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The perceived effects of psycho-spiritual integrative therapy and community support groups on coping with breast cancer: a qualitative analysis

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Abstract

Background: Few studies have assessed the efficacy of interventions that specifically address the unmet spiritual needs of cancer patients. This exploratory qualitative study sought to address this gap by comparing the subjective effects of Psycho-Spiritual Integrative Therapy (PSIT) groups and community-based support groups on coping and post-traumatic growth among women diagnosed with breast cancer. Community-based breast cancer support groups generally emphasize social support, emotional expression and problem solving, whereas PSIT emphasizes spiritual as well as psychological and existential development. PSIT offers a patient-centered approach in which this personal growth can be tailored to the participant's beliefs and values.
Methods: The study sample consisted of 24 participants; 12 from PSIT groups and 12 from community-based cancer support groups. Thematic analysis and grounded theory were used to analyze interview data.
Results: The qualitative analysis identified 4 phases of coping with breast cancer. Women attributed positive effects of both PSIT groups and community-based support groups on coping and post-traumatic growth in the following areas: self-acceptance, body image, life purpose and meaning, spirituality, reassessment of values and priorities and interpersonal relationships. However, women participating in PSIT reported more positive effects on spiritual and existential development and coping than did community sample participants.
Conclusion: Because of its inherent focus on spiritual and existential development, PSIT may both appeal to and help some women to better adapt to breast cancer survivorship.

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Introduction

Although 39% to 40% of cancer patients express unmet existential and spiritual needs, few studies have assessed the efficacy of interventions that specifically address spiritual needs [1,2]. The qualitative study we describe here sought to address this gap by determining how the subjective experiences of breast cancer patients who participated in either a community-based breast cancer support group or a Psycho-Spiritual Integrative Therapy (PSIT) group affected coping and post-traumatic growth. Community-based breast cancer support groups often emphasize emotional expression and problem solving, whereas PSIT is an integrative psycho-spiritual coping intervention that may counter the sense of fragmentation experienced by some breast cancer patients and facilitate an experience of personal growth, meaning and spirituality. PSIT seems well-suited for a person-centered approach to helping individuals find greater meaning through the experience of coping with cancer, because it provides a conceptual framework and exercises that can be adapted to virtually anyone's spiritual/religious/existential views - including individuals who do not view themselves as religious or spiritual [3].

A diagnosis of breast cancer and its subsequent treatment can impact upon a patient's physical health,

interpersonal relationships, daily functioning, familial and social roles, body image, sexuality and life purpose and meaning [4-6]. Cancer patients often struggle with an array of cancer and/or treatment-related symptoms, including chemically-induced menopause and diminished sexual functioning [7], reduced cognitive functioning [8], pain management issues, challenges with weight control, fatigue, difficulty with maintaining hope and finding meaning and anxiety surrounding treatment [4-6].

Additionally, patients with successful medical outcomes often report that their psychological functioning during the survivorship phase is diminished by intrusive thoughts of an uncertain future [4]. This array of physical and psychological symptoms may foster feelings of disconnectedness from the patient's normal support systems and from the routine aspects of everyday life [9]. Successful management of the disturbing emotions that accompany a diagnosis of breast cancer can lead to improved medical and psychosocial results [10].

Some women report that their coping mechanisms lead them to adjust negatively to breast cancer, which can produce psychopathology [1]. Cognitive coping, aimed at reducing or eliminating emotional distress, is a common mechanism for coping with illness [11]. However, in unremitting situations such as having been diagnosed with breast cancer, cognitive coping alone may lead to rumination, which can result in negative adjustment and may exacerbate psychological, existential and spiritual distress [1,4-6,12-14]. Symptoms such as depression and anxiety may persist for some cancer survivors, even when they are disease free and years beyond the active treatment phase [4-6,15-17].

Women coping well with cancer have found ways to adjust positively in the midst of the disruption caused by the disease and its treatment [18]. Coping approaches that may contribute to positive psychological states and personal growth include meaning-based coping and spiritual coping, where *meaning* refers to the patient's ultimate purpose or concern and *spiritual* refers to the patient's experience of the sacred [12,19,20]. Models of meaning-based coping describe meaning-making as the process of reconciling a newly appraised situational meaning of an event with the individual's global beliefs and goals until these are congruent [21]. Research suggests that meaning-based coping - which includes positive reappraisal; revising goals to foster meaning, purpose and control; finding existential meaning through spiritual beliefs and experiences and finding positive meaning in everyday events - may improve coping after traumatic events [12,22,23].

Research suggests that the cancer experience may also serve as a time for self-reflection, growth and increased spirituality [24-29]. This evidence suggests that extremely significant events, such as cancer, can shatter a person's assumptions about themselves and the world, creating an opportunity to re-structure these assumptions in a healthier way and leading to positive life changes [30]. Tedeschi and Calhoun [30] used the phrase *posttraumatic growth* (PTG) to capture the various positive life changes that can be activated by such a significant event. Studies show that breast cancer is a sufficiently significant and important enough event to result in PTG [24-27].

Spirituality is increasingly being recognized as an essential component of health and wellbeing by cancer physicians, researchers and mental health practitioners [29,31-35]. Several cross-sectional studies found that spirituality among cancer patients was related to a better quality of life, more positive moods and reduced symptoms of distress [29,36,37]. Researchers have found that, on average, more than half of cancer patients view religion/spirituality as personally important and experience spiritual needs [3,38,39]. Furthermore, a study focusing on female breast cancer survivors found that 85% reported that spirituality was an important part of their lives [40]. However, research conducted on spiritually-based interventions is sparse and many psychosocial interventions for cancer do not address spirituality.

PSIT integrates a variety of psychotherapies with a personalized sense of spirituality. There is no universally accepted definition of spirituality. In PSIT, spirituality is defined as a subjective experience of the sacred however the individual apprehends it [41]. It is informed by stress and coping theory [11,21], spiritual/religious coping [42,43], mindfulness [10,44] and elements of third wave behavioral therapies, especially Acceptance and Commitment Therapy (ACT) [45]. The therapy encourages an exploration of a personal sense of spirituality for coping and enriching the individual's life purpose, as has been recommended by others [46,47]. PSIT is non-doctrinal, relying on the individual's sense of the sacred and spiritual beliefs; therefore it is suitable to people from most spiritual/religious traditions. Also, it can be suitable for persons who do not view themselves as spiritual, yet who value a self-transcendent outlook on life that typifies healthy individuals [48]. A preliminary study on PSIT found significant improvements in participants' quality of life as well as in reductions of overall mood disturbance and in mood states that include tension, depression, anger and fatigue [49].

Through an improved understanding of the roles of spirituality and meaning in the coping process and their impact on quality of life (QOL), integrated interventions that address the psychological, spiritual and life meaning aspects of coping can be created and empirically tested [50]. The findings of this study may contribute to the integration of spiritual, psychological and meaning constructs with existing theoretical coping models. The findings of this study may also contribute to a better understanding of how spirituality can be utilized as a resource throughout the active disease phase and the survivorship phase of breast cancer. Results may also contribute to the refinement of PSIT and its application as a potential clinical tool that can be adapted to the needs and perspectives of the individual patient.

Methods

This study, which was part of a larger research study conducted in Northern California, USA, employed qualitative methods to explore how the experiences of breast cancer patients participating in a Psycho-Spiritual Integrative Therapy (PSIT) process group or a community-based breast cancer support group affected coping. The PSIT group taught psychological, spiritual and life meaning introspective tools and practices, whereas the community-based breast cancer support groups generally emphasized a supportive-expressive coping approach based upon group interactions [51]. The PSIT approach, which is individualized according to the patient's perspectives and values, has been described in detail elsewhere [52,53]. Thematic analysis informed by grounded theory principles was used to analyze the interviews of 24 women who have had breast cancer and participated in either type of support group.

Participants

Participants were accepted into the study based on the following criteria. Participants were enrolled in one of two interventions, a PSIT group or a community-based breast cancer support group and had completed at least 18 hours of either group intervention within the past 60 days. Participants must have been diagnosed with non-metastatic primary or recurrent breast cancer (stages 0 - III) within the past 10 years. Finally, all women were at least 18 years of age and were able to speak and read English proficiently to give consent and to describe their experiences clearly.

Women were excluded if they had Stage IV or metastatic breast cancer, any psychotic or bipolar diagnosis, intrusive suicidal thoughts or reported substance abuse from which they were not at least one year 'clean and sober'.

Recruitment

Fifty women responded to recruitment efforts for the larger PSIT research study. Thirty-one of the 50 met eligibility criteria, but only 30 completed a baseline assessment and were therefore considered to be in the original study. Of those 30, 24 completed a post-intervention and/or follow-up assessment.

For the current study, two samples of 12 women each, the PSIT-sample and the Community-sample, were recruited. Since eligibility requirements for the PSIT-sample were the same as those used for the larger study, a subset of 12 was randomly selected from the 24 participants who completed a post-intervention and/or follow-up assessment and a minimum of 18 hours of the PSIT group intervention within the past 60 days.

Community-sample recruitment was conducted through distribution of fliers plus in-person, email and phone contact with sources that provided or referred patients to psychosocial breast cancer support groups. Of the 14 women who responded to the Community-sample recruitment efforts, 12 met the eligibility criteria and were accepted into the study.

Procedure

Demographic information and informed consent were successfully obtained from all 24 participants. The interview protocol was based upon questions found to be useful in a previous qualitative study of illness, coping, spirituality and meaning (A.Warner, unpublished data). A total of 11 interview questions were included: pre-support group coping efforts; specific, impactful group experiences and their effects on emotion-focused, problem-focused and spiritual coping, body image, self-perception, relationships and world view and group experiences that influenced life meaning and purpose, values and priorities.

Demographics

Twenty-four women participated in this study including 12 from the PSIT-sample and 12 from the Community-sample. The 12 participants from the Community-sample represented 5 different community-based cancer support groups that met regularly and emphasized emotional expression, support and problem solving. Two of these groups were peer-facilitated and professionals facilitated the other 3; 4 were breast cancer specific and one was a mixed cancer support group. The participants ranged in age from 41 to 77; the PSIT-sample had an average age of 53.33, while the Community-sample had an average age of 59.25. The participant pool from both samples was mostly homogenous with regard to economic status, diagnosis of primary breast cancer, time since diagnosis and geographic locale (Table 1). There were some demographic differences between samples in marital status, treatment status and religious/spiritual orientation (Table 1).

Treatment of the data

The audio recordings of the interviews were transcribed, all personal identifying information was removed and pseudonyms were assigned to each participant. Data analysis was informed by the thematic analysis method of Braun and Clarke [54] and the grounded theory method of Charmaz [55]; MAXQDA 2007 software was used in the coding and analysis [56]. The lead researcher also followed the quality criteria for qualitative research advanced by Mertens [57], which includes credibility, transferability, dependability, confirmability and authenticity. Only transcript material deemed relevant to the study's topic was coded. A coded unit was determined for this study as a self-contained concept, idea or passage in the text that remained constant, but was repeated either within the transcript or across the data set.

The lead researcher identified initial units according to the grounded theory principle of open coding. Gerunds were used to formulate and assign codes to retain the

Table 1 Demographic characteristics of the participant samples

Variable	Combined *n* = 24	PSIT-sample *n* = 12	Community- sample *n* = 12
Time since last diagnosis			
0 - 1 year	5.21%	3.25%	2.17%
> 1 year to 2 years	12.5%	6.5%	6.5%
> 2 years to 3 years	1.4%	1.80%	N/A
> 3 years to 4 years	N/A	N/A	N/A
> 4 years to 5 years	4.17%	2.17%	2.17%
> 5 years to 6 years	1.4%	N/A	1.8%
> 6 years to 7 years	N/A	N/A	N/A
> 7 years to 8 years	1.40%	N/A	1.80%
Diagnosis type			
Primary	22.92%	11.92%	11.92%
Primary recurrent	2.8%	1.8%	1.8%
Treatment status			
Active primary treatment	8.33%	2.17%	6.5%
Completed treatment	10.42%	7.58%	3.25%
Ongoing treatment	6.25%	3.25%	3.25%
Race, ethnicity			
Caucasian	21.88%	10.83%	11.92%
Chinese-American	1.4%	N/A	1.8%
Jewish	1.4%	1.8%	N/A
Indonesian	1.4%	1.8%	N/A
Marital status			
Single	4.17%	3.25%	1.8%
Married	9.38%	6.5%	3.25%
Divorced	5.21%	N/A	5.42%
Widowed	2.8%	N/A	2.8%
Partnered	4.17%	3.25%	1.8%
Income (household)			
Less than $24,999	3.13%	1.8%	2.17%
$25,000 - $49,999	N/A	N/A	N/A
$50,000 - $74,999	9.36%	6.50%	3.25%
$75,000 - $99,999	3.13%	N/A	3.25%
More than $100,000	9.36%	5.24%	4.33%
Spiritual/religious orientation			
Episcopal	2.8%	1.8%	1.8%
Jewish	1.4%	1.8%	N/A
Catholic	5.21%	4.33%	1.8%
Christian	2.8%	N/A	2.17%
Presbyterian	1.4%	N/A	1.8%
Unitarian Universalist	2.8%	N/A	2.17%
Protestant	1.4%	1.8%	N/A
Religious Science	1.4%	1.8%	N/A
Jewish Secular	1.4%	1.8%	N/A
Not reported	1.4%	1.8%	N/A
None	7.29%	2.17%	5.42%

N/A = not applicable

action oriented process of the participant's experience [55]. Commonalities were tested and codes were refined by constant comparison; memos were written to capture initial ideas, diagrams, possible relationships and questions as the coding continued. Codes became grouped into categories that emerged organically from the participant transcripts in accordance with the inductive nature of this study.

Once the initial coding was completed across the data set, the lead researcher commenced axial coding by analyzing them for possible thematic groupings and relationships. Once themes and subthemes were established, frequency by participant was analyzed and recorded. As a general guideline, only coded units that were repeated by more than 4 participants were used as a dimensional subtheme. However, exceptions to this guideline were made if the researchers deemed it added relevant contrast or depth to the rich description in keeping with grounded theory principles.

The lead researcher engaged in 3 reviews with a methods expert during the data analysis process to ensure the data was handled with integrity. She also recruited 4 peers who worked primarily with cancer patients as psychologists and/or were breast cancer survivors to review a draft of the findings in light of their own personal and/or professional experience with breast cancer. They were asked to focus on resonance or dissonance with the findings, indications of any possible bias in the findings, missing information and general clarity and descriptive richness of the findings. All reviewers resonated with the themes and provided linguistic clarifications; some reviewers suggested possible study limitations.

Results

Data analysis revealed 4 major theoretical constructs, or phases, each with its own focus (see Figure 1). Together, these 4 phases summarized the participants' collective narrative of how breast cancer diagnosis and treatment: (a) challenged and sometimes fragmented their long-held perceptions of what is 'normal'; (b) how they managed the chaos in the midst of the shattering; (c) how they re-constituted a new sense of normal through their support group experiences and (d) how they enacted their new normal in daily life and relationships. A short description of the major themes within the 4 phases is provided. Quotes are accompanied by pseudonyms, which are followed by their sample designation – either PSIT or Community.

Themes in the first phase were common to most of the participants from both samples. They reflected participants' initial physical, mental, emotional and spiritual reactions to diagnosis and treatment and to the realization that cancer has irrevocably changed how they see themselves and the world. Louise-PSIT said:

> "It (the breast cancer) was a land mine, because I didn't see it coming. And it blew everything out of the water . . . blow everything apart and start over with what you think".

The crux of the shattering seemed to be a fearful and overwhelming experience of the body's vulnerability and ultimate impermanence. This experience of the salience of death seemed to be magnified by the ambiguity of not knowing if or when the breast cancer may become terminal. Veronica-Community said:

> "I was grappling with the fact of - the ambiguity. I could live or I could die. And I don't get to know . . . that was pretty hard to deal with. (It's the) whole sense that the future was altered. . . . but definitely not feeling like I was promised a future."

The experiential knowledge of their mortality magnified the fragility and preciousness of life experienced by the women, while stimulating an urgency to live life fully. Tamara‑Community said:

> "You know, life is too short. You're going to miss a lot if you don't put yourself out there in whatever way you can."

Most of the participants from both samples expressed a movement away from what they once considered to be normal living with no chance of ever going back to that norm. Jane-PSIT said:

> "I've sort of been trying to get back to normal – whatever that is. . . . I don't think you ever do go back . . . because you sort of left – and you just keep going. . . . Sometimes you don't know where that's going, but you do it."

Olivia-Community said:

> "People think . . . that once you get through this, you're going to be the way you were before . . . cancer changes you and it changes you for good and there's no going back."
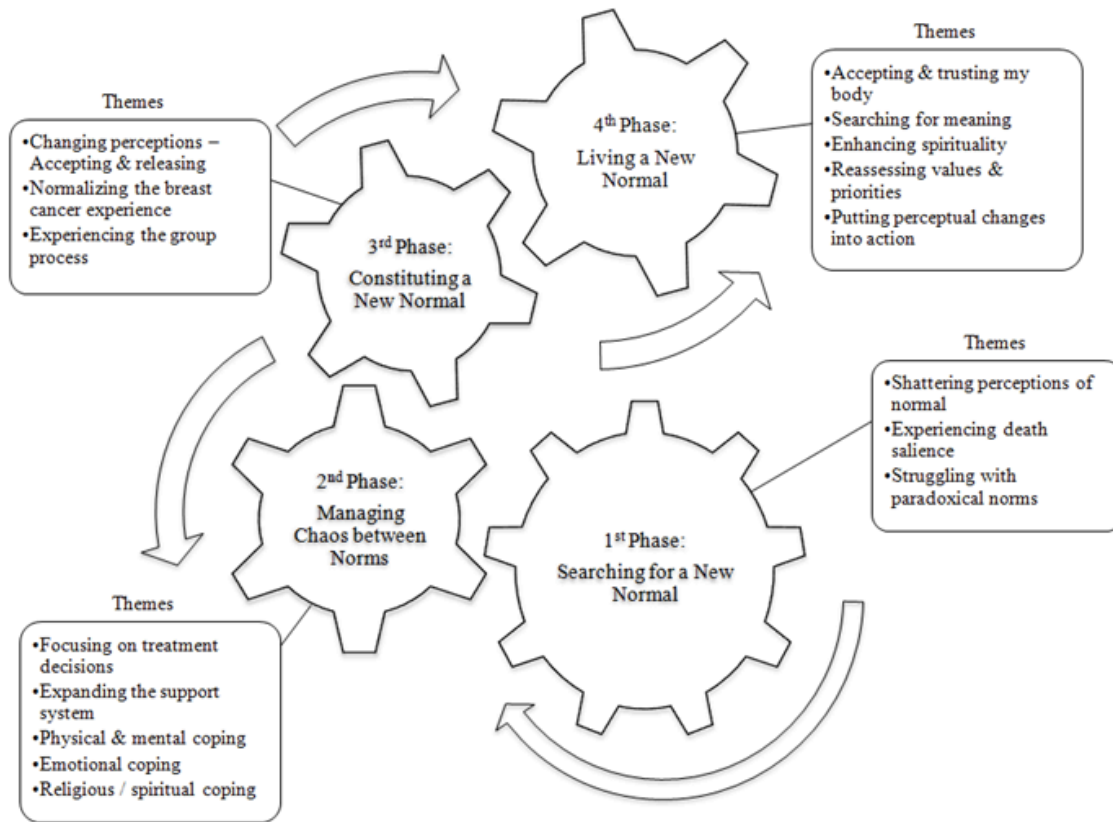
The challenge of holding this paradox between life before breast cancer and life with breast cancer seemed to be a driving force in the subsequent search for and/or creation of a new normal for each woman.

Themes in the second phase were also common to women from both samples. Participants verbalized the different ways they managed the whirlwind of treatment decisions and treatment side-effects prior to attending their support group. Their approaches to coping included physical activities, mental activities such as guided imagery and continuing to work and spiritual activities. Some participants said they put their emotions on hold in order to make treatment decisions and get through the physical intensity of treatment for the first 9 - 12 months. Mia-Community said:

> "I'm just now beginning to address those issues about how I see myself, how I face this catastrophic issue. I didn't know how I would face it when it first happened and there was just so much going on."

Physically, many participants were released from medical treatment, but mentally, emotionally, existentially and spiritually they were still attempting to integrate their

Figure 1 Phases and themes of the breast cancer experience

breast cancer experience and develop a new normality. Jane-PSIT said:

> "(the cancer) leaves your psyche in some kind of a weird state . . . how do you resolve your psyche's coming back into the world?"

This impetus to create a new normality in the midst of or after treatment often fueled participation in their chosen support group. As Ingrid-PSIT put it:

> "I think my goal in coming to the group was more about life after cancer than cancer."

In the third phase, participants verbalized how their group experiences influenced their coping. Participants in both types of groups came to utilize similar coping approaches, but through different means. Participants from both types of groups described that they found insight, integration, peace and freedom through learning to release resistance and control and simply accept life as it was brought to them. Women from the Community-sample seemed to derive their experience of 'letting go' and accepting life in the moment from their inherent beliefs or life philosophies or from the relational bonding and the mirroring and modeling of coping skills they experienced from other members of their support group. Ursula-Community said:

> "I would say it (hearing/watching group members cope) gives me a healthier look at my own life. It helps me to look more for the positive, don't look back, continue looking at the now, at the moment, the time you have right now. And be so thankful that you are where you are."

In comparison, women from the PSIT group most often mentioned the introspective tools they learned and the experiences they had practicing these tools as what helped them to cultivate an attitude of acceptance toward themselves and whatever life offered in the moment. Amy-PSIT said:

> "It was another way of having to give up control and be present with what really is true right now and just deal with it instead of . . . wanting things to be different and then spending all my energy railing against what really was. So I think these exercises helped me to deal with that and realize where I was getting caught up in the need to have things a certain way."

In the fourth phase, most of the women from both samples expressed a gradual re-construction of their relatively shattered perceptions of what they once considered "normal". This reconstitution process effected gradual changes in: (a) how they perceived themselves, others and the world; (b) their values and priorities and (c)

their attitudes towards their physical body. For participants in the Community-sample, these perceptual shifts seemed to be realized primarily through the formation of relationships based upon unconditional acceptance, the normalization of the breast cancer experience and the mutual modeling of new coping skills. In comparison, PSIT-sample participants most often cited individual internal experiences facilitated by the self-reflection and coping tools they learned in the group.

Participants from both samples described becoming more sensitive, aware, compassionate, accepting, honest and open toward themselves and others as a result of their group experiences. Participants also described feeling more empowered, self-confident and secure because of what they experienced in their groups. They expressed more hope and confidence in overcoming the breast cancer as well as increased confidence and strength for all of their life transactions. Emma-PSIT said:

> "Wow!! Well, it was in the (PSIT) class that I learned that (I was a fighter). It was really, really powerful. . . . and I'm going to take that with me for as long as I live."

Wanda-Community said:

> "Some of them are showing up bald, feeling sick . . . that's really amazing to see - it gives a sense of power over chemo . . . they're living, breathing, talking and laughing . . . in spite of the chemo they're still living their lives."

Prior to participating in their chosen support group, most of the participants reported feeling loss, fear, anger, unattractiveness, vulnerability and unfemininity relative to losing one or both breasts. After participating in their chosen support groups, women from both samples reported increased acceptance, sense of attractiveness and appreciation for their bodies. Mia-Community said:

> "I actually started to have a sense that maybe I was still an attractive person".

Most of the women from both samples reported an ongoing process of re-assessing personal values and priorities as a result of their support group experiences with the most commonly mentioned new priority being self-care. Although they acknowledged that it was the breast cancer experience itself that first made them realize the need for self-care, it was their group experiences that helped them to understand what self-care meant and how to put it into action. Gloria-PSIT said:

> "I think that through this experience of having cancer, I realized that I'm no longer superwoman and through this (PSIT) group, I felt that I just can't acknowledge that I'm not superwoman - I have to do something about it. I have to give myself a higher priority."

Several differences between samples were found in the following areas: (a) searching for meaning; (b) spiritual development; (c) cultivating skills of nonjudgmental self-awareness and (d) differences in the group process. First, women from the PSIT group seemed to describe more experiences related to seeking the larger existential meaning of their life; that is, "Why am I here?" more frequently than the women from the community support groups. As a result, most of the PSIT-sample participants said the experience of exploring life meaning and purpose encouraged them to look beyond the narrow definitions of breast cancer to a life lived larger. Fran-PSIT said:

> "The (PSIT) group has shown me that there is a purpose for everyone . . . (exploring my purpose) helps me to move forward. . . It's given me something to hang onto."

In comparison, women from the community breast cancer support groups seemed to describe experiences related to finding meaning for the cancer; that is, "Why me?" more frequently than the women in the PSIT group. Ursula-Community said:

> "You look at it as, 'Wow, how could this happen to me?'"

and Sofia-Community said:

> "I got this real sense of failure that I had cancer."

The experience of normalizing breast cancer as just a disease may have helped the women from Community-sample to start shifting their perceptions from negative to more neutral or positive. Paula-Community said:

> "With the breast cancer support group, (I learned that) it's (the breast cancer) not my fault . . . it's nothing you did - you're not being punished by God or something."

A second difference between the 2 samples was related to women's experiences of spiritual development. All of the women from the PSIT-sample said their experiences enhanced or provided a new focus for their spirituality. Helen-PSIT said:

> "There's no doubt that it (PSIT group) has (impacted my spirituality). I don't think I can articulate any more about it. I know a big shift has happened - I'm just not sure what it means yet."

In contrast, fewer women from the Community-sample reported distinct spiritual shifts and several reported no change to their spirituality as a result of participating in their community breast cancer support group.

A third difference between samples was the cultivation of non-judgmental self-awareness. The PSIT group taught specific tools that cultivated the ability to detach and observe without judgment as a means to decrease stress and facilitate self-knowledge. Many participants cited using this skill as a means to cope with physical and mental reactions to the cancer and to assist them in making life decisions. Amy-PSIT said:

> "I think the exercises helped me to separate from the free-floating thoughts that were making me very down."

A fourth difference between samples was variations in group processes. Women from the Community-sample

commented more frequently on whether having a facilitator who was a breast cancer survivor impacted their experiences of the group. Women from the PSIT-sample, however, commented more frequently about how beneficial it was for them to learn practical tools for coping and to have the time to practice these tools within the safety of the PSIT group process.

Discussion

Four phases of survivorship were identified in this study: (a) challenged assumptions of normality; (b) managing chaos; (c) re-constituting a new sense of normality through the support group experience and (d) enacting the new normality. The development of more person-centered approaches to helping women with breast cancer to cope and realize personal growth through the cancer experience may benefit from considering the different challenges faced in each of these phases of survivorship.

The first phase provided a thematic overview of what study participants experienced as a result of being diagnosed with and treated for breast cancer, including fragmentation of long-held perceptions of normality to varying degrees and in a variety of specific ways, the need to face death and dying and the subsequent struggle with seemingly paradoxical norms. In other words, the women that they now are with breast cancer did not quite fit the life or the self-perceptions they had before being diagnosed with breast cancer. This reported experience of paradox is corroborated by a qualitative study of paradox in the spiritual development of women with breast cancer [9]. Additionally, the shattering of normative assumptions is in alignment with literature on post-traumatic growth (PTG) after cancer [18,58] as well as the theoretical model of meaning-making coping [21].

The second phase thematically described the initial efforts participants employed to manage the often chaotic and overwhelming experiences of breast cancer including the urgency to focus on treatment decisions first, expansion of the support system and physical, mental, emotional and religious/spiritual coping efforts. Although an in-depth study of pre-support group coping was not within the scope of this research, the participants' efforts to cope with the challenges of having breast cancer seemed to be in alignment with those identified in previous research on coping with breast cancer [4-6,12-14,38,39].

In the third phase, participants voiced experiences of their chosen support groups including techniques, relational interactions and internal processes, some common to both samples and some unique to each, that facilitated a re-framing process that was critical to reconciling their shattered global assumptions with their situational meaning of the breast cancer experience [21,59]. Core to this re-framing process is a learned ability to accept life as it is in the moment and to release expectations, control and pre-conceived assumptions of themselves, others and/or their situations. These results support existing research that found that a balanced use of active acceptance [60], combined with active and yielding control efforts [61] may lead to optimal psychosocial adjustment and quality of life in the face of life-threatening illnesses.

In the fourth phase, most of the women from both samples expressed a gradual and highly individualized reconstitution of their relatively shattered global assumptions of self, other, world, beliefs, order and purpose - that is, their concept of normality. The individual differences in progression could be due to the relative nature of the intensity and specificity of the shattering for each participant in that some areas of life were more affected than others and some areas were not affected at all by the cancer experience. Furthermore, some participants may be experiencing a reconstitution within a specific area of their life, but may not have reported it because they did not attribute it directly to their group participation. From their perspective, the reconstitution of a new normality may be due to the trajectory of the cancer experience over time or perhaps due to other factors such as spousal or family support.

However, in keeping with PTG literature, the changes described by participants as being directly connected to their group experience seemed to go beyond an ability to be resilient; rather, these changes seemed to indicate an advancement beyond pre-trauma levels of adaptation to a transformation or qualitative change in their functioning that aligned with empirically supported factors of PTG [59,62,63].

Although the use of active acceptance and release seemed common to both samples, the means by which their group experiences supported these coping efforts were very different and could be due to variations in group processes. The Community breast cancer support groups processes were fundamentally externally focused; that is, they were based primarily upon interactive social support among group members that utilized relational bonding, mirroring and modeling. In comparison, the PSIT group was fundamentally internally focused, that is, it minimized advice-giving and focused primarily on learning and practicing tools that facilitated exploration of the individual's internal cognitions, sensations, emotions and spiritual experiences.

PSIT participants described experiences of observing with detached awareness their own thoughts, feelings, beliefs and body sensations; this process of non-judgmental and detached self-observance is a skill that is also employed in Mindfulness Based Stress Reduction (MBSR) [64]. Many PSIT participants described using their newly learned skill as a means for coping with a variety of relational issues and life circumstances, including breast cancer. They reported increased clarity, self-awareness, understanding, self-acceptance, emotional regulation, peace, calm, freedom and even bliss as a result of their experiences of neutral observation, active acceptance and release, which assisted them in their re-framing process. In contrast, the interactive processes employed by the Community-sample groups makes it more difficult to determine just how their support group experiences may have internally influenced their ability actively to accept themselves and/or their situations or to

release expectations, beliefs and outcomes - both of which seemed to be central to their re-framing process as well.

Differences in group process or demographics may explain why not all women from the Community-sample experienced spiritual changes as a result of group participation. It could be that women from the PSIT group had direct spiritual experiences imbued with personal meaning that may have facilitated a variety of inner transformational shifts. In comparison, women from the Community breast cancer support groups seemed limited to cognitive discussion about the topic of spirituality without the potential benefit of personal spiritual experience leading to transformational shifts. Additionally, participants in the PSIT-sample self-identified with a spiritual orientation more frequently than those in Community-sample which may suggest a pre-existing positive disposition toward spirituality in the PSIT-sample. However, it could also mean that Community-sample participants who self-identified with no spiritual orientation may be spiritually inclined or open, but prefer not to identify themselves with any particular tradition or practice. Therefore, demographic self-reports of spiritual orientation may not be an accurate indication of spiritual disposition.

Differences in demographics and group focus may also explain the variations in reported levels of existential development between the PSIT-sample and the Community-sample. Life meaning and purpose is intentionally facilitated as part of the PSIT group, whereas the focus in the Community breast cancer support groups seems to be on discussing the cancer experience itself. In light of this difference in focus, it may be reasonable to deduce that more women from the PSIT group would naturally describe experiences related to the search for significance in life, whereas Community-sample participants would naturally describe experiences related to finding meaning in the cancer experience accounting for the difference between samples in existential development. Additionally, more Community-sample participants reported being in active treatment for their breast cancer than those from PSIT-sample. This could account for more Community-sample participants describing experiences of trying to make meaning of the cancer experience, whereas with the trauma of treatment behind them, PSIT-sample participants may have been better able to focus on creating life meaning and purpose.

Qualitative studies and the methods used to conduct them do not seek to create findings that are generalizable to wide portions of a population. Rather, they strive to achieve a deeper understanding of a specific group, process or phenomenon [54,55,57]. These findings and models should not be extrapolated beyond the socio-cultural, ethnic or health status lines of the study sample. Additionally, the interview protocol may contain more questions related to possible support group influences on global assumptions and religiosity/spirituality, rather than to eliciting possible changes to situational coping skills. Thus, the results and data may be skewed towards these topics. Finally, results may have been affected by the honesty of the participants, their ability to articulate abstract experiences and the researchers' understanding of what participants were expressing.

PSIT seems to be a viable intervention for some breast cancer patients, particularly those who are open to experiencing the sacred however they define it, who have somewhat integrated the comprehensibility [58] of this threat into their global assumptions and who are now seeking to understand better the significance and value of the life they are living. PSIT is able to support and facilitate a highly individualized process of integration and transformation which is in alignment with the values and principles of person-centered medicine [52,53,65]. Take, for example, Helen-PSIT's conclusion:

"I think what made it (PSIT) so special is the freedom and openness of it. The ideas were presented in many different forms, so we could find the one that resonated for us, we could try these different things and yet the structure of it was meant to address one way or another all of these parts of ourselves that really needed integrative work. And so it was a platform for doing this integrative work without (a rigid formula or sectarian perspective) - you know, you go to Buddhism and everybody's gung-ho about this sutra and that sutra and you have try to 'explain' to the 'strangers' what it is you're doing - half the time I don't know 'myself!' . . . It (PSIT) was free of that. In that sense, it left 'me' free to explore what 'I' needed to bring to the practice. Instead of shoving myself through a hole into the practice, the practice sort of peaked out like flowers and said, 'Pluck me and see what works' Very, very different from anything I've done and yet very powerful."

Conclusion

With its inherent focus on psychological, spiritual and existential development, the PSIT tools and processes may be of assistance in helping some breast cancer patients to define for themselves what it means to live life more fully as survivors. Participants also reported PSIT had the additional clinical benefit of providing personalized, replicable processes that can be used in coping with life situations extending beyond the cancer experience.

Acknowledgements and Conflicts of Interest

References

[1] Brennan, J. (2001). Adjustment to cancer- Coping or personal transition? *Psycho-Oncology* 10, 1-18.

[2] Moadel, A., Morgan, C., Fatone, A., Grennan, J., Carter, J., Laruffa, G., Skummy, A. & Dutcher, J. (1999). Seeking meaning and hope: Self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. *Psycho-Oncology* 8, 378-385.

[3] Balboni, T.A., Vanderwerker, L.C., Block, S.D., Paulk, M.E., Lathan, C.S., Peteet, J.R. & Prigerson, H.G. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology* 25, 555-560.

[4] Ferrell, B. Grant, M., Funk, B., Otis-Green, S. & Garcia, N. (1998). Quality of life in breast cancer survivors: Implications for developing support services. *Oncology Nursing Forum* 25, 887-895.

[5] Ferrell, B., Grant, M., Funk, B., Otis-Green, S. & Garcia, N. (1997). Quality of life in breast cancer: Part I: Physical and social well-being. *Cancer Nursing* 20, 398-408.

[6] Ferrell, B., Grant, M., Funk, B., Otis-Green, S. & Garcia, N. (1998). Quality of life in breast cancer: Part II: Psychological and spiritual well-being. *Cancer Nursing* 21, 1-9.

[7] Archibald, S., Lemieux, S., Byers, S.E., Tamlyn, K. & Worth, J. (2006). Chemically induced menopause and the sexual functioning of breast cancer survivors. *Women & Therapy* 29, 83-89.

[8] Ferguson, R., Ahles, T., Saykin, A., McDonald, B., Furstenberg, C., Cole, B. & Mott, L.A. (2007). Cognitive-behavioral management of chemotherapy-related cognitive change. *Psycho-Oncology* 16, 772-777.

[9] Halstead, M. & Hull, M. (2001). Struggling with paradoxes: The process of spiritual development in women with cancer. *Oncology Nursing Forum* 28, 1534-1544.

[10] Carlson, L.E., Speca, M., Faris, P. & Patel, K.D. (2007). One year pre-post intervention follow-up of psychological, immune, endocrine and blood pressure outcomes of mindfulness-based stress reduction (MBSR) in breast and prostate cancer outpatients. *Brain Behavior Immunology* 21, 1038-1049.

[11] Lazarus, R. & Folkman, S. (1984). Stress, Appraisal, and Coping. New York, NY: Springer.

[12] Folkman, S. (1997). Positive psychological states and coping with severe stress. *Social Science and Medicine* 48, 1207-1221.

[13] Golden-Kreutz, D. & Anderson, B. (2004). Depressive symptoms after breast cancer surgery: Relationships with global, cancer-related, and life event stress. *Psycho-Oncology* 13, 211-220.

[14] Golden-Kreutz, D., Thornton, L., Wells-Di Gregorio, S., Frierson, G., Jim, H., Carpenter, K.M., Shelby, R.A. & Anderson, B.L. (2005). Traumatic stress, perceived global stress, and life events: Prospectively predicting quality of life in breast cancer patients. *Health Psychology* 24, 288-296.

[15] Deshields, T., Tibbs, T., Fan, M. & Taylor, M. (2006). Differences in patterns of depression after treatment for breast cancer. *Psycho-Oncology* 15, 398-406.

[16] Holland, J. (2002). History of Psycho-Oncology: Overcoming attitudinal and conceptual barriers. *Psychosomatic Medicine* 64, 206-221.

[17] Sharpley, C. & Christie, D. (2007). "How I was then and how I am now": Current and retrospective self-reports of anxiety and depression in Australian women with breast cancer. *Psycho-Oncology* 16, 752-762.

[18] Stanton, A., Bower, J. & Low, C. (2006). Posttraumatic growth after cancer. In: Handbook of posttraumatic growth: Research and practice. (eds. R. Tedeschi & L. Calhoun), p. 81-99. New York, NY: Lawrence Erlbaum.

[19] Clarke, J. (2006). A discussion paper about 'meaning' in the nursing literature on spirituality: An interpretation of meaning as "ultimate concern" using the work of Paul Tillich. *International Journal of Nursing Studies* 43, 915-921.

[20] Pargament, K., Desai, K. & McConnell, K. (2006). Spirituality: A pathway to posttraumatic growth or decline? In: Handbook of posttraumatic growth: Research and practice. (eds. R. Tedeschi & L. Calhoun), p. 121-137. New York, NY: Lawrence Erlbaum.

[21] Park, C. & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of General Psychology* 1, 115-144.

[22] Park, C.L., Malone, M.R., Suresh, D.P., Bliss, D. & Rosen, R.I. (2008). Coping, meaning in life, and quality of life in congestive heart failure patients. *Quality of Life Research* 17, 21-26.

[23] Park, C.L. (2007). Religiousness/spirituality and health: A meaning systems perspective. *Journal of Behavioral Medicine* 30, 319-328.

[24] Cordova, M.J., Andrykowski, M.A., Kenady, D.E., McGrath, P.C., Sloan, D.A. & Redd, W.H. (1995). Frequency and correlates of posttraumatic-stress-disorder-like symptoms after treatment for breast cancer. *Journal of Consulting and Clinical Psychology* 63, 981-986.

[25] Cordova, M.J., Studts, J.L., Hann, D.M., Jacobsen, P.B. & Andrykowski, M.A. (2000). Symptom Structure of PTSD Following Breast Cancer. *Journal of Traumatic Stress* 13, 301-319.

[26] Coward, D.D. (2003). Facilitation of Self-Transcendence in a Breast Cancer Support Group: II. *Oncology Nursing Forum* 30, 291.

[27] Taylor, E.J. (2003). Spiritual Needs of Patients With Cancer and Family Caregivers. *Cancer Nursing* 26, 260-266.

[28] Tomich, P.L. & Helgeson, V.S. (2004). Is finding something good in the bad always good? Benefit finding among women with breast cancer. *Health Psychology* 23, 16-23.

[29] Yanez, B., Edmondson, D., Stanton, A.L., Park, C.L., Kwan, L., Ganz, P.A. & Blank, T.O. (2009). Facets of spirituality as predictors of adjustment to cancer: Relative contributions of having faith and finding meaning. *Journal of Consulting and Clinical Psychology* 77, 730-741.

[30] Tedeschi, R.G. & Calhoun, L.G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry* 15, 1-18.

[31] Aukst-Margetic, B., Jakovljevic, M., Margetic, B., Biscan, M. & Samija, M. (2005). Religiosity, depression and pain in patients with breast cancer. *General Hospital Psychiatry* 27, 250-255.

[32] Cotton, S.P., Levine, E.G., Fitzpatrick, C.M., Dold, K.H. & Targ, E. (1999). Exploring the relationships among spiritual well-being, quality of life, and psychological adjustment in women with breast cancer. *Psycho-Oncology* 8, 429-438.

[33] Lin, H.R. & Bauer-Wu, S.M. (2003). Psycho-spiritual well-being in patients with advanced cancer: an integrative review of the literature. *Journal of Advanced Nursing* 44, 69-80.

[34] McClain, C.S., Rosenfeld, B. & Breitbart, W. (2003). Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients. *Lancet* 361, 1603-1607.

[35] Cox, J. & Verhagen, P.J. (2011). Spirituality, religion and psychopathology: towards an integrative psychiatry. *International Journal of Person Centered Medicine* 1, 146-148.

[36] Laubmeier, K.K., Zakowski, S.G. & Bair, J.P. (2004). The role of spirituality in psychological adjustment to cancer: A test of the transactional model of stress and coping. *International Journal of Behavioral Medicine* 11, 48-55.

[37] Rippentrop, A.E., Altmaier, E.M. & Burns, C.P. (2006). The relationship of religiosity and spirituality to quality of life among cancer patients. *Journal of Clinical Psychology in Medical Settings* 13, 31-37.

[38] Thune-Boyle, I., Stygall, J., Keshtgar, M. & Newman, S. (2006). Do religious/spiritual coping strategies affect illness adjustment in patients with cancer? A systematic review of the literature. *Social Science and Medicine* 63, 75-89.

[39] Jenkins, R.A. & Pargament, K.I. (1995). Religion and spirituality as resources for coping with cancer. *Journal of Psychosocial Oncology* 13, 51-74.

[40] Bloom, J.R., Kang, S.H., Petersen, D.M. & Stewart, S.L. (2007). Quality of life in long-term cancer survivors. In: Handbook of Cancer Survivorship. (M. Feuerstein, ed.), pp. 43-65. New York, NY: Springer.

[41] James, W. (1936). The varieties of religious experience: A study in human nature. New York, NY: Modern Library.

[42] Miovic, M. (2004). An introduction to spiritual psychology: Overview of the literature, east and west. *Harvard Review of Psychiatry* 12, 105-115.

[43] Pargament, K.I. (1997). The psychology of religion and coping: Theory, research, practice. New York, NY: Guilford.

[44] Kabat-Zinn, J. (2003). Mindfulness-based stress reduction (MBSR). *Constructivism in the Human Sciences* 8, 73-107.

[45] Hayes, S.C., Follette,V.M. & Linehan, M.M. (2004). Mindfulness and acceptance: Expanding the cognitive-behavioral tradition. New York, NY: Guilford.

[46] Emmons, R.A., Colby, P.M. & Kaiser, H.M. (1998). When losses lead to gains: Personal goals and the recovery of meaning. In: The human quest for meaning: A handbook of psychological research and clinical applications. (P.T. Wong & P.S. Fry, eds.), pp. 163-178. Mahwah, NJ: Lawrence Erlbaum Associates.

[47] Miller, W.R. (1999). Diversity training in spiritual and religious issues. In: Integrating spirituality into treatment: Resources for practitioners. pp. 253-263. Washington, DC: American Psychological Association.

[48] Cloninger C.R. & Cloninger, K.M. (2011). Person-centered therapeutics. *International Journal of Person Centered Medicine* 1, 43-52.

[49] Garlick, M.A., Wall, K., Corwin, D. & Koopman, C. (2011). Psycho-spiritual integrative therapy for women with primary breast cancer. *Journal of Clinical Psychology in Medical Settings* 18, 78-90.

[50] Jim, H., Richardson, S., Golden-Kreutz, D. & Andersen, B. (2006). Strategies used in coping with a cancer diagnosis predict meaning in life for survivors. *Health Psychology* 25, 753-761.

[51] 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.

[52] Wall, K., Corwin, D. & Koopman, C. (2012). Stories of survival: PSIT in women with breast cancer. In: Religion, Spirituality, and Positive Psychology. (T. Plante, ed.). Santa Barbara: Praeger.In press.

[53] Corwin, D., Wall, K. & Koopman, C. (2012). Psycho-spiritual integrative therapy: A theoretical model for treatment. *Journal for Specialists in Group Work.* In press

[54] Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77-101.

[55] Charmaz, K. (2006). Constructing gounded theory: A practical guide through qualitative analysis. Thousand Oaks, CA: Sage.

[56] Verbi. (2007). MAXQDA 2007 Software. Marburg, Germany: Verbi.

[57] Mertens, D. (2005). Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods (2nd edn.). Thousand Oaks, CA: Sage.

[58] Janoff-Bullman, R. (2006). Schema-change perspectives on posttraumatic growth. In: Handbook of posttraumatic growth: Research and practice. (R. Tedeschi & L. Calhoun, eds.), p. 81-99. New York, NY: Lawrence Erlbaum.

[59] Janoff-Bullman, R. (1992). Shattered assumptions: Towards a new psychology of trauma. New York, NY: Free Press.

[60] Nakamura, Y. & Orth, U. (2005). Acceptance as a coping reaction: Adaptive or not? *Swiss Journal of Psychology* 64, 281-292.

[61] Astin J.A., Anton-Culver, H., Schwartz, C., Shapiro, D., McQuade, J.. Breuer, A.M., Taylor, T.H., Lee, H. & Kurosaki, T. (1999). Sense of control and adjustment to breast cancer: The importance of balancing control coping styles. *Behavioral Medicine* 25, 101-109.

[62] Tedeschi, R. & Calhoun, L. (2004). Posttraumatic Growth: Conceptual foundations and empirical evidence. *Psychological Inquiry* 15, 1-18.

[63] Tedeschi, R. & Calhoun, L. The foundations of posttraumatic growth: An expanded framework. (2006). In: Handbook of posttraumatic growth: Research and practice. (R. Tedeschi & L. Calhoun, eds.), p. 81-99. New York, NY: Lawrence Erlbaum.

[64] Shapiro, S., Carlson, L., Astin, J. & Freedman, B. (2006). Mechanism of mindfulness. *Journal of Clinical Psychology* 62, 373-386.

[65] Miles, A. & Mezzich, J. (2011). The care of the patient and the soul of the clinic: Person-centered medicine as an emergent model of modern clinical practice. *International Journal of Person Centered Medicine* 1 (2) 207-222.