

PSYCHOLOGICAL AND PSYCHOTHERAPEUTIC APPROACHES IN ONCOLOGY: VALORIZATION AND STRENGTHENING OF THE PERSON

LAURA DAL CORSO
UNIVERSITY OF PADOVA

ALESSANDRO DE CARLO
CATHOLIC UNIVERSITY OF MILANO

TATIANA SANDLER
UNIVERSITY OF SURGUT

ANNAMARIA DI SIPIO
MARIA ARMEZZANI
UNIVERSITY OF PADOVA

This paper arose from the importance of psychological and psychotherapeutic approaches in improving cancer patients' quality of life and the results of treatment. A concise yet thorough review of the relevant literature, together with the theoretical models, and the effects reported in studies and meta-analyses was conducted, with particular reference to efficacy testing. On these bases, we here present the outlines for a clinical interview aimed to increase awareness and transformative learning. This interview, which can be carried out with the patient and his/her family, is intended to strengthen the person's values and ethics and to make him/her aware of the possibilities of action, even in situations of extreme suffering. This scheme, already successfully tested on a small sample of patients and family members, can be applied within compatible theoretical models. The results are presented here of a study carried out on psychological and medical staff already working or in training — which can also be extended to other professional groups involved in the care process. The study was based on reflection, consolidation, and internalization of writings on severe crisis situations by eminent authors, and therefore particularly significant in terms of ethics, values, and the construction of the self and the world.

Key words: Oncology; Therapy; Patients; Families; Care professionals.

Correspondence concerning this article should be addressed to Laura Dal Corso, Dipartimento di Psicologia Applicata, Università di Padova, Via Venezia 8, 35131 Padova (PD), Italy. E-mail: dalcorso@unipd.it

INTRODUCTION

According to the World Health Organization, each year over 10 million people throughout the world get cancer. In 2020 this number will increase, due to population growth, to approximately 15 million. Symptoms, treatment, course of illness, and chances of recovery are very different for the various cancers that may afflict the person.

Such variability makes it necessary to adopt the theoretical and methodological approaches of psychological and psychotherapeutic models particularly tailored for each specific

clinical situation as well as the life stages in which the malignancy arose, in the wider perspective of the psychology of the life cycle.

The disease is an event that may arise in people's lives suddenly and unexpectedly — often accompanied by intense stress — altering normal rhythms. It may make life more undefined and confused in terms of meaning, significance, and safety, in addition to having considerable effects in interpersonal relationships at a personal, social, and professional level and in the relationship with one's body (De Carlo, Faa, & Rutelli, 2008).

Diagnosis of cancer, disease status, duration and type of treatment can cause feelings of anxiety, anguish, frustration, helplessness, mistrust, and psychological disorientation, thereby influencing the patient's and his/her family's life. As Fisher and Tarquinio claimed (2006, p. 289) "serious disease is a disruption of health and psychic life, which plunges a person into radically different living conditions, directly threatening his/her existence." From a psychosocial perspective, disease is a unique and crucial experience, in which the system of values on which a person's existence is based collapses, yet at the same time it presents a real challenge to adapt to a new situation, often perceived as unbearable. According to the authors, the issue of psychological resource mobilization emerges in this case with all its problems.

In this perspective, psychological and psychotherapeutic methods — which in some cases may require psycho-pharmacological support — provide an important opportunity for people suffering from a neoplastic pathology. It enables them to express their personal experiences of suffering, to work them into a narrative, to reassess their own personal values, and to acquire others, thus giving new meaning to their lives. For the patient, the disease and symptoms associated with it do not simply identify with the case history related to the specific diagnosis, but take on a much more complex meaning because of the involvement of cognitive, emotional, relational, and planning aspects. In this perspective, the patient should be encouraged to externalize the "problem" disease through the medium of narration, avoiding identification with it: it is important that he/she understands that "the disease as a problem does not coincide with the patient, but it is a complex structure that can be faced as a whole or in part by the patient (a guilt-inducing and frustrating situation) together with the doctor and family members, all of them allies in the search for possible solutions" (Bert, 2007, p. 8). A potential conflict could arise from the fact that the doctor, accustomed to face the problem of cancer with the tools of logic and reason, cannot always grasp the importance of making the reality of a cancer diagnosis and of the required therapy understandable, and therefore more acceptable, to the patient through the construction of a relationship based on trust. "Informing a patient suffering from cancer at any stage or phase of the disease, does not at all mean to schematically state a pathologic truth and formulate a precise prognostic prediction" (Bonadonna, Robustinelli della Cuna, & Valagussa, 2007, p. 49). Starting from that consideration, the relationship between doctor and patient should not be confined to the expert merely providing diagnostic and prognostic information to a passive recipient of care, but it should be based on the sharing of awareness, also in line with the current requirements of informed consent. The doctor's duty, therefore, is to communicate with the patients and talk to them without reticence and yet tactfully. He/she should recognize the interlocutors' undoubted psychological difficulties in accepting a diagnosis of cancer, and provide support to face the emotional factors involved. He/she should help them overcome a stressful situation that could negatively affect their ability to understand the need for the proposed treatments. The mode of communication used by the doctor can affect the patient's response in tackling the disease, which can

be fought or endured, and can lead to valid consent to treatment. It is therefore essential for professionals to know the most useful communicational and behavioral strategies for providing correct and comprehensive information in situations in which the psychological impact is always very strong (De Carlo et al., 2008).

COGNITIVE AND AFFECTIVE ASPECTS, THE PROBLEM OF PAIN

In reacting to cancer, in adapting to, and facing it, a key factor is the patient's cognitive appraisal of the event. As is known, this evaluation process is influenced by both individual factors (including the patient's personality characteristics, personal and social identity, past experiences) and situational factors (for example: hospitalization, separation from the family, temporary, prolonged, or permanent absence from work). In ordinary situations, implementation of coping, an expression commonly used to denote the set of cognitive and behavioral strategies employed by a person to deal with a situation perceived as potentially stressful, is central and highly operational (Lazarus & Folkman, 1984). Such mechanism does not seem to be the only one involved in the complex process of adaptation to situations of serious illness (such as cancer), which cannot obviously be reduced to a problem of stress management. The two coping strategies proposed by Lazarus and Folkman, one centered on the problem and the other on emotions, do not seem to be exhaustive in oncology. The former is often less effective and less adaptive as it is less applicable to situations beyond one's control, such as cancer. The latter often seems appropriate, if focused on the processing and expression of negative emotions rather than their containment and/or reduction, in facilitating the delicate process of adjustment to the illness. A third coping strategy, proposed by Park and Folkman (1997) and centered on meaning, allows the patient to give a meaning to his/her situation, finding the motivation to pursue new goals and perhaps different priorities, even in the face of often limited life expectancy. Such a strategy may allow the patient to adapt to a perspective of deteriorating physical conditions, thus avoiding the perception of helplessness, failure, and loss of meaning underlying the state of malaise that Kirsane (2000) called "existential distress."

Therefore, although the experience of illness can produce considerable discomfort, at the same time it may bring about a positive review of personal values, strengthen emotional ties in general and, unexpectedly and apparently paradoxically, contribute to a different, and in some cases better, quality of life (Galli, 2009).

The psychological reaction following communication of diagnosis of cancer — in line with the more ample literature on stress — can be described as a process divided into four successive stages — shock, reaction, processing and, finally, re-orientation — after which the disease experience acquires a new meaning in the patient's existential project.

As repeatedly pointed out, the onset of a serious illness inevitably and significantly influences the patient's and family members' life (in its personal, social, and professional dimensions), activating different defense strategies against the psychological problems arising as a result of the difficulty or inability to meet the immediate need for health and well-being.

In the case of cancer, in a psychodynamic perspective, particularly relevant is the mechanism of "denial," through which the sick person tries to avoid physical and psychological pain caused by a disturbing, painful, and often unbearable reality, precisely by denying its existence.

This defense dynamic may have very serious implications, including, for example, refusal of the diagnosis, underestimation of its severity, or non-acceptance of the need for treatment.

Health professionals involved in the help relation, should recognize the presence of defense mechanisms both in the patient, in his/her family, and in themselves. In this context, new possibilities open up for psychological treatment and psychotherapy: the purpose of psychological elaboration is to identify and interpret the coercive defense mechanism, making what is unconscious conscious. It is therefore essential to recognize and interpret defense mechanisms when they appear in order to make them less automatic and more conscious. Although the mechanism of denial is the most frequently encountered defense dynamic in cases of diagnosis of disease, particularly if severe, it is necessary to stress the importance of other types of psychological responses that can be observed in the same situation, such as a patient's attitude of courage, hope, and trust in the specialists. This may be supported by an active search for more information (combative reaction). Or, conversely there may be a less frequent attitude of resignation, when the patient shows no particular interest in the disease and requests further information only when new symptoms appear. Other possible responses are anxiety reactions and/or depression, and even real despair. In these situations patients feel inevitably overwhelmed by their diagnosis, with negative effects on the quality of life, and are profoundly affected by anxiety and fear of death or, in case of recovery, of relapses.

Particular attention should also be paid to the possible psychological responses to invasive surgical procedures or drug therapies associated with significant side effects. There are numerous instances, in fact, where surgery involves the removal of organs or parts of the body (as in the case of radical mastectomy in patients with breast cancer, hysterectomy in treating tumors of the female genitalia, major abdomino-perineal surgery for treating tumors of the gastrointestinal tract, bladder, and prostate, total or partial amputation in the case of malignant cancers of the limbs) and the resulting and inevitable changes of the body Ego. Such treatments severely affect patients' quality of life, both in its dynamic-relational aspects, and as regards the representation of body image, creating a scenery of suffering and prospects of abandonment, which may further complicate the already hard overall psychological situation experienced by the patient. Finally, the psychological impact of side effects — often serious — of pharmacological therapies is not negligible: in this case the patient's full understanding of the importance of the treatment proposed and prior information about the nature and extent of possible side effects can positively influence the process of adaptation to the disease. In the case, for example, of chemotherapy, the most frequent symptoms, usually transient but with obvious implications for personal and work relationships, are anxiety, depression, fatigue and generalized weakness, insomnia, anorexia, alopecia, abnormal taste and smell, nausea and vomiting, which can arise even in anticipatory form. Psychological experiences, usually loaded with apprehension, may also be present in various forms in relation to different types of radiation therapy, and can be accompanied by anxiety, fear of isolation, claustrophobic syndromes, anger, depression, fatigue, anorexia, and sleep disorders, thus making the period of radiation treatment even more psychologically delicate. It is a fact that many of these psychological experiences can, if properly managed, be kept under control and/or mitigated through careful psychological preparation for the patient's therapeutic path, both during and after the treatment itself. Support measures can be introduced such as meetings with specialists to share the treatment plan, correct information on expected benefits and costs

represented by the major side effects, or even attendance at relaxation programs and use of imaginative techniques.

There is also the issue of pain, particularly significant in cancer, because it occurs in more than one-third of patients in outpatient cancer therapy and in over 70% of people with advanced malignancy. Chronic pain in cancer patients is the main problem of the terminal stages of malignant tumors and, if not properly controlled by specific therapy for cancer associated with adequate pain relief, can very negatively affect the patient's psyche by aggravating existing symptoms such as anxiety, depression, fatigue, anorexia, insomnia, and interfering with the patient's ability to tolerate treatment. The focus on pain, and consequently on the palliative treatment for its mitigation, is an integral part of the therapeutic relationship in the wider perspective of the physical, psychological, social, and spiritual assistance required for a cancer patient (Caraceni, Martini, & Zecca, 2007).

PSYCHOLOGICAL DISCOMFORT AND STRESS IN THE PATIENT, FAMILY, AND PROFESSIONALS

For the above-mentioned reasons, it is necessary to address the forms of psychological discomfort caused by the intense and sometimes prolonged stress faced by cancer patients with specific measures of psychological and psychotherapeutic methodology. Stress is present in 30-40% of cases and mainly represented by an adjustment disorder with mixed anxious-depressive symptoms and, less frequently, by mood alterations, post-traumatic stress disorder, psychotic disorder, or by clinical manifestation of personality disorders. Obviously, these psychic disorders may be transient or permanent: in most cases the anxiety and/or depression caused by the experience of disease and treatment tends to disappear with time. In other cases, however, psychological distress can become permanent, as in cases of chronic post-traumatic stress syndromes or even more so in psychotic and personality disorders.

Alongside the influence of diagnosis and treatment of malignant cancer on a patient's psyche, the possible influence of stress must be taken into consideration, because of the close interaction between nervous, immune, and endocrine systems, on the multi-articulated process of oncogenesis. In this context, however, caution is advisable, because the role of stress is complex and subject to cognitive subjective assessment (the same event can be either perceived as a threat or not) and studies conducted to date do not allow us to establish causal relationships between stress and changes in the immune system's surveillance against cancer (Tschuschke, 2006).

Diagnosis of cancer affects not only the individual concerned but also the entire family, often making management of disease even more difficult. Emergence of cancer in fact has a strong impact on the relations within the patient's family and requires activation of adaptation strategies in order to acquire a new family balance.

In the family it is possible to identify characteristic psychological reactions at different stages of the disease similar to those observed in the patient. At the moment of the diagnosis, the whole family usually goes through a stage of shock, characterized by disbelief and despair, followed by a phase of denial and then rationalization of the disease, which eventually leads to acceptance and to development of strategies for achieving a new family balance. In the final stages

of disease, the family may develop typical psychological reactions, predominantly depressive, of anticipatory and real grief.

As evidenced by the relevant literature (Bonner, Hardy, Willard, & Hutchinson, 2007; Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008; Kazak, et al., 2005; Kim, Baker, Spillers, & Wellisch, 2006; Ko et al., 2005; Manne et al., 2005; McMillan, et al., 2006; Northouse, Kershaw, Mood, & Schafenacker, 2005; Vanderwerker, Laff, Kadan-Lottick, McColl, & Prigerson, 2005), the onset of a malignant neoplasia can influence the quality of the couple's relationship as a result of a failure to adapt to the disease, which can affect the sphere of sexuality, too. The fear of the disease and its consequences can also be associated with that of no longer being desirable for one's partner. Also the experience of a child whose parent suffers from cancer is characterized by negative psychological reactions that vary in intensity in relation to the amount of information received and the child's age. In both situations, communication is a key factor for adaptation to the illness of a family member.

The medical and nursing staff working in oncology units also encounter significant psychological difficulties. Assisting cancer patients entails intense and prolonged stress for the staff, and this can often lead to the emergence of "burnout." The word "burnout" first appeared in English in the '30s in the jargon of athletics and professional sports, to describe the phenomenon where, after some successes, a promising athlete was exhausted and ended up performing much below expectations.

Given the relevance of this syndrome — a case of extreme stress — we deem it appropriate to summarize its main traits. In Freudenberger's definition (1974, p. 159), burnout means "to fail, wear out, or become exhausted by making excessive demands on one's energy, strength, or resources" and is now considered the outcome of stressful working conditions, a response to a work situation which has become intolerable, a phenomenon present in all those work situations in which the expectation of being able to meet the continuous requests is disappointed and gives way to feelings of failure, helplessness, and despair. In the various definitions proposed it is possible to see the underlying relationship between burnout and stress. At the root of burnout is the same mechanism that regulates stress at work, namely the excess of external stimuli that have a negative impact on a person's adaptive ability. However, while work stress is defined as the imbalance between available resources and requests that come from both the external and internal world, burnout refers specifically to a failure in the process of adjustment, accompanied by a chronic malfunction. It is the result of an inadequate response to work stress, characterized by dysfunctional behavior and negative emotions toward oneself, colleagues, and clients, through which the individual hopes to minimize the physical and psychological damage arising from the continuous contact with the demands of people with whom he/she works. Maslach (1977) — who is credited with having emphasized, unlike other authors, both individual and situational dimensions involved in burnout and having formulated a careful conceptual and operational definition of it — described it as a tridimensional construct referring to a syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment.

Studying the causes of burnout in operators in oncology means understanding that it is a complex phenomenon in which different factors come into play, based both on the individual and on the environment, as well as the relationship between them (Maslach, 1992; Maslach & Leiter, 1997; Maslach, Schaufeli, & Leiter, 2001). Two main orientations exist on the topic: one tends to emphasize the prevalence of personality traits, demographic characteristics, and personal motiva-

tions, the other is more context-bound, and therefore more interested in observing the impact of situational and organizational conditions (Leiter & Maslach, 2004). More recently, however, greater attention has been paid to studying the interaction between personal and environmental factors.

Health professionals working in oncology clinics and wards are considered a professional group particularly at risk for burnout, as evidenced by the numerous contributions in the literature (Arigoni, Bovier, Mermillod, Waltz, & Sappino, 2007; Italia, Favara-Scacco, Di Cataldo, & Russo, 2008; Liakopoulou et al., 2008; Quattrin et al., 2006; Sherman, Edwards, Simonton, & Mehta, 2006; Spinetta et al., 2000). Assisting an oncology patient entails deep emotional involvement because of the need to manage a daily confrontation with suffering and death and requires psychological expertise, which is not always present. The causes of burnout most commonly encountered by health workers involved in helping cancer patients are attributable both to the relationship with patients and their families (communication of the diagnosis, awareness of the patients' suffering for duration of the disease and their loneliness, care of patients with limited life expectancy) and to the type of work and organizational conditions, such as excessive work pressure, work shifts, conflictual relations with superiors and colleagues, and a difficult balance between work and private life.

Burnout symptoms occur at the physical, psychological, and behavioral levels and vary from person to person. Physically, a sense of exhaustion and fatigue may appear, as well as headaches, gastrointestinal disturbances, insomnia, increased vulnerability to ulcers, low blood pressure, a change in eating habits, and consequently in weight, sleeping disorders, tiredness, and recurrent intrusive thoughts and images relating to the discomfort experienced by people with whom one is in contact. At the psychological level, signs are: anger and resentment, guilt and low esteem, low self-confidence and reduced ability to listen, discouragement and indifference, altered mood, depression. In addition to the physical and psychological symptoms, negative behavioral responses toward oneself, work, and life in general may appear. These include absences, frequent delays, excessive adherence to standardized procedures, resistance to change, isolation and withdrawal, up to total detachment from work and patients.

There are several possible levels of intervention (at the cognitive level of the individual operator, at the emotional level, and at the organizational level) and forms of prevention and of psychological and psychotherapeutic intervention — both in individuals and in groups — of the burnout syndrome, which include professional supervision activities, emotional support, therapeutic counseling and training aimed to reduce and manage work stress (Di Nuovo, Dal Corso, & Falco, 2006; Le Blanc, Hox, Schaufeli, Taris, & Peeters, 2007).

As for cancer patients, even in cases of recovery, psychological support and psychotherapy may be needed to cope with the stress associated with the oncological experience, its emotional and affective implications, as well as possible problems concerning employment and professional environment (Rasmussen & Elverdam, 2008; Steiner et al., 2008). Although often cancer patients at the end of the therapeutic course, can go back to work normally, in some cases he/she may suffer discrimination, such as assignment to different tasks or denial of a previously promised career advancement, even up to real cases of mobbing. This term defines a form of psychological aggression in the workplace, exercised through repeated oppressive measures carried out, more or less intentionally, by one or more attackers (colleagues or superiors) against an individual with the aim and/or the effect of excluding him/her from the workplace.

ONCOLOGICAL DISEASES AND REHABILITATION

Another significant aspect is the fact that, despite considerable advances in oncology therapies, many of them still involve the persistence of functional deficits and thus residual disability; together with a sort of feeling that a pitying attitude toward cancer patients is not appropriate. This limits their effective productive and working recovery.

Prevailing thought on a cancer patient's employability is that the medico-legal assessment must result from careful consideration of both psycho-physical, objectively verifiable, impairments, and the prognostic characteristics of the tumor, without letting the generic "dangerousness" of neoplastic pathology influence the medico-legal assessment, unless "the adverse prognosis has such a significant probability in the short term as to make a disability assessment advisable" (Vitiello, Catalano, Antonelli, Vitiello, & Cei, 2007, p. 590).

It is therefore essential that the therapeutic approach to cancer patients includes rehabilitation measures for functional recovery, ensuring not only an acceptable quality of life but also the patient's return to work. We can therefore maintain that rehabilitation has become in recent years an integral part of the patient's therapy, providing the most appropriate tools for the prevention and treatment of iatrogenic sequelae, for the recovery of the affected functions, the reduction of chronic after-effects, the improvement of physical well-being. Equally important is the acquisition of new skills and a new psycho-physical balance, for the discovery of residual potentials, and the maintenance of the quality of life at the highest possible level.

As noted, modern anti-neoplastic therapy requires a multidisciplinary approach that goes beyond the biomedical model focused on the disease and on the doctor's contribution in the medical care process, in which the patient is considered as a passive problem carrier. Such a model highlights the unique and repeatable measurement of physical illness seen as objectively quantifiable, but it has some limitations, as identified by Engel (1977), concerning the difficulty in describing and explaining the complexity of the concept of health and of the events associated with it. Hence the gradual emergence of a "biopsychosocial" model able to valorize the biological, psychological and social dimensions, and the focus on the patient's participation not only during the therapy phase, but also during prevention. The biopsychosocial model is consistent with the concept of health adopted by the World Health Organization, whereby health is a state of complete physical, mental, and social well-being, not merely the absence of disease.

PSYCHOTHERAPEUTIC APPROACHES AND THEIR EFFECTIVENESS

In the past medical oncology adopted an approach which tended not to consider the importance of psychological intervention and psychotherapy in the medical treatment of cancer patients, despite many studies (mentioned below) suggesting the importance of psychosocial support and its influence on the course of the disease. With this support, in fact, patients show a reduction in symptoms of anxiety, stress, and/or depression, greater collaboration with specialists in the implementation of specific anticancer therapies, and a better quality of life. Qualified and constant psychological support should therefore become an integral part of the medical oncology treatment.

In light of the above considerations, we may wonder "what psychotherapy" is applicable to psycho-oncology, where several therapies seem to coexist and be widespread: behavioral, cog-

nitive-behavioral, cognitive-constructivist, relational-systemic, and analytical in addition to, albeit more limited, client-centered, or body psychotherapy.

Before describing the main types of psychotherapeutic intervention in oncology, however, there is need for an epistemological premise. The diversity and incompatibility of psychotherapeutic guidelines are particularly relevant: the diversity and incompatibility between present-day psychotherapies resist attempts at integration, suggesting that these efforts are not justified, and that the multiplicity of etiological criteria is only the necessary consequence of the structural complexity and versatility of the human being. At the application level, though, this could justify the arbitrariness of psychotherapeutic treatment. We should never forget that the diversity and incompatibility of psychotherapeutic etiologies results not only in the diversification of the treatments, in the use of specific methods and techniques, but also in the diversification of the very role of the psychotherapist.

Armezzani (1988) pointed out how the combination of methods and techniques that are rooted in different theoretical frameworks can be problematic: in fact, “the usability of the tools is limited by the purpose for which they were built, as exactly this purpose suggested their form and determined their usage value” (p. 291). In this perspective it may be useful to refer to the well-known distinction between eclecticism and syncretism in psychotherapy: for a close examination of the subject see the contribution of Beutler, Harwood and Caldwell (2002).

The various psychotherapies, as we know, differ in their theoretical bases, historical developments, clinical reference models, and underlying theories of care.

The cognitive-behavioral therapy in oncology focuses mainly on the crisis triggered by the oncological disease and on control of symptoms. It is configured primarily as a short-term psychotherapy. Its purpose is to analyze and modify adaptive and pathological patterns of response. The ultimate goal should not, however, be only resolution of the disorder, but also improvement of the quality of life. The process of change in the patients’ way of acting, feeling, and thinking must proceed from a dysfunctional to a functional mode. Moreover, the process of change is not limited to an overall improvement in the patient’s condition, but is designed to ascertain that he/she has acquired self-management skills that allow him/her to deal with future events and to properly manage his/her relationship with the disease over the years.

Cognitive-constructivist psychotherapy aims to make the patient more able to use the information potentially available in the environment to construct new meaning, to envision more functional ways to achieve his/her goals, to respond to disabilities using them to modify his/her structure, to increase his/her capacity to formulate potentially more “viable” constructions, to give new meaning to life events, particularly those that previously threatened his/her equilibrium, such as the onset of illness.

Systemic relational therapy seeks not only to reduce or eliminate symptoms, but also to bring about a significant change in patient’s behavior, that will allow his/her family to reclaim their role and time.

Finally, analytically-oriented psychotherapy, necessarily longer as it involves continuative psychodynamic work, aims to achieve a psychic change that allows the patient’s psychological growth and the development of greater psychic integration.

Particular caution should be taken in relation to a number of approaches for which an appropriate verification of effectiveness does not seem to exist, such as the method developed in the late ‘70s by Simonton (though applied in some major hospitals), who believed that the psyche had a particular influence in the onset of malignant cancers, to the point of maintaining that there

were personalities predisposed to developing cancer. Though some consensus led to its application, “the tragic aspect of the entire therapeutic event remains: taking frustration, fear and remorse out on the patient if conventional therapy fails, or if the outcome is temporary, and the cancer returns” (Robustinelli della Cuna & Bonadonna, 2007, p. 32).

Among the psychotherapist’s tasks, that of drawing attention to the risks inherent in research and adoption of treatments not based on proven scientific evidence has considerable importance.

A review of the literature led to the identification of a large number of publications regarding the effectiveness of psychological and psychotherapeutic methods for cancer patients. In conducting such analyses, both the different theoretical perspectives at the basis of psychotherapeutic approach and the effects of specific treatments on particular aspects of the disease were taken into account. For example, sleep, nutrition, anxiety, depression and phobias were studied for their effects on the most common symptoms (such as anticipatory nausea and vomiting), or on the quality of life.

In this respect, it is particularly useful to analyze, in addition to specific studies, some recent reviews and meta-analyses on the subject (Andrykowsky & Manne, 2006; Boesen & Johansen, 2008; Coyne, Lepore, & Palmer, 2006; Devine, 2003; Fritzsche & Wirsching, 2003; Kazak et al., 2007; Lepore & Coyne, 2006; Meyer & Mark, 1995; Rehse & Pukrop, 2003; Rodgers et al., 2005; Smedslund & Ringdal, 2004).

The meta-analytic approach, in particular, is especially effective and, therefore, increasingly used “to synthesize research on the subject, by calculating the weighted average effect obtained in the studies considered and then analyzing the moderator factors that may explain the variability of the cumulative effects” (Di Nuovo, 2005, p. 243). The same author, however, expressed dissatisfaction at a purely quantitative — experimental and statistical — approach, and stated that such method is not free from problems related to the selection of studies considered, the heterogeneity of research methods used, and the different reliability and validity of the instruments adopted. Newell, Sanson-Fisher and Savolainen (2002) and Chan et al. (2005) also came to similar critical conclusions. It can therefore be argued that research problems in this area are far from being solved, also because of an inherent difficulty to establish suitable methodologies for different types of psychotherapy and to collect meaningful and easily generalized data. At the methodological level, it is therefore advisable to encourage the mixed and integrated use of qualitative and quantitative methodologies, overcoming the ancient, and mutual, prejudices between those who advocate the former and those who emphasize the latter.

The extensive literature available also agrees on the difficulty of assessing the effectiveness of psychological and psychotherapeutic treatments for cancer patients, given the presence of conflicting results. The causes of this difficulty can be traced to both methodological and ethical factors. Specifically, the main methodological limitations can be identified in the aspects described below.

a) The difficulty in recruiting a sufficient number of patients for experimental trials (Coyne et al., 2006; Quesnel, Savard, Simard, Ivers, & Morin, 2003): many studies in the literature consider a very small sample, generally variable from a few dozen participants down to a few individuals, so it is difficult and often impossible to state with reasonable certainty that the psychological and psychotherapeutic treatment provided, regardless of the theoretical background reference, is effective.

b) The difficulty in identifying subjects to include in the control group (Chan et al., 2005; Edelman, Craig, & Kidman, 2000) and in performing experiments with randomized samples (Chan et al., 2005; Edelman et al., 2000; Fritzsche & Wirsching, 2003).

c) The fact that some patients may not recognize the need for psychological treatment and may be even less willing to be included in psychological trials (Chan et al., 2005).

d) The lack of a longitudinal perspective to assess the stability of the psychological intervention over time (Elkins et al., 2008; Rehse & Pukrop, 2003). This difficulty is most apparent in studies on patients with types of cancer in an advanced stage and whose life expectancy is reduced, but it is less clear for those who suffer from malignancies that can be handled with better results or for survivors of the disease.

e) The difficulty for patients in following a long-term therapeutic path to be continued outside the hospital, that entails the need to travel (Andrykowsky & Manne, 2006).

f) The multiplicity and variety of oncological diseases and their specific symptoms: the existing studies focus on particular types of disease and therefore the effectiveness assessment of any therapeutic intervention is mostly limited to the group of individuals belonging to the sample in question.

g) The stage at which the psychological and psychotherapeutic treatment is given (diagnostic, prognostic, therapeutic), the patient's health (survival or terminal phase), the type of medical intervention to which the patient is subjected (chemotherapy, radiotherapy, hormone treatment, surgery) are all examples of the difficulty in assessing the effectiveness of psychological treatment and psychotherapy in oncology.

h) Demographic aspects, including, for example, gender, age, and stage of life (childhood, adolescence, adulthood, old age) in which the disease manifests itself can affect the choice of type of intervention and its effectiveness.

i) Other methodology issues are the scanty literature data on the relative abundance of non-respondents to research about the effectiveness of a psychological intervention and the fact that many patients (and their families) undertake a personal course of psychotherapy outside traditional healthcare institutions and are therefore difficult to fit into psychological trials aimed to measure the effectiveness of psychological and psychotherapeutic treatments.

l) It should be noted, finally, that studies reporting negative results are rarely published (Chan et al., 2005; Edelman et al., 2000; Newell et al., 2002).

The literature presents many contributions on the efficacy of psychological and psychotherapeutic approaches in the treatment of specific symptoms, regardless of the type of cancer diagnosed, medical treatment to which patients are subjected, and the stage of disease. In particular, among the most common disorders which can be relieved through psychological treatment and psychotherapy are: depression and anxiety (Caplette-Gingras & Savard, 2008), pain (Strouse, 2008; Ward et al., 2008), insomnia (Bardwell et al., 2008; Kangas, Bovbjerg, & Montgomery, 2008; Savard, Simard, Hervouet et al., 2005), anticipatory nausea and vomiting (Glare et al., 2008; Shelke et al., 2008).

In the light of this methodological background and the recent literature, the main scientific evidence demonstrating the effectiveness of the theoretical frameworks of intervention most used in psycho-oncology are presented below.

In their study, Fritzsche and Wirsching (2003) included psychotherapeutic interventions inspired by different theoretical orientations (cognitive-behavioral, psychoanalytic, family) that

had shown a positive influence on emotional and social parameters such as decreased anxiety and depression and increased fighting spirit.

Behavioral and cognitive-behavioral psychotherapy show positive results in reducing depressive symptoms and physical exertion (Anderson, Watson, & Davidson, 2008; Gielissen, Verhagen, Witjes, & Bleijenbergh, 2006; Sherwood et al., 2005), in pain treatment (Devine, 2003; Tarrow & Montgomery, 2006), and in the treatment of insomnia (Savard, Simard, Ivers, & Morin, 2005), thereby improving the quality of life (Quesnel et al., 2003). It also emerges how patients prefer individualized therapy, face to face with the specialist, whereas group therapy is less acceptable. Various professionals consider one-to-one interaction to be optimal, but they also deem group therapy to be effective (Semple, Dunwoody, Sullivan, & Kernohan, 2006).

The use of hypnosis can be good for the control and reduction of some symptoms: a study by Elkins and colleagues (2008) on women with breast cancer, showed a significant effect on reducing anxiety and depression as well as hot flashes. In other studies, the use of hypnosis showed an improvement in controlling pain (Spiegel, 1985) or in the management of nausea and vomiting in patients undergoing chemotherapy, especially adults (Richardson et al., 2007).

Other types of interventions have effects aimed to improve the condition of cancer patients. For example, the use of biofeedback and progressive muscle relaxation techniques (PMRT) lead to positive effects on anxiety and a general improvement in quality of life, especially in the dimensions of physical, psychological, and social health (Cheung, Molassiotis, & Chang, 2003) and on the management of nausea and vomiting (Campos de Carvalho, Titarelli Merizio Martins, & Benedita dos Santos, 2007). Guided-imagery techniques as well lead to positive effects on the general well-being of cancer patients (Roffe, Schmidt, & Ernst, 2005).

The psychoanalytic approach is based on the assumption that cancer patients' symptoms are the result of unconscious conflicts causing psychological defenses, including rationalization, regression, and denial. The therapist's goal is therefore to intervene in such conflicts. An explanation for cancer had already been given in the '20s (Freud, 1920/1971), when cancer cells were considered narcissistic entities destroying the body. Later, other authors belonging to the same approach made different assumptions about the onset of cancer: for example Bahnson and Bahnson (1964) argued that neoplasias are the result of the excessive use of defense mechanisms that lead to a psychological regression (which will develop into mental illness) or to a somatic regression that could cause physical disorders, even serious ones, such as malignancies. Other authors (Fornari, 1985) considered cancer an ontogenetic regression to the fetal stage, where malignant cells develop survival strategies within the organism-environment that hosts them, and their subsequent proliferation is called "cytopsychosis." Nowadays, the most used psychoanalytic model for oncological disease, especially in patients at advanced disease stages, is that proposed by LeShan (1979). This approach is based on the assumption that, in order to help the cancer patient, it is necessary to focus therapy on conflicts and past experiences that block the individual's most authentic needs, ignoring past negative experiences and focusing on positive ones to face the present. The psychoanalytic approach has, however, various limitations ranging from the need for a strong and long-term therapeutic relationship to the difficulty of measuring and evaluating the actual effectiveness of the therapy itself.

Psychoeducational approaches lead to benefits in the treatment of pain, not replacing analgesic therapy, but enhancing it (Devine, 2003; Haeberli et al., 2008).

Studies on psychosocial interventions provide evidence for the positive effects that this type of action has on quality of life during long-term treatment (Daniels & Kissane, 2008; Rehse

& Pukrop, 2003), suggesting that such actions may be included in the regular treatment program, thus enhancing the necessary medical protocols. Moreover, positive effects on reduction of distress were shown (Lepore & Coyne, 2006).

Recent literature does not report any significant evidence for the effectiveness of psychotherapy in extending life expectancy for cancer patients (Boesen & Johansen, 2008; Coyne, Stefanek, & Palmer, 2007; Edelman et al., 2000; Watson, Homewood, Haviland, & Bliss, 2005). On this topic, the conclusion of various authors — in the light of often conflicting results — seems to suggest a cautious approach taking into account both the known methodological limitations described above and the important relationship between some disorders associated with oncological disease (including stress, depression) and the endocrine-immunological system (Tschuschke, 2006).

Psychological and psychotherapeutic methods in oncology also involve the different figures (family members, health professionals and volunteers) who daily assist and take care of the patients. The objectives of these approaches can be very different, depending on the nature of the specific role that the various figures have in assisting the cancer patient.

Taking care of a loved one requires people closely involved emotionally to face delicate and difficult situations in terms of emotions and required effort. This is especially true for the spouse (Baucom et al., 2009; Hagedoorn et al., 2008; Manne et al., 2005; Manne et al., 2007; McLean et al., 2008; Ponto & Barton, 2008; Romero, Lindsay, Dalton, Nelson, & Friedman, 2008), parents (Bonner et al., 2007; Forrest, Plumb, Ziebland, & Stein, 2009; Kazak et al., 2005), and children (Kim, Wellisch, & Spillers, 2008; Osborn, 2007; Vannatta, Grollman, Noll, & Gerhardt, 2008). These situations have an immediate impact on life quality, and, if the relatives are do not possess appropriate coping and problem solving strategies, they inevitably lead to severe psychological distress (Kim et al., 2006; McMillan et al., 2006). Recent contributions reported empirical evidence for the effectiveness of psychological intervention and psychotherapy in containing or reducing the most common psychological disorders and related symptoms not only in patients but also in caregivers (Ko et al., 2005; Northouse et al., 2005; Vanderwerker et al., 2005).

In particular, as has already been pointed out, the work of health professionals (doctors, nurses, psychologists, social and health workers) involved in oncology can, in the long run, lead to forms of distress and burnout (Liakopoulou et al., 2008; Quattrin et al., 2006; Sardiwalla, VandenBerg, & Esterhuyse, 2007; Sherman et al., 2006), which may endanger their physical and mental health and negatively affect work performance, with a consequent considerable impact at both individual and organizational level (Burish, 2002; Maslach et al., 2001). This requires targeted treatments with a view both to prevention and treatment. The volunteers assisting cancer patients are also particularly prone to various forms of malaise (Argentero, Bonfiglio, & Pasero, 2006; Glass & Hastings, 1992).

EXPERIENCES OF EMPATHIC, CONCRETE, ETHICAL, AND VALUE SUPPORT

As previously reported for scientific evidence, a vast amount of literature exists on the main psychological and psychotherapeutic approaches used in oncology, which must be carefully and constantly referred to. We proposed a scheme which can be used in the clinical interview of the patient and his/her family, finalized — consistently with theoretical models — to capture some important aspects useful for supporting people in the various difficult situations.

The interview model was used in an exploratory study of 24 people suffering from cancer (and their relatives) who, also considering their health conditions, were willing to participate. Their conformity greatly reduced the difficulties that the interviewers may have experienced in carrying out their task. The model is divided into three phases.

1) Empathic sharing of anxieties and fears associated with the disease: in this initial phase, which may include various encounters (as in all the subsequent phases), a personal relationship is established with the interlocutor (patient or family member) in which he/she is free to express his/her fear of any kind, immaterial and material, and can feel listened to, understood, and fully surrounded with solidarity.

2) Focus on specific social, organizational, and economic aspects, with possible consequent coping strategies — both current and potential. In this second phase, which is both a continuation and a development from the first, the focus is on elements of daily life and relations that can be compromised by the disease. This implies the need to build opportunities for reflection, to search for solutions, to find advisors/consultants, and to seek out the most appropriate network of cooperation (including legal or financial).

3) Acknowledgment of possible actions and of the necessary consequent reconstructions of reality and one's experience: the third phase aims to strengthen and support the person so that he/she is able to fully accomplish his/her transformative learning (Mezirow, 1991), by knowing how to identify, to acquire, and to implement the most appropriate initiatives.

The experience yielded positive results in relation to the expected objectives of support to patients and family members, particularly with regard to lowering anxiety levels and developing better defined strategies for patients and their families in coping with difficulties. Our experience suggests that the three steps stated above might be a sort of operational common denominator — within different theoretical models — for promoting the aforementioned transformative learning process. Such learning, as is known, leads both the patient and family members to a broader and more problematic perception of reality in a perspective of coping which is as active as possible against disease and its course, as well as problems of different orders (social, economic, organizational) connected to it and often not adequately considered by operators.

On the level of ethics and values, it is not possible to avoid management of pain by circumscribing a “concrete” sphere (taking into account the different situations that must necessarily be faced). For one should also be sensitive to immaterial and somehow mysterious needs. In fact, life is worth living and savoring for what it can give — under any circumstances, even the most tragic — in terms of awareness, of sharing with loved ones and with operators (who also are fellow travelers on this path), of hope and sacrifice, of exchanging and giving, as theorized in logopaedics by Frankl (1959). All of this regardless of beliefs in another, transcendental, existence or of not going beyond immanent nature. Specific measures are therefore needed to strengthen personal ethics and values and increase a person's sense of his/her own worth.

Support and care can be not only means of controlling pain in its broadest sense, but also components to ensure that those who suffer may feel fully human, in possession of the ability to relate with others and with the future, with the immaterial at hand.

The medical staff must be constantly tuned to such wavelengths. Also care professionals, indeed, must take these issues into account, as well as, obviously, technical excellence in treating disease.

With these objectives an educational experience was then also conducted, with particular reference to ethical and value dimensions, for the support of 17 doctors and psychologists train-

ing in a graduate course in psychotherapy. The approach consisted of a careful reflection on the ethics of transcendence (Pera, 2008; Pera & Ratzinger, 2004; Ratzinger & Habermas, 2004) and immanence (Giorello, 2005; Lecaldano, 2006; Pievani, 2006) and how they could come together in a kind of common denominator for both perspectives, important for the psychological and psychotherapeutic action: values and suffering, hopes and setbacks, construction-change of the self and of the world. These issues were addressed with a methodological approach including both an introduction on the theoretical aspects of the various problems, and the reading and discussing of other people's crisis experience (through the choice of appropriate literary passages) for personal internalization (Demetrio, 2008). The texts were taken from the works of De Monticelli (2004), Frankl (1959), Hillesum (2007), Levi (1986), Weil (1947; 1962), and Giovanni Paolo II (1981).

Afterwards, participants produced a written self-evaluation on their professional work, explaining what kind of empathic feelings, understanding, and operational responsibility was generated in them by the writings proposed. Below, is a self-evaluation of particular importance on this subject (Siragusa, 2009).

"The reading of each of the passages allowed me to recognize some key nuclei of considerable interest in psychotherapeutic practice and in the construction of our professional identity.

The first of these nuclei refers to the value of seizing the meaning of life, or rather of giving meaning to life. I refer in particular to the importance of identifying one or more goals to be pursued and concrete actions to achieve them. The locus of control, in this perspective, is not external but internal: the aims, the objectives do not exist in the abstract, nor must come from outside, but are the fruit of labor and human efforts, derived from the concrete implementation of actions and behaviors that are continuously redefined according to the destination. The ability to give meaning to life, even if it may seem impossible, resides in the individual. The meaning that we give to life may derive from several factors: we can find meaning in work (and here it is fit to remark that the person is the ultimate purpose of work and not a mere instrument of opportunity and that work is an expression of personal values), in affection, in love of neighbor, there are as many possible meanings as there are people. In trouble situations, finding the meaning of life, working on the person's life plan, valorizing the resources that one has and helping one to perform actions, even symbolic ones, leading to a goal, are fundamental psychotherapeutic tools.

A second nucleus that reading the passages revealed is that of welcoming suffering: in a society where the denial of pain and the incessant search for gratification are predominant, there is a need to rediscover the value of pain. Pain is an important component of our humanity and, as such, deserves to be lived. Too often people do not have the time to dwell on their pain and get to know it; rather, they often escape it voluntarily. Accepting and living the pain, taking care of it is, instead, important not only because living it fully allows to gradually overcome it, but also in order to leave room for the full expression of oneself and one's emotions. All suffering can produce growth and strengthen the structure of the person, but this can only happen if pain has the time to express itself, without being denied, but, on the contrary, being lived with dignity.

The third nucleus regards the figure of the psychotherapist. During the course, we have repeatedly emphasized the need for the psychotherapist to be a well-educated and open-minded person: he/she must know alternative worlds as potentially infinite stories may show up in work practice (as many as the people whom he/she will meet) and there will be multiple opportunities for restructuring to be shown to those in need. The professional's open-mindedness and culture are also useful antidotes against prejudice, from which no human being, including the psychotherapist, can be completely immune. Such antidotes and the awareness of existence itself and of the danger of prejudice, however, allow the therapist to be careful and make sure that this element affects his/her professional practice as little as possible.

Another nucleus that seems very important to me, also in line with the course contents, concerns the awareness that life can be difficult, unfair, that may try us to the limit, but nothing is already defined or written. It is important to be aware and make others aware that every moment there is the

possibility of change, and yet not demand it. In line with this, as stated in Simone Weil's passage, is the consideration that the future is made of the same stuff as the present: what can change, then, is the way we confront life, the meanings we give to events and the acquisition of the awareness of the value of life itself and of happiness that can derive from simply living every expression, even the simplest.

A final nucleus that I think is important to note is the relevance of the identity of the person and his/her adaptability and cognitive restructuring ability. It is the person's authenticity, the strength of personal identity that makes a difference facing life difficulties when one is deprived of the most superficial aspects of one's being or of personal reference points. It is having built (or not) a defined identity based on being rather than appearing, and the possibility to refer to universal values that can provide the strength to overcome difficulties. Furthermore, the ability to adapt to changing situations and to restructure parts of one's ego are basic steps that allow people to react to unforeseen or highly destabilizing events."

A personal and group reflection was also conducted on authenticity as a condition of effectiveness and quality of psychological intervention and psychotherapy. Also in this connection, a meaningful self-evaluation follows (Rossi, 2009).

"The suggested passages present to our attention the basic paradigms for the profession of the psychotherapist who wishes to be authentic toward the person asking for his/her help:

- the need to be capable of continuous questioning, tireless research, to be open, even in the eschatological perspective, to the Other (De Monticelli, 2004);*
- facing the call for meaning that comes from pain (Frankl, 1959);*
- discovering and valorizing the irrepressible originality of each person and experience (Frankl, 1959), even in work (Giovanni Paolo II, 1981);*
- recognizing the inherent limitations of any merely human response and, hence, the need to decentralize one's own certainties and beliefs as psychotherapists to make room for the Unexpected (Levi, 1986).*

With this readiness stemming from hope and faith, the psychotherapist frees him/herself (in a Kelyan sense) from all limitations, becomes emancipated from all ideologies seen as false consciousness. This is his/her authenticity.

Conversely, the picture of the psychotherapist prisoner of ideological constriction is dramatically depicted by Etty Hillesum (2007, pp. 310-311): Leading lights from cultural and political circles in the big cities have also been stranded on this barren stretch of heath five hundred by six hundred metres. With one mighty convulsion all their scenery has collapsed about them, and now they stand around a little hesitantly and awkwardly on this draughty, open stage called Westerbork. [...] Their armour of position, esteem, and property has collapsed, and now they stand in the last shreds of their humanity.

How could we fail to recognize, among the leading lights from cultural and political circles in the big cities, those therapists who, outside of the metaphor, set themselves up as guardians and defenders of those life models that, in the last few years, have taken up large spaces in Western civilization and that Emmanuel Mounier (1985) would have defined as established disorder?

And how could we fail to see, in the collapse of their armour, the crisis of this civilization, effectively described and expressed by the authors of the Frankfurt school in their critique of the lack of authenticity of man reduced to be used, manipulated by the principle of the strictest illuminist tradition? (Adorno & Horkheimer, 1944)."

CONCLUSIONS

It does not seem possible, today, to refer to only one type of psychological and psychotherapeutic approach in oncology. The approach, in fact, takes shape as an articulated project in

which the main psychotherapeutic guidelines that have actual confirmations of effectiveness can be implemented, for an action plan that must consider the role played by different variables, such as the patient's life experiences and needs, his/her system of relationships — family, social, and work — as well as the operators involved and their training.

The psychological and psychotherapeutic intervention must be designed to “control” suffering, to encourage patients and their families to express and take in thoughts and feelings of different types. There is a need to develop more adaptive attitudes and behaviors and restore a sense of personal control over their lives. Communication between patients, care professionals, and families should be fostered to explain the influence and weight of psychological dimensions in physical illness. The patient and his/her loved ones need to regain a sense of the future, also and especially a perspective of values and ethics. At the same time, care professionals need to be sustained and their strategies for reflection and action implemented, so that they can always be supportive in this process of transformative learning. Both the experiences carried out and described here — the three-phase interview with patients and families and the training course on ethics and value issues for doctors and psychologists — are also operational proposals, the applicability and effectiveness of which have been evaluated, though still as a mere exploratory study. Further experiences of confirmation, growth, integration are awaited.

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