Comprehensive Guide to Post-Traumatic Stress Disorder
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Positive Psychotherapy in Cancer: Facilitating Posttraumatic Growth in Assimilation and Accommodation of Traumatic Experience

Cristian Ochoa Arnedo[a]* and Anna Casellas-Grau[b]
[a]Institut Català d'Oncologia, Hospital Duran i Reynals, Barcelona, Spain
[b]Departament de Psicologia Bàsica, Evolutiva i de l'Educació, Universitat Autònoma de Barcelona, Barcelona, Spain

Abstract

Being diagnosed with cancer and undergoing subsequent treatment can produce high levels of distress among patients. Several psychotherapeutic approaches have sought to help cancer patients manage these negative impacts. In addition, however, there is now increasing evidence regarding the collateral positive outcomes of the cancer experience, it being concluded that positive life changes may also result from such adversity. Consequently, therapies focusing on the emergence of these positive changes have also been developed. In this chapter, we describe a positive psychotherapy for cancer survivors, one which aims to facilitate posttraumatic growth as a way of achieving a significant reduction in negative emotional states (emotional distress or posttraumatic symptoms). A further goal of this positive psychology approach in cancer is to work with positive emotions and positive functioning so as to promote healthy lifestyles, a return to work, and social supportive behaviors.

List of Abbreviations

PPC Positive psychotherapy for cancer
PTG Posttraumatic growth
QoL Quality of life

Introduction

Severe illnesses like cancer are adverse experiences with a high psychological impact. Many studies have explored the negative psychological consequences of cancer, which include fatigue, distress, and depression (Haberkorn et al. 2013; Sheppard et al. 2013; Przezdziecki et al. 2013). In fact, the mere diagnosis of cancer is reported to produce distress in 35–38 % of patients (Faller et al. 2013). There is now a considerable body of evidence associating this distress with poorer quality of life (QoL), less adherence to cancer treatments and worse general survival, as well as a less healthy lifestyle and poorer self-care. However, it is also known that in addition to stress and distress, a cancer diagnosis can trigger positive life changes in survivors (Cordova et al. 2001; Ochoa 2009; Ochoa et al. 2013; Sawyer et al. 2010). In the literature, these positive changes are referred to as posttraumatic growth, benefit finding, or stress-related

Article Note: Description of a positive psychotherapy protocol focused on facilitating posttraumatic growth through assimilation and accommodation of the traumatic experience in cancer. Strategic approaches and specific techniques.

*Email: cochoa@iconcologia.net

*Email: cochoa@ub.edu

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growth, among other terms. As a result of these findings, the focus of research on the psychological impact of cancer has shifted toward the understanding of how positive psychological outcomes may emerge from the cancer experience and of how such outcomes may be facilitated through psychological interventions.

Positive Interventions

Traditionally, the focus of therapy has been on damage repair, with many practitioners learning little about how a good life might be encouraged (Rashid and Seligman 2013). Over the last two decades, however, psychology has placed greater emphasis on the positive aspects of human functioning, and this has led to a number of positive psychology interventions being proposed, including well-being therapy (Fava et al. 1998), quality of life therapy (Frisch 1998), and Seligman's positive psychotherapy (Seligman et al. 2006), among others. In this context, it is now acknowledged that whereas people can develop little strength or make few personal changes from their negative emotions, their positive emotions can indeed serve to enhance strengths and drive personal changes; furthermore, these positive emotions can also act as a buffer against negative states such as stress (Castilla and Vázquez 2011). Building on these ideas and findings from the field of positive psychology, the goal of positive psychotherapy in cancer (PPC) is to address not only suffering and damage but also growth and personal development, and to do so in an integrated way (Ochoa et al. 2010). The central premise of PPC is to make psychological intervention more closely focused on patients' positive resources, such as positive emotions, personal meanings, and strengths (including existential and spiritual meaning), at the same time as addressing their psychopathological symptoms and emotional distress (Ochoa et al. 2010; Rashid and Seligman 2013). One of the basic assumptions of PPC, which is relevant in cancer and derives from the humanistic-existential tradition, is that individuals have an inherent desire for growth, fulfillment, and happiness, rather than merely seeking to avoid misery, worry, or anxiety. In this chapter, these positive changes will be referred to as posttraumatic growth (PTG), a phenomenon that implies changes in (1) the view of oneself (better confidence, self-esteem, and empathy), (2) the view of others (closer and more intimate relationships with people and easier communication), and (3) one's life philosophy or existential position (focusing on the present moment, greater appreciation of life, change in life priorities and values, and increased interest in spiritual issues and the issue of meaning in life). In this context, the basic aim of PPC is to facilitate PTG in patients, caregivers, and patients' significant others. Based on extensive research and a review of the literature on trauma and the growth process after undergoing cancer (Sumalla et al. 2009), our PPC program was developed to complement and enhance more traditional psychological treatments, such as those focused on stress management (Antoni 2003, 2006) . More specifically, the PPC program is aimed at cancer survivors with moderate or severe problems of adjustment after completing their cancer treatment.

A Guide to Facilitating Positive Life Changes in Cancer by Means of the PPC Program

The main aim of PPC is to promote positive life changes (e.g., PTG) in cancer survivors by managing the psychotherapeutic elements related to the emergence of such changes. The authors of a clinical guide to promote personal growth (Calhoun and Tedeschi 1999) regard this proposal as a new perspective on coping with potentially traumatic events, one which can be integrated by therapists from various schools into their work. PPC has mainly been developed as a group-based therapy (Ochoa et al. 2010) and primarily integrates elements from the cognitive-behavioral and humanistic-existential perspectives, along with strategies and tasks from positive psychology. Table 1 shows the modules and sessions that

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Table 1 Stages, modules, sessions, and aims of PPC

Module	Session	Aim	Therapeutic elements in each session
Initial stages: favoring assimilation processes			
1	1–2	1. Promoting attitudes that facilitate growth from disease. 2. Encouraging emotional expression and processing.	1. "What did the diagnosis of cancer mean to me?" Promoting curiosity about life, group universality, and openness to change. 2. Working with positive and negative emotions: body awareness, symbolization, and adaptive emotional reframing.
2	3–5	Emotional regulation and coping	3. Coping styles and emotional regulation: awareness and emotional balance. 4. Horizons of positive change and healthy lifestyle. 5. Personal strengths and memories of success in coping with past adverse events.
Intermediate and final stages: favoring accommodation processes			
3	6–9	Growth facilitation	6. Giving meaning to the experience. Work with recent and remote positive memories. 7. Giving meaning to the experience. Personal realization guidelines and hope-based interventions 8. Relational growth: Promoting and awaking interest towards significant others and working with positive models against adversity 9. Relational growth: Gratitude and forgiveness-based interventions.
4	10–12	1. Existential and spiritual aspects 2. Group conclusion	10. Foreseeing recurrence, increased awareness of mortality and transience, and dealing with emotional and existential numbness 11. Transcendence and regret as a constructive pathway 12. Farewell letter and review of the group experience

form part of the PPC program, as well as their corresponding objectives and the therapeutic elements used to achieve them. In the next section, we describe and justify the different components of the program.

Practice and Procedures

The Therapeutic Focus

In addition to integrating elements from cognitive-behavior and humanistic approaches through therapist narratives (Spiegel and Classen 2000), the PPC program also draws upon common components of group therapy. Group-based interventions share some therapeutic elements that are specially important to be applied on cancer. All group-based therapies promote emotional expression and release (catharsis), help oneself to realize that he or she is not the only one who is suffering (universality), as well as offer a guide and information to the therapist, facilitating altruism cohesion, more socialization, and interpersonal learning.

Formal Aspects of the Program

The formal aspects of the program, in other words the number and duration of sessions and the group composition (8–12 members), are based on the general recommendations featured in the main manuals and literature regarding group interventions in cancer. Specifically, the program consists of 12 weekly sessions of 90–120 min of length, with two follow-up sessions being held at 3 and 12 months post intervention. Groups are formed around 1 month after completing primary cancer treatment, it being considered that this is a suitable point at which to begin psychotherapy given the aim of favoring the survivor's psychosocial adaptation. Indeed, this is a critical point because illness control shifts from

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medical staff to survivors themselves and this generates important life issues, which can be summarized in a question that most patients pose: "And what now?"

Stages of Psychotherapy

Sessions are spread across four modules (see Table 1) of different lengths and with different aims, and they are adapted to the pace of the group. The general objective of the first two modules is assimilation of the cancer experience, while the final two modules are focused more on encouraging accommodation and personal transformation (growth) from the illness experience.

Having suffered from cancer and the threat it poses to life, most patients find they experience a progressively greater sense of the inherent human desire for growth, fulfillment, and happiness. Clearly, a key part of patients' suffering is related to the possibility of death that a cancer diagnosis provokes. However, another part of their suffering relates to the realization that the need for growth, for positive life changes, is being frustrated. Personal growth is facilitated through the assimilation of lived experiences as something belonging to oneself and, above all, through achieving a renewed vision of oneself, of others, and of the world. This kind of renewal is especially necessary when the experience of cancer cannot be integrated into the existing view of illness, or is only integrated at the cost of considerable suffering or distress. Most models of growth from adversity distinguish between the assimilation and the accommodation of the adverse experience (e.g., cancer). In general, a distinction is made between, on the one hand, patients who change their interpretation of their experience so that it fits into their existing worldview (assimilation) and, on the other, patients who change their worldview in order to integrate their experience (accommodation). The assimilation process tends to appear immediately after the adverse event and includes emotional expression, processing, and regulation as coping strategies focused on the management of the event, although the relationship between adversity and assimilation is not strictly sequential. The strategies used in the initial stages of the PPC program seek to capitalize on this process of assimilation, before moving on, in the intermediate and final stages of the intervention, to strategies that address the process of accommodation or personal transformation. A number of factors associated with both assimilation and accommodation have been related to the process of personal growth from adversity (Zoellner and Maercker 2006), although many authors consider that real growth only takes place through the accommodation process (Joseph and Linley 2006; Sumalla et al. 2009). Consequently, our group-based program devotes more session time to accommodation than to assimilation. In the following paragraphs, we describe the specific aims of each module and the strategies used to facilitate personal growth (see Table 1).

Initial Stage: Facilitating the Assimilation Process in Cancer

Module 1: Promoting Attitudes That Facilitate Growth and Encouraging Emotional Expression and Processing of the Cancer Experience

Promoting Curiosity About Life, Group Universality and Cohesion, and Openness to Change

The first aim of this module is to promote attitudes within the group that may facilitate personal growth: curiosity about life, universality, and openness to change. Curiosity about life is one of the survival mechanisms that facilitate the development of new abilities and ways of understanding reality, and therefore, it can encourage growth. People who score higher on personality dimensions such as "openness to experience," and who are imaginative, emotionally reactive, and intellectually curious, are more likely to experience growth (Tedeschi and Calhoun 1996). Thus, group-based interventions should aim to promote patients' curiosity and openness not only on the individual level but also within the group

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setting, such that group members transmit their curiosity and openness to one another. This work, which is characteristic of the initial group sessions, normally revolves around the question of identity after cancer: "Who am I after having suffered this disease?" The first step in helping patients to assimilate losses is to facilitate self-dialogues about how things were before and how they are now after the illness, and then to encourage them to share this with the other group members. It is also important to help them identify the influence that the adverse event has had on their life, as this is normally a step prior to facilitating growth in cancer (Cordova 2008). By enabling patients, during these initial sessions, to see that the question of identity involves elements (e.g., emotions, reactions, affected relationships) that are shared with other members, the therapist can begin to build group cohesion through the experience of universality. "I am not the only one who feels this way" is a common initial expression of this universality, with patients gaining some comfort through their identification with the group. At the same time, it is also important to explore their implicit theories or beliefs regarding the likelihood of personal change, as well as the issue of what each member hopes to get from the group. In this regard, the therapist may ask questions like "Do you think that, in general, people don't change, or that experiencing a disease like cancer can change your life?" or "How would we know that the group has been useful for each one of you?" The responses given to these questions serve to indicate the initial motivation toward change and may influence the likelihood that personal growth will be experienced.

Working with Positive and Negative Emotions: Body Awareness, Symbolization, and Adaptive Emotional Reframing

The second aim of this module is the processing and expression of positive and negative emotions. This focus, which is especially characteristic of the initial stages of PPC, is consistent with the work of Stanton and colleagues (Stanton et al. 2000), who state that emotion-focused coping consists of two factors: (1) emotional processing, that is, active efforts to explore, discover, and understand emotions, and (2) emotional expression, that is, verbal and nonverbal efforts to communicate or symbolize what is expressed emotionally. Research with women with breast cancer has reported long-term benefits of emotional expression during therapy, including increased vigor, a reduction in distress, and a better quality of life (Stanton et al. 2000). It is important to encourage emotional processing and expression during the early stages of cancer as this can facilitate the realization of positive life changes. In a longitudinal study of 167 women with breast cancer and their partners, patients' benefit finding was predicted by their emotional expression at the time of diagnosis, whereas partners' benefit finding was predicted by their emotional processing at the same point (Manne et al. 2004). The strategies used to promote emotional processing can be grouped into those that favor increased awareness (especially somatosensory), those that favor the symbolization of emotions, and those that help patients to regulate and give meaning to their emotions.

During the first sessions of the PPC program, the focus is mainly on negative emotions (sadness, fear, anger, and blame), because bearing witness in a group normally heightens a person's pain in relation to his or her illness. Our work with negative emotions draws upon a similar approach described by Greenber and Paivio (2000). At the same time as working with negative emotions, we progressively introduce work with positive emotions.

While the damaging impact that negative emotions can have on health is irrefutable, evidence regarding the positive effect of positive emotions on health has also begun to emerge. An important review (Pressman and Cohen 2005) suggested that stable positive affect is associated with less morbidity and greater longevity, although limited data are as yet available regarding the effect of more intense and transitory positive emotions (e.g., states of happiness or jubilation). Positive emotions have, however, been linked to increased resistance against adversity (resilience), given their role in preventing, minimizing, and/or modulating negative emotions (Tugade and Fredrickson 2004). In her broaden-and-build

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theory of positive emotions, (Fredrickson 2001) argues that negative emotions tend to involve clear and specific responses designed to solve immediate problems of survival, such that the range of possible responses a person can adopt is reduced. By contrast, positive emotions broaden our repertoire of thoughts and actions, build resource reserves for future crises, and seek to resolve issues related to development, personal growth, and social connection. Therefore, the aim of working with positive emotions (or positive affect in a broader sense) is to attenuate and reduce emotional distress and to broaden a person's ways of behaving, thinking, feeling, and linking with others.

In the initial sessions of the PPC program, positive emotions are managed through the following exercises:

B.1. Becoming Aware of Positive Emotions

Emotional distress commonly blocks some patients from becoming aware of the positive emotions they may still experience. Noting those moments in which patients experience positive emotions is important throughout therapy, but it is particularly important in the early stages in order to buffer the emotional distress that may be evoked when first bearing witness. Positive emotions also help to demystify the effect of talking about the most painful emotions and can encourage patients not to avoid them. In the process they become aware of their capacity to experience pleasurable states; they realize that they can both cry and smile. Pointing out positive emotions also helps to reduce and limit unproductive rumination, thereby breaking the vicious circles that are likely to characterize patients' thought processes.

The awareness of positive emotions can also be encouraged by drawing attention to a patient's nonverbal discourse. For example, a patient may be crying with downcast eyes while explaining how she has suffered during her cancer treatment, and then suddenly she realizes she has used up all the tissues. At this point she looks at the therapist, smiles, and says, "Sorry, I finished the box." The therapist may then highlight all those other gestures that suggest positive emotions, such as smiling, an upright posture, or looking directly into the eyes of others. This work can then continue within the group as a whole, for example, (1) emphasizing the comments that encourage her to appropriate these positive emotions (e.g., "you've done it on your own"), (2) underlining changes in posture (openness: head upright and back, looking ahead), (3) highlighting the effect of transmission, attraction, and connection between this patient and the group ("you've surprised me in a really good way," "you look great"), and (4) the positive model she generates ("yes you can, as can everyone in the group").

In those cases where changes are less spectacular, small gestures or expressions, such as a shy, funny face or smile, can be used to suggest the emergence of a positive emotion and to focus on and intensify this experience.

B.2. Symbolization of Emotional Experience

The person who suffers an extreme event such as cancer may, at times, find it impossible to describe the experience. However, expressing the emotions associated with it is a basic prerequisite for emotional processing. Simple strategies like assigning an emotional label to the patient's unfinished sentences may be useful. For example, a therapist could explain to the patient, "When you go to the hospital, you sit down in the waiting room and hear your name called, you feel. . . (Silence)."

In most cases the emotions overlap, and their expression becomes difficult. For this reason, other types of somatosensory elements, guided imagination, or metaphors are often useful.

B.3. Adaptive Emotional Reframing: Giving Meaning to the Symptoms of Distress as Normal Responses to Abnormal Situations. "The Positive Intention of the Stress Symptoms"

Another common therapeutic intervention in the initial sessions is related to facilitating an adaptive explanation of the emotional distress caused by the illness in terms of "the positive intention of the stress

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symptom." Faced with these symptoms of distress (e.g., posttraumatic symptoms), the patient is encouraged to reconceptualize them from a positive point of view, without resorting to the mistaken idea that "what is happening to you is normal" (see Table 2 for some examples). In most of these examples, giving a positive meaning to emotions is complemented by elements that would indicate when the symptom may be maladaptive (e.g., when a patient feels angry, the anger may be a way of presenting oneself as unavailable to others, thereby allowing the experience to be assimilated without being disturbed; in other words, it is an adaptive function; however, if the anger is maintained, it could become a social problem by generating isolation and solitude).

Module 2: Emotional Regulation and Coping

The aim of this module is to facilitate the emergence of aspects related to psychosocial regulation and coping among group members. Relevant strategies in this regard are

Copying Styles and Emotional Regulation: Awareness and Emotional Balance

The focus here is not only on exploring negative emotions but also on recognizing and working with positive emotions. Thus, we not only ask about how cancer and its consequences have affected patients but also about how they have managed to overcome, resist, and survive the illness. Patients are considered to be the experts in relation to their experience, and the therapist's job is to facilitate the patient's role as observer-protagonist. During the interventions of each group member, the therapist should aim to highlight the positive emotions that are present at that time. Drawing attention to positive emotions is especially important during these early stages, since they have a buffering effect on emotional distress and favor reconceptualization of the cancer experience from a positive perspective.

Horizons of Positive Change

Identifying small positive changes or improvements and highlighting them can help promote the feeling that recovery is possible (Pérez-Sales 2008), if not from the illness itself, then at least from the associated psychological symptoms. In this context, questions such as "How would we know that you are beginning to feel better?" can help to establish a realistic horizon of positive change.

Personal Strengths and Memories of Success in Coping with Past Adverse Events

It is important to point out the positive elements of coping with adversity that cancer patients may overlook, as these aspects reflect their underlying strengths or qualities (Pérez-Sales 2008). The identified strengths can then be used as the basis for change or for developing an alternative way of coping. Asking patients about past situations that, in emotional terms, echo their current situation (e.g., "Have you ever felt like that before?") can help to establish parallels with past situations, thereby encouraging them to draw upon the skills and strengths that were useful then and will likely be of help now. Obviously, the most useful aspects are those that are remembered as successful coping skills.

Intermediate and Final Stages: Facilitating Accommodation Processes in the Cancer Experience

Module 3: Growth Facilitation

Giving Meaning to the Experience

In her review of the meaning-making literature, including the question of how giving meaning to experience facilitates adaptation to stressful situations, (Park 2010) synthesizes the concept of meaning

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Table 2 Adaptive emotional reframing of the symptoms of emotional distress in cancer

Symptom	Emotional reinterpretation / Positive intention of stress symptoms
Irritability or anger	A way of communicating to others that one is not available to them, thereby allowing oneself both time and space to assimilate the experience and to share it when needed.
Hyperactivity or hyper-alertness	A way of preparing ourselves for action. A way of paying attention to what is happening when there is a threat. In the initial stages of the disease it is necessary to cope with its challenges. However, once the main threat has passed, it still takes some time for the body to slow down.
Anesthetizing Emotional distancing	The mind tries to disconnect from a painful and emotionally intensive experience in order to keep a distance and cope better with it.
Negative ruminations and nightmares.	The brain tries to assimilate and give meaning to the experienced event.
Social isolation	An initial way of protecting oneself when one still feels incapable of revealing to others that one is or has been suffering from an illness. These are attempts to avoid losing control.

as follows: "meaning connects things." When experiencing growth from adversity, a number of changes take place in the meaning of significant life events. Survivors from cancer, in their attempt to bring some kind of coherence to their life experience, often try to integrate and to give answers to those aspects of their life that have been questioned by their illness. This search for new meanings is, for most of them, the basis of their posttraumatic growth. In the PPC program, two strategies are used in order to explore an alternative and constructive view of these aspects:

A.1. Work with Recent and Remote Positive Biographical Memories

The role of traumatic memories in relation to posttraumatic stress symptoms has been widely studied (Leskin et al. 1998). More recently, however, this work has been complemented by research on strategies for encouraging and retrieving positive autobiographical memories. Although the use of written exercises or guided imagery (Ochoa et al. 2010; Serrano et al. 2004) to favor these processes may initially heighten a person's awareness of loss, this approach also encourages a re-experiencing of pleasant sensations, as well as personal and relational autobiographical realization, a sense of fulfillment, and, if all goes well, personal growth. In addition, recalling positive memories makes it more likely that the behavior or experience they refer to will be repeated (Wirtz et al. 2003). In the context of cancer, positive memories may lead patients toward the wish to visit significant places or people once again, putting them in touch with a core identity that the disease could not eliminate. In the PPC program we normally suggest working with (1) recent positive memories during the cancer process (e.g., "What would you like to remember from this difficult period? Do you remember any story or pleasant or funny moment that helped you cope with your illness?") and (2) remote positive autobiographical memories. Usually, between sessions 6 and 7, we suggest that the therapist begin to work with these memories in three steps: (1) retrieving through guided imagery a preillness life episode in which the person felt good, where he or she experienced sensations that are now missed (e.g., freedom, a sense of calm, bravery, etc.); (2) opening their eyes and talking about the episode, during which time the group can explore how these sensations remain present; and (3) how might these sensations be experienced again in the future? The intervention here is based on building hope through goal-setting, through the development of skills that can help the person to achieve these aims and to generate the self-motivation that is required to do so.

A.2. Guidelines for Personal Realization

Psychotherapists often look for connections between facts, people, and emotions in order to identify problematic patterns that might explain patients' suffering or emotional distress. However, it is also worthwhile looking for connections between those satisfactory aspects that emerge time and again and

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which generate meaning, self-realization, and a sense of purpose in life. These positive views of significant connections among past, present, and future life are what we call guidelines for personal realization (Ochoa et al. 2010; Vázquez et al. 2014). Although these guidelines may be sought through direct questions to the patient (e.g., "What things have left a positive impression on your life?"), it is better if patients reach their own insights into these aspects. In the context of cancer, the guidelines that are easiest to identify are those connected to significant relationships which help patients to maintain a sense of greater continuity after the disease (e.g., "family members who were there," "my partner has made me feel loved," "the hobbies that make me feel useful and valid," etc.).

Relational Growth

One of the relevant indicators of an improvement in mental health and personal growth is the capacity to transcend one's ego (Joseph 2011). Relational growth has to do with an interest in others and a commitment to them, as well as loving and being loved. These are key elements in the facilitation of personal growth among cancer patients. However, the effects of trauma and growth after an illness are not limited to survivors but are also relevant to those relatives or significant others who help with, witness, and experience the patient's illness. In fact, a review focused on cancer survivors and their partners (Ochoa et al. 2013) concluded that significant others around cancer patients experience vicarious personal growth, which is transmitted and closely related to patient's personal growth. In the PPC program the strategies used to facilitate relational growth are

B.1. Promoting and Arousing Interest in Others and Working with Positive Models Against Adversity

Many psychological interventions are focused on promoting empathy, that is, on the ability to experience the emotions and intentions of others and to understand their limitations. In our positive psychotherapy model we often use an "anthropological task" (Nardone et al. 1999) to encourage a patient's interest in others following illness. Specifically, we invite group members to carry out an "anthropological investigation" of between one and three people they know over a period of a few weeks. They are asked to write down all the things that make these people suffer or which they are worried about, as well as the things that make them smile and those activities that help the patient make contact with that person (talking, sharing, etc.). The aim of this exercise is to help patients shift their focus away from themselves toward others, thereby encouraging them to broaden their social network and, hopefully, increase their well-being.

Cancer survivors may spontaneously wish to have contact with someone who has had the same cancer. Therapy groups and patient networks reflect this willingness to share and deal collectively with the problems being faced. This kind of contact can often be a source of personal growth if the person agrees to interact freely, and the group provides its members with the experience of positive role models. Weiss (2004) demonstrated the importance of this modeling in women who had contact with other breast cancer survivors who perceived benefits of their experience, noting significantly personal growth in those seeking benefits (positive life changes) in contrast to women who had not had that contact. In our program we encourage patients to think about a significant person in their life who had overcome an important difficulty (ideally, a severe illness), and we then ask them what it is that makes this person special. What are this person's virtues? How does he or she behave in this situation?

B.2. Gratitude and Forgiveness

In severe and chronic illnesses, interpersonal relationships may be affected by the relative balance or imbalance between what is given and what is received. It is common for survivors to make a mental checklist of people who have helped them and those who have not. Gratitude and forgiveness interventions are focused on this process of assessment and its consequent strengthening or reparation of personal relationships. Gratitude-based interventions, therefore, aim to facilitate an awareness of having received

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something positive from someone, as well as seeking ways of thanking them (gratitude letters, public recognition, etc.). With forgiveness-based interventions the aims are (1) to encourage empathy toward the aggressor when this has personal meaning, (2) to recognize one's own faults and defects, (3) to value the type of attribution and behavior shown by the aggressor, trying if possible to reduce the perceived intentionality, and (4) to reduce rumination on the event or events, as this favors a desire for revenge and reduces the likelihood of forgiveness.

Module 4: Existential and Spiritual Aspects and Group Conclusion

Existential and Spiritual and Aspects

A.1. Foreseeing Recurrence and Increased Awareness of Mortality and Transience and Dealing with Emotional and Existential Numbness

Leaving religious or spiritual beliefs aside, a severe disease generates primary emotions and makes people think about their existence and meaning in life. A person may become aware of their own mortality, which can lead to a heightened interest in existential and spiritual concerns. Indeed, cancer patients often ask transcendental questions about death, freedom, loneliness, and meaninglessness (Yalom 2000). In this context, growth in illness may be regarded as a different existential position, one which emerges from increased awareness and clarity and the depth of these existential worries. In our group work the question that serves to open up these existential topics on a deeper level is "How do you think you would cope with a cancer relapse?" The most common answer involves worries about the loss of significant others, a fear of suffering, or loss of autonomy, among other issues.

In group interventions, narratives of emptiness and existential numbness often emerge through expressions of disillusionment, defenselessness, and the feeling of living without waiting for anything. Making this explicit at the right time can help some group members to react against this image.

A.2. Transcendence and Regret as a Constructive Pathway: Working with Values, Legacy, and the Possibility of Becoming a Role Model at the End of Life

Anticipating the possibility of relapse is another way of dealing with topics related to transcendence, and it can be guided through questions like: How would you like to be remembered in the event of your death? What values would you like to pass on to others before you die? Questions such as these facilitate the transmission of intergenerational values, of the possibility of leaving behind a legacy for significant others, and they can help the patient position themselves in a transcendent way in relation to others.

Although regret is not normally constructive, it can be used as a way of encouraging change, for example, through questions such as: How would you like to experience and remember the period prior to relapse? What things would you like not to regret in the event of a relapse?

Group Conclusion

B.1. Farewell Letter

This is used as a way of capturing what has been learned and reflected upon during the group experience, and it aims to address questions such as: What has taking part in this group meant for me? What things are still pending for me to do once the group is over? The farewell letter also prepares the ground for later follow-ups (at 3 and 12 months after the group ends).

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Evidence for the Effectiveness of Positive Psychotherapy in Cancer

Several recent meta-analyses report a consistent relationship between variables related to psychological well-being (positive emotions, growth, or benefit-finding) and associated health outcomes such as mortality, physical health indicators, and the degree of recovery in physical illness (Vázquez 2013). In addition, the overall results of meta-analyses in the field of cancer show that patients who experience PTG are better adapted after the disease, showing improved mental health and better perceived physical health (Helgeson et al. 2006; Sawyer et al. 2010). In particular, PTG in cancer has been associated with less emotional distress and fewer posttraumatic symptoms (Sawyer et al. 2010). Although high levels of posttraumatic stress have been linked to loss of quality of life in cancer patients (Cordova et al. 1995), this association is buffered (Morrill et al. 2006) by the presence of PTG, suggesting that growth can be an avenue which therapists could use to enhance quality of life among cancer survivors. PTG has also been associated with more health-promoting behaviors (Milam 2004) upon survival. For example, growth has been linked to better adherence to routine surveillance checks in women with breast cancer (Sears et al. 2003). Note, however, that the adaptive value of personal growth in cancer patients must not be understood in relation to the absence of emotional distress but, rather, as a way of channeling, metabolizing, and dampening it (Ochoa 2014).

In general, meta-analytic studies show that positive psychology interventions are effective for various clinical problems (Bolier et al. 2013; Sin and Lyubomirsky 2009), although more studies using control groups and longer follow-up are required (Bolier et al. 2013). A recent systematic review (Casellas-Grau et al. 2014) of positive psychology interventions for survivors of breast cancer concluded that these interventions are able to increase quality of life, well-being, posttraumatic growth, hope, meaning, happiness, optimism, life satisfaction, and benefit finding. The PPC program has also been evaluated and was shown to be effective. Specifically, PPC was found to be capable of reducing emotional distress and posttraumatic stress, as well as facilitating PTG among cancer patients (Ochoa 2009, 2010, 2012), when compared with a list group and also with a standard cognitive-behavioral stress management therapy (Antoni 2003, 2006). Moreover, preliminary studies of outcomes at 3 and 12 months follow-ups indicate that the PPC program generates higher rates of stress management than the standard cognitive-behavioral management therapy (Ochoa 2012).

Key Facts

Cancer patients and their significant others experience a range of negative states.

These negative states can, however, trigger the emergence of growth and positive life changes which have a strong adaptive value.

Positive psychotherapies promote growth and are now opening up an interesting and useful area of research.

Facilitating growth in cancer patients may be a better therapeutic strategy for reducing distress than is traditional stress management.

Positive psychotherapies reduce distress and posttraumatic symptoms, and also facilitate growth.

Summary Points

The experience of a disease like cancer can produce negative emotions and states among patients.

Negative states can, however, trigger the emergence of positive life changes and positive emotions among cancer survivors.

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Positive psychotherapy aims to promote positive life changes such as posttraumatic growth in cancer survivors.

Our positive psychotherapy program comprises 4 modules spread across 12 sessions that recreate the natural and therapeutic process of assimilation and accommodation of the cancer experience.

The four modules address emotional processing and expression, emotional regulation and coping, the facilitation of growth, and existential and spiritual aspects.

Positive psychotherapy in cancer has proved effective in reducing distress and facilitating PTG.

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