

Adjustment to cancer: exploring patients' experiences of participating in a psychodramatic group intervention

J. MENICHETTI, MS, PHD STUDENT, *Department of Psychology, Università Cattolica del Sacro Cuore, Milan*, L. GIUSTI, MS, PSYCHOLOGIST, *Unit of Clinical Psychology, San Paolo University Hospital, Milan*, I. FOSSATI, MS, PSYCHOTHERAPIST, *Unit of Clinical Psychology, San Paolo University Hospital, Milan*, & E. VEGNI, MS, ASSOCIATE PROFESSOR, *Department of Health Science, Università degli Studi di Milano, Milan, Italy*

MENICHETTI J., GIUSTI L., FOSSATI I. & VEGNI E. (2015) *European Journal of Cancer Care*

Adjustment to cancer: exploring patients' experiences of participating in a psychodramatic group intervention

The main purpose of the present study was to understand the subjective experience of patients adjusting to cancer by focusing on how that experience might be affected by participating in a psychodramatic group intervention. In-depth interviews using an interpretative-phenomenological approach were conducted with eight cancer patients involved in a psychodrama group. Four key themes were identified: (1) outside and inside relationships; (2) identities: nurturing other selves; (3) a feelings' gym: performing the internal world; and (4) many ends: mourning death and dying. Participation in cancer group using a psychodramatic approach provided positive results. In detail, the group setting: (1) favoured relationships in which it was possible to freely express oneself and (2) empowered patients in their feelings of being able to give and receive help; the psychodramatic approach: (1) supported the physical mobilisation of sense of agency and (2) permitted to deal with the grieving process. Cancer healthcare pathways would benefit from psychotherapeutic programmes using a similar approach, since psychodrama by actively involving body seems to work on areas that are often underwhelmed by other approaches, such as (i.e., physical mobilisation, body engagement, grieving adjustment). Psychodrama supports patients to achieve insights into their own possibilities to actively participate in their own life situations despite having cancer and undergoing treatment for it.

Keywords: cancer, oncology, psychodrama, IPA, qualitative study, group therapy.

INTRODUCTION

Receiving a diagnosis of cancer, as a life threatening illness, can be destructive for patients and their families (Bradley *et al.* 2001; Gotheridge & Dresner 2002; Gillies & Johnston 2004). Psychosocial implications of cancer

have been widely documented (Watson *et al.* 2006; Gustafsson *et al.* 2008; Grassi & Nanni 2013), and have been found to be associated to disease progression (Satin *et al.* 2009). Patients with cancer and their families not only must cope with physical stresses due to treatments and pain but also with psychological problems brought on by diagnosis (Adler & Page 2008). This often results in psychological difficulties that can lead to social problems, which, together with physical burden, result from and contribute to each other and to cancer course (Adler & Page 2008). Dealing with psychosocial implications of cancer and improving psychological adjustment have become priorities in healthcare practices (Raingruber 2011).

Corresponding address: Julia Menichetti, Department of Psychology, Università Cattolica del Sacro Cuore, Largo Gemelli 1, 20042 Milan – Italy (e-mail: juliapaola.menichettidelor@unicatt.it).

Accepted 1 October 2015

DOI: 10.1111/ecc.12412

European Journal of Cancer Care, 2015

For these reasons, interventions for cancer-related problems are to date considered key domains of vital importance in cancer care (Rehse & Pukrop 2003; Uitterhoeve *et al.* 2004; Osborn *et al.* 2006; Raingruber 2011; Sheinfeld Gorin *et al.* 2012). In particular, group therapy has proved to be effective in mitigating the psychological effects of cancer (Blake-Mortimer *et al.* 1999; Classen *et al.* 2001; Breitbart 2002; Zabalegui *et al.* 2005) and in presenting peculiar benefits, such as social and mutual support and cost-effectiveness (Spiegel *et al.* 1999). A meta-analysis of 20 randomised controlled trials showed that participation in a group therapy resulted in improvements in various psychosocial areas (i.e., emotional state, illness adaptation, quality of life, marital relationships) (Zabalegui *et al.* 2005). The possibility offered by group therapy to temporarily improve also social aspects of living with cancer is particularly relevant considering that the symptoms experienced by patients with cancer involve different areas: physical, psychological, spiritual and interpersonal (Grassi *et al.* 2007). A psychotherapeutic programme considering all these different levels should be a specific ingredient of the oncological care pathway (Zabalegui *et al.* 2005). However, group therapies have more easily addressed psychological, spiritual or social areas of living with cancer, while physical aspects have been overshadowed. Furthermore, while there is a vast knowledge regarding cognitive-behavioural (Beatty & Koczwara 2010) and supportive-expressive (Kissane *et al.* 2007) group psychotherapies addressing specific psychosocial problems related to cancer, only few reports have addressed other types of interventions aimed to globally support patients in their psychosocial recovery (Blake-Mortimer *et al.* 1999), such as psychoanalytic (Krenz *et al.* 2014) or psychodramatic group therapies. In particular, studies on psychodramatic group psychotherapy for cancer patients are absent, despite the potentiality of this approach in involving the physical aspects of dealing with cancer together with the psychological and social ones. Indeed, the psychodramatic psychotherapy includes active methods in which clients use spontaneous dramatisation, role reversal, and self-presentation to explain and gain insights into their lives. The use of theatrical elements allows the creation of real-life situations, or the externalisation of inner mental processes, acting them out during the sessions. In a group context, selected auxiliaries usually enter the presented roles alternately, allowing an actual interaction to take place. Properly guided, such role reversal aims at producing a shift in perception so that one can see the other and himself in a new and fresh way. Through a psychodramatic approach, bodies are spontaneously activated and involved to act situations; emotions are directly experi-

enced, and thoughts are finally expressed and shared. For these reasons, psychodrama can be used both in non-clinical and clinical arenas and is particularly suitable to treat patients with chronic diseases (Blatner & Cukier 2007). Studies exploring this approach rarely involved clinical patients; a small part of them focused on mental health disturbances (Zhou & Gao 2004; Nazar *et al.* 2014) and few articles concerned with chronic disease patients, such as HIV patients (Karabilgin *et al.* 2012) or patients with psoriasis (Karadağ *et al.* 2010). All of them showed the effectiveness of psychodrama in reducing psychological symptoms thanks to the possibility offered to contemporary work on psychological, social and physical aspects concerning the cancer adjustment process. Although the promising features of this approach of taking into account both psychosocial and physical aspects (Kipper & Ritchie 2003), there is a lack of studies exploring psychodramatic group therapy among cancer patients.

Furthermore, results of interventions with cancer patients are often expressed in terms of improved quality of life and/or reduction in psychological comorbidities (pain, depression, anxiety, emotional distress) assessed by questionnaires or others measuring instruments that patients are asked to complete (Maccormack *et al.* 2001). The inner voices of cancer patients and what they experience from their specific and generally untapped perspective are often absent (Raingruber 2011).

The main purpose of the present study was to understand the subjective experience of cancer patients adjusting to illness by focusing on how that experience might be affected by participating in a psychodramatic group intervention. In our perspective, the psychodramatic psychotherapy (Moreno 1946, 1964; Moreno & Moreno 1969) could take a crucial role; thanks to its methodological structure aimed at fostering affective expression, mutual support, identification between members and adaptive coping strategies, adopting active methods in which the body is mainly involved (Vegni *et al.* 2010).

METHODS

Intervention

Two independent group psychotherapies each of 1½-h duration were held on a weekly basis in the public practice setting of the San Paolo Hospital (Milan, Italy).

The group interventions followed the classical psychodrama therapeutic approach founded on the seminal work of Moreno (1946, 1964) and Moreno and Moreno (1969). Spontaneity and creativity are core concepts in this approach, allowing participants to discover new solutions to problems in their lives and learn new roles they can

inhabit. Psychodrama incorporates general group processes as well as a range of psychodramatic techniques. An example of these is role reversal, where a participant is invited to play the role of another person and another one portrays the participant. With role reversal, participants are allowed to think as another person and to see themselves as portrayed by the other participants, also taking some of the benefits of the mirroring technique. In this way, internal representations are acted out on the stage, lived and elaborated. Following the standard structure, sessions were usually broken up into three phases: the warm-up, the action, and the group sharing (Kellermann 1992). No aspect of the intervention was modified for oncological patients; however, it was considered the physical strain and burden of patients and emphasised that participation in any of the physical movement techniques was completely voluntary.

Procedures and participants

Parameters for inclusion in the study were: (1) having received a diagnosis of cancer, (2) being or having been participants in a psychodrama group for oncological patients, (3) being able to speak and convey their experience in Italian, and (4) being able to provide written informed consent. We recruited subjects accordingly to these inclusion criteria and we involved a purposive sample of patients who shared the same experience of participation in a psychodrama group to have a sample as homogeneous as possible (Brocki & Wearden 2006; Osborn & Smith 2008). An interpretative-phenomenological approach (IPA) was adopted during interviews to promote a deep and idiographic understanding of patients' experience (Osborn & Smith 2008). IPA is described as phenomenological

because it is related to the viewpoint of individuals, rather than attempting to provide an objective explanation of what is being investigated (Bullen *et al.* 2010). It is interpretative because it requires the personal interpretation of the researcher to make sense of what participants are saying (Smith 1996). Therefore, it 'involves a two-stage interpretation process whereby the researcher attempts to interpret how the participants make sense of their experience' (Pringle *et al.* 2011, p. 20). As in the first stage, the researcher tries to access to the participants' experiences, in the second stage, the researcher positions the experiences in relation to a wider context and speculates on 'what it means' for the participant to have expressed the claims in a particular situation (Larkin *et al.* 2006). This combination is guided and informed by Heidegger's phenomenology, which supports an extremely subjective view of world where people are moved in the attempt of understanding the person in its context and in its relatedness to the world in a particular situation (Larkin *et al.* 2006). Its suitability to investigate the individual's perceptions and thoughts about their bodies' experience make it an appropriate method to be employed in the present study. Interviews were semi-structured and divided into three sections: (1) general questions designed to understand the patients' experience about their participation in the group; (2) questions concerning the group effects on cancer and its treatment; and (3) a section regarding the impact of the group on self-perception and identity. The schedule was used very flexible in the interview (Smith and Osborn 2007). In Table 1, the interview schedule with exemplifications of questions is reported.

Participants were drawn from a pool of cancer patients who joined the two psychodrama groups funded by the San Paolo Hospital ($n = 21$). All participants except for those

Table 1. Interview schedule

Section	Exemplificative questions
Patients' experiences about their participation in the group	<ol style="list-style-type: none"> 1. Could you give me a brief history of your participation in the psychodramatic group from when it started to now? 2. Could you describe what happens in the group, in your own words? 3. How do you feel when you participate in the group? How do you feel before and after starting the session? Prompt: physically, emotionally, mentally 4. If you had to describe what the group means to you, what would you say? Prompt: What images/metaphors come to mind?
The group effects on cancer and its treatment	<ol style="list-style-type: none"> 5. How the group was useful for you during the cancer adjustment? Why? 6. If you think about your illness experience, what aspects of the group have contributed to treatments? How?
The impact of the group on self-perception and identity	<ol style="list-style-type: none"> 7. How would you describe yourself as a person? Prompt: before/after cancer, before/after starting the intervention, now 8. Has having cancer made a difference to how you see yourself? Has starting participating in the group changed how you see yourself? How?

who had died during the study or withdrawn from the study were invited by the therapist to participate in the research ($n = 15$); one patient refused to participate. In addition, patients considered by the therapist (IF) too psychologically or clinically vulnerable to participate in this research were not approached. This evaluation was merely clinical and based on the personal perception of the therapist. Therefore, out of the 15 patients available for the research, 11 were finally contacted by phone from two clinical researchers (LG, JM) and agreed to give an interview. Any possible biases of the researchers were considered. Researchers were of different gender to control relational and interpretative differences, none of them had a formation in psychodrama techniques, and none had personal or professional involvements with cancer problems. Figure 1 shows the details of the recruitment flow. The interviews took place at the hospital and lasted between 45 and 75 min. The study protocol was approved by the Ethical Committee of the participating hospital before proceeding with the recruitment. Patients signed an informed consent form and were free to withdraw it whenever they wanted.

Finally, a total of eight subjects took part in the study ($n = 8 \times \text{age} = 59.25$, range = 47–73). As an idiographic method, small sample sizes are usual for studies using IPA as it seeks to provide in-depth analyses of a small group's accounts rather than generalise conclusions (Smith 1996; Smith & Osborn 2003; Bullen *et al.* 2010). The sample was Italian, mostly of female sex, well educated. For a summary of demographic, intervention-related, and relevant descriptive characteristics refer to Table 2.

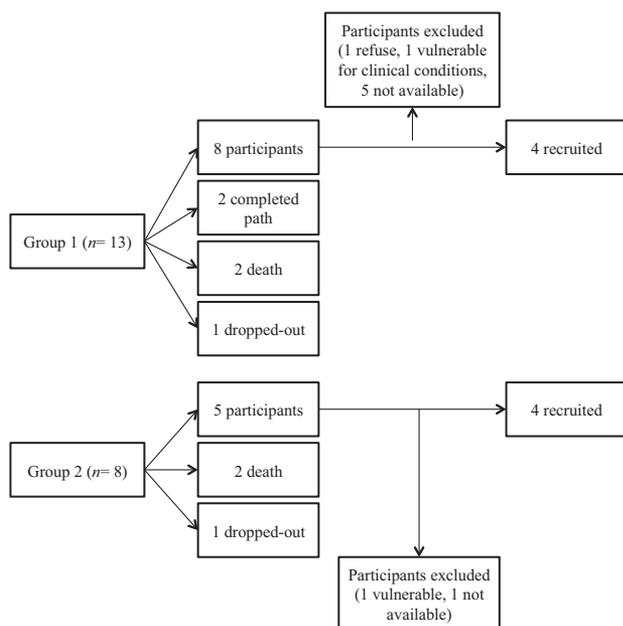


Figure 1. Recruitment flow.

Analysis

All interviews were audio-recorded and transcribed verbatim. We interviewed participants and analysed the material they generated in an ongoing manner, discussing themes emerging in an iterative way (Smith & Osborn 2003). Although IPA is not a prescriptive approach, it provides a clear set of flexible guidelines to help researchers in the analytical process (Smith & Osborn 2003). Transcript analysis was completed in stages. The first transcript was read several times to develop familiarity with the text. Thoughts, observations and reflections that occurred while reading the transcripts were noted on the script. At this stage, researchers re-read the text and identified themes that best captured the essential qualities of that interview (Biggerstaff & Thompson 2008). Thereafter, emergent themes were gathered into clusters, leading to a 'master-theme list' for each transcript (Smith *et al.* 1999); the central focus was on the meaning rather than on frequency. The same process was repeated for each transcript. Each researcher conducted stage 1 independently. Comparison across transcripts generated lists of preliminary themes; among these, common topics were developed from group analysis discussions (stage 2). Group analysis discussion with involvement of a supervisor (EV) took place after the first four interviews – to align the way interviews were conducted – and at the end of interviewing – to discuss themes emerging and solve discrepancies. During stage 3, definitive themes were produced and illustrative exemplars identified. Finally, after an iterative process, a table was produced that showed each higher order theme and the subthemes which comprised it (Smith & Osborn 2003).

RESULTS

The interpretive analysis of interviews allowed researchers to identify four key topics featuring the experience of cancer patients joining sessions of group psychotherapy with a psychodramatic approach. Here follows the description of the topics, with reference to the interviews and their details (interview's number, participant's sex, number of sessions he/she attended, disease type and treatment).

Outside and inside relationships

The matter about the social and relational effects of cancer was widely present in the interviews. Patients experienced cancer as a disrupting life event, deeply impacting also on relatives.

Table 2. Participants details at time of interview

Participant no.	Age	Sex	Marital status	Sessions no.	Treatment	Disease type
1	68	F	Dowager	22	Chemotherapy	Ovarian cancer
2	47	F	Cohabiter	3	Remission	Tongue cancer
3	61	F	Married	16	Hormonal therapy	Breast cancer
4	60	M	Married	1	Chemotherapy	Colon cancer
5	51	F	Married	60	Remission	Breast cancer
6	63	F	Divorced	63	Remission	Breast cancer
7	73	M	Married	80	Under control	Colon cancer
8	48	F	Married	3	Hormonal therapy	Breast cancer

Having cancer all of a sudden it's an experience that literally crashes you into the wall (int. 4, M, 1st session, colon cancer, chemotherapy)

Patients often perceived the relatives' reaction as a burden that they had to deal with and that created additional worries. Moreover, relatives were often described as unable to understand patients and cancer.

When I was found with cancer in my ovary and then had immediately surgery, my husband had an emotional and physical collapse...I didn't know on whom to rely and my daughter was very scared...by the way, she was also divorcing, so I had many other worries (int. 1, F, 22nd session, ovarian cancer, chemotherapy)

I said to my brother: I don't need to come and eat at your house, I need you to come and eat at my place! Nobody understood me...they don't understand the needs of someone who finds all of a sudden a mark in the video (int. 4, M, 1st session, colon cancer, chemotherapy)

Patients said the only way to cope with that was putting a mask on their own face. So far, relationships were described as a fiction where they used to wear masks of good health, a necessary equipment to be accepted by others. This could become an insane tangle of false relations that pushed them away from their everyday life.

External relationships are always characterised by a mask that we must put on to be accepted...the only way to be accepted is to mask cancer as an organic disease and simulate over and over again. You must simulate also with children because a mother must be strong and cannot be helped...as long as you cannot pull through this tangle of false relationships (int. 5, F, 60th session, breast cancer, remission)

Thus, for patients, loneliness and social problems were more easily a cause of pain and a reason to ask for help rather than cancer itself.

I started to participate in the therapy for different reasons, but honestly not for health problems, but for family problems...for loneliness (int. 6, F, 63rd session, breast cancer, remission)

In their descriptions, patients often set against group relationships with social relationships. If social relationships are familiar but apparent, group relationships are unfamiliar but heartfelt. The members of the group were described as strangers met for 1 h a week and as special friends able to give support and to understand without judgements at the same time.

Among the members of the group there is a strange, but beautiful relationship...it is strange because it was founded with strangers that you met only in this hour and half... They are strangers and at the same time they are not strangers because they are worried about you, they understand your problem and try to help you (int. 7, M, 80th session, colon cancer, under control)

Our group is formed by people suffering from cancer... it makes all of us similar, but at the same time we are different... for example, at the beginning we didn't know each other but we accepted one another (int. 5, F, 60th session, breast cancer, remission)

This double feature fostered the creation of a mutual help bond with feelings of comfort and safety among participants. This gave patients the chance to explore, express and identify feelings they otherwise would not have shared. While being able to share their experience with the other members, patients also felt less isolated.

An affinity not present in your home took shape... it's impossible to express and open yourself with your family... whereas you can do it with unknown people (int. 7, M, 80th session, colon cancer, under control)

They listen and learn, and a needy, depending and mutual help relationship takes shape... thus allowing to understand and feel that you are not alone (int. 5, F, 60th session, breast cancer, remission)

Being part of a group is a very strong experience because you feel problems and pains of others and this helps you not feeling alone (int. 2, F, 3rd session, tongue cancer, remission)

As respondents explained, they shared similar stories. Indeed, it was reassuring for the patients to know that there were others who were experiencing similar thoughts and feelings to theirs, and that there were not the judgments, the worries, the anxiety of the daily relationships. Thus, this helped patients to build a free place apt to express themselves openly.

In the group, we feel like being part of a community living together with someone you can speak to without any prejudice, without worries, without pretending to be someone else (int. 5, F, 60th session, breast cancer, remission)

The group has been a lifeline, because I can't talk to my children about these topics... they would get scared and sad... I can't even talk to my husband, he is more scared than me... here I find a place where I can pour out my feelings... for the first time I cried, before I was not even able to drop a tear! (int. 3, F, 16th session, breast cancer, hormonal therapy)

Finally, there seemed to be a kind of connection between participants that did not require words and which often occurred with a startling immediacy and intensity. This instant bonding was experienced as unique in the lives of many of the patients interviewed.

We are like distant twins: without the need to see and talk to each other; they are connected (int. 7, M, 80th session, colon cancer, under control)

Identities: nurturing other selves

The break in daily life marked by cancer was largely present in the interviews. Patients described that the diagnosis of cancer was followed by the permanence of negative feelings of fear, depression, sadness and anxiety. Thoughts and desires of death were also present.

My illness brought me out of my normal life and of my 60 years old man day-by-day routine (int. 4, M, 1st session, colon cancer, chemotherapy)

I started this path just wishing death (int. 1, F, 22nd session, ovarian cancer, chemotherapy)

My wig annoyed me, my prosthesis annoyed me, I was depressed... so I found myself alone, barely going out and I was always sad; restless sad and unhappy... I lost my desire to live and I wished only to die... that was me (int. 3, F, 16th session, breast cancer, hormonal therapy)

The feeling of being deprived of humanity and positive feelings was common in the participants' stories of cancer. As the patients explained, cancer led them to lose their identity, to change and to build a new identity including the role of patient.

A patient affected by cancer that loses his identity is like being a number... it's good that he lives again his own feelings, so he can realise that he is still a person (int. 3, F, 16th session, breast cancer, hormonal therapy)

When suddenly you have headaches you find yourself changing your life, your mind... being aware that you are closer to negative parts of life than to the positive ones is a strong experience that you wouldn't wish for anyone (int. 4, M, 1st session, colon cancer, chemotherapy)

Patients also talked about and emphasised personal changes in attitudes, character and behaviours after cancer.

For 60 years I have been a very shy person... now I don't care, I have realised that I have changed... I'm worse than before (int. 4, M, 1st session)

My cancer made me wiser, allowed me to understand my limits (int. 6, F, 63rd session, colon cancer, chemotherapy)

People pictured me as a completely crazy person, scared by everything, unable to leave the house; now the people who are close to me find more difficult to get in touch with me because I'm different from before (int. 5, F, 60th session, breast cancer, remission)

As the patients said, the group and the possibility to share experiences openly gave them the occasion to rethink about their general life plans after the cancer. Seeing the others facing with their problems and taking care of them allows a more positive attitude to life and sustains

patients in circumscribing their new health conditions and their new 'role of patients' to only one domain of their life. As the participants pointed out, during the group session they experienced the possibility to receive cares from the others and to take care of them. Most of the participants reported the experience of getting valuable help from the group and also of giving help to the group or to the individuals in the group.

By coming here, I learn from the problems of the other members and I try to bring something to the group (int.7, M, 80th session, colon cancer, under control)

As a consequence, patients had the perception of being able to help themselves. Thus, while group participants were empowered by the group, they also considered themselves acting to empower the others.

Now I'm different: if before I was a needy person and I needed someone to take care of me, now I'm normal and I can take care of me by myself (int. 5, F, 60th session, breast cancer, remission)

Maybe I'm helpful too... this allows me to be helpful to myself too (int. 6, F, 63rd session, breast cancer, remission)

When I think about the group I imagine us hugging each other and with our hands close, in circle... giving and receiving strength and energy (int. 2, F, 3rd session, tongue cancer, remission)

Moreover, acting other roles during psychodrama sessions permitted patients to put themselves in other members' shoes and to see the others dressing their own clothes. This allowed them to break the 'script of the patient' strictly repeated and to play new roles.

Solidarity arises from the group... since you empathise with the situation of another person, you must find the right words to cheer her up... there is a swap of roles (int. 3, F, 16th session, breast cancer, hormonal therapy)

Sometimes speaking about myself as being someone else is enlightening... during those nights in which I can't sleep, I think and process these things and I can give a sense to all my sufferings that before were senseless to me... so I can find peace (int. 5, F, 60th session, breast cancer, remission)

Thus, patients felt more legitimised and able to plan new life trajectories that included their health condition.

Such life trajectories were psychologically better sustainable and more positive than those they used to follow. As a consequence, the role of the patients was perceived as only one of the individual multiple selves. As suggested, the group was perceived by patients as an opportunity to play different identities – and not only the patient's one – allowing them to take a more active role in life and in the care process.

Then I started to work again because, when I realised to be able to give a positive message I perceived me being back on my rails... now there is something that compensate from my unmet need due to cancer and I can live again that part of my life that was previously taken away from me (int. 3, F, 16th session, breast cancer, hormonal therapy)

Cancer threw me away, now because of the group I feel like doing... I hope it will help me a little bit more to leave this shell that I made (int. 2, F, 3rd session, tongue cancer, remission)

This is not to say that patients did not feel anymore to be patient and did not have their fear of being sick again. However, the group therapy context was one in which they felt able not only to disclose their deeper thoughts and feelings but also, in some instances, to begin to explore, make sense and face them together with the other participants.

The days before screenings, CT, scans I'm always scared that something may go wrong... it's terrible... the fear is present, but at least we face it (int. 2, F, 3rd session, tongue cancer, remission)

A feelings' gym: performing the internal world

Interviews showed that patients made a wide use of expressions and metaphors regarding concrete and physical dimensions (e.g., 'put yourself in somebody else's shoes', 'join hands', 'as coloured rags'). In fact, as patients said, during a psychodrama session, they do and act a personal scene. Actions were used as a direct vehicle of feelings, thoughts and experiences. Patients were invited to act a part and to express the words of others, putting themselves in the others' place and using instruments (i.e. colours or cloths) to represent what they felt.

The method of psychodrama, of making a drama of what happened and of the relational dynamics is important... everyone has the own part and must

put himself in other shoes... at the beginning it is difficult, but then you feel better and by wearing other clothes you can understand some relational mechanisms (int. 5, F, 60th session, breast cancer, remission)

At the beginning he takes your hand and asks you to put down a cloth with a specific colour that represents your starting situation... then you do some steps and you arrive to another cloth – the intermediate situation -... then to the arrival point, experience it and finally you try to live in the future (int. 5, F, 60th session, breast cancer, remission)

Patients perceived the active strategies adopted during sessions as useful for different reasons and goals.

The possibility to perform experiences or situations through theatrical actions was felt as an opportunity to try to do something possible. Patients perceived the group as a place to train themselves and where it was possible to simulate alternative pasts and hypothetical futures within the bounds of a protected space.

It was great when they said: imagine to be the other person, what would your daughter say to you? And you – and now you are your daughter – what would you say to her? (int. 1, F, 22nd session, ovarian cancer, chemotherapy)

The psychodrama group permitted to feel and express emotions that normally remained covered, thus favouring the expression and disclosure of participants. Moreover, patients viewed role reversal and drama as useful strategies to express something inexpressible.

All of us were representing his parent and were giving voice to his impressions... in this moment you feel something... something comes out (int. 5, F, 60th session, breast cancer, remission)

The possibility to identify with something abstract – like representing an oak: a sturdy figure – is a simple way to express an action, a feeling that otherwise I don't know how to name (int. 4, M, 4th session, colon cancer, chemotherapy)

Participants reported that within a protected gym they have the possibility to live a future that creates negative emotions.

He let live something that before was scaring or worrying (int. 1, F, 22nd session, ovarian cancer, chemotherapy)

The performance played in the session allowed the patients, as they said, to feel new and more positive emotions together with others.

Then we represent the situation... everyone was part of the picture and expressed how they felt... particular, beautiful and exciting things to do together. The fact of being wind, of perceiving the strength and freedom of wind... I enjoyed being the wind (int. 2, F, 3rd session, tongue cancer, remission)

Emotions and feelings expressed using active methods were perceived as easier to be felt and understood than those in the form of words, thus fostering empathy among participants.

I understand very well what they feel! When someone complained about the absence of the leaden colour between the cloths because he felt like "leaden grey" for undergoing exams, I understood him because I feel "leaden grey" too when I'm undergoing exams... I understand the feeling of leaden grey (int. 2, F, 3rd session, tongue cancer, remission)

Finally, performing and sharing one's own emotions was perceived by patients as a strong method apt to work and able to join not only body and mind, but also theory and practice.

The intellectual and practical sharing between members, and the aid of a cloth or a pillow to represent one's feelings combine a practical aspect with a theoretical and intellectual aspect... this is very strong (int. 5, F, 60th session, breast cancer, remission)

Many ends: mourning death and dying

The theme of death was widely present in the interviews and was evoked by different situations. Patients often reported that they had encountered deaths of other group members. Dealing with the loss of the others is undoubtedly one of the most challenging aspects of the membership in cancer psychodramatic group, sometimes to the point of threatening to overwhelm the group itself, but finally revealing its healing impact.

I must admit it: when a member died, I thought that I couldn't deal anymore with death... I suffered a lot and I had doubts about continuing... but at the end I saw how death has been dealt with thanks to them and this convinced me it was the right place (int. 5, F, 60th session, breast cancer, remission)

The death of other members elicited thoughts of death between participants and revealed an historical structure and a memory of the group.

Last year the founder of the group died... we suffered very much for this loss... and now I can't fall asleep at night and I think: what is going to happen if I die? (int. 7, M, 80th session, colon cancer, under control)

Patients talked also about situations where death was not proved, but only supposed.

When xxx died, we were not informed because they were a little bit evasive... we tried to call her but she never answered... so we were quite sure that she was dead... then xxx joined the group but after some sessions she didn't come anymore (int. 3, F, 16th session, breast cancer, hormonal therapy)

Abounds were described by patients as similar to the members' deaths, but were conceived as a part of a healing process favouring the expression of thoughts of retirement from the group. However, the desertion of the group was perceived as a betrayal.

Currently the first participants are not in the group anymore ... one died last year... another one left the group last Friday and another one-three weeks ago... in these last few days I have been thinking about leaving the group too because I was feeling healed... but it seems to me like betraying the new entries (int. 7, M, 80th session, colon cancer, under control)

During the interviews, the issue about dealing in the best possible way with losses and deaths in the groups turned out to be a topic of discussion for many patients. Patients often described the adoption of ceremonies or active strategies to acknowledge the losses and to elaborate the fear of death. The possibility to represent and express one's own feelings regarding deaths and losses was viewed by patients as a way to give sense to their pain and sorrow, thus allowing feelings of peace and communion.

A very important moment was when we lost a member, it was very hard for me to accept it and we processed the pain through images... the therapist asked me to locate my pain in my body and invited us to take a pillow or a puppet to represent our pain and it was possible to talk to it... in this way you can give sense to the pain without crying alone in your room (int. 5, F, 60th session, breast cancer, remission)

One day has been very important because we spoke about death and suffering, and we asked our therapist to lead us in this path... he put a cloth on the floor and invited us to simulate that, beyond the cloth, there was the afterlife... he guided us in the afterlife and asked us how we imagined it... it was beautiful... I imagined to be finally in peace... it was ensuring (int. 3, F, 16th session, breast cancer, hormonal therapy)

It is unclear to participants whether, or to what degree, the group might change over time to incorporate loss and death more explicitly into their meetings. Some participants expressed the wish for death to remain an untreated topic because treating death would be too hard or something that is useful to forget.

In the group two things are avoided: we never talk about death and about medical care... because in my opinion it would be too much (int. 4, M, 1st session, colon cancer, chemotherapy)

Sometimes we talk about death but superficially (int. 7, M, 80th session, colon cancer, under control)

Generally, death was perceived as a normal part of group pathway, referring to the dynamicity and changeability of group and life.

I figured out an image to represent the group: a river in the wood with the water coming and leaving... maybe this is because many thoughts and situations are passing through the group... as it is a member who died... we know it for sure... (int. 1, F, 22nd session, ovarian cancer, chemotherapy)

DISCUSSION

The present study, although exploratory, contributes to the deepening of the participants' viewpoint and their experiences about the group psychotherapy conducted with a psychodramatic approach and its effects in fostering the adjustment process; it even provides a first important contribution from the use of psychodrama to orient healthcare practices in oncological settings. Our aim was to explore the subjective experience of cancer patients joining sessions of psychodramatic psychotherapy. At the same time, we wanted to give voice to the patients' experiences of their therapy, so that we could learn how a similar intervention could impact their disease, their identities and their care management to better suit the needs of the cancer patients.

When patients are asked to reflect about the experience of psychodrama group within their disease pathway, relationships appear as a central element. Social relationships, with friends and family, are a cause of discomfort for the patients. Results show that, from the participants' perspective, cancer goes along with relational problems, which often become more invasive than cancer itself. The contrast between the positioning of the support they receive in the group and the one they have from relatives and friends confirms previous findings revealing that, following the diagnosis of cancer, individuals report feelings of isolation in relation to their previous and taken for granted social world (Davison *et al.*, 2000; Yaskowich & Stam 2003; Adamsen *et al.* 2006). This appears to be an element to consider in cancer care settings and in health-care practices, implementing specific strategies and interventions. Patients perceived that the group dimension suited their unmet needs, fostering the creation of a place in which openly self-disclose themselves. Joining a psychotherapy group within the oncological care pathway represents, from the participants' perspective, an intense experience to elaborate emotional and relational pains due to the cancer.

There is compelling evidence that group interventions are effective in reducing mood and relational disturbance and pain, and in improving the quality of life in patients with cancer (Spiegel & Bloom 1983; Spiegel 1993; Blake-Mortimer *et al.* 1999). Moreover, studies have emphasised the relationship established between therapists and clients (Maccormack *et al.* 2001). Contrary to this, our results suggest that peer relationships between cancer patients prevail on those they have with the therapists and that such peer relations have a specific nature. The central position of the relationships between members in the therapeutic process might be due to the mutual actions between the participants in the inter-subjective field. Actions among members and the inter-subjective field are indeed fundamental elements of the psychodrama approach (Tavon 2010). The possibility offered by the psychodrama approach to use mutual actions among participants as way to express personal experiences and elaborate them, might strengthen the peer relationships and, consequently, the social benefits of the group therapy.

A second major fact found in interviews is the identity shift required from cancer and supported by the group work. The opportunity to take care of the others, to put oneself in other members' shoes and to see others dressing one's own clothes is reported by patients with an increased sense of strength, empowerment and sense of agency. Furthermore, patients report that feeling to be

helpful to the others and playing new roles improves their quality of life.

Positive changes in well-being and identity, in particular with regard to the increase of the sense of agency and the empowerment, are supported by previous research where mutuality is reported as being a benefit for patients attending cancer support groups (Carlsson & Strang 1998; Campbell *et al.* 2004), and previous qualitative research where participation in cancer support groups results in an increased sense of empowerment, hope and confidence (Mok & Martinson 2000; Coreil *et al.* 2004; Mok *et al.* 2004), and in a movement from the position of the victim to the one of the agent (Adamsen *et al.* 2006). In this sense, the physical activation is effectively required during psychodrama sessions, and thus the sense of agency may be reinforced by a similar approach (Greco 2009). Moreover, the enactments during psychodrama sessions naturally induce a personal involvement by engaging a temporary Self-in action, which usually does not arise in different approaches (Yaniv 2014).

There is a third major aspect referring to the peculiar features of the psychodramatic approach. As mentioned before, psychodrama adopts active methods in which clients use spontaneous dramatisation, role reversal and self-presentation to explain and gain insights into their lives. The body is directly involved during sessions, thus allowing the free expression of participants' thoughts and feelings. Our results show that participants widely use expressions regarding the spheres of body and sensory experience. The participants' experiences are characterised by mobilisation of positive physical sensations that are instrumental in developing a sense of agency and in improving a shared reliance. This is particularly true if we consider that cancer has a strong impact on the body of patients, above all with respect to physical experiences and perceptions. While exploring physical and mental experiences, the participants are given the opportunity to reclaim their voices, and recapture their stories (Schutzenberger 1975). Thus, the enactment of such a practice and the possibility of re- and pre-experiencing life episodes through psychodrama, may help contextualise cognitive activity (Kipper 2002; Yaniv 2014). In an action context, first comes experience, then comes learning (Yaniv 2014). As a consequence, thanks to the psychodrama approach the internal world of patients is fortified and the personal life trajectories are recaptured.

A final common topic among patients' interviews regards death. Dealing with cancer means dealing with thoughts of death. In the group, abounds were seen as a moment of death and an occasion to deal with death. Results have shown that there are three different experi-

ences of death/abound: abound for real death, abound for supposed death and declared abound. These three different experiences allow the elaboration of the own mourning and fear of dying. The discussion on death has been identified as one of the most difficult aspects concerning cancer support groups in previous qualitative studies (Cella & Yellen 1993; Grey *et al.* 1997; Yaskowich & Stam 2003). The importance of coming to terms with death, both individually and as a community, is often stressed in grieving literature, as are the negative consequences of avoiding the grieving process (Stroebe & Schut 2010; Shear 2012). In addition, facing death openly and together is a central topic of cancer group intervention (Spiegel *et al.* 1989; Gore-Felton & Spiegel 1999). There is good support for the idea of including active discussion of death in groups, and active mourning of the members who die.

In our perspective, the possibility offered by psychodrama to represent losses and mourning through active strategies is perceived by patients as a valuable tool to foster the grieving process. During mourning, people have faced only the dead's mental image, thus making the grieving process difficult and long. Psychodrama allows to give a body to the dead phantom and to make a real experience of loss by an incarnation of the representation in action, thus fostering the elaboration of the feelings of abandonment (Cohen 1978). As usual in group therapies, death is discussed verbally, whereas in the psychodrama approach, deaths are enacted and faced physically. For example, enacting the dead phantom and simulating the afterlife are perceived by patients as effective instruments to come to term with death, and these active instruments are able to let the body make experience of death, thus stimulating cognitively, emotionally, physically the grieving process.

Thus, according to Merleau-Ponty's phenomenology of perception (1962), bodily experiences provide meaning beyond that established simply through thought, and the actual interaction between subjects enables phenomenological immediacy of the social situation. In this perspective, the human body is conceived as an expressive space, which contributes to the significance of personal actions. Thus, the intervention can be said to contain liberating

elements closely linked to experiencing freedom and developing meaning, which may be strengthened by the fact that the physical actions were carried out with others in a similar situation (Midtgaard *et al.* 2007). The adoption of an approach that actively involves bodies may have an impact on physical and social mobilisation, supporting the individual to achieve insights into one's own possibilities to actively participate in his/her own life situations despite having cancer and undergoing treatment for it.

It is important to acknowledge the limitations of the present study. Since the patients who were interviewed were selected in consultation with group facilitators, this may have introduced unknown biases limiting the implications of the study findings. Furthermore, additional studies are needed to clinically and psychologically assess the effectiveness of psychodramatic group in improving health outcomes and in reducing psychological symptoms in cancer patients, in short-term as well as in long-term period. Further researches are also needed to understand the real efficacy of psychodramatic group sessions and to explore the influence of clinical, organisational and contextual factors in such a therapeutic process.

In our perspective, participation in cancer group using a psychodramatic approach provides positive results by favouring relationships in which it is possible to freely express oneself, empowering patients in their feelings of being able to give and receive help, supporting the physical mobilisation of sense of agency, and permitting to deal with the grieving process. Although patients following group therapies with different approaches report some of these benefits also, psychodrama seems to work on psychosocial areas that are often underwhelmed by other approaches, such as physical mobilisation, body engagement and grieving adjustment. Developing psychotherapeutic programmes using a similar approach seems to represent a clinical need that should be considered as a specific ingredient within cancer healthcare pathways.

ACKNOWLEDGEMENTS

We gratefully thank Francesca Pasqui for her kind linguistic revision of the English version of the manuscript.

REFERENCES

- Adamsen L., Quist M., Midtgaard J., Andersen C., Møller T., Knutsen L., Tveterås A. & Rorth M. (2006) The effect of a multidimensional exercise intervention on physical capacity, well-being and quality of life in cancer patients undergoing chemotherapy. *Supportive Care in Cancer* **14**, 116–127.
- Adler N.E. & Page A.E. (eds) (2008) *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*. National Academies Press, Washington, USA.
- Beatty L. & Koczwara B. (2010) An effectiveness study of a CBT group program for women with breast cancer. *Clinical Psychologist* **14**, 45–53.
- Biggerstaff D.L. & Thompson A.R. (2008) Interpretative phenomenological analysis (IPA): a qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology* **5**, 173–183.

- Blake-Mortimer J., Gore-Felton C., Kimerling R., Turner-Cobb J.M. & Spiegel D. (1999) Improving the quality and quantity of life among patients with cancer: a review of the effectiveness of group psychotherapy. *European Journal of Cancer Care* **35**, 1581–1586.
- Blatner A. & Cukier R. (2007) Moreno's basic concepts. In: *Psychodrama: Advances in Theory and Practice* (eds Clark B., Burmeister J. & Maciel M.), pp. 293–306. Taylor and Francis, London (UK), Routledge.
- Bradley C.J., Given C.W. & Roberts C. (2001) Disparities in cancer diagnosis and survival. *Cancer* **91**, 178–188.
- Breitbart W. (2002) Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer. *Supportive Care in Cancer* **10**, 272–280.
- Brocki J.M. & Wearden A.J. (2006) A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health* **21**, 87–108.
- Bullen K., Edwards S., Marke V. & Matthews S. (2010) Looking past the obvious: experiences of altered masculinity in penile cancer. *Psycho-Oncology* **19**, 933–940.
- Campbell H.S., Phaneuf M.R. & Deane K. (2004) Cancer peer support programs—do they work? *Patient Education and Counseling* **55**, 3–15.
- Carlsson M.E. & Strang P.M. (1998) Educational support programme for gynaecological cancer patients and their families. *Acta Oncologica* **37**, 269–275.
- Cella D.F. & Yellen S.B. (1993) Cancer support groups: the state of the art. *Cancer Practice* **1**, 56–61.
- Classen C., Butler L.D., Koopman C., Miller E., DiMiceli S., Giese-Davis J., Fobair P., Carlson R.W., Kraemer H.C. & Spiegel D. (2001) Supportive-expressive group therapy and distress in patients with metastatic breast cancer: a randomized clinical intervention trial. *Archives of General Psychiatry* **58**, 494–501.
- Cohen U.R. (1978) Psychodrama: coming to terms with death. *Psychology Today* **12**, 104.
- Coreil J., Wilke J. & Pintado I. (2004) Cultural models of illness and recovery in breast cancer support groups. *Qualitative Health Research* **14**, 905–923.
- Davison K.P., Pennebaker J.W. & Dickerson S.S. (2000) Who talks? The social psychology of illness support groups. *American Psychologist* **55**, 205–217.
- Gray R., Fitch M., Davis C. & Phillips C. (1997) A qualitative study of breast cancer self-help groups. *Psycho-Oncology* **6**, 279–289.
- Gillies B. & Johnston G. (2004) Identity loss and maintenance: commonality of experience in cancer and dementia. *European Journal of Cancer Care* **13**, 436–442.
- Gore-Felton C. & Spiegel D. (1999) Enhancing women's lives: the role of support groups among breast cancer patients. *Journal for Specialists in Group Work* **24**, 274–287.
- Gotheridge S.M. & Dresner N. (2002) Psychological adjustment to gynecologic cancer. *Primary Care Update for OB/GYNS* **9**, 80–84.
- Grassi L. & Nanni M.G. (2013) Beyond psychiatric classification in oncology: psychosocial dimensions in cancer and implications for care. *Psycho-Oncology* **7**, 235–242.
- Grassi L., Biancosino B., Marmai L., Rossi E. & Sabato S. (2007) Psychological factors affecting oncology conditions. *Advances Psychosomatic Medicine* **28**, 57–71.
- Greco M. (2009) Intersoggettività e interdipendenza: Ovvero dello stile relazionale nella metodologia psicodrammatica. *Psicodramma Classico* **9**, 1–2.
- Gustafsson O., Theorell T., Norming U., Perski A., Öhström M. & Nyman C.R. (2008) Psychological reactions in men screened for prostate cancer. *British Journal of Urology* **75**, 631–636.
- Karabılgin Ö.S., Gökengin G.B., Doğaner İ. & Gökengin D. (2012) The effect of psychodrama on people living with HIV/AIDS. *European Journal of Psychotherapy and Counselling* **14**, 317–333.
- Karadağ F., Kalkan Oğuzhanoglu N., Özdel O., Ergin Ş. & Kaçar N. (2010) Psychodrama in patients with psoriasis: stress and coping. *Anadolu Psikiyatri Dergisi* **11**, 220–227.
- Kellermann P.F. (1992) Processing in psychodrama. *Journal of Group Psychotherapy, Psychodrama and Sociometry* **45**, 63–73.
- Kipper D.A. (2002) The cognitive double: integrating cognitive and action techniques. *Journal of Group Psychotherapy, Psychodrama and Sociometry* **55**, 93–106.
- Kipper D.A. & Ritchie T.D. (2003) The effectiveness of psychodramatic techniques: a meta-analysis. *Group Dynamics: Theory, Research, and Practice* **7**, 13.
- Kissane D.W., Grabsch B., Clarke D.M., Smith G.C., Love A.W., Bloch S., Snyder R.D. & Li Y. (2007) Supportive expressive group therapy for women with metastatic breast cancer: survival and psycho-social outcome from a randomized controlled trial. *Psycho-Oncology* **16**, 277–286.
- Krenz S., Godel C., Stagno D., Stiefel F. & Ludwig G. (2014) Psychodynamic interventions in cancer care II: a qualitative analysis of the therapists' reports. *Psycho-Oncology* **23**, 75–80.
- Larkin M., Watts S. & Clifton E. (2006) Giving voice and making sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology* **3**, 102–120.
- Maccormack T., Simonian J., Lim J., Remond L., Roets D., Dunn S. & Butow P. (2001) "Someone who cares": a qualitative investigation of cancer patients' experiences of psychotherapy. *Psycho-Oncology* **10**, 52–65.
- Midtgaard J., Stelter R., Rørth M. & Adamsen L. (2007) Regaining a sense of agency and shared self-reliance: the experience of advanced disease cancer patients participating in a multidimensional exercise intervention while undergoing chemotherapy—analysis of patient diaries. *Scandinavian Journal of Psychology* **48**, 181–190.
- Mok E. & Martinson I. (2000) Empowerment of Chinese patients with cancer through self-help groups in Hong Kong. *Cancer Nursing* **23**, 206–213.
- Mok E., Martinson I. & Wong T.K.S. (2004) Individual empowerment among Chinese cancer patients in Hong Kong. *Western Journal of Nursing Research* **26**, 59–75.
- Moreno J.L. (1946, IV ed. 1977) *Psychodrama First Volume*. Beacon House, New York, NY, USA.
- Moreno J.L. (1964) *Psychodrama First Volume*, 3rd edn. Beacon House, Beacon, NY, USA.
- Moreno J.L. & Moreno Z.T. (1969) *Psychodrama, Vol. 3. Action and Principles of Practice*. Beacon House, Beacon, NY, USA.
- Nazar F.J., Zare-Bahramabadi M., Delavar A. & Gilan N.R. (2014) Efficacy of psychodrama techniques in internalizing symptoms (anxiety, depression and somatization) among adolescent girls victims of bullying in Kermanshah. *Journal of Mazandaran University of Medical Sciences* **24**, 142–148.
- Osborn M. & Smith J.A. (2008) The fearfulness of chronic pain and the centrality of the therapeutic relationship in containing it: an interpretative phenomenological analysis. *Qualitative Research in Psychology* **5**, 276–288.
- Osborn R.L., Demoncada A.C. & Feuerstein M. (2006) Psychosocial interventions for depression, anxiety, and quality of life in cancer survivors:

- meta-analyses. *International Journal of Psychiatry Medicine* **36**, 13–34.
- Pringle J., Drummond J., McLafferty E. & Hendry C. (2011) Interpretative phenomenological analysis: a discussion and critique. *Nurse Researcher* **18**, 20–24.
- Raingruber B. (2011) The effectiveness of psychosocial interventions with cancer patients: an integrative review of the literature (2006–2011). *ISRN Nursing* **2011**, 2011.
- Rehse B. & Pukrop R. (2003) Effects of psychosocial interventions on quality of life in adult cancer patients: meta analysis of 37 published controlled outcome studies. *Patient Education and Counseling* **50**, 179–186.
- Satin J.R., Linden W. & Phillips M.J. (2009) Depression as a predictor of disease progression and mortality in cancer patients. *Cancer* **115**, 5349–5361.
- Schutzenberger A.A. (1975) *Le corp et le group*. Privat, Toulouse, UK.
- Shear M.K. (2012) Grief and mourning gone awry: pathway and course of complicated grief. *Dialogues Clinical Neuroscience* **14**, 119–128.
- Sheinfeld Gorin S., Krebs P., Badr H., Janke E.A., Jim H.S., Spring B., Mohr D.C., Berendsen M.A. & Jacobsen P.B. (2012) Meta-analysis of psychosocial interventions to reduce pain in patients with cancer. *Journal of Clinical Oncology* **30**, 539–547.
- Smith J.A. (1996) Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health* **11**, 261–271.
- Smith J.A. & Osborn M. (2003) Interpretative phenomenological analysis. In: *Qualitative Psychology. A Practical Guide to Research Methods* (ed. Smith J.A.), pp. 51–80. Sage, London, UK.
- Smith J.A. & Osborn M. (2007) Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic back pain. *Psychology and Health* **22**, 517–534.
- Smith J.A., Jarman M. & Osborn M. (1999) Doing interpretative phenomenological analysis. In: *Qualitative Health Psychology: Theories and Methods* (eds Murray M. & Chamberlain K.), pp. 218–240. Sage, London, UK.
- Spiegel D. (1993) Psychosocial intervention in cancer. *Journal of the National Cancer Institute* **85**, 1198–1205.
- Spiegel D. & Bloom J.R. (1983) Group therapy and hypnosis reduce metastatic breast carcinoma pain. *Psychosomatic Medicine* **45**, 333–339.
- Spiegel D., Kraemer H., Bloom J. & Gottheil E. (1989) Effect of psychosocial treatment on survival of patients with metastatic breast cancer. *The Lancet* **334**, 888–891.
- Spiegel D., Morrow G.R., Classen C., Raubertas R., Stott P.B., Mudaliar N., Pierce H.I., Flynn P.J., Heard L. & Riggs G. (1999) Group psychotherapy for recently diagnosed breast cancer patients: a multicenter feasibility study. *Psycho-Oncology* **8**, 482–493.
- Stroebe M. & Schut H. (2010) The dual process model of coping with bereavement: a decade on OMEGA. *Journal of Death and Dying* **61**, 273–289.
- Tauvon L. (2010) Psychodrama: active group psychotherapy using the body in an intersubjective context. *Body, Movement and Dance in Psychotherapy* **5**, 257–267.
- Uitterhoeve R.J., Vernooij M., Litjens M., et al. (2004) Psychosocial interventions for patients with advanced cancer: a systematic review of the literature. *British Journal of Cancer* **91**, 1050–1062.
- Vegni E., Tomasoni N., Fossati I., Felisati G., Foa P. & Moja E.A. (2010) Interventi di supporto per pazienti oncologici: un'esperienza di psicodramma classico. *Psicologia della Salute* **1**, 22–34.
- Watson M., Greer S., Blake S. & Shrapnell K. (2006) Reaction to a diagnosis of breast cancer relationship between denial, delay and rates of psychological morbidity. *Cancer* **53**, 2008–2012.
- Yaniv D. (2014) Don't just think there, do something: a call for action in psychological science. *The Arts in Psychotherapy* **1**, 1–28.
- Yaskowich K.M. & Stam H.J. (2003) Cancer narratives and the cancer support group. *Journal of Health Psychology* **8**, 720–737.
- Zabalegui A., Sanchez S., Sanchez P.D. & Juando C. (2005) Integrative literature reviews and meta-analyses: nursing and cancer support groups. *Journal of Advanced Nursing* **51**, 369–381.
- Zhou Y.P. & Gao X.C. (2004) Effect of psychodrama therapy on the trait-anxiety of patients with schizophrenia. *Chinese Journal of Clinical Rehabilitation* **8**, 5753–5755.