Development of a Compassion for Cancer curriculum for female breast cancer patients in stages I-III and cancer survivors. Origins, rationale and initial observations

Julia E. Wahl[a] *, David Sheffield, Frances A. Maratos, Stephanie Archer[b]

[a] *University of Derby, UK*

[b]*Imperial College London, UK*

*****Corresponding author.* E-mail addresses: juliawahl@juliawahl.co.uk, j.wahl@derby.ac.uk

Abstract: Compassion is an intrinsic trait and is linked to psychological and physiological well-being. It can be trained and improved through a systematic contemplative training programme. The purpose of this paper is to present a new training programme for cancer patients and survivors (CforC) that was designed and tested in a pilot study. We review the potential benefits of CforC which include attention regulation, self-regulation, mental awareness, and acceptance of physical sensations (including pain experiences). We also consider limitations. Results of the pilot suggest that the current intervention is feasible and provides potential psychological benefits for female breast cancer patients/survivors. Future research may benefit from examining other potential effects of the CforC programme, including emotional and physical outcomes in cancer patients and survivors, and the application of the intervention to other populations of chronically ill patients.

Keywords: Compassion, self-compassion, cancer training, compassion-focused therapy

Desarrollo de un Currículo de Compasión para el Cáncer para Pacientes con Cáncer de Mama en etapas I-III y Sobrevivientes de Cáncer. Orígenes, Fundamentos y Observaciones Iniciales

Resumen: La compasión es un rasgo intrínseco y está vinculada al bienestar psicológico y fisiológico. Puede ser entrenada y mejorada a través de un programa de entrenamiento contemplativo sistemático. El propósito de este artículo es presentar un nuevo programa de entrenamiento para pacientes con cáncer y sobrevivientes (CforC) que fue diseñado y probado en un estudio piloto. Revisamos los beneficios potenciales de CforC que incluyen en la regulación de la atención, la autorregulación, la conciencia mental y la aceptación de las sensaciones físicas (incluidas las experiencias de dolor). También consideramos limitaciones. Los resultados de la prueba piloto sugieren que la intervención actual es factible y proporciona beneficios psicológicos potenciales para pacientes/sobrevivientes de cáncer de mama. Las investigaciones futuras pueden beneficiarse al examinar otros posibles efectos del programa CforC, incluidos los resultados emocionales y físicos en pacientes con cáncer y sobrevivientes, y la aplicación de la intervención a otras poblaciones de pacientes con enfermedades crónicas.

Palabras clave: compasión, autocompasión, entrenamiento del cáncer, terapia centrada en la compasión

Introduction

The current paper will present details of the development and potential applications of a psychosocial intervention for breast cancer patients and survivors entitled *Compassion for Cancer (CforC)*, which is based on compassion-focused therapy (CFT) (Gilbert, 2010a). The three main purposes of this paper are to describe the theory, explain the process of development of the curriculum, and evaluate its application in clinical practice. 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 analyzed thematically.

Defining compassion

Compassion can be defined as a sensitivity to the suffering of self and others with a deep commitment to relieve (and prevent) it" (Bstan-'dzin-rgya-mtsho & Thupten Jinpa, 1995). Leading from this, compassion is described as encompassing two "psychologies" or two different sets of skills (Gilbert, 2010a). The first skill is the ability to see and be with distress or discomfort, and the second skill concerns specific actions that can be taken to alleviate or prevent distress or discomfort. The CforC programme described here is based on two components: Firstly, a common (shared) feeling with the world; and, secondly, a way of communicating with the phenomenal world and responsiveness by skillful means (wisdom) to alleviate the suffering (*e.g.* discomfort, fear, doubt, stress, and/or pain) of the other and oneself. The first aspect includes empathy, and common humanity, and the second includes skillful means ("upaya") or activities that help alleviate various forms of suffering. 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. We first focus on the intention of kindness which inspires our motivational systems, and ultimately changes behavioural patterns towards oneself and others.

Compassion-Focused Therapy

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. Gilbert (2009), amongst others, has demonstrated that CFT reduces shame and self-criticism in chronically depressed patients. CFT has also been used with traumatized individuals (Au et al., 2017). It is the first psychotherapy which explicitly uses compassion as both its target outcome and the basis of its tools. CFT addresses issues with shame and self-criticism that often occur in the process of severe illness such as breast cancer (Kaiser, 2008; Taylor, Lichtman, & Wood, 1984). Neff and Pommier (2013) report that greater self-compassion is linked to less anxiety and depression in the general population. 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. Taken together, these findings suggest that

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

Compassion 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. This is particularly important when working with female 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).

Cancer patients often experience symptoms of anxiety, depression, PTSD, pain, insomnia and cognitive impairments (Ahles, Root, & Ryan, 2012). Related to this, in Meyerowitz's seminal work (1980), three psychosocial responses to breast cancer are listed: i) psychological discomfort (anxiety, depression, or anger); ii) behavioural changes caused by physical discomfort, marital or sexual disruption, or altered activity level; and iii) fears and concerns related to body image, recurrence, or death. It should be emphasized that these exacerbate the suffering of the person, beyond what is caused by the physical pain. CFT addresses some of these issues, i.e. anxiety, depression, anger and fears of various natures, but does not address the issue of physical pain (Gilbert, 2010a). Aaronson et al. (2014) emphasize 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 that would include fatigue, anxiety, depression, and sleep disturbance. Taken together, these provide the main focus for CforC.

Of note, some breast cancer patients also describe positive outcomes associated with their experiences including post-traumatic growth (PTG). Werdel and Wicks (2012, p. 12) define PTG as "the positive psychological changes as a result of enduring stress and trauma". 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 emphasizes 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. 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.

To date, there are few studies that focus on the relationship between cancer and compassion. 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; the preliminary results showed that it was a successful intervention.

To summarise, whilst it is acknowledged that there are other contemplative traditions that focus on the issue of psychological management of cancer (for example, mindfulness), 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 stabilizing attention, improving memory function and other cognitive processes (Mrazek, Franklin, Tarchin, Baird, & Schooler, 2013). Often referred to as "sniper's mindfulness" (Ricard, 2015), whilst the interventions include practices which are open, non-judgmental, and focused on the present moment, snipers do not include the qualities of kindness and compassion. Furthermore, the well-meaning intention of mindfulness to reduce our suffering (understood as emotional, physical or relation pain, loss or gain) by means of detaching oneself from the solid identification of 'me-ness' can paradoxically solidify suffering if the compassion component is missing. This may be because 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' being overly invested in oneself; 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 to improve their overall well-being. As Germer and Neff (2013) state: "we give ourselves compassion not to feel better, but because we feel bad" (p. 386), There are certain aspects of life we cannot escape, but we can still learn to suffer less and while not

discarding suffering, we 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.

Method

Background

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 but do not focus on cancer, e.g. mindful self-compassion training (Germer & Neff, 2013), compassion cultivation training (Jinpa, 2015), and compassion-focused therapy (Gilbert, 2009; 2010b). The proposed training integrates ideas from both approaches. The structure of the proposed Compassion for Cancer training for female breast cancer patients and survivors 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. 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; one that focuses on compassion-based exercises (in addition to mindfulness) may be a more helpful intervention for patients with cancer.

The process of developing and adapting many therapeutic and training curricula is often unclear. It can be assumed that the main methods employed by most "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. 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. However, each individual approached had a different idea on how to run and design courses and shared, at times, opposing theoretical views and understanding. This is similar to having supervisors from different schools of psychotherapy – each might give contradictory advice dependent upon their skills perspectives. This additionally influences their philosophy and tools; with these attuned to their own values, personal style and their patients' needs. Given the substantial work on compassion by Gilbert (2009; 2010b), we decided to use an adapted version of CFT.

Theory

When designing a programme, 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 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 skillful 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. Drive concerns being able to finish treatment, going 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.

Insert Figure 1 about here

CforC makes use of various emotion regulation tools (see Figure 2). Drawing on Germer (2011, personal communication), three main emotion regulation skills are included in the curriculum; attention, mindfulness, and compassion. Attention is the ability to focus on one object and sustain attention on it, and the ability to shift focus when necessary. Mindfulness is familiarization with internal and external phenomena by the means of systematic expansion of attention, which is preceded by courage and facilitated by kindness.

Mindfulness allows us to slow down; in doing so, one can soothe as well as provide oneself with safeness. Yet it does not necessarily make us more connected to others. Mindfulness

refers to expanded awareness and moment-to-moment awareness of our body, thoughts, feelings and surroundings. The basic axioms are that awareness and mindfulness are inseparable. Mindfulness also entails equanimity - learning to respond rather than react, to have an "even-minded state" (Desbordes et al., 2015). It also concerns the ability to be with various internal and external phenomena without rejection or aversion. This expanded awareness should implicitly include kindness (gentle way of behaving and acting, gentle facial expression, gentle voice tone) and courage (the willingness, strength and sensitivity to be with difficult phenomena), which leads to compassion. Compassion is, however, the explicit facilitation of these qualities 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 three circular flows/directions (Gilbert, 2010b); 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 we notice that "something is going wrong" in other sentient beings or in ourselves (e.g. some form of suffering). With mindfulness, we can spot suffering, and we can feel empathy which informs us about the situation as well as the probable root of the problem. Through gaining wisdom and our experience, we recognize that suffering stems from the belief in our separateness (Kornfield, 2002). Gilbert (2010) describes compassion as "behavior that aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging, to benefit another person" (p. 217). This differs from empathy, as it provides a motivation to act. Another important aspect of compassion is the explicitness of suffering (the undeniable fact that there is suffering) as a means of developing compassion and post-traumatic growth. Compassionate approaches emphasize the

necessity of learning from one's suffering of all forms (mental, physical, and relational). Compassion unblocks, develops and increases feelings of commonness and togetherness that alleviate belief in our separateness. Taken together, compassion increases both the wisdom 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.

Insert Figure 2 about here

CforC Description of Curriculum

CforC is an 8-week programme with weekly 2.5-hour long sessions. Each session may consist of guided meditations, gentle movement exercises (such as mindful yoga), didactic lecture, and group discussion/inquiry, which is part of the experiential learning/psychological debriefing process after each exercise. The course also includes a half-day session on a Saturday after week six. The half-day practice includes 4 hours of practice and 1 hour of group discussion. Between classes, students deepen their participation by practicing 10-30 minutes a day with meditation CDs and have daily home assignments, described in their Home Practice Manual. The main practices include (1) contemplative meditation, (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 rhythm breathing and awareness of breathing practices enable participants to have access to the soothing/contentment system (Gilbert, 2010a). In turn, this allows participants to explore more visual and possibly emotionally

stimulating practices of compassion (various compassion-based practices and exercises) and emptiness (contemplative meditation). Emptiness is understood as the ability to expand one's mental parameters and detach oneself from formal concepts of self (Hopkins & Napper, 1996).

Eight weekly sessions (themes) have been designed and included in the final version of CforC. Each session 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.

In the first session, it was important to primarily establish the skills of attention and mindfulness (groundedness was emphasized) before practicing compassion, as the latter can trigger challenging memories (Gilbert, 2009). Participants need to first stabilize 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. They also learn to physiologically and mentally self-soothe (e.g. by using the soothing rhythm breathing practice). They also need to 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, 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 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.

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 safeness and 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 brain vs. old brain), and the means to alleviate some amount of this suffering (compassion). During the first two sessions, the concepts of attention, mindfulness and compassion are explained as the three tools to regulate our emotions and emotional states.

The next six sessions focus more directly on specific compassion-based exercises and aim to teach participants to look at their experiences and themselves from a compassionate perspective, irrespective of the nature of the experience. The training course ends with a recap of all the practices and provides an opportunity for the participants to choose their own set of practices. An evaluation of the first trial of CforC is outlined below.

Pilot study

Participants

The first trial of CforC focused on a non-clinical population to ensure the practices were of practical value. The inclusion criteria included physically and mentally healthy females, between the ages of 30 and 65 years. No previous experience of mindfulness and/or compassion practices was required. Participants were recruited by email from university staff mailing and from people interested in compassion (via the Compassionate Mind Foundation), and face-to-face from free practice mindfulness evenings. Eleven female participants were recruited; 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 1). Prior to being recruited, all participants completed a registration form to evaluate mental and physical health. Based on this evaluation, they were excluded if they had any of the following: 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 behavior, suicide risk, learning disability, personality disorder, and/or severe social anxiety.

Insert Table 1 about here

Procedure

Each 2.5-hour session was dedicated to a different theme and was comprised of various contemplative practices, followed by discussion; one break for coffee was also included. All sessions were conducted by Julia Wahl who is a psychologist and a mindfulness/compassion teacher with eight years of experience. 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 1). 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, additional issues). At the end of the programme participants were also invited to a focus group. 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.

Data analysis overview

The analysis was based on participants' written evaluation after each session (W1); written evaluation after the whole training (W2) (see Table 2); and their focus group contributions at the end of the programme (focus group questions were based on the W1 and W2 feedback). Thematic analysis was used to identify recurrent themes (patterns of meaning) in the data. This analysis was employed collectively across questions from both forms and the focus group, rather than for each open-ended question/form individually. The aim of the analysis was to understand participants' experiences of the pilot programme.

Insert Table 2 about here

Results

Four themes (see Figure 3.) were identified as (1) "gaining mental awareness", (2) "gaining bodily awareness", which included two subthemes: "lessening pain" and "gaining strength", (3) "slowly growing in compassion" with two subthemes: "reflecting on intentions" and "growing and changing understanding of mindfulness", and (4) "practical considerations". These themes focused on the participants' experiences and training processes. The first three themes have been

described by classifying meditative practices into three groups that have different cognitive mechanisms: Attentional (attention regulation and meta-awareness), constructive (perspective taking and reappraisal) and deconstructive mechanisms (self-inquiry; Dahl, Lutz, & Davidson, 2016).

Insert Figure 3 about here

Theme 1: Gaining mental awareness

This theme signified gaining insight (as an ongoing process) into, and stabilizing 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, becoming more mentally and emotionally resilient:

> *"…in regards where I was emotionally, these spiraling 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 spiraling 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 (which supports previous findings). The healthy participants may have perceived losses; 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 (Eric Cassell, personal communication, 2015); this includes understanding one's difficult emotions. This aspect should be emphasized in future training programmes. 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 employ more body-oriented practices and repeat these throughout the course of the training, to help patients gain bodily awareness in helping them lessen symptoms of pain and gain strength (groundedness in the body).

a) Lessening pain

This subtheme 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). The course would therefore aim to lessen the mental pain (suffering) and be able to gain a new perspective:

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

b) *Discovering strength*

This subtheme 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 in order to be with it. As a result, specific exercises have been incorporated into the curriculum. The "discovering strength" subtheme also highlights a critical issue for future courses that are aimed for 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 subthemes: "reflecting on intentions" and "growing and changing understanding of mindfulness". It was the most important, comprehensive, and prevalent theme. It included: Reflecting on 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 conceptualize 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 as 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 resource for all appropriate situations (including difficult ones). Working with or on compassion starts with reflecting on intentions; the issues, values that one wants to focus on in life, thus activating motivation which ultimately change 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 did they want 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 helped 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, defusion* 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. 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 (enables to access 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 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 (classroom and the ethos of academia) when one sits in a class 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 we 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 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.

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 evaluations after each session, an evaluation after the whole training programme and from 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 (meta-awareness). The latter, meta-awareness, 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, it also includes introspective metacognition (Dorjee, 2016) or what we 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 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 bodily with the cognitive and affective parts. It also included a stronger sense of self: this sense of self constantly changes, depending on how one feels, 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), and teach participants to respond to these with compassion (Chapin et al., 2014); this 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, sessions' 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).

Clinical observations included noticing the group and individual processes during formal sessions. Two recommendations stem from this. Firstly, a limited number of participants would 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 (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, 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 practice systematically build their motivation which 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 practice 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's 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, 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 practicing (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 concerns the nature of a contemplative

training environment; 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).

Based on the described benefits and recommendations, compassion practice helps practitioners not only in coping better with thoughts, emotions, and physical circumstances, but may also warm up the 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 resiliency. When referring to MBSR, Santorelli (1999) called it a "'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 clinical population of cancer patients, future research will examine the benefits of the CforC programme on 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 current course as well as its effectiveness.

Overall, we found that the 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 and with potentially radical changes in 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.

Compliance with Ethical Standards

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.
Informed consent: Informed consent was obtained from all individual participants included in the study.

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. doi.org/10.1016/j.ejcsup.2014.03.005

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. 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. doi.org/10.1200/JCO.2012.43.0116

Angiola, J. E., & Bowen, a. M. (2012). Quality of Life in Advanced Cancer: An Acceptance and Commitment Therapy View. *The Counseling Psychologist*, *41*(2), 313–335. doi.org/10.1177/0011000012461955

Au, T. M., Sauer-Zavala, S., King, M. W., Petrocchi, N., Barlow, D. H., & Litz, B. T. (2017). ScienceDirect Compassion-Based Therapy for Trauma-Related Shame and Posttraumatic Stress : Initial Evaluation Using a Multiple Baseline Design. *Behavior Therapy*, *48*(2), 207–

221. doi.org/10.1016/j.beth.2016.11.012

Bstan-'dzin-rgya-mtsho, D. L. X., & Thupten Jinpa. (1995). *The power of compassion: a collection of lectures by His Holiness the XIV Dalai Lama ; translated by Geshe Thupten Jinpa*. London, UK: Thorsons.

Buswell, R. E., & Lopez, D. S. (2013). *The Princeton dictionary of Buddhism*. Princeton, NJ: Princeton University Press.

Calhoun, L. G., & Tedeschi, R. G. (Eds.) (2006). *Handbook of posttraumatic growth: research and practice*. New York, NY: Lawrence Erlbaum Associates.

Carlson, L. E., & Speca, M. P. (2010). *Mindfulness-based cancer recovery : a step-by-step MBSR approach to help you cope with treatment & reclaim your life*. New Oakland, CA: Harbinger Publications.

Cassell, E. J. (2004). *The nature of suffering and the goals of medicine*. Oxford, UK: Oxford University Press.

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. doi.org/10.1186/s40639-014-0004-x

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. doi.org/10.1002/cpp.718

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. doi.org/10.1016/j.tics.2015.12.005

Davies, J. (James P. (2012). *The importance of suffering: the value and meaning of emotional*

discontent. London: Routledge.

Dąbrowski, K. (1979). *Dezintegracja pozytywna*. Warszawa: Poland: Państwowy Instytut Wydawniczy.

Desbordes, G., Gard, T., Hoge, E. A., Hölzel, B. K., Kerr, C., Lazar, S. W., Vago, D. R. (2015). Moving beyond mindfulness: Defining equanimity as an outcome measure in meditation and contemplative research. *Mindfulness, 6,* 356–372 356–372. doi.org/10.1007/s12671-013-0269-8

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. 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*, 1–15. doi.org/10.3389/fpsyg.2016.01788

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. doi:10.1371/journal.pone.0133481

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.

Gendlin, E. T. (1998). *Focusing-oriented Psychotherapy: A Manual of the Experimental Method*. New York, NY & London, UK: Guilford Press.

Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology*, *69*(8), 856–67. doi.org/10.1002/jclp.22021

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208. 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, UK: Constable & Robinson.

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. doi.org/10.1007/s12671-014-0302-6

Hansen, G. R., & Streltzer, J. (2005). The Psychology of Pain, Emergency Medicine Clinics of North America, 23, 339–348. doi.org/10.1016/j.emc.2004.12.005

Hopkins, V., & Kuyken, W. (2012). Benefits and barriers to attending MBCT reunion meetings: An insider perspective. *Mindfulness*, *3*(2), 139–150. 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.

Jinpa, T. (2015). *Fearless Heart.* London, UK: Piatkus Books.

Kabat-zinn, J. (2003). Mindfulness-Based interventions in context: Past, present, and future. (2002), 144–156. 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. doi.org/10.1080/14639947.2011.564844

Kaiser, K. (2008). The meaning of the survivor identity for women with breast cancer. *Social*

Science and Medicine, *67*(1), 79–87. doi.org/10.1016/j.socscimed.2008.03.036

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. 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., 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. doi.org/10.1016/j.pec.2008.10.003

Kornfield, J. (2002). *A Path with Heart: The Classic Guide through the Perils and Promises of Spiritual Life*. New York, NY: Bantam Books.

Krippner, S. (2017). The Mind-Body-Spirit paradigm: Crisis or opportunity ? *American Journal of Clinical Hypnosis*, *56*, 210–215. doi.org/10.1080/00029157.2014.857503

Meyerowitz, B. E. (1980). Psychosocial correlates of breast cancer and its treatments. *Psychological Bulletin*, *87*(1), 108–131. doi.org/10.1037//0033-2909.87.1.108

Mrazek, M. D., Franklin, M. S., Tarchin, D., Baird, B., & Schooler, J. W. (2013). Mrazek, M. Mindfulness training improves working memory capacity & GRE performance while reducing mind wandering. *Psychological Science*, *24*(5), 776-781. doi.org/10.1177/0956797612459659

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. doi.org/10.1080/15298868.2011.649546

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. doi.org/10.1016/j.jrp.2006.08.002

Norcross, J. C., & Goldfried, M. R. (2005). *Handbook of Psychotherapy Integration*. Oxford, UK: Oxford University Press.

Pace, T. W. W., Negi, L. T., Adame, D. D., Cole, S. P., Sivilli, T. I., Brown, T. D., … Raison, C. L. (2009). Effect of compassion meditation on neuroendocrine, innate immune and behavioral responses to psychosocial stress. *Psychoneuroendocrinology*, *34*(1), 87–98. doi.org/10.1016/j.psyneuen.2008.08.011

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. doi.org/10.1002/cpp.1838

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*(4), 348-359.

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 ?, *9*(7), 824–835. doi.org/10.1111/j.1526-4637.2007.00391.x

Ricard, M.(2015). *Altruism: The Power of Compassion to Change Yourself and the World*. London, UK: Atlantic Books.

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. doi.org/10.1037/a0023861

Rosenbaum, E., & Kabat-Zinn, J. (2012). *Being Well (even when you're sick): Mindfulness Practices for People with Cancer and Other Serious Illnesses*. Boston: MA: Shambhala.

Santorelli, S. (1999). *Heal Thy Self: Lessons on Mindfulness in Medicine*. New York, NY: Bell

Tower.

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, 22*(5), 487–497. doi.org/10.1037/0278-6133.22.5.487

Smith, R. (2010). *Stepping Out of Self-deception: The Buddha's Liberating Teaching of No-self*. Boston, MA: Shambhala.

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*, 85–93. doi.org/10.1348/135910707X250866

Taylor, S. E., Lichtman, R. R., & Wood, J. V. (1984). Attributions, beliefs about control, and adjustment to breast cancer. *Journal of personality and social psychology, 46*(3), 489.

Trungpa, C., Baker, J., & Casper, M. (2002). *The Myth of Freedom and the Way of Meditation*. Boston, MA: Shambhala.

Van Oudenhove, L. & 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, Healthcare and Philosophy, 17*(2), 201-213. doi: 10.1007/s11019-013-9521-1

Werdel, M. B., & Wicks, R. J. (2012). *Primer on Posttraumatic Growth: An Introduction and Guide*. Hoboken, NJ: John Wiley & Sons.

Table 1 – Information on Participants

Participants (pseudonyms)[i]	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

Table 2 – 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?

[i] All of the names have been changed