



Cultivating Courage in Cancer Care: Strengths-Based Counselling and Positive Psychology Approaches to Resilience in Cancer Patients and Family Caregivers

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Abstract

Cancer affects emotional, relational, social, and existential well-being alongside physical health. This integrative review synthesises evidence on strengths-based counselling and positive psychology approaches that may support resilience among adults with cancer and family caregivers. Literature published primarily from 2015 to 2026 was identified through targeted searches of PubMed and Google Scholar, reference chaining, and authoritative oncology and Indian public-health sources. Five themes emerged: resilience as adaptive capacity; meaning, dignity, and realistic hope; acceptance and psychological flexibility; self-compassion and relational resilience; and caregiver/dyadic support within stepped psychosocial care. Evidence supports selected positive psychological, Acceptance and Commitment Therapy, dignity-focused, meaning-centred, and dyadic interventions, although heterogeneity warrants cautious application. The proposed COURAGE Cancer Care Framework translates these findings into a culturally responsive model integrating distress screening, strengths assessment, values, relationships, caregiver inclusion, and referral pathways for Indian oncology settings.

Keywords: psycho-oncology; positive psychology; resilience; strengths-based counselling; family caregivers.

1. Introduction

Cancer is simultaneously a biomedical, psychological, social, relational, and existential experience. Emotional consequences may arise at diagnosis and continue through treatment, remission, survivorship, recurrence, progressive disease, palliative care, and bereavement. Fear of death or recurrence, uncertainty regarding treatment outcomes, treatment-related symptoms, changes in body image and functioning, financial strain, disruption of family roles, dependency, and concern for children or partners can substantially influence psychological well-being.

The growing cancer burden in India makes psychosocial cancer care increasingly important. The Indian Council of Medical Research–National Centre for Disease Informatics and Research estimated approximately 13.9 lakh cancer cases in 2020 and projected approximately 15.7 lakh cases by 2025, an increase of about 12% based on prevailing trends (ICMR–NCDIR, 2020). These figures have implications beyond oncology departments because cancer frequently affects an entire family system.

Psychological distress in cancer should not be interpreted as personal weakness. Anxiety, sadness, uncertainty, anger, grief, and fear may be understandable responses to an illness that threatens health, identity, relationships, future plans, and mortality. At the same time, individuals differ markedly in how they adapt. Distress and resilience are not mutually exclusive: a person can be frightened and still remain connected to values, relationships, and purposeful action (Deshields et al., 2022).

Resilience is therefore best understood as a dynamic process of adapting to adversity rather than as uninterrupted positivity, invulnerability, or rapid recovery. Contemporary psycho-oncology increasingly complements symptom-focused work with attention to protective processes such as meaning, psychological flexibility, self-compassion, hope, strengths, social connection, self-efficacy, and post-traumatic growth (Marziliano et al., 2020; Tian et al., 2024).

Positive psychology is relevant to this shift but is vulnerable to misapplication. Messages such as “stay positive,” “fight harder,” or “everything happens for a reason” can invalidate

suffering and imply that outcomes depend on attitude. Such forced positivity is inconsistent with compassionate psycho-oncology. A responsible strengths-based approach creates space for pain and possibility at the same time. The present review therefore adopts a dual-focus position: distress should be recognised and treated, while strengths and adaptive resources should also be identified and cultivated.

2. Aim and Review Questions

The primary aim of this integrative review is to examine how strengths-based counselling and positive psychology approaches may support resilience among adults living with cancer and their family caregivers. The review addresses four questions:

RQ1. Which strengths-related psychological processes appear relevant to adaptation across the cancer trajectory?

RQ2. Which counselling and positive psychological interventions have evidence supporting their use in cancer care?

RQ3. How can patient and caregiver resilience be supported without promoting forced positivity?

RQ4. How might these approaches be translated into culturally responsive and feasible psycho-oncology practice within Indian cancer-care settings?

3. Method

3.1 Review Design

An integrative-review approach was selected because the topic spans heterogeneous evidence, including systematic reviews, meta-analyses, randomized trials, observational research, clinical guidance, caregiver research, and culturally relevant literature. The review was organised according to the broad stages described by Whittemore and Knafl (2005): problem identification, literature search, data evaluation, data analysis, and presentation of integrated conclusions. Hopia et al. (2016) were also used to guide transparent reporting of the integrative process.

3.2 Literature Identification

Literature published primarily between January 2015 and September 2026 was prioritised, while seminal earlier publications were retained where necessary to establish methodology or therapeutic foundations. Targeted searches were undertaken using PubMed and Google Scholar and were supplemented by backward and forward reference checking of key systematic reviews, meta-analyses, guidelines, and Indian studies. Authoritative public-health sources were used for national cancer-burden estimates. This was an integrative, practice-oriented synthesis rather than a de novo systematic review with pooled effect sizes.

Search concepts combined population terms (cancer, oncology, advanced cancer, survivor, palliative cancer, family caregiver, informal caregiver, patient-caregiver dyad), psychological terms (resilience, distress, meaning, hope, optimism, post-traumatic growth, self-efficacy, self-compassion, dignity, psychological flexibility), and intervention terms (positive psychology, strengths-based counselling, psychoeducation, ACT, dignity therapy, meaning-centred therapy, compassion intervention, caregiver intervention, and dyadic intervention).

3.3 Eligibility and Data Integration

Evidence was retained when it involved adults affected by cancer or their family/informal caregivers; examined resilience, psychological adjustment, meaning, hope, strengths, well-being, distress, or related outcomes; evaluated or described relevant psychological, counselling, psychosocial, or dyadic interventions; or provided important Indian cultural or health-system context. Pharmacological studies without a psychosocial component and literature without clear relevance to cancer-related psychological adaptation were not central to the synthesis.

Findings were compared across populations, illness phases, intervention models, psychological outcomes, and practice implications. Because the included evidence was methodologically and clinically heterogeneous, results were integrated narratively rather than statistically pooled. Five themes were identified: resilience beyond distress reduction; meaning, dignity, and realistic hope; acceptance and psychological flexibility; self-compassion and relational resilience; and caregiver/dyadic support within culturally responsive stepped care.

4. Results and Integrative Synthesis

4.1 Distress and Resilience Are Related but Not Opposites

Cancer-related distress and resilience should be assessed together rather than treated as opposite ends of a single continuum. If clinicians focus only on symptoms, they may overlook protective factors that can be mobilised in counselling. Conversely, a strengths-only focus may miss depression, suicidality, anxiety, trauma symptoms, demoralisation, or complicated grief. A balanced clinical assessment asks both “What is hurting?” and “What is helping you continue?”

Indian evidence reinforces this need. In a chemotherapy outpatient service in Bengaluru, 53.4% of patients and 22.2% of caregivers reported moderate-to-severe distress; 85.2% of patients and 80.1% of caregivers expressed interest in psycho-oncology services (Rajeshwari et al., 2020). These findings support routine psychosocial assessment that leads to triage, intervention, follow-up, or referral rather than screening as an isolated administrative exercise.

4.2 Positive Psychological Interventions: Promise With Necessary Caution

Positive psychological interventions in oncology include approaches focused on meaning, gratitude, strengths, optimism, self-compassion, hope, mindfulness, life review, expressive writing, values, and benefit finding. A systematic review and meta-analysis of 29 randomized controlled trials reported improvements in quality of life and positive psychological outcomes including well-being, meaning, self-esteem, optimism, resilience, and self-efficacy, together with reductions in depression, anxiety, and hopelessness (Tian et al., 2024). The authors also reported substantial heterogeneity for several outcomes, reflecting wide variation in intervention content and study design.

Accordingly, positive psychology should not be promoted as a universal intervention or a substitute for evidence-based treatment of significant psychiatric symptoms. Its clinical value lies in broadening the patient’s psychological repertoire, not prescribing a particular emotional state. A patient should not be made to feel that crying, fear, anger, or grief represents therapeutic failure.

4.3 Meaning, Purpose, Dignity, and Realistic Hope

Cancer often disrupts assumptions about identity, fairness, purpose, relationships, unfinished responsibilities, suffering, death, and legacy. Meaning-centred approaches therefore have particular relevance to advanced illness and palliative care. A meta-analysis of meaning-centred interventions for patients with advanced or terminal cancer reported benefits across

meaning, spiritual well-being, quality of life, anxiety, and selected physical outcomes (Kang et al., 2019).

Meaning does not require the patient to interpret cancer as beneficial. Therapeutic meaning may involve being emotionally present with family, repairing an important relationship, passing values to children, engaging in spiritual practice, completing unfinished communication, contributing to others, or living according to personal values despite uncertainty.

Dignity therapy is one structured approach for people facing advanced or life-limiting illness. It invites reflection on identity, accomplishments, relationships, important messages, hopes, and legacy. A meta-analysis of 14 randomized controlled trials found significant post-intervention effects on hope, anxiety, and depression, while the effect on quality of life was not statistically significant (Zhang et al., 2022). These findings support careful use of dignity-oriented work while avoiding overstatement of effects.

4.4 Psychological Flexibility and Acceptance

Acceptance in cancer care is frequently misunderstood as resignation. Within ACT, acceptance refers to willingness to make room for difficult internal experiences while choosing actions consistent with personally meaningful values. This distinction is important because many sources of cancer-related distress—uncertainty, mortality, fear of recurrence, bodily change, and loss—cannot simply be removed through problem-solving.

A 2024 systematic review and meta-analysis of 16 randomized controlled trials involving 711 participants found significant improvements in anxiety, depression, and psychological flexibility among cancer patients receiving ACT compared with control conditions (Jiang et al., 2024). Earlier meta-analytic work in advanced cancer likewise suggested benefits for emotional outcomes and quality of life, although certainty varied across outcomes (Fang et al., 2023). ACT-informed counselling may therefore be particularly relevant when avoidance is constricting life, uncertainty cannot be eliminated, or the therapeutic goal is to support meaningful action despite ongoing symptoms or fear.

4.5 Self-Compassion and Compassion-Based Care

Patients and caregivers may respond to cancer-related suffering with harsh self-judgment: “I am becoming a burden,” “I should be stronger,” or “I should feel grateful because treatment is

over.” Self-compassion offers an alternative stance of kindness, common humanity, and balanced awareness. A recent systematic review and meta-analysis of 24 studies involving 3,626 participants across 13 countries found medium-to-large negative associations between self-compassion and anxiety/stress and a large negative association with depression (Bitan et al., 2026).

Self-compassion is compatible with strengths-based counselling because it reframes strength. Strength does not always mean enduring without emotion; it can include allowing vulnerability, accepting support, setting limits, and resting without guilt. Evidence for specific compassion-based intervention protocols in oncology is promising but remains less mature than evidence for the association between self-compassion and distress.

4.6 Resilience in Family Caregivers

Cancer affects a relational system, not only the individual diagnosed. Family caregivers may coordinate appointments, administer medicines, manage finances, communicate with clinicians and relatives, provide emotional support, complete household responsibilities, make difficult decisions, and witness suffering while suppressing their own concerns. Indian research has documented substantial caregiver burden and impaired quality of life in family caregivers of patients receiving chemotherapy (Mishra et al., 2021).

Caregiver resilience is shaped by coping repertoire, social support, family relationships, socioeconomic resources, illness trajectory, cultural expectations, and access to healthcare. In India, travel, treatment costs, loss of income, limited supportive-care access, and expectations of family caregiving may intensify burden. Psychosocial assessment should therefore ask not only “How is the patient coping?” but also “Who is carrying the care, and how is that person coping?”

4.7 Dyadic Approaches: Supporting Patient and Caregiver Together

Patient and caregiver distress can influence each other through communication, avoidance, vigilance, role strain, and shared uncertainty. Dyadic interventions treat the patient-caregiver pair as an interconnected system. A systematic review and meta-analysis found that dyadic psychoeducational interventions significantly reduced depression in both patients and caregivers, although evidence across broader outcomes remained variable (Chen et al., 2025). Another meta-analysis found benefits of cancer patient-caregiver dyadic interventions for

psychological distress and identified intervention characteristics that may moderate effects (Pang et al., 2022).

A 2025 network meta-analysis of 37 studies further suggested that different dyadic approaches may have distinct advantages across quality of life, anxiety, depression, caregiver burden, and dyadic adjustment (Wang et al., 2025). Potential components include joint psychoeducation, communication training, collaborative coping, problem-solving, emotional expression, role clarification, symptom-management education, caregiver self-care, and shared values. Dyadic work should not replace private individual assessment where violence, severe conflict, psychiatric illness, or confidentiality concerns are present.

Table 1. Selected Evidence Informing Strengths-Based Psycho-Oncology Practice

Domain	Evidence base	Main finding	Source
Positive psychological interventions	29 RCTs; systematic review/meta-analysis	Improved quality of life and several positive psychological outcomes; reduced depression, anxiety, hopelessness; heterogeneity was substantial.	Tian et al., 2024
Acceptance and Commitment Therapy	16 RCTs; 711 participants	Improved anxiety, depression, and psychological flexibility compared with controls.	Jiang et al., 2024
Dignity therapy	14 RCTs	Improved hope, anxiety, and depression; no significant pooled effect on quality of	Zhang et al., 2022

Domain	Evidence base	Main finding	Source
		life.	
Self-compassion	24 studies; 3,626 participants	Higher self-compassion associated with lower anxiety, depression, and stress.	Bitan et al., 2026
Dyadic psychoeducation	8 RCTs; 1,234 dyads	Reduced depression in patients and caregivers; broader outcomes less certain.	Chen et al., 2025
Indian distress screening	102 patients; 101 caregivers	Moderate-to-severe distress in 53.4% of patients and 22.2% of caregivers; strong interest in psycho-oncology.	Rajeshwari et al., 2020

Note. RCT = randomized controlled trial; ACT = Acceptance and Commitment Therapy. Evidence is summarised narratively; effect estimates and certainty vary across reviews.

5. Resilience Across the Cancer Continuum

5.1 Diagnosis and Active Treatment

At diagnosis, priorities often include emotional stabilisation, normalising reactions, reducing informational overload, identifying support, and establishing manageable next steps. During active treatment, counselling may focus on coping with treatment effects, problem-solving, adherence, emotional regulation, role adjustment, caregiver support, and realistic short-term goals. The therapeutic objective is not immediate optimism but restoration of psychological footing and agency.

5.2 Survivorship

Survivorship may involve fear of recurrence, altered identity, relationship and intimacy concerns, employment challenges, persistent symptoms, and social pressure to “return to normal.” Strengths work should therefore recognise that medical recovery and psychological recovery may proceed at different rates. Interventions may help survivors reconnect with valued roles while making room for uncertainty and ongoing adjustment.

5.3 Recurrence, Advanced Disease, and Palliative Care

With recurrence or advanced disease, the focus of hope may change. Hope can shift from cure toward symptom relief, meaningful time, reconciliation, dignity, family preparedness, or peaceful care. Changing the object of hope is different from removing hope. Palliative psycho-oncology may integrate meaning, dignity, anticipatory grief, legacy, spiritual concerns, unfinished communication, relational closure, and caregiver preparation. Positive psychology in this context must never minimise grief, mortality, or symptom burden.

6. Positive Psychology Versus Forced Positivity

The distinction between compassionate positive psychology and forced positivity is central to ethical practice. The former validates painful emotions and expands coping options; the latter imposes optimism and risks creating shame or responsibility for outcomes.

Cancer progression is not evidence that a patient “did not fight hard enough.” A psychologically responsible intervention should never imply that survival depends on positive thinking or create moral responsibility for disease progression.

Table 2. Forced Positivity Compared with Compassionate Positive Psychology in Cancer Care

Forced positivity	Compassionate positive psychology
“You have to stay positive.”	“You do not need to hide what you are feeling.”
Avoids painful emotions	Makes room for painful emotions
Treats optimism as an obligation	Treats hope as flexible and personal
May imply responsibility for outcome	Separates emotional response from disease outcome

Forced positivity	Compassionate positive psychology
Focuses mainly on positive thinking	Focuses on strengths, values, meaning, coping, and connection
May invalidate grief	Validates grief and suffering
Imposes an interpretation	Encourages patient-defined meaning

Note. The comparison is conceptual and intended to guide clinical communication rather than function as a diagnostic or treatment algorithm.

7. The Proposed COURAGE Cancer Care Framework

Based on the integrated literature, we propose the COURAGE Cancer Care Framework as a practice-oriented structure for psycho-oncology services. It is a conceptual framework derived from this synthesis and has not yet been psychometrically or clinically validated as a standalone intervention protocol. Its purpose is to guide assessment and counselling priorities while remaining compatible with established evidence-based treatments.

Table 3. COURAGE Cancer Care Framework

Element	Clinical focus
C — Check distress and safety	Screen distress, depression, anxiety, hopelessness, suicidal ideation, sleep disturbance, trauma symptoms, caregiver overload, psychiatric history, and safeguarding concerns.
O — Observe existing strengths	Identify prior coping, personal qualities, sources of courage, supportive relationships, and retained capacities.
U — Understand context	Explore illness stage, family structure, culture, language, economic circumstances, spirituality when relevant, health literacy, caregiving responsibilities, and treatment access.
R — Reconnect with relationships and	Map family, friends, peer support, oncology

Element	Clinical focus
resources	and palliative teams, psycho-oncology, social work, community organisations, and practical/financial resources.
A — Accept what cannot immediately be changed	Use acceptance, present-moment awareness, cognitive defusion, and psychological flexibility for uncertainty, difficult emotions, irreversible loss, bodily change, recurrence fears, and mortality awareness.
G — Generate meaning and realistic hope	Explore values, identity beyond illness, purpose, gratitude without obligation, unfinished goals, legacy, and personally meaningful sources of hope.
E — Engage in small value-based actions	Translate insight into manageable action such as one meaningful conversation, brief relaxation, asking for help, reconnecting socially, completing one valued activity, or arranging caregiver respite.

Note. The COURAGE framework is a proposed practice framework derived from the present integrative synthesis. It requires prospective evaluation before being considered an evidence-based protocol.

8. Proposed Stepped-Care Pathway for Indian Oncology Settings

A feasible approach in resource-constrained cancer services is to combine universal psychosocial care with progressively more intensive intervention according to need. This aligns with contemporary psycho-oncology guidance that emphasises identification and management of anxiety and depression while integrating appropriate supportive care (Carlson et al., 2023; Pirl et al., 2023).

Level 1: Universal Psychosocial Care

For all patients and caregivers: brief distress screening; normalisation and psychoeducation; information about psycho-oncology; identification of support resources; and simple coping strategies.

Level 2: Focused Counselling

For mild-to-moderate psychosocial difficulty: strengths assessment; ACT-informed work; brief positive-psychology exercises; meaning-centred counselling; caregiver sessions; structured psychoeducation; and support groups.

Level 3: Specialist Mental Health and Complex Psycho-Oncology Care

For severe, persistent, or high-risk distress: comprehensive psychological assessment; psychiatric consultation where indicated; structured psychological therapies; suicide-risk management; trauma treatment; complex grief interventions; and multidisciplinary palliative-care involvement. Positive-psychology techniques must not delay urgent psychiatric or safety intervention.

9. Implications for Psycho-Oncology Practice in India

Several practice priorities follow from the synthesis. First, distress screening should be linked to a real care pathway rather than treated as a stand-alone formality. Second, caregivers should be included in psychosocial assessment whenever feasible because caregiver distress is clinically meaningful and can affect the patient-caregiver system. Third, counselling should be available in the patient's preferred language. Concepts such as dignity, acceptance, burden, hope, family duty, and grief may have culturally specific meanings that cannot always be translated literally from Western intervention manuals.

Fourth, interventions need to be feasible for short outpatient encounters, support groups, and tele-counselling, particularly where specialist psycho-oncology resources are limited. Fifth, family involvement should be individualised rather than assumed to be uniformly helpful; family relationships can be supportive but may also involve conflict, information concealment, overprotection, or differences about disclosure and treatment. Sixth, counselling should address practical realities including treatment costs, travel, employment disruption, caregiving workload, and access to supportive resources.

Finally, strengths-based approaches should extend across the cancer continuum, including palliative and end-of-life care. Meaning, dignity, self-compassion, psychological flexibility, connection, and realistic hope can remain relevant even when cure is no longer possible.

A practical challenge in India is that psychosocial oncology services are unevenly distributed and may be concentrated in tertiary centres. A strengths-based model should therefore be designed for graded intensity. At the lowest level, oncology nurses, social workers, counsellors, and trained volunteers can reinforce empathic communication, normalize emotional responses, identify existing coping resources, and provide brief psychoeducation in the patient's preferred language. Patients with persistent distress, trauma symptoms, complicated grief, marked caregiver strain, or functional impairment require assessment by appropriately trained mental-health professionals. High-risk presentations, including suicidal ideation, severe depression, psychosis, uncontrolled substance use, or major safeguarding concerns, require urgent specialist referral. This stepped approach protects against a common error in positive-psychology practice: using a low-intensity strengths exercise when the person actually needs risk assessment, psychiatric treatment, or intensive psychotherapy.

Cultural responsiveness also requires more than translating worksheets. Concepts such as hope, dignity, autonomy, family responsibility, spirituality, and acceptance may be understood differently across Indian families. Some patients prefer individual decision-making, whereas others expect relatives to participate closely in communication and treatment decisions. Counsellors should therefore explore the person's own understanding of illness, family roles, faith or spiritual resources when relevant, financial pressures, and preferences for disclosure rather than assuming a single cultural norm. Strengths may be expressed through caregiving, religious practice, humour, perseverance, community participation, or responsibility toward children and elders. The therapeutic task is to identify resources that are meaningful to the individual, while avoiding romanticisation of sacrifice or pressure to tolerate harmful family dynamics.

Language and health literacy are equally important. Brief interventions are more usable when they employ simple, concrete language and examples connected to daily life. For Telugu-speaking or other regional-language populations, key ideas such as values, acceptance, self-compassion, and realistic hope may require culturally familiar explanations rather than literal

technical translation. Audio or tele-counselling formats may extend access for people who cannot return frequently to tertiary hospitals, but digital delivery should include privacy safeguards and clear escalation pathways. In this context, the COURAGE framework is intended as a flexible clinical map rather than a fixed manual: its value lies in helping services combine compassionate assessment, strengths identification, family support, and referral in a sequence that can be adapted to available resources.

10. Discussion

This integrative review supports a shift from a solely deficit-oriented approach toward a dual-focus model of suffering and strength. This does not reduce the importance of detecting and treating depression, anxiety, suicidality, trauma, demoralisation, or severe caregiver burden. Instead, it recognises that absence of psychiatric disorder does not necessarily equal psychological flourishing, and the presence of distress does not necessarily mean that resilience is absent.

Across the reviewed evidence, several processes recur: psychological flexibility, meaning, dignity, self-compassion, hope, social connection, perceived coping ability, family functioning, and the ability to act according to values despite uncertainty. Different interventions reach these processes through different therapeutic languages. ACT emphasises flexibility and values; dignity therapy addresses identity and legacy; meaning-centred interventions address existential concerns; positive-psychology interventions cultivate selected strengths and well-being processes; and dyadic approaches recognise relational interdependence.

The evidence nevertheless requires moderation. Effects vary by intervention, population, outcome, and study quality. Resilience is also influenced by socioeconomic, relational, medical, and cultural conditions. Counselling cannot compensate for uncontrolled symptoms, catastrophic expenditure, lack of treatment access, family violence, or severe poverty. Strengths-based psycho-oncology should therefore avoid placing responsibility for adaptation entirely on the individual; supportive healthcare systems are also necessary.

The synthesis suggests that resilience in cancer care is best conceptualised as a process supported by interacting psychological and relational mechanisms rather than as a stable trait.

Psychological flexibility may help a person make room for fear while continuing valued action; meaning may preserve coherence when illness disrupts identity; self-compassion may reduce harsh self-judgement; realistic hope may direct attention toward achievable goals; and supportive relationships may distribute emotional and practical burden. These processes overlap, but they are not interchangeable. A patient facing curative treatment may benefit from behavioural activation, coping planning, and values-based goals, whereas a patient with progressive disease may place greater importance on dignity, unfinished relationships, legacy, comfort, or preparation for death. A caregiver may require permission to acknowledge resentment, fatigue, or anticipatory grief in addition to encouragement to recognise competence and connection.

This stage-sensitive view also clarifies why positive psychology should not be treated as a universal package. Gratitude exercises, strengths reflection, meaning-focused dialogue, ACT-consistent practices, and dignity work may each be useful for selected people, but timing, readiness, illness burden, cognitive capacity, and personal preference matter. Forcing a growth narrative can become another demand placed on people already carrying substantial emotional and physical burdens. Clinicians should therefore ask whether an intervention increases agency and psychological space or whether it inadvertently communicates that the patient should feel better, be more grateful, or find meaning before they are ready. The ethical criterion is not whether an intervention sounds positive, but whether it supports the person's values, dignity, safety, and functioning.

Caregiver findings reinforce the need to move beyond an exclusively patient-centred model. Distress can circulate within the patient-caregiver relationship: uncertainty, sleep loss, financial strain, role changes, and communication difficulties may amplify one another. Dyadic interventions are therefore promising because they can strengthen shared coping and communication while also identifying needs that differ between partners. At the same time, not every caregiver relationship is supportive, and family inclusion should never override the patient's preferences or safety. Future models should distinguish supportive interdependence from coercion, conflict, overprotection, or caregiver burnout. The COURAGE framework addresses this by treating relationships as a domain to assess, not an automatic source of strength.

Taken together, the review supports a balanced formulation in which distress reduction and resource building are complementary goals. Screening identifies suffering and risk;

strengths-oriented assessment identifies capacities and contexts that can be mobilised; evidence-based interventions target specific processes; and repeated review determines whether the approach is helping. This formulation may be especially useful in settings where specialist psycho-oncology time is limited because it offers a common language for triage and collaborative care without suggesting that all staff should deliver psychotherapy.

11. Implications for Research

Indian psycho-oncology research would benefit from multicentre trials of culturally adapted resilience interventions; evaluation of brief ACT-informed protocols; dignity and meaning-centred interventions adapted to Indian languages; caregiver-specific resilience programmes; dyadic interventions; tele-psycho-oncology models; studies involving rural and socioeconomically disadvantaged populations; cost-effectiveness and implementation research; and longitudinal research across diagnosis, treatment, survivorship, recurrence, palliative care, and bereavement. The proposed COURAGE framework should be prospectively evaluated for feasibility, acceptability, clinical utility, and outcomes before being presented as an evidence-based protocol.

Future studies should report not only symptom change but also implementation outcomes such as acceptability, feasibility, completion, referral uptake, cultural relevance, and clinician time. Mechanism-focused research could test whether changes in psychological flexibility, self-compassion, meaning, hope, or dyadic coping mediate improvement in quality of life or distress. Studies should also identify who benefits, who does not, and at which point in the cancer trajectory an intervention is most useful. Such analyses would reduce the risk of treating heterogeneous patient and caregiver populations as if they have identical needs.

For the COURAGE framework specifically, an appropriate research sequence would begin with expert review and patient-caregiver consultation, followed by feasibility testing in one or two oncology settings, refinement of training and referral procedures, and then comparative evaluation using validated patient-reported outcomes. Indian studies should include regional-language participants and report socioeconomic context, cancer stage, treatment status, caregiver relationship, and access barriers. These steps would allow a practice-oriented framework to develop cautiously into an empirically supported model rather than being presented prematurely as a validated treatment protocol.

12. Limitations

This review has several limitations. First, integrative methodology permits broad evidence synthesis but introduces methodological heterogeneity. Second, much intervention evidence originates outside India, limiting direct cultural generalisation. Third, positive-psychology interventions vary considerably in theoretical basis, dose, delivery format, and outcome measurement. Fourth, caregiver populations differ by relationship to the patient, illness stage, caregiving intensity, and socioeconomic context. Fifth, resilience itself is defined and measured in different ways. Finally, because this is a targeted integrative review rather than a de novo systematic review with exhaustive database screening and pooled analysis, it should not be interpreted as providing a complete quantitative estimate of intervention effects.

13. Conclusion

Cancer challenges physical health while also affecting identity, relationships, roles, meaning, hope, and the imagined future. Psycho-oncology should therefore do more than reduce symptoms; it should help individuals maintain dignity, connection, values, and agency while acknowledging genuine suffering.

Strengths-based counselling and positive psychology offer clinically useful approaches when integrated responsibly with distress screening, evidence-based psychological treatment, caregiver support, and palliative care. The therapeutic message is not “You must be positive.” It is: “Your fear, grief, and uncertainty can be acknowledged while we also discover what still gives you strength, meaning, connection, and a reason to take the next step.”

The proposed COURAGE Cancer Care Framework offers a culturally adaptable structure for translating this principle into practice. Future Indian research should evaluate its feasibility, effectiveness, and acceptability across diverse oncology and palliative-care settings.

Declarations

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Author contribution details are provided in the separate cover file and are omitted here to preserve blinded review.

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Conflict of Interest

The authors declare no conflict of interest.

Ethics Statement

This manuscript is an integrative review of previously published literature and does not report newly collected identifiable patient data. Institutional ethics approval and individual informed consent were therefore not applicable.

Data Availability

No primary dataset was generated for this review. Evidence discussed in the manuscript is available through the cited publications and public sources.

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