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RE-CREATING YOUR LIFE: A SPIRITUAL/PSYCHOTHERAPEUTIC INTERVENTION FOR PEOPLE DIAGNOSED WITH CANCER

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SUMMARY

This paper describes a pilot psychotherapy program for people who have experienced cancer that integrates spiritual issues and resources. The name of the program is: *Re-Creating Your Life: During and After Cancer*. The literature suggests that people experiencing cancer wrestle with existential concerns related to control, identity, relationships, and meaning. For spiritually oriented people, religious and spiritual issues are likely to be embedded in these existential concerns. Moreover, spiritual resources are likely to play a role in resolving these issues. This seems even more likely given the body of research suggesting that spirituality and religion play a helpful role when people face a traumatic life event. The few studies that have examined the importance of religious variables for people experiencing cancer have found that this is also true for this population. Thus, a psychotherapeutic program for persons diagnosed with cancer might be more efficacious if it integrated spiritual issues and resources. This paper describes a treatment program oriented towards this goal and presents rationales for the interventions that are included in the therapy process. The program addresses the four existential concerns listed above, in ways that integrate spiritual issues and assist participants in drawing on spiritual resources. An outcome study is currently underway to evaluate the effectiveness of this intervention. Ten participants have participated, results are promising, and will be published when data collection is completed. Copyright © 1999 John Wiley & Sons, Ltd.

INTRODUCTION

Psychotherapy can offer important benefits to people confronted by a diagnosis of cancer. A variety of psycho-educational and supportive group therapies have reduced the psychological distress related to coping with cancer. Interventions have positively impacted functioning in terms of increased self-esteem, fighting spirit, vigor, positive body image, better relationships with partners, more internal locus of control; and decreased anxiety, depression, aggression, confusion, sense of helplessness, fatigue, psychological distress in general, and intrusive thoughts related to cancer (Bos-Branolte *et al*., 1988; Fawzy *et al*., 1990; Greer *et al*., 1992; Baider *et al*., 1994; Moorey *et al*., 1994). In addressing specific symptoms related to illness and treatment, training in self-hypnosis has been efficacious in reducing pain intensity (Spiegel and Bloom, 1983), relaxation training has been helpful in reducing the negative side-effects of chemotherapy (Lyles *et al*., 1982; Morrow *et al*., 1998), and relaxation training as an adjunct in radiation treatment has decreased tension, anger, depression, and fatigue (Decker *et al*., 1992). Moreover, a few studies are beginning to suggest a link between psychological interventions and physiological well-being. While conclusions are tentative given the small number of studies that have examined this relationship, there is some evidence that interventions may impact immune system functioning (Fawzy *et al*., 1990; Gruber *et al*., 1993) and survival rates (Spiegel *et al*., 1989; Fawzy *et al*., 1993; Classen *et al*., 1998). Thus overall, interventions have reduced many of the psychological stresses associated with this life-threatening illness. As further support, a recent meta-analysis confirmed that psychosocial interventions from a variety of treatment modalities positively impact emotional and functional adjustment, and symptoms related to disease and treatment (Meyer and Mark, 1995).

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Thorough reviews of the literature on interventions for people diagnosed with cancer are available elsewhere (Andersen, 1992; Fawzy *et al.*, 1995; Fawzy and Fawzy, 1998) and one will not be presented here. However, we will highlight two specific studies utilizing interventions that share some similarities with the one described here: psycho-educational interventions with a strong cognitive-behavioral emphasis. Both studies used randomized treatment and control groups.

First, Fawzy *et al.* (1990) assessed the effectiveness of a structured group intervention for persons diagnosed with malignant melanoma having a good prognosis. Participants were randomly assigned to a treatment group or control group. The intervention included six weekly-sessions that lasted 1.5 h. It involved health education (nutrition, exercise, and sun exposure precautions), stress management (self-assessment of stress and relaxation techniques), problem solving strategies related to the cancer experience, and psychological support from the staff and peers. Outcome measures were administered pre and post-treatment and six months post-treatment. Scores on the Profile of Mood States at post-treatment revealed that the intervention had a significant effect on vigor. The positive effects of the intervention were even more evident at the 6-month follow-up. The participants in the treatment group continued to report more vigor relative to the control group. But significant gains were also evident in reports of less depression, fatigue, confusion and lower overall mood disturbance relative to the control group.

A second study by Greer *et al.* (1992) provided additional support for the helpfulness of a cognitive-behaviorally focused intervention. The participants in this program varied in cancer site and were experiencing psychological distress as determined by their scoring a standard deviation from the mean on measures assessing anxiety, depression, helplessness, or fighting spirit. They were randomly assigned to a treatment group or control group. The intervention included: exploration of the meaning of a cancer diagnosis to the individual, discussion of the patient's coping strategies, problem-solving focused on the participant's current concerns, building on current strengths, identification and challenge of negative automatic thoughts, use of imagination and role play to prepare for anticipated stressful events, increasing positive activities related to achievement and pleasure, increasing effective communication, and progressive muscle relaxation. The intervention was intended to include eight weekly-sessions but compliance rates varied and the average number of sessions attended in a 4-month period was five. This poses some problems in interpreting the data since the treatment content and dosage consequently varied considerably across participants. Only 31% of the participants received six or more sessions by the end of the 8-week treatment period. Keeping this limitation in mind, the intervention had a positive impact on several dimensions assessed at the end of the intervention period. The participants in the treatment group were reporting lower degrees of helplessness, anxious pre-occupation, fatalism, anxiety, fewer psychological symptoms, a better orientation towards health care, and more of a fighting spirit relative to the control group. Gains for the treatment group participants were also evident at follow-up assessments. Relative to the control group they reported lower scores on anxiety, psychological symptoms, and psychological distress at 4 months. One year later the therapy group continued to report significantly less psychological distress and was less likely to report clinical levels of anxiety (Moorey *et al.*, 1994).

These two studies are good examples of the ways in which psychosocial interventions can be helpful in the coping process, providing benefits that extend well beyond the intervention period. Along with interventions like these, spiritual resources are also likely to play a helpful role for several reasons. First, the literature suggests that existential concerns often arise in the face of life threatening illness. For spiritually oriented people, these concerns evoke spiritual issues and call for spiritual resolutions. Second, empirical studies indicate that religious issues are commonly relevant and religious coping may help people confronted with difficult life events. Moreover, research suggests that these findings apply to people experiencing cancer. And finally, spiritually framed psychotherapeutic interventions have proven efficacious in treating psychological distress. Below we examine each of these three rationales for including spiritual issues in efforts to assist people with cancer.

Yalom (1980) suggests that existential themes of death, freedom, meaning, and isolation often emerge in psychotherapy. Researchers and people experiencing cancer have noted similar themes emerging from the cancer experience. In particular, facing cancer evokes concerns about limits of

control (Fiore, 1991; Howe, cited by Tsongas, 1984; Dreifuss-Kattan, 1990), *identity* (Kaufman and Micha, 1987; Doyle, 1992; Lourde, cited by Dreifuss-Kattan, 1990), *relationships* with others (Wood *et al*., 1978; Vastyan, 1986; Kaufman and Micha, 1987; Bos-Branolte *et al*., 1988; Doyle, 1992; Spiegel, 1994), and *meaning* (Peteet, 1985; Vastyan, 1986; Dreifuss-Kattan, 1990; Doyle, 1992).

For religious persons, spiritual or religious issues are likely to be embedded in these themes (Vastyan, 1986; Doyle, 1992) and may facilitate a satisfactory resolution of these existential concerns. Spirituality (i.e. one's experience of being in relationship to a transcendent reality) offers a means for coming to terms with the limits of personal *control*. Surrendering the uncontrollable into the hands of a transcendent power may facilitate acceptance of human limitations and generate a sense of peace and security (Baugh, 1988; Cole and Pargament, 1999). As Vastyan (1986) has suggested from his observation of people with cancer, spirituality additionally allows the patient to find *meaning* in the event and an enhanced *identity*. This may come about as the patient experiences a connection to an infinite reality (i.e. God, Higher Power, etc.) that transcends biological existence. As Propst (1988) suggests, such a relationship may also relieve feelings of insignificance. And finally, a spiritual orientation may ease alienation and positively impact *relationships* with others. Spirituality is said to facilitate an experience of oneness with all existence (Randour, 1987; Shainberg, 1993) and a sacred interconnectedness with other people (Houff, 1989). Thus, a program that integrates spiritual issues and resources in psychotherapy is likely to be doubly helpful for individuals facing the diagnosis and treatment of cancer.

Empirical research also supports the value of including a spiritual focus in therapy for people diagnosed with cancer. First, studies suggest that patients are at times troubled by religious issues. Peteet (1985) found that 36% of a sample of patients referred for a psychiatric consultation were struggling with religious issues that were related to their cancer. Second, studies suggest that religion and spirituality often play a helpful role in the coping process (O'Brien, 1982; Maton, 1989; Pargament *et al*., 1990; Park *et al*., 1990; Siegel and Kuykendall, 1990; Kass, 1991; Kass *et al*., 1991; Koenig, 1993; Park and Cohen, 1993; Pargament, 1997; Bickel *et al*., 1998). Additional studies suggest that these findings hold true for people with cancer as well as people facing other traumatic events. Among people with cancer, strong religious beliefs have been associated with decreased levels of pain, anxiety, hostility, social isolation, and increased life satisfaction (for a review see Jenkins and Pargament, 1995). Jenkins and Pargament (1995) suggest that people diagnosed with cancer, in general, tend to find 'comfort, solace, and support' through their religion and a framework that provides meaning for their experience (p. 62). For example, in one study, people with advanced cancer who reported feeling close to God or nature experienced greater satisfaction with life, increased happiness and positive affect, and decreased pain (Yates *et al*., 1981). Other researchers have recognized the importance of religion in providing 'meaning' and 'explanations' (Musick *et al*., 1998). One study found that a majority of a sample of adolescents with cancer reported that their religious beliefs provided meaning, purpose, security in the face of death, and a means of gaining assistance with things beyond their control (Tebbi *et al*., 1987).

A spiritually framed intervention is also likely to be helpful for this population given that similar interventions have been helpful for other people experiencing emotional distress (Propst, 1980; Propst *et al*., 1992). Propst and colleagues have randomly assigned depressed clients to either a cognitive behavioral treatment (CBT) condition or similar condition that integrated a spiritual framework. For example, Propst *et al*. (1992) included cognitive restructuring exercises and behavioral assignments in their CBT condition. The spiritually framed intervention provided a Christian rational for the interventions, Christian beliefs were used to dispute irrational beliefs, and religious imagery was used to support cognitive restructuring. The results of both studies indicated more favorable outcomes for the spiritually integrative interventions.

This review of the literature suggests that spirituality plays a helpful role for religious people as they cope with the diagnosis and treatment of cancer. Therefore, it seems important to design psychotherapy interventions for this population that integrate spiritual issues and resources. Equally important is assessing the efficacy of such a protocol in comparison to currently used psychotherapy protocols. However, no studies have attempted to assess the effectiveness of integrating a spiritual perspective in therapy for this

population. In reviewing treatment outcome studies in the literature, only one was found that mentioned spirituality as a component of the treatment. In this study spiritual issues were discussed as one part of a comprehensive psychoeducational treatment design (Cunningham and Tocco, 1989, cited by Fawzy *et al*., 1995). The treatment was significantly more effective relative to a no treatment control group. However, the multifaceted nature of the treatment does not permit conclusions about the unique effectiveness of the spiritually oriented discussion.

In response to this gap in the literature, the first author has designed a treatment manual integrating spirituality and psychotherapy for this population and both authors are jointly conducting outcome research on the efficacy of this form of treatment. Currently, ten participants have taken part in a promising pilot study (Cole *et al*., 1998). In the rest of this article we describe a few of the major components of the treatment protocol and the rationales for the interventions. The interventions are formulated around the four existential issues noted above: control, identity, relationships, and meaning.

TREATMENT PROGRAM

Control

The narratives of people who have faced cancer suggest that the loss of control is an especially salient and painful aspect of the experience (Tsongas, 1984; Dreifuss-Kattan, 1990; Fiore, 1991). For example, Howe (cited by Dreifuss-Kattan, 1990) had this to say about his experience:

> Over the past few weeks I pondered how chemo was ruining my life. By late fall I no longer considered myself a Harvard graduate student researching and teaching international affairs. I was a cancer patient, totally dependent upon forces which I could neither understand nor influence... 'It's not that life is so unfair', I concluded, 'but that it's so uncontrollable' (pp. 52–53).

Howe's reactions are not atypical. Therapists have observed feelings of loss of personal control as well as helplessness among cancer patients (Kaufman and Micha, 1987) and have found it an important theme during group therapy sessions (Wood *et al*., 1978). Thus, it seems that control is an important issue to address, especially considering that increased perceptions of personal control are associated with better psychological outcomes (O'Brien, 1982; Ell *et al*., 1989; Thompson *et al*., 1993).

Our program focuses on two aspects of control: things under personal control and things beyond personal control. We assist participants in delineating differences between these two domains through an activity adapted from Baugh (1988). Participants are provided a sheet of paper with two large circles on it. One circle is labeled 'Things under my control' and the other is labeled 'Things under God's control'. Participants are then asked to write in concerns or problems that they have, placing each in the appropriate circle. They then present their diagrams to the group and the group helps them reconsider any items that appear to be placed in the wrong circle. Things appropriate for the 'under my control' circle include: choosing a doctor, how many hours I work, eating well. Things typically placed in the 'under God's control' circle include things like: the final outcome of treatment or how my family will cope with my death.

When they are finished, the group is asked to first focus on the second circle, things under God's control. Participants are introduced to an activity to assist them in letting go of things beyond their control. Religious imagery and teachings can be especially helpful in this regard. Propst (1988) has used images of Christ with Christian clients to facilitate a relaxation response. She writes, 'The idea is to let go of all competing distractions until we are truly centered only on this image of Christ. This is an active surrender, an abandonment of oneself, one's thoughts, and one's cares to the Divine One' (p. 138). The helpfulness of this type of reflection was supported by a study by Carlson *et al*. (1988). Participants in their study were asked to practice contemplative prayer, prayer which involved experiencing God 'in a quiet, non-verbal and open manner' (p. 363). These participants subsequently reported greater reductions in anxiety and anger than did a non-treatment control, or group using progressive muscle relaxation. Thus, for people with cancer, letting go through religious practices and imagery is likely to be helpful in coping with things beyond their personal control. This approach to coping is more reflective of emotion-focused coping than more control oriented problem-focused coping as delineated by Lazarus and Folkman (1984). And research suggests that

emotion-focused coping is more helpful than problem-focused coping in low control situations (Strentz and Auerbach, 1988).

To facilitate letting go, we lead the participants in our groups through a guided imagery relaxation exercise we call the 'Breath of God'. We help them relax through deep breathing and imagining a peaceful scene. We then ask them to visualize God's presence around them as a white light, and to imagine inhaling this white light with each breath. Next, we encourage them to ask God, 'What do I most need to surrender to you', to listen for the answer, and then to visualize surrendering this to God. Many participants have told us that this exercise is particularly comforting and meaningful.

We next ask the participants to focus on the first circle: 'things under my control'. We first point out the paradoxical nature of surrender. Letting go inadvertently increases control—control over anxiety and bodily tension. Thus, they are encouraged to practice the surrendering exercise not only as a way of letting go of things they cannot control, but also as a way of controlling physiological arousal. In addition, nurturing self-care is particularly important in managing stress and can increase perceptions of control. It is especially important for people with cancer to spend time each day providing for their physical and emotional needs for rest, relaxation, time for reflection, exercise, nutrition, and social support. In supporting this goal, participants are given a creative living plan, a weekly calendar on which to schedule in times for these types of activities. They are then led through a short guided imagery in which they visualize God's loving presence providing emotional support and encouragement to take time out for themselves.

The group also discusses increasing control through assertive conflict management. Therapy often assists clients to act assertively to resolve conflicts with others. This skill is likely to be especially important for people with cancer. Conflict with doctors, other medical personnel, family, and friends is likely to arise in the healing process. If not resolved effectively, this conflict could further undermine feelings of control, self-esteem, and exacerbate emotional distress. In addressing this issue, participants are first helped to assess their assertiveness skills by completing the Assertiveness Scale, a subscale of the Personal Assertion Analysis questionnaire (Hedlund and Lindquist, cited by Fischer and Corcoran, 1994). In place of one of the items on the scale we insert 'When my doctor says something that I disagree with or don't understand I ask questions'. Participants compare their scores to the scale mean and to their own self-evaluations of assertiveness. To develop assertiveness further, the therapist presents information on assertive conflict resolution strategies and the group role plays several conflict situations. In one group, one of the women needed to return a specialized bra that she had purchased following her mastectomy. She was feeling hesitant and worried about being able to stand up to the sales clerk who had recommended the product. With the group's help she practiced presenting herself assertively to the sales clerk and, as a result, felt well prepared to handle the conflict on her own.

To bring spirituality alive in this discussion, and to explore any potential conflicts between religious beliefs and assertive behavior, the participants are asked the question, 'How do you think God is feeling about your assertiveness'. If participants have difficulty seeing caring, assertive behavior as congruent with their spirituality, they are helped to explore the basis of this belief. They are also encouraged to identify assertive religious leaders from their own religious orientations and to use these figures as role models. They are then led through a short guided visualization in which they imagine themselves acting assertively in the presence of God, imagine their religious role model cheering them on, visualize the look on God's face, and reflect on God's role versus their own role in the situation.

Throughout this process, participants are encouraged to view God as a partner in their work towards conflict resolution. Studies of coping with stressful events suggest that a collaborative approach is more helpful than a deferring (Pargament *et al.*, 1988) or self-directing approach (Pargament *et al.*, 1990), especially in low control situations (Bickel *et al.*, 1998). In the collaborative approach, the individual sees God as a supportive, active, and helpful partner, who works with the individual in the coping process. In a deferring approach, the individual passively defers problem solving to God and no personal effort is made to actively resolve the conflict. And in a self-directing approach, the individual may recognize that God plays a role in the universe, but believe that the outcome of events is entirely in the person's own hands. Bickel *et al.* (1998) found that in high stress situations a collaborative

approach was associated with decreased depression while a self-directing approach was associated with increased depression. The deferring approach was not associated with either higher or lower levels of depression. These results suggest that a collaborative approach may be especially helpful for persons with cancer as they face limits on personal control.

Identity

Along with threats to personal control, cancer often threatens one's sense of identity and self-worth. As social and familial roles, physical strength, and appearance undergo radical transformations, one's self image and accompanying feeling of being needed by others are severely threatened. Doyle (1992) provides this poignant example:

> How clearly I remember thoughtlessly hurting a grossly Cushingoid lady on steroids for her breast carcinoma—a lady whom the family doctor had asked me to see because she was isolating herself from her husband and becoming a recluse. I observed a photograph on the piano of a voluptuously beautiful bathing belle and remarked what a lovely daughter she had. It was, she pointed out tearfully, actually a photograph of her taken a year before! 'I'm not me anymore', she cried. 'I can't make sense of it all' (p. 306).

An American poet, Audre Lourde (1980, cited by Dreifuss-Kattan, 1990), felt a similar loss:

> I want to write of the pain I am feeling right now, of the lukewarm tears that will not stop coming into my eyes—for what? For my lost breast? For the lost me? And which me was that again anyway? For the death I don't know how to postpone? Or how to meet elegantly? (p. 5).

These women echo the despair and confusion of many others for whom cancer disrupts their sense of self. They are not alone in their struggle to find new identities and a renewed sense of self-worth. Clinicians have identified issues of 'professional identity, role, independence, sense of self, and change in body image' as salient for cancer patients (Kaufman and Micha, 1987, p. 542). Moreover, in one study of 83 cured gynecological patients, 20% reported problems with body image and 30% reported problems with self-esteem (Bos-Branolte *et al.*, 1988). Thus, the conclusion Dreifuss-Kattan (1990) draws from the stories of 31 cancer authors may be accurate: 'The cancer stories... are often accounts of finding a new identity, of becoming a new person' (p. 7).

In our program we help people come to terms with changes in identity in a two step process. First, we focus on expressing the grief that accompanies a cancer diagnosis. In grief resolution, therapists have typically emphasized acknowledging the loss and expressing feelings related to the loss (Rando, 1984; Baugh, 1988; Worden, 1982, cited by Dershimer, 1990). To work towards this goal, we have participants create a 'loss list' of all the things they have lost with the diagnosis of cancer. They pair off with another group member and each one reads his/her 'loss list'. In this way each one acts as a witness, acknowledging the losses of the other. Then, as a homework assignment, they are encouraged to read their list twice a day at home until the list no longer arouses strong feelings.

This technique of reading through a loss list is likely to be helpful due to exposure effects. Exposure to distressing stimuli has historically been helpful in decreasing negative affect related to that stimuli (Emmelkamp, 1990). Grief counselors use imagined exposure to death related events or losses to help the bereaved deal with grief related issues (Kleber and Brom, 1985, cited by Dershimer, 1990). Empirical studies suggest that these types of exposure techniques are helpful to the bereaved. Participants in exposure treatment groups experienced moderately less phobic avoidance and depression relative to participants who were directed to avoid thinking about the deceased (Lieberman, 1978; Mawson *et al.*, 1981; both cited by Rando, 1984).

Exposure techniques may work in part by aiding the assimilation of information that is counter to one's self-schema. Referring to stressful life events, Horowitz (1979, cited by Cleiren, 1993), believes that new information (memories and thoughts about the stressful experience) has to be repeatedly processed until it can be assimilated into current knowledge structures. Cleiren (1993) suggests that this process is also important in the initial phases of bereavement. Similarly, this is likely to be an important process in coping with cancer. Losses related to one's identity (physical strength and appearance, work and familial roles, interpersonal relationships, and possibly emotional resilience) may need to be repeatedly presented and processed until the loss can be integrated into one's self-schema in a way that re-establishes a sense of self-worth.

Therefore, this type of intervention is likely to be helpful for most participants. However, there is some risk that it may prove to be too distressing for some individuals. This impact is not likely given the self-directive nature of the activity and ability of the individual to avoid confronting losses that are too distressing. The risk can be further minimized by encouraging participants to be respectful of their own readiness to face loss. Furthermore, the therapist should monitor individual reactions to the exercise, intervene where appropriate, and process the homework assignment during the next group session.

As the second part of the grieving process, we ask the participants to complete an 'I am list'. They list things that continue to be valuable about themselves in spite of having a cancer diagnosis. Reading this list, following the 'losses list' places the losses in a broader perspective and reinforces positive aspects of one's self-schema. Moreover, focusing on the positive is an activity encouraged by cognitive psychologists (Propst, 1988; cf. Rehmn, 1982, cited by Propst, 1988). Propst (1988) recommends this type of list-making especially for depression, a problem often experienced by people diagnosed with cancer. During the session, and subsequent to processing the 'losses list', we have participants pair off and read their 'I am list' to a partner. At home during the week, they are also asked to read their lists twice a day after reading their 'losses list'.

To integrate spirituality in this two step grieving process, we ask the participants to imagine God present with them as a witness to their loss and pain as they read their lists at home. Some participants experience God's presence as comforting and reassuring. One member reported that the loneliness she had felt in facing cancer had decreased considerably after a week of doing this exercise. Imagining God's presence may help participants feel that their losses are acknowledged and their feelings validated. Thus, just as their partner in the group initially provided a compassionate witness, God can continue to provide a compassionate presence. In addition, as participants move from acknowledging losses to reading the 'I am list', visualizing God's presence may again be helpful. God may be experienced as accepting and affirming of the individual's self-worth.

As the final part of the session on identity, participants are led through a transformation guided imagery similar to one described by Krystal and Zweben (1988). After going through a relaxation exercise, we have participants imagine wearing a robe that is indicative of themselves prior to their cancer experience and to reflect on the meaning of that robe. We next have them imagine the robe changing to represent the self that has been diagnosed with cancer. They are encouraged to reflect on the significance of this robe. We then suggest they imagine leaving behind their past selves by symbolically taking off all robes and walking out into a lake of cleansing waters. We suggest they wash in the lake, washing away the selves that they used to be, and cleansing their spirits. We ask them to reflect on their present experiences of themselves, their human qualities, weaknesses and strengths. We then suggest that they imagine walking out of the water and feel the presence of God surrounding them as they are asked to ponder the question: Who are you now? We suggest that there is a new robe waiting for them on the bank, a robe that represents their true spiritual identity, their unique talents, and the special role that they play in creation. We ask them to reflect on the significance of this robe and ponder who has left it there for them.

We believe that transformation imagery like this, focusing on letting go of one's past identity and embracing one's current self, inclusive of both human and spiritual aspects, is helpful for people diagnosed with cancer. It offers them the opportunity to see beyond human limitations, involving pain and suffering, and to affirm their strengths and positive attributes. Moreover, by including the Sacred within the context of the guided imagery, the patient may reaffirm his/her spiritual identity and spiritual worth that transcends the human experience of cancer.

Relationships

A diagnosis of cancer may have devastating consequences for relationships with oneself and with others. This was evident in the above description of the Cushingoid woman who not only felt separated from her previous identity, but also had become isolated from others, including her spouse. When Doyle saw her, she had not found a way to recreate her relationships with others. Her course, instead, was to withdraw. Her reaction may not be uncommon. Others have observed that patients fear being rejected by others

(Kaufman and Micha, 1987) and often become isolated and withdrawn (Vastyan, 1986; Spiegel, 1994). And therapists have noted that isolation is a common theme that arises in group therapy (Wood *et al.*, 1978). Moreover, for some people, relationship difficulties persist even months after successful treatment. In a sample of cured gynecological cancer patients at least 6 months in remission, 29% reported difficulties in closeness with their partner (Bos-Branolte *et al.*, 1988). Finally, along with withdrawing from social contact, the feeling of being abandoned or punished by God that some patients experience, especially the terminally ill (Doyle, 1992), suggests that many may withdraw even from God.

Therefore, in our program we focus on three types of relationships that can be disrupted in coping with cancer: relationships with oneself, with others, and with God. The exercises directed towards relationships with others were already discussed above in the section on control. In this section we describe activities directed toward improving relationships with oneself and with God.

In the first half of the session, the group focuses on the relationship with oneself. Participants discuss the extent to which they treat themselves lovingly and the impact this has on their sense of well being and level of stress. The group explores three ways in which a relationship with oneself can be nourished: listening to one's feelings, positive self-talk, and self-care. First, participants discuss the importance of listening to one's feelings. Weekly self-monitoring forms are used for participants to practice identifying feelings and accompanying triggers for both negative and positive affect. Next, participants discuss the importance of positive self-talk. The therapist leads them through an exercise in which they intentionally give themselves negative self messages like, 'I'm so stupid and useless', and asks them to monitor their affective reactions. Next, the therapist has participants give themselves positive self-messages like, 'I am lovable and my life is worthwhile', and again monitor their affective response. This exercise leads to a discussion of how our thoughts affect how we feel. And finally, participants discuss the importance of self-care in the form of taking time out for play, rest, relaxation, reflection, exercise, and being spiritually present to the moment.

Spirituality is integrated into this discussion in two ways. First, participants are asked to reflect on questions like: What is Gods' reaction to these types of self-nurturing activities? Can they imagine God encouraging them to take time out for themselves and helping them by providing loving support? Secondly, in order to facilitate being spiritually present to the moment, participants read and discuss a verse by Helen Mallicoat (source unknown):

> I was regretting the past and fearing the future.
> Suddenly my Lord was speaking: 'My name is I AM'.
> He paused. I waited. He continued,
> 'When you live in the past with its mistakes and regrets, it is hard.
> I am not there. My name is not I WAS.
> When you live in the future, with its problems and fears, it is hard.
> I am not there. My name is not I WILL BE.
> When you live in this moment it is not hard. I am here, My name is I AM.

In the second half of this session, the participants focus on their relationship with God. They discuss how close they feel to God as well as any anger, guilt, or abandonment that they may feel with God, related to their diagnosis of cancer. To resolve conflict in their relationship with God and distressing feelings they may have in that relationship, participants are led through a 'Circle of Light' guided imagery. Again, we begin by leading participants through a relaxation protocol and then have them visualize God present, become mindful of feelings they have towards God, share these feelings with God, and then listen for God's response. They then imagine themselves surrounded by a circle of light symbolizing harmony and oneness with God.

This exercise is a version of the 'two chair' technique used by Gestalt psychologists. Gestalt therapists have traditionally employed this technique successfully to resolve intra-personal and inter-personal conflict (Greenberg, 1979; Clarke and Greenberg, 1988; Pavio and Greenberg, 1995). Applied to inter-personal conflict, clients are asked to sit across from an empty chair. They then are asked to imagine that the person with whom they are in conflict is seated in that chair. Clients are then directed to enter into a dialogue between themselves and the significant other with whom they have experienced unresolved conflict (Passons, 1975; Greenberg *et al.*, 1989; Pavio and Greenberg, 1995). The therapist invites the client to re-experience 'previously unexpressed emotional reactions' related to a 'negative or troubling

view of the other' (Greenberg *et al.*, 1989, p. 185). The 'other' may be a person currently alive, deceased, or even imaginary (Passons, 1975). Clients are then helped to take on the viewpoint of the 'other' with the goal of developing greater understanding of the other. And finally, clients are helped to reconstruct 'a new schematic representation of the self-other relationship' (Greenberg *et al.*, 1989, p. 185). Our guided imagery mirrors this process, with God playing the role of the significant other. Through an imagined conversation with God the individual is helped to reconstruct a relationship with the Sacred that integrates the negative affective response to the diagnosis and re-establishes a sense of trust, mutual affection and connectedness.

Meaning

Researchers and clinicians emphasize that cancer threatens the individual's sense of meaning (Peteet, 1985; Vastyan, 1986; Doyle, 1992). It brings to focus questions about the meaning of the diagnosis of cancer, and questions about the meaning of life in general, in the face of suffering and possible death (Peteet, 1985; Vastyan, 1986; Doyle, 1992). Patients ask: Why me? Why right now? What is the point of it all? (Sauer and Seitz, 1988). Resolving questions like these often involves struggling with culturally conveyed and stigmatized meanings. Dreifuss-Kattan (1990) suggests that many patients experience cancer as 'a punishment for a life poorly lived or for suppressed hostility' (p. 2). Moreover, questions about meaning are often spiritual in nature. Doyle (1992) provides one example:

> A woman of deep faith now racked with pain from metastatic carcinoma once asked of me when I was called to see her, 'Why do I have to suffer as much pain as Jesus did when I have tried to be so faithful: Is it a punishment? Is it inevitable, or did God sanctify pain by making Jesus endure it? (p. 304).

This woman attempted to understand her experience within the context of her relationship to the sacred. Her words express her struggle to come to a new understanding about her relationship with God and the role that her cancer played in that relationship. Her questioning exemplifies what Park and Folkman (1997) have pointed out, that meaning making is a salient and important coping mechanism when one is confronted with a significant loss. They suggested that experiences of loss often create a conflict between situational and global meaning. They defined situational meaning as meaning attributed to a specific event and global meaning as 'enduring beliefs and valued goals' (p. 5). The meaning making process involves working through this discrepancy. This process is evident in the quote above. This woman with cancer seems to be struggling to resolve the discrepancy between her experience of pain and the implication that she has done something to deserve suffering, and her global belief in a loving God. An inability to resolve discrepancies like these puts one at risk for poorer adjustment and depression (see Park and Folkman, 1997).

A satisfactory resolution to this conflict and finding answers to the 'why me' question seems to play an important role in coping with loss. Park and Folkman (1997) cited evidence suggesting that finding answers to this question is often associated with better adjustment for various types of losses including losses related to breast cancer. Moreover, their review suggested that positive outcomes in terms of personal growth, goal revision, and new priorities often accompany stressful life experiences. Taylor (1983) reported that this is also true for persons diagnosed with cancer. In agreement, Vastyan (1986) has observed that being confronted by a diagnosis of cancer can lead to a re-prioritization of values and new purpose in life. He provides an example of such a transformation as he quotes one patient (Mack, 1984, cited by Vastyan, 1986):

> It became poignantly clear to me... that this was a time of real choice. I could sit back and let my disease and my treatment take their course, or I could pause, and look at my life and ask, 'What are my priorities? How do I want to spend the time that is left?' (p. 111).

As further support, Cella and Tross (1986), in a survey of 60 male survivors of Hodgkins disease, found that 85% reported an enhanced appreciation for life. Moreover, the results suggested that this change was significantly more likely for people who had experienced cancer than for individuals who had experienced non-cancer related stressful life experiences ranging from personal injury to death of a spouse.

It is not clear, however, how frequently threats to meaning are successfully resolved. Based on clinical observations, Vastyan (1986) suggested that positive transformations are not typical. He lamented that most patients '[bear] in silence and

in solitude—and so often in depression and despair—their inner agony' (p. 111). And the fact that some individuals continue to experience distress even in remission suggests that the cancer experience is not easily integrated into a perception of life as having meaning, value, and purpose. In their review of the literature, Park and Folkman (1997) concur that satisfactory resolutions and answers to the 'why me' questions, while helpful for the most part, do not always lead to positive outcomes. They argued that ambiguous findings may be due to the types of attributions that evolve out of the meaning making process. Certain kinds of meanings seem to be more beneficial. For example, several studies cited suggested that distress following the loss of a spouse may be less severe if the person believes 'that all things are part of God's larger plan or that all things have a purpose and work out for the best' (p. 18). Similarly, positive reframing has also been associated with less distress for women undergoing surgery for breast cancer (Carver *et al.*, 1993).

Thus, it is likely to be helpful for therapists working with persons diagnosed with cancer to address questions of meaning in order to facilitate the resolution of inner conflict and to foster the development of positive meanings associated with the cancer experience.

During our session on meaning, participants discuss the possibility of finding or creating meaning out of their experience of cancer. The discussion is kicked off with some of the quotes above and the group discusses feelings that their cancer is a punishment. Included in this discussion is the question of whether cancer is a punishment from God. The intent is to help participants become aware of any punishing feelings they have towards themselves and to facilitate a more positive interpretation of their diagnosis. If a member of the group holds fast to the idea that cancer is a punishment from God, the therapist helps the client explore paths for purification and forgiveness within the person's religious tradition. A referral to his or her clergy is given if appropriate. The group then explores the possibilities of discovering or creating meaning out of their cancer experience. A quote from Tsongas (1984) initiates this discussion:

> The illness made me face up to the fact that I will die someday. It made me think about wanting to look back without regret whenever that happened. It made me appreciate [my wife's] strengths as I had never quite done before... The lymphoma caused me to realize the preciousness of the moments of a child's development. I would have spent too much time away from my daughters had I continued my career (pp. 164–165). The cancer had... caused me to understand what truly made me happy, and what truly counted (p. 122).

Following this discussion, participants reflect on the spiritual meaning of their cancer experience. They are led through a guided imagery in which they first become relaxed, then imagine entering a truth room, feel God's presence around them, and go to a box sitting in the center of the room. They are told that inside the box is a symbol of the spiritual significance of their cancer experience. When they are ready, they open the box and view the contents. The participants later describe the symbol that they received in the imagery and discuss its significance for them. As an example, one participant described finding a pretzel in the box. She shared that the pretzel represented what she had learned about herself through her cancer experience, that she was wound too tightly and too wrapped up in herself. In associating to the pretzel's saltiness, she shared that she had also been too salty herself, too reality focused and not able to let herself go and play with her two young children. Cancer was teaching her to let go and more fully enjoy significant others in her life.

In the last part of the session, the group discusses finding meaning through giving and receiving from others. They do an exercise in which they turn to the person on their left and say, 'From you I have received...'. This exercise reinforces the importance of each member in the group and facilitates a deeper intimacy among members. Finally, as a homework assignment during the coming week, participants build on this theme of meaning by keeping a journal in which they note meaningful moments that they experience each day.

Closing session

For the final session, participants take part in a 'naming the gift ritual'. They sit in a circle with a candle and basket of polished stones placed on the floor in the center, one stone for each participant. The leader shares with the group that the circles created by the participants symbolize wholeness, completion, and unity. The leader asks participants to visualize a circle of white light

extending out from the candle and encircling the group. This circle, it is suggested, represents God's presence. The leader then reminds participants that it is now time to take with them whatever insight or wisdom they have gained from this group as they go about the rest of their lives. They are asked to sit quietly and reflect on what they have most gained through participation in this group, the treasure that they have received. They are told that the stones in the center of the circle symbolize this treasure. The basket of stones is then passed around and participants are asked to pick out a stone and share with the group what this stone symbolizes to them. After each person completes this task, the group is asked to again envision the circle of light around them. The leader suggests that this light is not limited to this room. Participants are asked to imagine the circle expanding, filling the room, flowing out of the room and into the streets, becoming larger and larger until it encircles their families, friends, places where they live and work. Finally, the image is extended to include the entire world, so that wherever they travel from this group they will be surrounded by this circle of light.

SUMMARY

This program was especially developed to foster a holistic healing process in coping with cancer, a process that integrates spiritual and psychological resources. During the program four existential issues are explored that appear to be important when facing a life threatening illness: control, identity, relationships, and meaning. In processing these four issues participants are exposed to psychotherapeutic interventions with established efficacy, that provide tools for working through these existential concerns. In addition, participants are helped to reflect on spiritual issues embedded in these existential themes and to draw on spiritual resources that support the coping process.

Of the ten participants who have, to date, taken part in this program all but one said that they preferred this type of program over one that did not have a spiritual focus. Thus, spiritually oriented individuals may be more likely to take part in therapy programs if spirituality is an integral part of the program. Moreover, given research supporting the importance of religious/spiritual issues and resources for people experiencing cancer, a program that explicitly integrates spiritual resources into the psychotherapy process may hold considerable promise for this population. The benefits of such a program may even exceed those offered by traditional psychotherapy programs. We are currently conducting an outcome study assessing the efficacy of this type of program (Cole *et al.*, 1998). Preliminary data are promising, but conclusions will have to wait for additional data collection.

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