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Holistic Healing for Women With Breast Cancer Through a Mind, Body, and Spirit Self-Empowerment Program

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This article reports results of an integrated mind-body-spirit self-empowerment program for breast cancer survivors. Fifty-one women at various stages of breast cancer completed a series of eclectic lessons offered in a support group format. The program followed an integrated and cumulative lesson plan that progressively and systematically introduced multiple strategies for creating a balance among mental, emotional, spiritual, and physical health. The program's goals were to enable participants to experience a reduction in distress, improve perceived quality of life, reach a deeper sense of meaning and purpose in life, and experience a greater sense of perceived wellness. Self-assessments were obtained on four well-documented measures relating to both pre- and postprogram participation. Differences in pre- and postscores showed statistically significant improvement and large estimated effect sizes on all four measures. Participants' written comments provide examples of the scope and benefits of the program.

Keywords: *nursing; holistic healing; theory-based intervention; self-empowerment; breast cancer*

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As a life-threatening and life-altering disease, a cancer diagnosis produces an emotionally jarring experience accompanied by multiple stressors, challenges, and disruptions (Simonton & Sherman, 1998). Response to a breast cancer diagnosis has been characterized by the National Cancer Institute (1997) as eliciting greater distress than any other diagnosis, requiring a woman to draw on many resources—both within herself and externally—first to survive, then to recover, and finally to heal.

There is a *before* and an *after* the cancer diagnosis event that brings ordinary life to an end and challenges the individual's view of the world, self, and future (Howell & Fitch, 2002; Moadel et al., 1999). Bolen (1998), a Jungian psychoanalyst, eloquently described the experience as a "soul event":

We are in uncharted terrain, and there is no turning back. Illness is a profound soul event, and yet this is virtually ignored and not addressed. Instead, everything seems to be focused on the part of the body that is sick, damaged, failing, or out of control. (p. 14)

This existential distress and its effect on the individual's sense of well-being often continues beyond completion of the prescribed medical treatment. McKinley (2000) explained what she calls the "uncertainty of survivorship" this way:

Being in the midst of active treatment means being seen regularly by a nurse or a physician—being cared for. As I got up off that radiation table for the last time and walked away, I found myself alone with a cancer ghost who would not let me forget where I had been or allow me to freely choose where I might be going. (p. 479)

This article describes an interdisciplinary, nursing theory-based program designed to help women with breast cancer adjust to their changed lives and to develop ways to better utilize their internal and external resources for survival, recovery, and healing. The Mind, Body, and Spirit Self-Empowerment Program (MBSSP) introduces

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breast cancer survivors to integrative strategies for becoming active and informed participants in creating a balance among mind, body, and spirit. It combines the authors' backgrounds in nursing and theology with experiences in group interventions, theory-based nursing practice, and spiritually based wellness programs. The 12-week program uses a support group format with weekly 3-hour sessions on mind, body, and spirit education, focusing and relaxation techniques, stress reduction and coping skills, guided imagery and meditation practices, and dream interpretation. Program materials are eclectic, combining Eastern and Western philosophies with theories from mystical and contemporary psychology.

The MBSSP's outcome was evaluated through self-report assessments on four well-validated instruments administered prior to the beginning and on completion of the program. Statistically significant improvement and large effect sizes were observed on all four quantitative measures. Also, participants were asked to describe orally and in writing any benefits and concerns associated with the program. These comments provided some insights into the scope of changes reflected in their self-assessments.

BACKGROUND

Research shows that patients' subjective impressions of their illness and their own coping skills strongly influence their survival processes. For example, tests of the stress and coping model of Lazarus and Folkman (1984) suggest that those who view disease as more threatening or who have little confidence in their ability to handle illness-related problems are more likely to be distressed (DeLongis, Folkman, & Lazarus, 1988; Kanner, Coyne, Schaefer, & Lazarus, 1981). Individuals who cope by relying on avoidance or denial experience greater distress than do those using other coping patterns (Carver et al., 1993; Manne et al., 1994; Stanton & Snider, 1993). Those who feel more isolated and who perceive limited emotional support from others experience greater adjustment problems (Bloom, 1986; Bloom & Spiegel, 1984). Shorter survival in cancer patients has been associated with emotional distress and depression (Gilbar, 1997; Watson, Haviland, Greer, Davidson, & Bliss, 1999), and increased psychological distress has been shown to correlate with disease progression and poorer health (Andersen, Kiecolt-Glaser, & Glaser, 1994; Cohen & Williamson, 1991).

Support group intervention research indicates that active participation in such a group can contribute significantly to the quality of life (Spiegel et al., 1999) and to the survival rate of women with advanced breast cancer (Spiegel, Bloom, Kraemer, & Gottheil, 1989). An especially relevant intervention study of women with advanced breast cancer by Spiegel et al. (1989) shows that women in a mind and body program offered in conjunction with their conventional cancer treatments lived twice as long as those who did not participate (36 months vs. 18 months). This program consisted of visualization techniques, meditation, and guided imagery taught in weekly group sessions. Other research has shown that guided imagery and visualization practices can lead to physiological changes that help to strengthen the body's natural defenses and immune functions (Kogon, Biswas, Pearl, Carlson, & Spiegel, 1997; Spiegel & Moore, 1997).

Evidence is mounting that psycho-educational, supportive-expressive, and mind-body intervention programs are effective in reducing distress and improving quality of life for cancer patients. These interventions typically incorporate multiple components, including behavioral, cognitive, and supportive-expressive techniques, and are often described as holistic or mind-body approaches (Blake-Mortimer, Gore-Felton, Kimerling, Turner-Cobb, & Spiegel, 1999; Carlson, Ursuliak, Goodey, Angen, & Specca, 2001; Cotton, Levine, Fitzpatrick, Dold, & Targ, 1999).

The spiritual component of the mind, body, and spirit construct and the combination of the three have received much less research attention than have the mind and body components individually. For example, a keyword electronic search of the PubMed database revealed only two articles (Mytko & Knight, 1999; Targ & Levine, 2002) discussing the joint effects of all three factors. The spiritual component may elude understanding because it is less tangible than the physical or mental components. Yet spirituality has been described as "the essence of being," the unfolding awareness of who and what we are, our purpose in being, and our inner resources; spirituality "shapes our life journey" (Burkhardt & Jacobson, 2000, p. 94).

Further, spiritual need has been defined as "the need for meaning, purpose and fulfillment in life: hope/will to live, belief and faith" (Ross, 1995, p. 457). As Burkhardt and Jacobson (2000) indicated, "spiritual issues are core 'life issues' " (p. 97) that bring us to look deep within ourselves. Addressing spiritual needs is "vital to the process of discovering meaning and purpose in life" (Burkhardt,

1998, p. 128). Facing a serious illness often presents individuals with their first experience of confronting a soul event that in turn may inspire them to direct their attention to such existential concerns as finding one's meaning and purpose in life (Kinney, 1996).

The present study presumes that a truly holistic approach used to address a soul event, such as being diagnosed with breast cancer, should incorporate a person's spiritual needs along with mental and physical needs. In a review of the nursing literature, Baldacchino and Draper (2001) indicated that holistic care incorporates various spiritual coping strategies to safeguard the wholeness and integrity of those with cancer. Moreover, nursing care directed at the whole person "emphasizes healing and maintenance of health where disease or illness is viewed as part of the whole; it is seen as a positive opportunity for growth" (Rew, 1996, p. 35).

Fortunately, the modeling and role-modeling (MRM) integrative nursing theory provides guidance for including spirituality in holistic care, and it posits that the individual's view of his or her life and experiences are key to the provision of such care (Erickson, Tomlin, & Swain, 1983/1988). Within this nursing paradigm, the spiritual component is viewed as an integral aspect of the whole of the individual where "the whole is greater than the sum of the parts," "conscious and unconscious processes are of equal importance," and "most useful changes result from a blend of both" (Erickson et al., 1983/1988, p. 45).

The MRM theory delineates a foundation for understanding the individual's worldview and provides guidance for facilitating optimal well-being. Specifically, individuals are seen as holistic beings, composed of multiple interactive components including cognitive, biophysical, psychological, and social subsystems. Intersecting all four components is a genetic base and spiritual drive (or what might be called the drive for a sense of meaning and purpose in life).

The MRM theory also asserts that humans have continuous mind-body-spirit interactions that are both inherent and learned. Further, the potential and innate drive to grow and develop is present across the life span. Health is a dynamic state of holistic well-being that is a result of positive adaptation to internal and external stressors through the mobilization of self-care resources (Erickson et al., 1983/1988). The theoretical principles of MRM provide the foundation for the philosophy and approaches used in the MBSSP.

DESCRIPTION OF THE MBSSP

The MBSSP builds on a mind, body, and spirit program originally developed and tested with persons with multiple sclerosis (Rodgers, Khoo, MacEachen, Oven, & Beatty, 1996) and then modified for those experiencing various types of cancer (Rodgers, Beltz, & Oven, 1997). Specifically, the goals of the MBSSP are to enable women with breast cancer to experience a reduction in distress, improve perceived quality of life, reach a deeper sense of meaning and purpose in life, and experience a greater sense of perceived wellness. The MBSSP encourages participants to examine the meaning that having breast cancer has for them, to explore and express their feelings and concerns in a safe and supportive environment, and to develop new self-care resources to assist them in coping with the increased stresses imposed by their diagnosis, treatment, and recovery.

The MBSSP for the present study was offered over a 12-week period with one 3-hour meeting each week. The support group format encouraged and facilitated expression of feelings and helped group members build understanding that they were not alone in facing particular issues in their own lives. The program followed an integrated and cumulative lesson plan that progressively and systematically introduced multiple strategies for creating a balance between mental, emotional, spiritual, and physical health. The balance was intended to help participants shape the cancer diagnosis into an opportunity for personal growth and transformation.

The lesson series presented a wide range of topics including: developing willpower, a conceptual model of the mind, the healing power within, the benefits of meditation, dream symbolism and interpretation, developing intuition, developing intimacy, getting in touch with and expressing emotions, and acknowledging and experiencing gratitude and abundance. During each group meeting the lesson material was read and discussed, and participants were asked to reread the written material each day between the meetings.

At strategic points throughout the program, participants learned and practiced exercises designed to help them develop mental discipline and to enhance their ability to mobilize their own innate healing capabilities. Various methods of meditation were introduced to promote increased awareness of inner wisdom and guidance. Participants were asked to keep a dream journal because remembering and understanding symbolism and messages of dreams is often an effective method for increasing communication with the inner,

subconscious mind (Condrón, 1997). During group meetings, participants' dreams were shared and interpreted using Condrón's (1997) dream interpretation method.

Facilitator-led guided imagery was offered during each meeting. Participants were assisted in creating mental images that would help them relax, release anxieties, create positive expectations, and tap inner healing resources. Guided imagery audiotapes were provided for participants' use between meetings.

The importance of communicating thoughts and concerns and expressing feelings, emotions, and needs to others was emphasized throughout the program. Participants were encouraged to set goals for themselves and to discuss ways they could apply what they were learning in the program to their everyday lives.

Notebooks were provided so the participants could keep lesson materials organized and readily available to them. In addition to the weekly distribution of lesson materials, logs outlining the exercises to be practiced and an affirmation to be read each day of the subsequent week were provided. An example of a daily affirmation developed for the program is,

I have come into this life with all the potential and capability that I need. I can fulfill my highest aspirations as I recognize the beauty of each step. Labels that define me as limited or inadequate are not a part of my reality. I remove all labels or judgments from my thoughts that do not fit my real identity. As I peel off each outgrown or untrue label—I will see inner beauty, strength and worth come into light. I am WHOLE and HEALTHY.

Each homework assignment required approximately 45 minutes per day. Therefore, participants had to commit to making time for themselves each day for the purpose of focusing on self-discovery, self-healing, and self-empowerment. Progress on homework assignments was discussed weekly during the group meeting and participants submitted their exercise logs for review.

During each group session, group facilitators (the first two authors and three similarly prepared professionals trained by the authors) provided guidance and feedback to the participants and helped them interpret their experiences into an integrated whole. Consistent with MRM, facilitators provided an atmosphere of nurturance, guidance, and unconditional acceptance and conveyed understanding of the participant's perspective or model of the world. Then through role modeling, the facilitator promoted growth, health, and well-being

through individualized responses consistent with the participant's perspective. For example, as concerns of participants emerged naturally from a group's interactions, the facilitators linked the relevance of the concerns to general issues experienced by women with breast cancer and assisted the participants in reframing difficult situations into potential learning opportunities.

In summary, the strategies implemented in the MBSSP were designed to introduce participants to self-empowerment techniques that would help them become advocates for their own health and life. The overall program goals were to help participants utilize internal and external resources that enhance awareness of their spiritual nature, learn methods to improve physical and emotional health, and experience a greater sense of purpose and meaning in life.

METHOD

Design

To evaluate the effectiveness of the MBSSP, a cross-sectional descriptive study was conducted using a single group pre- and post-test design to assess differences in MBSSP participants on measures of depression, general quality of life, spiritual well-being, and perceived wellness. This study received institutional review board approval from the University of Texas Medical Branch at Galveston.

Procedure and Sample

A convenience sample was recruited by the authors through contacts with local breast cancer service organizations and physician referrals in three urban southwestern communities. A broad cross-section related to phase of treatment was desired so no restrictions were placed on time since cancer diagnosis. During recruitment, the MBSSP and the study were explained to potential participants and signed informed consents were obtained. Baseline self-assessments were completed before the first group meeting and posttest self-assessments were obtained immediately following completion of the program.

Seven groups were conducted by MBSSP-trained facilitators. The group sizes ranged from 4 to 10 participants each with a total of 51 participants. All participants were female; the age range was from 38 to 78 years with a mean age of 55 years ($SD = 9.9$). Group sizes were

TABLE 1
Demographic Characteristics (N = 51)

	<i>Number (Percentage)</i>
Education	
High school graduate	6 (11.8)
Some college	8 (15.7)
Undergraduate degree	13 (25.5)
Graduate degree—master's/Ph.D., professional	24 (47.1)
Religious background	
Catholic	13 (25.5)
Protestant	26 (51.0)
Judaism	3 (5.9)
Nondenominational	4 (7.8)
Other	5 (9.8)
Marital status	
Single	6 (11.8)
Married	33 (64.7)
Divorced	10 (19.6)
Widowed	2 (3.9)
Years since breast cancer diagnosis	
2 or fewer	35 (68)
3 to 5	6 (12)
More than 5	9 (18)
Not reported	1 (2)

too small to allow statistical tests of demographic differences across groups, but no concentrations of demographic characteristics were noted within groups.

Instruments

Four self-report instruments (described below) were used to quantify relevant effects of the MBSSP, and participants were asked to provide oral and written descriptions of any benefits they believed that they gained from the program. The quantitative instruments were:

1. Beck Depression Inventory (2nd ed.) (BDI-II)
2. Functional Assessment of Chronic Illness Therapy–Breast Cancer (FACT-B)
3. Functional Assessment of Chronic Illness Therapy–Spirituality (FACIT-SP)
4. Perceived Wellness Survey (PWS)

BDI-II. The BDI-II, a 21 item self-report instrument, was used to assess the participant's level of depression as an indication of degree of psychological distress (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI-II takes approximately 10 to 20 minutes to complete; each item contains four statements and uses a 4-point response format. Items are scored from 0 through 3, with higher scores indicating a higher degree of distress.

Beck et al. (1961) developed the original BDI. The depressive symptoms listed in the instrument reflected descriptions by patients who had been diagnosed with depression. Two extensive reviews of the BDI's applications and psychometric properties support its reliability and validity in various clinical populations (Beck, Steer, & Garbin, 1988; Steer, Beck, & Garrison, 1986). Content validity of the revised items for the BDI-II was addressed, in part, by modifying the original items to reflect the criteria for depression listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (American Psychiatric Association, 1994).

Information about the psychometric properties of the BDI-II (Beck et al., 1988) included alpha internal consistency estimates from .92 to .93. Test-retest reliability estimates for stability were reported at .93 ($p < .001$) for data collected from a sample of 26 adult outpatients diagnosed with depression (Beck et al., 1988). The BDI-II is also positively correlated with the Beck Hopelessness Scale (Beck & Steer, 1988) and the Scale for Suicide Ideations (Beck, Kovacs, & Weissman, 1979), offering support for the construct validity of the BDI-II. Coefficient α reflecting internal consistency for the MBSSP sample was .92 for the pretest and .86 on the posttest.

FACT-B. Both FACT-B and FACIT-SP are from a collection of quality-of-life questionnaires based on the more widely known FACT survey series. The FACT surveys measure the functional assessment of cancer therapy and many versions are currently available, each specific for a different form of cancer therapy. The measurement system began with the development of the FACT-G (general) in 1987 (Cella, 1997). The FACT-G is a 27-item quality-of-life questionnaire divided into four main areas of well-being: physical, social/family, emotional, and functional. It is appropriate for use with clients with any form of cancer.

The FACT-B version of the FACT is specifically intended for individuals with breast cancer. FACT-B is a self-report instrument designed to measure multidimensional quality of life in breast cancer

survivors and takes approximately 10 minutes to complete. It contains the 27 items from the FACT-G with 9 additional items that specifically address breast cancer. The items are presented with a 5-point response scale with the two anchors of 0 = *not at all* and 4 = *very much*.

Item development for the FACT-B was guided by intensive interviews conducted with breast cancer patients and experts in breast cancer research. Content experts then reviewed the initial item pool and only items rated as highly important were retained, resulting in a 44-item tool. Total scores can range from 0 to 144, with higher scores indicating a higher quality of life. Brady et al. (1997) reported internal consistency reliability estimates with coefficient $\alpha = .90$. Overall, the FACT-B demonstrates reliability and validity. Internal consistency estimates for this sample (coefficient α) were .94 for both the pre- and posttests.

FACIT-SP. This instrument, also known as the spiritual well-being subscale (Brady, Peterman, Fitchett, Mo, & Cella, 1999), was designed to measure various aspects of spirituality and to provide an overall assessment of spiritual well-being. It is designed for use without regard to particular religious beliefs. Rather, it assesses aspects of spirituality and existential concerns related to one's sense of life meaning and peace and the role of faith in illness. The FACIT-SP has 12 items with a 5-point response scale with the two anchors 0 = *not at all* and 4 = *very much*. Higher scores indicate higher levels of spirituality.

Reliability and validity estimates reported in the FACIT-SP manual (Cella, 1997) for a sample of 1,617 adults are .87 for the overall scale. Convergent validity of the FACIT-SP with other measures of religion and spirituality underscores its usefulness for measuring nonreligious spirituality in quality of life. The total score for overall spiritual well-being was used in this study. The coefficient α internal consistency estimate for the pretest was .78 and .81 on the posttest.

PWS. This instrument, developed by Adams, Bezner, and Steinhardt (1997), is a 36-item self-report instrument measuring an adult's perceived wellness on the physical, spiritual, psychological, social, emotional, and intellectual dimensions. Each dimension has six items that are scored from 1 = *very strongly disagree* to 6 = *very strongly agree*. An individual's scores are averaged across questions, and mean scores range from 1.00 to 6.00 with higher mean scores indicating higher levels of perceived wellness.

TABLE 2
Differences in BDI-II, FACT-B, FACIT-SP,
and PWS Among MBSSP Participants

	M	SD	t	Coefficient α	R ²
BDI-II (<i>n</i> = 45)					
Pre-MBSSP	10.20	8.12		.92	
Post-MBSSP	5.77	6.53		.86	
Difference	-4.42	6.23	-4.76*		.33**
FACT-B (<i>n</i> = 46)					
Pre-MBSSP	78.78	18.63		.94	
Post-MBSSP	116.41	19.54		.94	
Difference	36.02	16.68	15.87*		.84**
FACIT-Sp (<i>n</i> = 42)					
Pre-MBSSP	32.85	9.13		.78	
Post-MBSSP	36.45	5.93		.80	
Difference	3.59	7.65	3.04*		.18**
PWS (<i>n</i> = 43)					
Pre-MBSSP	4.29	0.69		.92	
Post-MBSSP	4.52	0.58		.90	
Difference	0.22	0.42	3.60*		.21**

NOTE: BDI-II = Beck Depression Inventory (2nd ed.); FACT-B = Functional Assessment of Chronic Illness Therapy–Breast Cancer; FACIT-SP = Functional Assessment of Chronic Illness Therapy–Spirituality; PWS = Perceived Wellness Survey; MBSSP = Mind, Body, and Spirit Self-Empowerment Program.

* $p < .01$. **"large" effect size (see Cohen, 1988, p. 228).

Content validity was addressed during item development by using a comprehensive review of the literature and a test grid for test construction. Reliability estimates determined for data from 558 adults were reported at $p = .91$ for the total scale. A factor analysis of the data from the original adult sample supported perceived wellness as a unidimensional concept (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2000). The coefficient α internal consistency estimate for the total scale for the MBSSP sample was .92 on the pretest and .90 on the posttest.

RESULTS

To evaluate the effects of the MBSSP on the participants, paired sample t tests were used to compare pre- and postintervention scores

measured on the BDI, FACT-B, FACIT-SP, and PWS. Sample sizes vary across tests due to incomplete pre- or post-MBSSP responses for some participants. Results are shown in Table 2.

Participants showed statistically significant improvement in posttest self-assessments on all four measures, with $p < .01$ in all cases (a Bonferroni adjustment was used for multiple significance tests). In addition to the statistically significant improvements, the model R -squared indicates large effect sizes for all four measures suggesting potential practical importance of the changes in the measures at posttest (see Cohen 1988, p. 228).

To assess possible differences in responses due to marital status, education level, and time since diagnosis, independent sample t tests for each of the measures of well-being compared the modal category to the rest of the sample. For example, married women were compared with single, divorced, and widowed women as a group. With the exception of the depression scores (BDI-II), there were no significant differences on the modal demographic tests for any of the difference measures. Both pre- and post-MBSSP BDI-II scores for those in the group who were 2 or fewer years from cancer diagnosis at the start of the program were nominally higher (more depressed) than those who were more than 2 years from diagnosis, and BDI-II scores decreased significantly for both groups. However, those in the 2 or fewer years group exhibited a significantly larger decrease in scores at $p = .001$ (one-sided).

DISCUSSION

The results of this initial implementation of the 12-week MBSSP show improvement in the participants' self-assessments of health and well-being on all four quantitative measures. After the MBSSP, participants assessed themselves as lower on the scale for depression (particularly those who were 2 or fewer years from cancer diagnosis) and higher on the scales for general quality of life, spiritual well-being, and perceived wellness. The biggest improvement was on the FACT-B quality of life measure designed especially for breast cancer survivors. The large change may reflect the value of a support group comprised entirely of breast cancer survivors. The difference may also be due to particular components of the MBSSP that were tailored to breast cancer. Future research may help determine relative causation. The other FACT-based score, the FACIT-SP, reflects spiritual well-

being and showed substantial effect size, although the difference was smaller than for FACT-B.

The two FACT-based scores can be compared with means reported in Cotton et al. (1999). That study of women diagnosed with breast cancer showed FACT-B mean scores of 95.86 ($n = 142$, $SD = 18.76$). Thus, prior to the program, the MBSSP participants' mean score of 78.78 on FACT-B was about 1 standard deviation lower than the mean score of those in the Cotton et al. study. After the program, the mean score of 116.41 was about 1 standard deviation higher than the Cotton et al. study.

For FACIT-SP, the Cotton et al. (1999) group scored 28.34 ($n = 130$, $SD = 9.24$). The MBSSP participants scored above the Cotton et al. group both before the MBSSP ($M = 32.85$) and after ($M = 36.45$). On one hand, MBSSP participants may have been more conscious of the spiritual dimension as evidenced by their higher initial FACIT-SP scores and may have chosen to participate because of this awareness. On the other hand, the FACIT-SP improvement may indicate that programs such as the MBSSP can substantially improve participants' self-assessments of their spiritual well-being, even when participants already score high on FACIT-SP and may have been subject to a "ceiling effect" on the measure. These results could mean that the spirituality component of the mind-body-spirit combination is subject to intervention, as are the mind and body components.

Finally, the BDI-II assessing degree of emotional distress, and the perceived wellness measure, PWS, also showed statistically significant improvements and substantial effect sizes for the improvements. Both are encouraging and warrant further study.

As with any empirical study, limitations apply to the present study. For example, due to the nature of the program, we were unable to conduct a null-treatment or "placebo" group for comparison. Also, due to the desire for a broad cross section of time since cancer diagnosis, we could not track potential participants at comparable stages prior to beginning the MBSSP. Thus, the findings may have resulted, in part, from the interest, concern, and support provided by the facilitator, or as a function of the time since a participant's diagnosis and treatment. Also, participants who most wanted to improve their health and well-being and who had more resources to do so may have self-selected into the program.

As to written comments by participants, each was asked to describe in her own words the benefits, if any, that she had received from the MBSSP. More than three fourths of the participants (40 of 51) com-

pleted an open-ended comment form. The following excerpts reflect the breadth of comments received.

This was one of the most difficult things I've done. In spite of this, there are several ways in which I see the differences that the class has made in me. I am calmer now and am better able to focus on the task at hand. . . . I feel at peace more than I used to and confident of decisions I make.

—Middle school teacher

Your course has brought me the tool of visualization, an ability that has long eluded me. For this major addition to my life, I am tremendously grateful. . . . I can really achieve insight into what I truly feel about issues, wish to do in certain situations (rather than buckling under to others' wishes), and most importantly—relax—not have to carry the weight of the world on my shoulders. I CAN develop an optimistic outlook and possibly discard my endless need to measure all things by their negative aspects.

—Stay-at-home wife, mother, and grandmother

This has been a wonderful experience; I've learned so much that is helping me now, yet if only I'd had the opportunity to go through this program years ago. I'm a 10-year survivor and I've struggled with some fears and concerns that have now been dispelled.

—Retired school teacher

While I've had some concerns about what this program has asked me to do related to uncovering and expressing my thoughts and fears, I've still benefited from the support I've had from all the very special women. It is not easy for me to open up, but I felt whatever I said was accepted as normal by the group.

—Research scientist

These and other comments suggest that particular aspects of the MBSSP positively affected participants in different ways and that the eclectic nature of the integrated program may have value across a broad audience such as those diagnosed with breast cancer. Also, as the first and last quotes illustrate, the program is demanding and requires considerable commitment and trust.

CONCLUSION

Overall, the pretest to posttest improvement results and written comments from participants in this initial offering of the MBSSP are

encouraging for further development and testing of integrated mind-body-spirit self-empowerment programs and research.

Although exploratory, results of this study are consistent with the guiding principles of MRM theory. Specifically, interventions that expose a participant to new ways of thinking about her diagnosis and feelings allow her to better understand her own model of the world and to see her experiences with cancer as part of her life's journey. Further, the eclectic nature of the program allows each participant to select from various existing and newly developed internal and external self-care resources—those that she perceives address her current needs.

In closing, we share an additional comment by a participant that brings us full circle to the soul event and the existential issues described by Bolen (1998) and McKinley (2000) at the beginning of this article. This participant acknowledged the MBSSP's profound effect that changed her thinking about healing and her ability to face the future.

Participating in this program gave me the opportunity to learn about a whole new body of knowledge in healing and to connect intimately with other women breast cancer survivors. Practicing new tools and developing new skills gave me the courage to face THE DARK NIGHT OF THE SOUL. Meeting in and outside of class on a regular basis with 10 incredibly beautiful, wise women gave me the options I needed in order to choose to live, not only in body, but also in mind and spirit.

—Physician

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