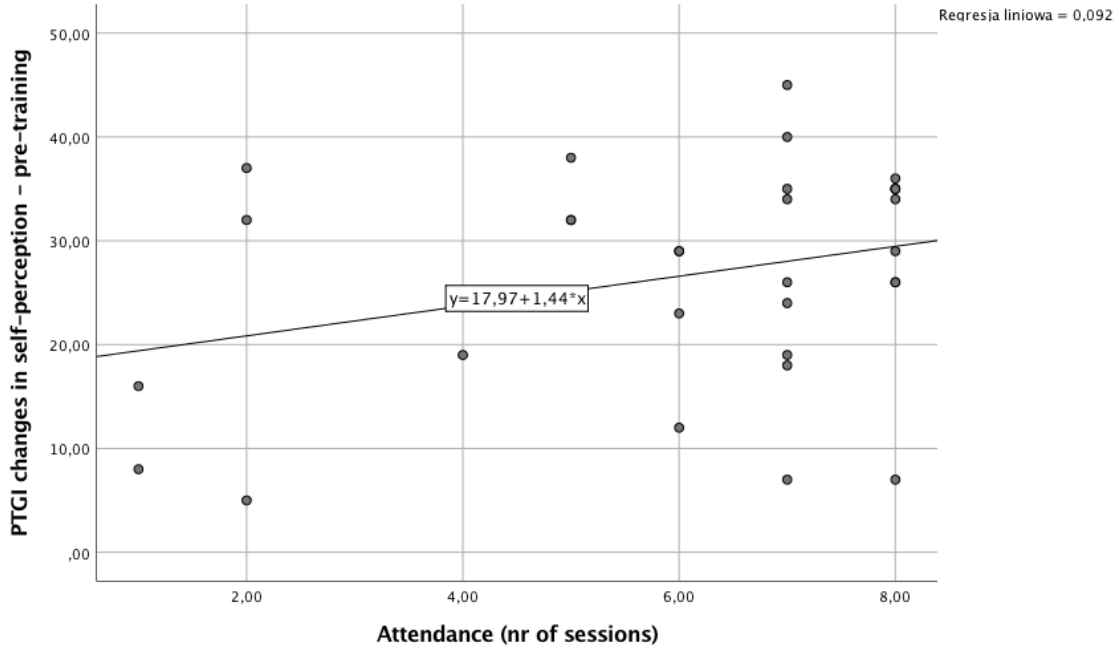

Regresja liniowa = 0,046
ERQExpressive Suppression facet pre-training
20,00
15,00
10,00
5,00
y=9,51+0,46*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)

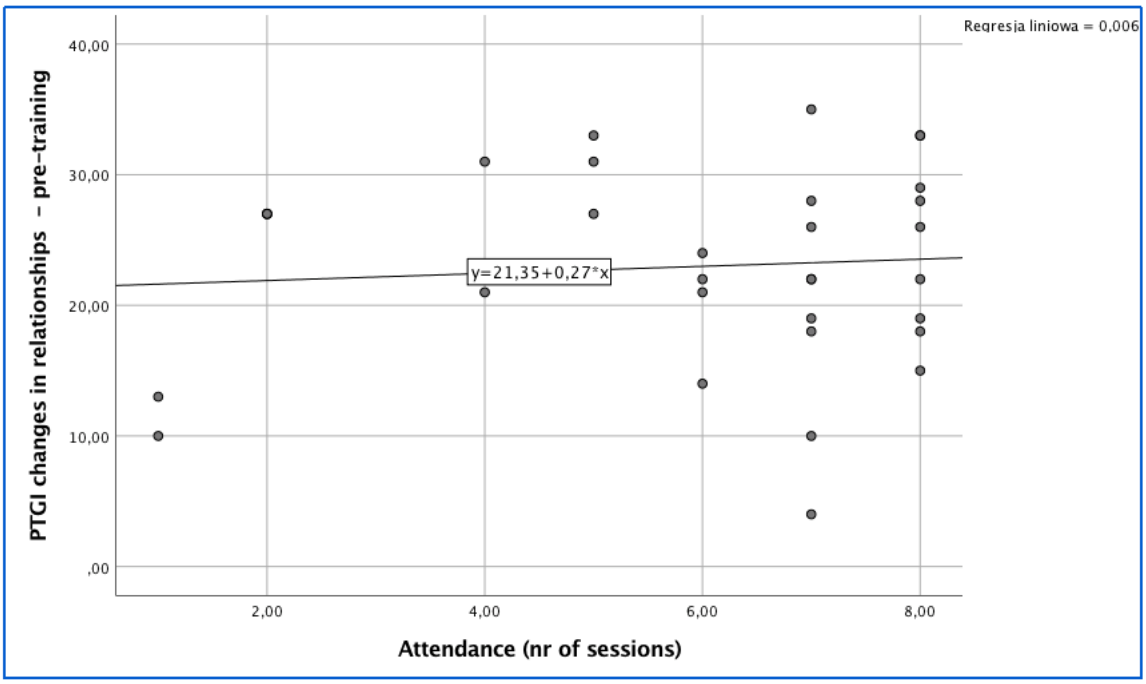

Regresja liniowa = 1,114E-7
Wynik ogólny SWLS pre-training
30,00
25,00
20,00
15,00
10,00
y=20,06+8,12E-4*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)

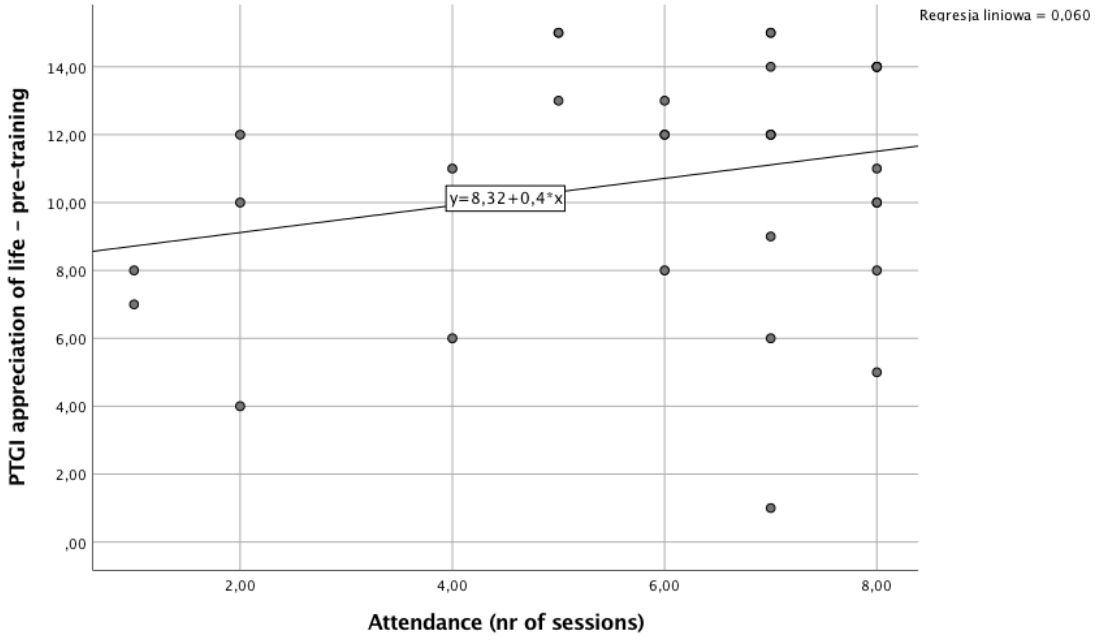

Regresja liniowa = 0,039
Wynik ogólny MAAS – pre-training
80,00
70,00
60,00
50,00
40,00
30,00
20,00
y=57,12-0,94*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)

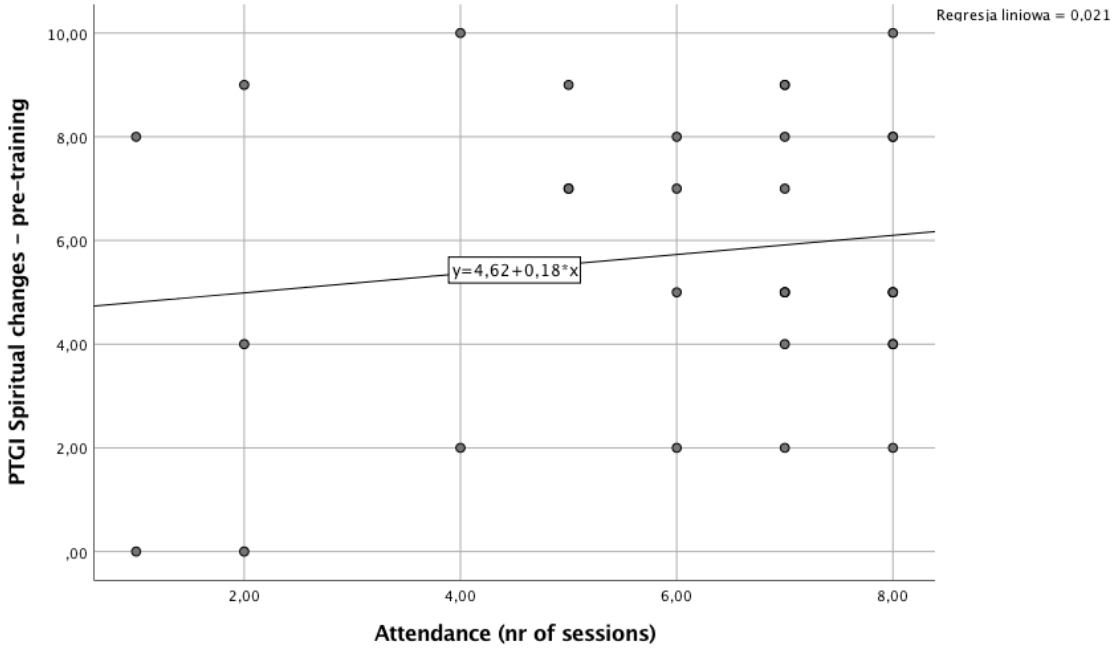

Regresja liniowa = 0,026
MLQ search of meaning pre-training
30,00
25,00
20,00
15,00
10,00
5,00
y=22,96-0,29*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)


Regresja liniowa = 0,004
MLQ presence of meaning pre-training
35,00
30,00
25,00
20,00
15,00
10,00
5,00
y=23,65-0,14*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)


Regresja liniowa = 0,092
PTGI changes in self-perception - pre-training
50,00
40,00
30,00
20,00
10,00
,00
y=17,97+1,44*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)


Regresja liniowa = 0,006
PTGI changes in relationships - pre-training
40,00
30,00
20,00
10,00
,00
y=21,35+0,27*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)


Regresja liniowa = 0,060
PTGI appreciation of life - pre-training
14,00
12,00
10,00
8,00
6,00
4,00
2,00
,00
y=8,32+0,4*x
2,00
4,00
6,00
8,00
Attendance (nr of sessions)



APPENDIX 19. OWN WORK BASED ON THE CURRENT BODY OF RESEARCH.

- Wahl, J., Sheffield, D. et al. (2018). Development of a Compassion for Cancer curriculum for female breast cancer patients in stages I-III and cancer survivors. Origins, rationale and initial observations. *Journal of Mindfulness & Compassion, 3*(1) 47-76.

- Wahl, J. (2018, July). Development of a Compassion for Cancer curriculum for cancer patients in stages I-III and cancer survivors. Origins, rationale and initial observations. Paper presented at the International Conference on Mindfulness (ICM), Amsterdam, the Netherlands.