# Psycho-Oncological Interventions and Psychotherapy in the Oncology Setting

Mirjam de Vries and Friedrich Stiefel

**Abstract**

A person who faces the diagnosis of cancer is subjected to changes within his body, but also with regard to his view of himself and his social relationships. Cancer-related psychological distress occurs frequently and has been reported to have different prevalence according to cancer type and stage of disease. Psychological disorders are known to be underdiagnosed and thus undertreated in the oncology setting, since clinicians might miss the symptoms of psychological distress, misinterpret them, or lack the time and resources to respond adequately. The main psychiatric disturbances observed in patients with cancer are adjustment disorders and affective disorders (anxiety and depression), which in the majority of patients are due to stressors related to the disease and pre-existing psychological vulnerabilities; however, they might also be a direct consequence of biological causes either resulting from treatment side effects or from modifications induced by the cancer. This chapter aims to provide theoretical and practical information concerning psycho-oncological approaches, complemented by some reflexions on their clinical and scientific evidence, focussing essentially on verbal psychological interventions and especially on psychotherapy in patients with cancer.

M. de Vries
Institut Universitaire de Psychothérapie, Département de Psychiatrie, Centre hospitalier universitaire vaudois, Avenue de Morges 10, 1004, Lausanne, Switzerland

F. Stiefel (✉)
Service de Psychiatrie de Liaision, Département de Psychiatrie, Centre hospitalier universitaire vaudois, Rue du Bugnon 21, 1011, Lausanne, Switzerland
e-mail: Frederic.stiefel@chuv.ch

U. Goerling (ed.), *Psycho-Oncology*, Recent Results in Cancer Research 197,
DOI: 10.1007/978-3-642-40187-9_9, © Springer-Verlag Berlin Heidelberg 2014

## Contents



## 1 Introduction

A person who faces the diagnosis of cancer is subjected to changes within his body, but also with regard to his view of himself and his social relationships. Since each individual reacts differently when facing such a life-threatening event, the psychological responses should not be considered as «adequate» or «inadequate» but rather as whether the response is adaptive or an expression of psychological disturbances. Cancer-related psychological distress occurs frequently: for example, prevalence of major depression is estimated to occur in 10–25 %, of depressive symptoms in 21–58 % (Massie 2004; Mitchell et al. 2011; Pirl 2004), and of pathological demoralization in 14 % (Kissane et al. 2004a, b) of patients with cancer. Furthermore, anxiety disorders were reported in 15–28 % of cancer patients (Kerrihard et al. 1999), and a recent meta-analysis showed that 38.2 % of them suffered from any type of emotional disorders (Mitchel et al. 2011), a finding which is confirmed by a large prevalence study which identified 35.1 % to suffer from distress at a clinical level (Zabora et al. 2001). Psychological distress has been reported to have different prevalence according to cancer site: it was found to be highest in pancreatic (56.7 %), lung (43.4 %), and brain cancer (42.7 %), and lower in gynecological (29.6 %), prostate (30.5 %), and colon cancer (31.6 %) (Zabora et al. 2001). Also patients with advanced stages may be more vulnerable to psychological distress, especially when taking into account acute confusional states (Massie 2004; Razavi and Stiefel 1994); however, some research, for example in breast cancer, suggests that stage of cancer does not influence prevalence of psychological distress (Kissane et al. 2004a, b).

Psychological disorders are known to be underdiagnosed and thus undertreated in the oncology setting (Razavi and Stiefel 1994), since clinicians might miss the symptoms of psychological distress, misinterpret them or lack the time and resources to respond adequately.

This chapter aims to provide theoretical and practical information concerning psycho-oncological approaches, complemented by some reflections on their clinical and scientific evidence, focusing essentially on verbal psychological interventions, and especially on psychotherapy in patients with cancer.

## 2 Psychological Challenges for Patients Facing Cancer and Its Treatment

The main psychiatric disturbances observed in patients with cancer are adjustment disorders and affective disorders (anxiety and depression), which in the majority of patients are due to stressors related to the disease and pre-existing psychological vulnerabilities; however, they might also be a direct consequence of biological causes either resulting from treatment side effects or from modifications induced by the cancer (e.g., treatment with interferon or radiation therapy, brain metastases, hypercalcemia, paraneoplastic syndroms, hypothyreosis) (Razavi and Stiefel 1994).

Therefore, treatment of psychological distress calls for a careful evaluation in order to determine the most appropriate intervention, which might be to focus on biological, psychological, psychopharmacological or combined causal factors. In the following, we will only focus on distress for which psychological interventions are appropriate and beneficial.

From the moment of the diagnosis, the patient is confronted with a new situation that he will need to understand, shape, and accept and which will modify his perception of himself, his interpersonal relationships, and his sense of belonging to a group: he might reflect on his past and will definitely have to adjust to the present and adapt his plans for the future. Pre-existing self-image, quality of interpersonal relationships, and sense of belonging are therefore factors that can either contribute to the protection of the individual against stress and emotional difficulties or they might be a source of increased vulnerability.

Adjustment to cancer is associated with six distinct hurdles, as defined by Faulkner and Maguire (1994): (1) managing uncertainty about the future, (2) searching for meaning, (3) dealing with loss of control, (4) having a need for openness, (5) emotional, and (6) medical support. Failing to deal with these hurdles might lead to psychosocial difficulties. Psychological interventions are often initiated in order to help the patient with these issues so as to help him to cope and adjust to the disease, and have been demonstrated to have a positive effect on distress, anxiety, and depression (Devine and Westlake 1995; Meyer and Mark 1995; Sheard and Maguire 1999).

While the spectrum of psycho-oncological interventions is large, from psychopharmacological treatments, relaxation and music-therapy to psychotherapy, we will concentrate on the verbal psychological interventions and focus on psychotherapy for patients with cancer.

# 3 Psychological Interventions

## 3.1 Psychoeducation

Psychoeducation refers to the education offered by a professional to a patient about a mental or physical condition that causes psychological stress. By learning about his condition the patient is thought to feel more in control, which might help to reduce psychological distress.

## 3.2 Psychological Support

Psychological support knows many definitions and covers approaches from individual psychological support interventions (Hellbom et al. 1998), single techniques derived from psychotherapies, such as relaxation or structured problem-solving, to community or peer support services, and range from one to several sessions. The aims of supportive interventions might be to contribute to alleviate worries of the patient, to increase his perception of mastering the situation, to help him to regulate stress, or to facilitate his participation in the treatment. Psychological support might be presented by health personal or other persons, since its use is generally not regulated or controlled by training institutes or licensing bodies.

## 3.3 Psychotherapy

Psychotherapy has been defined by Frank (1988) as the relief of distress or disability in one person by another, using an approach based on a particular theory or paradigm, with the requirement that the agent performing the therapy has had training. Franck and Frank (1991) identified four broad dimensions shared by all therapeutic approaches: (i) a relationship in which the patient considers that the therapist is competent and cares about his state; (ii) a setting which is defined as a place of healing; (iii) a rationale which explains the patient's suffering and how it can be overcome; (iv) a set of procedures requiring active participation of the patient and the therapist and of which both believe to be means of restoring the patient's health.

These general dimensions allow the inclusion of all psychotherapeutic interventions, but they lack the specificity to identify an included approach as a psychotherapeutic intervention. Wampold (2001) and Lambert and Ogles (2004) also underline the necessity that psychotherapy is a professional activity or service that implies a certain level of skills, which have to be formally recognized by training institutes and licensing bodies, and anchored in a psychological theory; in addition psychotherapeutic treatment should be supported by scientific evidence and provided by mental health specialists, who undergo training and who benefit from

regular supervision and continuous postgraduate education. In many countries, psychotherapeutic treatments can therefore only be provided by certified psychiatrists and psychologists.

In the following, we will present and discuss the three most widely used psychotherapeutic approaches: psychodynamic, systemic, and cognitive behavioral psychotherapy. These approaches have a long history of theoretical and conceptual development and are widely utilized in psychiatric and somatic settings, including oncology. Some of them have gained an important body of evidence confirming their effectiveness and all provide specialized and certified training programs and allow a large clinical application. Finally, the important movement of psychotherapy integration will also be discussed.

### 3.3.1 Psychodynamic Psychotherapy

Psychodynamic psychotherapies are derived from Freud's work, object relation theory elaborated by Klein and Winnicott and self-psychology based on Sullivan's interpersonal psychotherapy (Lewin 2005). Psychodynamic techniques are intended to develop self-understanding and insight into recurrent problems. In the therapeutic process, symptoms and interpersonal difficulties are identified, analyzed, and interpreted based on the assumption that the subsequent insight and the experiences in the therapeutic relationship can be transferred to «the world outside the therapeutic setting» (Kaplan and Sadock 1998).

Psychodynamic psychotherapies rely on key theoretical concepts, such as (i) the existence of an unconscious, which influences our thoughts, emotions, and behaviors; (ii) the impact of early development on later stages of life; (iii) the organization of the psyche by the ego, which has the capacity to reason and to anticipate, the id, which is a source of sexual and aggressive drives, and the superego, which contains theses drives by a «guilty conscience»; (iv) the protection of the individuals' equilibrium by (unconscious) defense mechanisms, such as rationalization, projection, or denial, which are triggered by threatening emotions or thoughts; and (v) the observation, that unresolved issues of the patient are re-enacted in the therapeutic setting, where they can be identified, discussed, interpreted, and modified.

The different types of psychodynamic psychotherapy reach from insight-oriented psychotherapy, which uncovers repressed, unconscious thoughts and feelings, and aims to enhance patient's autonomy, to supportive psychotherapy, which aims to suppress anxiety-provoking material and to foster ego functions and adaptive defenses (Lewin 2005). Supportive psychotherapy is more often indicated for patients in a palliative phase of their illness, as for most of these patients, the objective is to enhance adaptation, to diminish dysfunctional coping, to decrease psychological distress, and to restore psychological well-being (Guex et al. 2000; Rodin and Gillies 2000; Stiefel et al. 1998). Insight-oriented therapy is suitable for less vulnerable patients with intact ego functions, who are motivated to explore their thoughts and feelings in order to enhance reflection, and have the capacity to analyze adverse events (Rodin and Gillies 2000). A special form of

psychodynamic psychotherapy is the Psychodynamic Life Narrative (PLN), which can be understood as a way to conceptualize maladaptive responses to physical illness. PLN aims to help the patient to understand their current psychological reactions to illness by linking it to important elements of their life trajectory (Viederman 1983; Viederman and Perry 1980). This type of therapy provides the patient with an opportunity to enhance a sense of control and coherence when facing illness (Viederman 2000).

With regard to the content of therapeutic interventions, the occurrence of cancer is not conceived as being the sole focus of the encounter with the patient, but other questions, such as how the specific reaction of the patient toward disease can be understood or why his relationships have been modified by the disease, are addressed (Krenz et al. 2013, submitted). A given psychological symptom is not just a target to suppress, since psychodynamic therapies aim to understand its underlying meaning: for example, it would be important for a psychodynamic-oriented therapist to understand whether the depressed mood of a women with breast cancer is due to the fact that she feels pressured by an increasing difficulty to fulfill her duties (loss of pre-existing capacities), to a modification of her self-image (loss of her breast), or to an alteration of her relationship with her husband (loss of commitment to the relationship). Depending on the source of the depressive symptoms, the therapeutic approach would be different, focusing on diminishing superego pressure, (pre-existing) difficulties with self-esteem or construction, and meaning of relationships.

While there are only few clinical trials evaluating the effectiveness of psychodynamic therapies in the physically ill (Ando et al. 2007, Ludwig et al. 2013, submitted), several single cases studies have been published over the past few years (Lacy and Higgings 2005; Redding 2005; Tepper et al. 2006).

### 3.3.2 Systemic Psychotherapy

Systemic psychotherapy is based on general systems theory, which conceives a system, such as the family, as organized and tries to understand the functions of its different elements, and their interrelations. Therefore, systemic psychotherapy views social coexistence of people as a complex and integrated whole, which is greater than the sum of its parts (Minuchin 1988; Sameroff 1983). Family therapists utilize special techniques and focus on variables, such as cohesion and hierarchy of the family, as well as attributed roles and implicit and explicit rules (Bressoud et al. 2007). Family members are considered to be helpful resources to by the patient, who can assist him in decision making and provide emotional and practical support (Xiaolian et al. 2002), but who may at times also be the source of conflict and suffering (Lyons et al. 1995).

In a report on the evidence of systemic family therapy, Stratton (2005) indicates that systemic therapy started with a common basis, but has over the past 50 years grown in various directions, with the most significant specific interventions belonging to the work of Bateson and the Palo Alto team (Jackson 1968a, b), the family structural therapy by Minuchin (1974), the strategic family therapy

developed by Haley (1976) and Madanes (1981), and the approaches of Selvini Palazzoli and the Milan team (1978, 1991).

Being a systemic therapist does not imply that clinical care is restricted to social systems; systemic therapists also treat individual patients, but they are probably more sensitive to achieve an integrated systemic perspective in the analysis of the patient's problem and address more systematically intergenerational and intrafamilial problems and resources. Family response to illness is an important feature of systemic therapy with the physically ill: for example family myths—beliefs about a family member, such as «he has always been quickly irritated and prone to give up»—and family paradigms, such as «we function best by denying disagreements and avoiding difficulties», play an important role in systemic therapies.

Examples of scientifically evaluated systemic therapies in the medical and oncology setting are the Medical Family Therapy (Doherty et al. 1994) and the Family-Focused-Grief Therapy (FFGT), a preventive intervention for high-risk families (Kissane et al. 2006). FFGT is based on the assumption that the family is the primary provider of care for the terminally ill patient and that the type of functioning of the family is essential for the patient (Kissane et al. 1996a, b). Its aim is to optimize family functioning and to facilitate common grief. FFGT is a time-limited intervention (four to eight sessions of 90 min each), over a 9–18 month period, based on a manual with specific guidelines and clinical illustrations; its efficacy has been demonstrated in a randomized controlled trial (Kissane et al. 2006).

An other systemic approach, which has been examined in mostly qualitative research, is narrative therapy developed by Michael White and David Epston (White and Epston 1990). Narrative therapy is based on the concept that our identity is shaped by narratives and stories that we tell ourselves and others. Reality is thus a co-construction between different individuals, and the relational consensus produces the judgment that a perception is acceptable or not. Thus, not only the mind creates impressions based on observations, but confirmations of these impressions are sought with members of the society, the family or other systems, leading to interpersonal exchange which finally colors the way we perceive life. Therefore, the way a patient perceives his cancer, and the way he talks about it to his family or to medical professionals, will influence the perception and meaning he attributes to the disease and thus the psychological impact the situation will have. Narrative therapy implies that the patient is motivated to explicitly verbalize his thoughts and feelings with regard to the current situation, to communicate how he relates them to his life history and to evaluate the meaning he attributes to his disease in light of his trajectory.

In addition, systemic psychotherapy plays an important role in the treatment of childhood cancer, childhood cancer survivors, and their families. For example, Kazak (1989) found that multifamily group intervention reduced the posttraumatic stress symptoms and anxiety in childhood cancer survivors and their families. Furthermore Martire et al. (2004) demonstrated that systemic interventions for people with chronic illness (including cancer) were more effective than standard care.

### 3.3.3 Cognitive Behavioral Psychotherapy

Cognitive behavioral therapy (CBT) is a general term for several forms of therapies with similar characteristics, such as cognitive therapy, behavior therapy, rational emotive therapy, schema focused therapy, dialectical behavior therapy, mindfulness, motivational therapy, or cognitive–behavioral stress management. These interventions intend to reduce psychological distress and enhance adaptive coping by modifying maladaptive thoughts and behaviors, by raising awareness of emotional states and their connection with thoughts and behaviors, and by providing new skills (Hollon and Beck 2004).

CBT assumes that thoughts, behaviors, and emotions are at the base of human well-being and of the etiology and persistence of psychological disorders. For example, individual responses to illness are influenced by cognitive factors such as symptom perception (Lacroix et al. 1991), and variability in emotional reactions and self-care behaviors can be partly explained by disease-specific illness representations (Petrie et al. 1996; Prohaska et al. 1987). Or, the same situation encountered when feeling sad or happy will be followed by very different thoughts and behaviors (Segal et al. 2002). While it becomes more and more current in western healthcare to promote active self-management in patients (Tattersall 2002), CBT, which focuses on analysis of the function of the symptoms, skills acquisition, and increasing the autonomy of the patient, has been proposed as beneficial for patients with comorbid physical and psychological difficulties.

CBT offers several models for the somatic setting and patients with chronic medical problems. For example Acceptance and Commitment Therapy (ACT), an approach developed by Steven Hayes and colleagues (Hayes et al. 1999), is based on the concept that (i) instead of «controlling» our thoughts and feelings, we could choose to observe and accept them as they are and (ii) instead of putting our energy in avoiding our problems, we could act in the direction of personal values. For example, a patient with cancer might consider that if he is not cured, his life is meaningless, and he might avoid to be active due to fears of suffering from certain symptoms due to his cancer or its treatment: in ACT he would be invited to observe his emotions and thoughts inducing avoidance, and to reflect on the question whether «avoiding» is a strategy that really helps him in the long run. By investigating his values he might find reasons and motivation to confront life again, for example by connecting to other people, sharing his thoughts and emotions, or discovering new aspects of life.

CBT can be used as individual or group treatment and therapists feel free to follow a model, or to integrate different techniques (e.g., relaxation, exposure, meaning seeking) depending on the needs of the patient. As in other therapeutic approaches, the therapeutic relationship is an important part of CBT which is utilized by the therapist, for example by working on what happens in the therapeutic relationship and how this can be understood in light of the patient's difficulties.

CBT strives to be evidence based and much effort has been put in scientific research, including large randomized controlled studies. In patients suffering from

cancer, CBT has been demonstrated to improve anxiety and depressive symptoms, self-esteem, immune functions, quality of life, optimism, self-efficacy, compliance, coping effectiveness and satisfaction, and to decrease cancer-related fatigue, cortisol levels, pain, and distress (Andersen et al. 2007; Daniels and Kissane 2008; Greer et al. 1992; Hopko et al. 2005; Lee et al. 2006; Manne et al. 2007; Mefford et al. 2007; Moorey et al. 1998; Osborn et al. 2006; Penedo et al. 2007; Tatrow 2006; Witek-Janusek et al. 2008; Wojtyna et al. 2007).

### 3.3.4 Psychotherapy Integration

The first official comment on the need to integrate different psychotherapeutic approaches to best serve patients could be attributed to Freud when he stated that psychoanalytic technique alone seems insufficient for certain patients: «these patients cannot bring out the material necessary for resolving their phobia so long as they feel protected by obeying the condition which it lays down», only after they learned to no longer need the protection of their phobia, «does the material become accessible, which, when it has been mastered, leads to a solution of the phobia» (Freud 1910/1975, p 145). This comment can be understood as showing that Freud realized that, for some patients, psychoanalytic interpretation alone might not be enough and that an alternative approach might be necessary before interpretation (Trijsburg et al. 2005). Nowadays, neither monism (psychotherapeutic modalities have unique qualities differentiating them) or specificity (one intervention has one intended result), nor eclecticism (interventions are effective irrespective of the particular theory from which they derive) or universality (common factors among psychotherapeutic treatments) can adequately reflect clinical reality in its totality, instead it is considered that specific interventions reinforce common factors, and common factors reinforce the effects of specific interventions (Strupp and Hadley 1979).

Integrative approaches are more and more practiced, with one-half to two-thirds of clinicians working with a variety of concepts derived from several theoretical schools (Lambert et al. 2004). A survey, conducted in the Netherlands with 1143 therapists from various orientations found that self-declared monotherapists of all orientations use interventions from other theoretical approaches (Trijsburg et al. 2004).

Four ways to integrate psychotherapies have been identified: (i) technical eclecticism, which uses the combination of different interventions without adopting the underlying theoretical models, (ii) theoretical integration, which synthesizes existing theories in a new structure with its own theoretical framework, (iii) common factors approach, which combines core elements that are common to all psychotherapies, and (iv) assimilative integration, grounded in one psychotherapeutic approach, but integrating practices from other approaches (Norcross and Goldfried 2005). Examples of common factors based on different studies (Grencavage and Norcross 1990; Lambert et al. 1994; Trijsburg et al. 2004) include therapist empathy, congruence, acceptance and involvement, patient expectations, hope, quality of communication, working alliance and engagement.

Several integrative psychotherapeutic approaches have been developed (e.g., the Common Factor Model of Arkowitz 1992; Interpersonal Therapy by Klerman et al. 1984; Cognitive analytic therapy by Ryle and Kerr 2002; Systematic Eclectic psychotherapy by Beutler and Consoli 1992; Multimodal therapy by Lazarus 1989, 2005; Kissane's cognitive-existential group therapy 1997). Psycho-oncology could benefit from this work, for which encouraging results have been found endorsing the common factors theory in cancer care and the effectiveness of technical eclecticism and theoretical integration (Liossi and White 2001; McLean et al. 2013; Schnur and Montgomery 2010).

## 4 Outcome of Psycho-Oncological Interventions

Outcome of psycho-oncological interventions are not easy to determine, since some patients value a decrease of distressing symptoms, such as feelings of depressed mood, while others emphasize personal growth, finding meaning in a situation perceived as chaotic, or improved interpersonal relationships and communication. Up to now, most studies evaluate outcome with traditional psychometric assessments, which do not necessarily reflect the therapeutic process and might not be relevant to all psychotherapeutic approaches, such as the psychodynamic approach (Krenz et al. 2013, submitted).

While there is a real need for creativity with regard to the evaluation of individual psycho-oncological interventions, outcomes for partners and family members have also been neglected.

Finally psycho-oncological interventions seem to influence treatment adherence, but its relevance for survival is controversial (Chow et al. 2004; Smedslund and Ringdal 2004; Spiegel et al. 1989). A systematic Cochrane review examining the effectiveness of psychosocial interventions in breast cancer patients on survival outcome showed insufficient evidence for such an effect (Edwards et al. 2008). Possible pathways for prolonging survival, taking into account adherence to treatment, self-care, or enhanced immune system, might deserve attention. For example, it is known that mood disturbance is associated with poorer response to chemotherapy (Walker et al. 1999), and that feelings of helplessness or hopelessness are associated with poorer survival (Watson et al. 1999).

## 5 Conclusions

For different psycho-oncological and psychotherapeutic interventions, clinical validity and scientific evidence have been demonstrated. Since existing psychological interventions which have been proven to be beneficial can easily be adapted to cancer patients, it seems that instead of conceiving new interventions for the oncology setting, and thus reinvent the wheel, it is more relevant to identify

patients who benefit from specific psycho-oncological interventions and to develop and implement programs that cover the spectrum of treatment modalities, which can than be evaluated with regard to effectiveness (Ludwig et al. 2013, submitted).

## References


Andersen BL, Farrar WB, Golden-Kreutz D et al (2007) Distress reduction from a psychological intervention contributes to improved health for cancer patients. Brain Behav Immun 21(7):953–961

Ando M, Tsuda A, Morita T (2007) Life review interview on the spiritual well-being of terminally ill cancer patients. Support Care Cancer 15:225–231

Arkowitz H (1992) A common factors therapy for depression. In: Norcorss JC, Goldfried MR (eds) Handbook of psychotherapy integration. Basic Books, New York, pp 402–432

Beutler LE, Consoli AJ (1992) Integration through fundamental similarities and useful differences among schools. In: Norcross JC, Goldfried MR (eds) Handbook of psychotherapy integration. Basic Books, New York, pp 202–231

Bressoud A, Real del Sarte O, Stiefel F et al (2007) Impact of family structure on long-term survivors of osteosarcoma. Support Care Cancer 15:525–531

Chow E, Tsao MN, Harth T (2004) Does psychosocial intervention improve survival in cancer? A meta-analysis. Palliat Med 18:25–31

Daniels J, Kissane DW (2008) Psychosocial interventions for cancer patients. Curr Opin Oncol 20:367–371

Devine EC, Westlake SK (1995) The effects of psychoeducational care provided to adults with cancer: meta-analysis of 116 studies. Oncol Nurs Forum 22:1369–1381

Doherty WJ, McDaniel SH, Hepworth J (1994) Medical family therapy: an emerging arena for family therapy. J Fam Ther 16:31–46

Edwards AGK, Hubert-Williams N, Neal RD (2008) Psychological interventions for women with metastatic breast cancer (Review). Cochrane database of systematic reviews 3

Faulkner A, Maguire P (1994) Talking to cancer patients and their relatives. Oxford University Press, New York

Franck JD, Frank JB (1991) Persuasion and healing: a comparative study of psychotherapy. John Hopkins Universtiy Press, Baltimore

Frank J (1988) What is Psychotherapy? In: Bloch S (ed) An Introduction to the Psychotherapies. Oxford University Press, Oxford [1979]

Freud S (1910/1975) The future prospects of psycho-analytic therapy. In: Strachey J (ed and trans) The standard edition of the complete psychological works of Sigmund Freud, vol 11. Oxford University Press, Oxford, pp 139–151

Greer S, Moorey S, Baruch JD et al (1992) Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. Br Med J 304:675–680

Grencavage LM, Norcross JC (1990) Where are the communalities among therapeutic common factors? Prof Psychol Res Pract 21:278–372

Guex P, Stiefel F, Rousselle I (2000) Psychotherapy for the patient with cancer. Psychother rev 2:269–273

Haley J (1976) Problem-solving therapy: new strategies for effective family therapy. Josey Bass, San Francisco

Hayes SC, Strosahl KD, Wilson KG (1999) Acceptance and commitment therapy: an experiential approach to behavior change. The Guilford Press, NewYork

Hellbom M, Brandberg Y, Glimelius B et al (1998) Individual psychological support for cancer patients: utilisation and patient satisfaction. Patient Educ Couns 34:247–256

Hollon SD, Beck AT (2004) Cognitive and cognitive behavioral therapies. In: Lambert MJ (ed) Bergin and Garfied's handbook of psychotherapy and behavior change, 5th edn. Wiley, New York

Hopko DR, Bell JL, Armento MEA et al (2005) Behavior therapy for depressed cancer patients in primary care. Psychother Theory Res Pract Train 42:236–243

Jackson DD (1968a) Human communication, T.1: communication, family and marriage. Science and Behavior Books, Palo Alto

Jackson DD (1968b) Human communciation,T.2: communcation, family and marriage. Science and Behavior Books, Palo Alto

Kaplan HI, Sadock BJ (1998) Kaplan and Sadock's synopsis of psychiatry: behavioral sciense/ clinical psychitary, 8th edn. Williams and Wilkins, Baltimore

Kazak AE (1989) Families of chronically ill children: a systems and social-ecological model of adaptation and challenge. J Consultation Clin Psychol 57:25–30

Kerrihard T, Breitbart W, Dent R et al (1999) Anxiety in patients with cancer and human inmmunodeficiency virus. Semin Clin Neuropsychiatry 4:114–132

Kissane DW, Bloch S, Dowe DL et al (1996a) The Melbourne family grief study, I: perceptions of family functioning in bereavement. Am J Psychiatry 153:650–658

Kissane DW, Bloch S, Dowe DL et al (1996b) The Melbourne family grief study, II: psychosocial morbidity and grief in bereaved families. Am J Psychiatry 153:659–666

Kissane DW, Bloch S, Miach P et al (1997) Cognitive-existential group therapy for patients with primary breast cancer–techniques and themes. Psychooncology 6:25–33

Kissane DW, Grabsch B, Love A et al (2004a) Psychiatric disorder in women with early stage and advanced breast cancer: a comparative analysis. Aust N Z J Psychiatry 38:320–326

Kissane DW, McKenzie M, Bloch S et al (2006) Family focused grief therapy: a randomized, controlled trial in palliative care and bereavement. Am J Psychiatry 163:1208–1218

Kissane DW, Wein S, Love A et al (2004b) The demoralization scale. A report of its development and preliminary validation. J Palliat Care 20:269–276

Klerman G, Weissman M, Rousevill B et al (1984) Interpersonal psychotherapy of depression. Basic Books, New York

Krenz S, Sodel C, Stagno A et al. (2013) Psychodynamic interventions in cancer care II: a qualitative analysis of the therapists' reports (submitted)

Lacroix JM, Martin B, Avendano M et al (1991) Symptom schemata in chronic respiratory patients. Health Psychol 10:268–273

Lacy TJ, Higgins MJ (2005) Integrated medical-psychiatric care of a dying patient: a case of dynamically informed 'practical psychotherapy'. J Am Acad Psychoanal Dyn Psychiatry 33:619–636

Lambert MJ, Bergin AE (1994) The effectiveness of psychotherpy. In: Bergin AE, Garfield SL (eds) Handbook of psychotherapy and behavoir change, 4th edn. New York, Wiley, pp 143–189

Lambert MJ, Ogles BM (2004) The efficacy and effectiveness of psychotherapy. In: Lambert MJ (ed) Bergin and Garfield's handbook of psychotherapy and behavior change, 5th edn. Wiley, New York

Lambert MJ, Bergin AE, Garfield SL (2004) Introduction and historical overview. In: Lambert MJ (ed) Bergin and Garfield's handbook of psychotherapy and behavior change, 5th edn. New York, Wiley, pp 3–15

Lazarus AA (1989) The practice of multimodal therapy. Systematic, comprehensive, and effective psychotherapy. Johns Hopkins University Press, Baltimore

Lazarus AA (2005) Multimodal therapy. In: Norcross JC, Goldfried MR (eds) Handbook of psychotherapy integration, 2nd edn. New York, Oxford, pp 105–120

Lee V, Cohen SR, Edgar L et al (2006) Meaning—making intervention during breast or colorectal cancer treatment improves self-esteem, optimism, and self-efficacy. Soc Sci Med 62:3133–3145

Lewin K (2005) The theoretical basis of dynamic psychiatry. In: Gabbard GO (ed) Psychodynamic psychiatry in clinical practice: the DSM-IV edition. American Psychiatric Press, Washington
Liossi C, White P (2001) Efficacy of clinical hypnosis in the enhancement of quality of life of terminally ill cancer patients. Contemp Hypn 18:145–160
Ludwig S, Krenz S, Zdrojewski C et al (2013) Psychodynamic interventions in cancer care I: psychometric results of a randomized controlled trial (submitted)
Lyons RF, Sullivan MJL, Ritvo PG (1995) Relationships in chronic illness and disability. Sage Publications, Thousand Oaks
Madanes C (1981) Strategic family therapy. Josey Bass, San Francisco
Manne SL, Rubin S, Edelson M et al (2007) Coping and communication-enhancing intervention versus supportive counseling for women diagnosed with gynecologic cancers. J Consult Clin Psychol 75:615–628
Martire L, Lustig A, Schultz R et al (2004) Is it beneficial to involve a family member? A meta-analysis of psychosocial interventions for chronic illness. Health Psychol 23:599–611
Massie MJ (2004) Prevalence of depression in patients with cancer. J Natl Cancer Inst Monogr 32:57–71. doi:10.1093/jncimonographs/lgh014
McLean LM, Walton T, Rodin G et al (2013) A couple-based intervention for patients and caregivers facing end-stage cancer: outcomes of a randomized controlled trial. Psychooncology 22:28–38
Mefford K, Nichols JF, Pakiz B et al (2007) A cognitive behavioral therapy intervention to promote weight loss improves body composition and blood lipid profiles among overweight breast cancer survivors. Breast Cancer Res Treat 104:145–152
Meyer TJ, Mark MM (1995) Effects of psychosocial interventions with adult cancer patients: a meta-analysis of randomized experiments. Health Psychol 14:101–108
Minuchin P (1988) Relationships within the family: a systems perspective on development. In: Hinde RA, Stevenson-Hinde J (eds) Relationships within families: mutual influences. Wiley, New York
Minuchin S (1974) Families and famliy therapy. Harvard university, Cambridge
Mitchell AJ, Chan M, Bhatti H et al (2011) Prevalence of depression, anxiety, and adjustment disorder in oncological, heamatological, and palliative-care settings: a meta-analysis of 94 interview-based studies. Lancet Oncol 12:160–174
Moorey S, Greer S, Bliss J et al (1998) A comparison of adjuvant psychological therapy and supportive sounselling in patients with cancer. Psychooncology 7:218–228
Norcross JC, Goldfried MR (eds) (2005) Handbook of psychotherapy integration, 2nd edn. Oxford, New York
Osborn RL, Demoncada AC, Feurerstein M (2006) Psychosocial interventions for depression, anxiety, and quality of life in cancer survivors: meta-analyses. Int J Psychiatry Med 36:13–34
Penedo FJ, Traeger L, Dahn J et al (2007) Cognitive behavioral stress management intervention improves quality of life in Spanish monolingual Hispanic men treated for localized prostate cancer: results of a randomized controlled trial. Int J Behav Med 12:164–172
Petrie KJ, Weinman J, Sharpe N et al (1996) Roles of patients' view of their illness in predicting return to work and functioning after myocardial infarction: longitudinal study. Br Med J 312:1191–1194
Pirl WF (2004) Evidence report on the occurrence, assessement, and treatment of depression in cancer patients. J Natl Cancer Inst Monogr 32:32–39. doi:10.1093/jncimonographs/lgh026
Prohaska TR, Keller ML, Leventhal EA et al (1987) Impact of symptoms and aging attribution on emotions and coping. Health Psychol 6:495–514
Razavi D, Stiefel F (1994) Common psychiatric disorders in cancer patients. I. Adjustment disorders and depressive disorders. J Support Care Cancer 2:223–232
Redding KK (2005) When death becomes the end of an analytic treatment. Clin Work Soc J 33:69–79

Rodin G, Gillies LA (2000) Individual psychotherapy for the patient with advanced disease. In: Ghochinov HM, Breitbart WGO (eds) Handbook of psychiatry in palliative medicine. Oxford University Press, New York

Ryle A, Kerr I (2002) Introducing cognitive analytic therapy: principles and practice. Wiley, Chichester

Sameroff AJ (1983) Developmental systems: context and evolution. In: Mussen PH, Kessen W (ed) Handbook of child psychology: history, theory, and methods, 4th edn. Wiley, New York

Schnur JB, Montgomery GH (2010) A systematic review of therapeutic alliance, group cohesion, empathy, and goal consensus/collaboration in psychotherapeutic interventions in cancer: uncommon factors? Clin Psychol Rev 30:238–247

Segal Z, Teasdale J, Williams M (2002) Mindfulness-based cognitive therapy for depression. Guilford Press, New York

Selvini Palazzoli M (1978) Self starvation: from the individual to family therapy. Aronson, New York

Selvini Palazzoli M (1991) Team consultation: an indispensable tool for the process of knowledge. J Fam Ther 13:31–53

Sheard T, Maguire P (1999) The effect of psychological interventions on anxiety and depression in cancer patients: results of two meta-analyses. Br J Cancer 80:1770–1780

Smedslunc G, Ringdal GI (2004) Meta-analysis of the effects of psychosocial interventions on survival time in cancer patients. J Psychosom Res 57:123–131

Spiegel D, Bloom JR, Kraemer HC et al (1989) Effect of psychosocial treatment on survival of patients with metastatic breast cancer. Lancet 2:888–891

Stiefel F, Guex P, Real O (1998) An introduction to psycho-oncology with special emphasis to its historical and cultural context. In: Bruera E, Portenoy R (eds) Topics in palliative care 3. Oxford University Press, New York

Stratton P (2005) Report on the evidence base of systemic family therapy. Association for family therapy

Strupp HH, Hadley SW (1979) Specific vs. Nonspecific factors in psychotherapy. Arch Gen Psychiatry 36:1125–1136

Tatrow K, Montgomery GH (2006) Cognitive behavioral therapy for distress and pain in breast cancer patients: a meta-analysis. J Behav Med 29:17–27

Tattersall RL (2002) The expert patient: a new approach to chronic disease management for the twenty-first century. Clin Med 2:227–229

Tepper MC, Dodes LM, Wool CA et al (2006) A psychotherapy dominated by separation, termination, and death. Harv Rev Psychiatry 14:257–267

Trijsburg RW, Colijn S, Holmes J (2005) Psychotherapy integration. In: Gabbard GO, Beck JS, Holmes J (ed) Oxford textbook of psychotherapy. Oxford, New York

Trijsburg RW, Lietaer G, Colijn S et al (2004) Construct validity of the comprehensive psychotherapeutic interventions rating scale. Psychother Res 14:346–366

Viederman M (1983) The psychodynamic life narrative: a psychotherapeutic intervention useful in crisis situations. Psychiatry 46:236–246

Viederman M (2000) The supportive relationship, the psychodynamic life narrative, and the dying patient. In: Chochinov HM, Breitbart WGO (eds) Handbook of psychiatry in palliative medicine. Oxford University Press, New York

Viederman M, Perry SW (1980) Use of a psychodynamic life narrative in the treatment of depression in the physically ill. Gen Hosp Psychiatry 2:177–185

Walker LG, Walker MB, Ogston K et al (1999) Psychological, clinical and pathological effects of relaxation training and guided imagery during primary chemotherapy. Br J Cancer 80:262–268

Wampold BE (2001) The great psychotherapy debate: models, methods and findings. Mahwah NJ, Lawrence erlbaum associates

Watson M, Haviland JS, Greer S et al (1999) Influence of psychological response on survival in breast cancer: a population-based cohort sutdy. Lancet 354:1331–1336

White M, Epston D (1990) Narrative means to therapeutic ends. WW Norton, New York
Witek-Janusek L, Albuquerque K, Chroniak KR et al (2008) Effect of mindfulness based stress reduction on immune function, quality of life and coping in women newly diagnosed with early stage breast cancer. Brain Behav Immun 22:969–981
Wojtyna E, Zycinska J, Stawiarska P (2007) The influence of cognitive-behaviour therapy on quality of life and self-esteem in women suffering from breast cancer. Rep Pract Oncol Radiother 12:109–117
Xiaolian J, Chaiwan S, Panuthai S et al (2002) Family support and self-care behaviour of Chinese chronic obstructive pulmonary disease patients. Nurs Health Sci 4:41–49
Zabora J, Brintzenhogeszoc K, Love A et al (2001) The prevalence of psychosocial distress by cancer site. Psychooncology 10:19–28