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## REVIEW ARTICLES

# Meaning in adjustment to cancer: A model of care

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## ABSTRACT

*Objectives:* In the clinical setting of cancer, meaning may well have a central role in the life changes the illness experience brings about. As health care professionals working with people with life-threatening illness, we are exposed to one of the major turning points in life and the ways people confront this transition. Meaning can assist coping by offering a framework, perspective, and counterbalance to the challenge of illness. However, the absence of meaning can be a precursor to profound despair.

*Methods:* This article brings together the clinical implications of two studies conducted by the authors that explored the role of meaning in adjustment to cancer, presenting a theoretical understanding of the experience of meaning in cancer and identifying some potential approaches to intervention.

*Results:* Our findings point to some specific goals of care as well as a number of therapeutic modalities aimed to meet these goals. We examine four goals of care—acknowledging suffering, encouraging a search for meaning, strengthening connection with others, and ensuring optimal physical care—as foundational in any clinical approach and then examine the key models of therapy that assist the clinician in pursuing these goals.

*Significance of results:* Our aim is to create an integrated approach to care provision that locates meaning centrally in any patient's adaptation.

**KEYWORDS:** Meaning based coping, Adjustment to cancer, Suffering, Psychosocial intervention, Strengthening connection with others

## INTRODUCTION

In the clinical setting of cancer, meaning may well have a central role in the life changes the illness experience brings about. As health care professionals working with people with life-threatening illness, we are exposed to one of the major turning points in life and the ways people confront this transition. For some, meaning is gained through this experience, whereas for others meaning is lost when the difference between what they perceived their life to be and their encounter with cancer is too great.

This article brings together the clinical implications of two studies conducted by the authors that explored the role of meaning in adjustment to cancer: The first was a qualitative examination of the lived experience of cancer through the domains of suffering, coping, and meaning (Lethborg et al., 2006); the second explored the same concepts quantitatively in an observational study of 100 patients with cancer (Lethborg et al., 2007). From this work we present a theoretical understanding of the experience of meaning in cancer and identify some potential approaches to intervention. This research highlights that the individual's experience of illness is inextricably related to his or her unique construction of the world. The interface between worldview and lived experience fundamentally

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shapes the manner in which a person encounters his or her illness.

The compelling force to make sense of life experiences and to find significance in existence influences the encounter with illness and adds to the complexity of the coping process. Meaning can assist coping by offering a framework, perspective, and counterbalance to the challenge of illness. However, the absence of meaning can be a precursor to profound despair. Regardless of prognosis, the process of bridging the gap between life before and after the diagnosis becomes an important component of the illness experience. From a clinical perspective, our findings point to some specific goals of care as well as a number of therapeutic modalities aimed to meet these goals. We examine four goals of care—acknowledging suffering, encouraging a search for meaning, strengthening connection with others, and ensuring optimal physical care—as foundational in any clinical approach and then examine the key models of therapy that assist the clinician in pursuing these goals. Our aim is to create an integrated approach to care provision that locates meaning centrally in any patient's adaptation.

## GOALS OF CARE

The first two goals of care are linked:

1. Encouragement of meaning and purpose.
2. Acknowledgment of suffering.

The more a person believes life has meaning and purpose, the more likely he or she is to positively adjust to cancer. However, suffering must also be acknowledged as central to the experience. The process of adjustment can therefore be construed as the struggle to achieve meaning in the face of suffering. It is for this reason that interventions that simply focus on enhancing meaning without acknowledgment of the patient's suffering will be inadequate. Indeed, aside from the importance of recognizing and encouraging the expression of suffering, wholly focusing on meaning misses the connection between meaning and suffering. Suffering exposes the limitation of one's existence, bringing about a greater awareness of the meaning in life. The important factor in this equation is that the person is not incapacitated by his or her suffering (Younger, 1995) and thus is able to experience meaning (Steeves & Kahn, 1987). In addition, his or her suffering must be acknowledged as a substantive part of the cancer experience.

A focus on suffering is required because, in the setting of cancer, it can be overlooked by focusing more on measurable cognitive reactions while failing to

include the "awfulness" of the experience (Blanchard et al., 1998). "Suffering is a fundamental experience of the human condition," Gregory (1995) asserts, "whereas the arts and humanities have struggled to make sense of this condition, no concerted effort has taken place in nursing. Suffering is painfully absent within the cancer nursing research literature, a place where suffering should be conspicuous." This acknowledgement of suffering may result in patients being assisted to reestablish control in stressful situations, overriding their need to express suffering in a safe and supportive setting.

Avoiding suffering can be a response to the intensity of such distress on the part of the clinician, and focusing on shifting patients from suffering to coping through brief therapy may be preferable to the clinician than exploring such distress. Although cognitive and educational interventions are appropriate for certain patient needs, supporting the expression of existential pain is also required and may be neglected in general patient care.

In addition to the factors of meaning and suffering, our research identified social support and physical distress as central to adjustment and are thus included in the goals of care in this clinical approach.

### 3. Strengthening connections with others.

Social support was an important theme in our qualitative study (Lethborg et al., 2006) and arose as a central influence associated with enhanced meaning and reduced psychological distress in our quantitative study (Lethborg et al., 2007). Thus the value of focusing on the social context of a patient is clear. A patient's social world can provide an environment where they can share their suffering, process their appraisal of cancer, and feel connected to others. Although some withdrawal from others can be a coping mechanism for those facing existential distress, many "return" to their social world in order to pursue adjustment. "Our solitude can easily become loneliness," Tillich (1963) contends, "and so we return to the world of man" (p. 21).

The findings in this exploration point to a relational component of meaning whereby the social context of a person's life is attributive to the need for significance, belonging, and connection with others, especially in the face of stressful life experiences.

Although a few patients may find time in solitude important, interventions that uphold the cancer patient's social world can be important in providing a way out of the solitude of suffering. Through the expression of pain with a compassionate other (Soelle, 1975), the intervention can influence their reengagement with life and the restoration of their sense of significance (Clarke, 2003). Supporting this finding,

a review of social support as a moderator of life stress concludes, “we should start now to teach all our patients, both well and sick, how to give and receive social support,” (Cobb, 1976, p. 314) confirming the central role of social work in the medical setting.

#### 4. Ensuring optimal physical care.

The suffering of cancer displayed in these studies had a clear physical manifestation. Physical distress was the factor most strongly associated with psychological distress even when controlling for demographic factors, meaning, and social support. The meaning placed on the physical impact of cancer contributes to distress as it threatens personal integrity and triggers feelings of shame, worthlessness, and, for many, a loss of control (Lawton, 1998). However the literature on suffering frequently neglects both the importance of physical suffering (other than pain) and its interrelationship with existential distress.

In the setting of cancer, physical distress needs to be relieved before psychological or existential suffering can be attended to. Patients experiencing a loss of meaning or existential distress requires an assessment of their physical status as a starting point to their care. Even for those health care professionals whose clinical focus is psychosocial, an understanding of the physical impact of cancer remains essential.

### THERAPEUTIC MODALITIES

In addition to these goals of care, our research points to potential benefits from a range of therapeutic modalities, including narrative therapy, meaning-based cognitive therapy, meaning-based existential therapy, strengthening social supports, and physical symptom management, that further inform the development of intervention strategies to enhance adjustment to cancer. Although managing physical symptoms is outside the scope of this article and is more appropriately addressed elsewhere, the other four modalities will be discussed in relation to the findings.

#### The Role of Narrative in Therapy

*The battering continues. I stop waiting for the universe to right itself. I am terrified that I have lost my story.*

Brett, 2001, p. 329

Understanding the narrative of the patient is a powerful starting point in therapy that is meaning based. The participants in our qualitative study used narrative to share their experience of cancer in the context of their lives. They described how they were affected

by the trauma of their cancer, how their experience of the world and their place in it fundamentally changed due to their cancer and the way in which cancer created a discontinuity of their life story. This sharing of their story helped in three important ways: enabling the expression of existential pain and suffering, cognitive processing of a life that has been disrupted, and enhancing dignity by enabling the patient to share who he or she is as a unique person. These aspects of sharing a patient’s story can each be used in the therapeutic setting.

#### *The sharing of Existential Pain*

*He who has no one to love or confide in has little hope.*  
Samuel Johnson, 1759, *The History of Rasselas*

Sharing one’s suffering is therapeutic in itself because it counters the sense of isolation inherent in such a state. Another person bearing witness to one’s suffering lessens the fear so often avoided by family, friends, and the health care team. The case example below of an interaction with the partner of a person in the final stage of advanced cancer is illustrative of this point.

*Case Example of the Benefits of Sharing Existential Pain.* The social worker in a medical oncology department was asked to see the wife of a patient with advanced cancer. Mary was with her husband at his bedside. He had deteriorated rapidly in the past hour and it was felt he would die before her family would arrive from their country home hundreds of kilometers away. The social worker entered the room, sat by her side and, after a brief introduction, asked her simply, “So, when did you two meet?” What ensued was a narrative about their life together, their children, their encounter with hardship, their love of dancing, and his secret desire to become a pilot. Her husband died one hour later, and when the family arrived, the social worker left them to be together.

Mary contacted the social worker later. “I wanted to say thank you for all you did for me that day, it was the worst time of my life, so dark, but you stayed and that was everything.” This act personified the line in Psalm 23 that she paraphrased, “Even though I walk through the valley of the shadow of death, I will fear no evil, for you are with me” (New International Version, Psalm 23:4). Watching her husband “slip away” was less distressing because she was not alone and was able to discuss the depth of her love for, and pain of losing, him.

The “valley of the shadow of death” is undoubtedly one of the most distressing and frightening of all experiences, yet Psalm 23 also speaks of the comfort that comes from being accompanied on this most

isolating of journeys, “I will fear no evil, for you are with me; your rod and your staff, they comfort me” (New International Version, Psalm 23:4). The two most cogent interventions used here involved Mary being heard and her suffering witnessed. Storey and Knight (1997) highlight similar skills intrinsic to spiritual care: listening to the patient’s story, encouraging the search for meaning, acknowledging loss, generating hope whenever possible, and being aware of one’s limitations.

The narrative enables access to the depth of a person’s suffering and the potential to connect with them at a deeper level. When asked what he needed most if faced with a life threatening illness, Dessaix (2000) called for two crucial elements, an awareness of his pain and support:

You need to be made to feel, I think, two things: one, that this person is aware that for you this is an utterly transfiguring moment. You want to feel that they know this. And the second thing is that they’re going to help you from now on to feel in some way precious, that they are not going to tell you this and leave you. That you will be held in some way from now on.

Caring in this view is interactional and transcends both carer and patient (Pruyser, 1984). Reducing the isolation so devastating in the midst of suffering offers a starting point from which a person may begin to find hope and meaning (Rousseau, 2000).

#### *The Cognitive Processing of Suffering*

*People say you only play the blues because you’re blue, but when I play the blues I feel better.*

B.B. King, 2005

Narrative is more than sharing; it can also play a role in patients regaining a sense of continuity through interpreting their experience anew (Bruner, 1986, 1987). The narrative contributes to the maintenance of a sense of coherence and meaning (Carlick & Biley, 2004). As people hear themselves relate an experience, they make connections between their recall and their worldview. The story may be revised afresh each time they tell it as they reflect on how coherent it is in the light of their worldview.

Although the process of interviewing the participants in our qualitative study was not intended to be therapeutic, follow-up sessions suggested its potential to locate meaning in their lives. The processing that occurred between interviews helped participants to shape the way they reviewed their life and enabled consideration of their strengths and resources. In the follow-up interviews, participants described the value of relating their story,

reflecting on the interview and transcript, and sharing this with significant people in their lives.

#### *Enhancing Dignity*

*The best way to recognize and acknowledge the person’s worth is to get to know those features of his history and nature that make him unique.*

Cassem, 2000, p. 21

Accessing a patient’s narrative also enables the health care professional to begin to “know” his or her uniqueness. The life lead, dreams dreamed, people loved—these distinguish who they are (Mount, 1993). This personal account strengthens the therapeutic relationship by honoring the patient as a person with a sense of dignity.

Chochinov (2002) has highlighted the power of the narrative to understand and conserve the “the quality or state of being worthy, honored, or esteemed” of patients in the setting of palliative care. He has set out a series of questions that encourage a patient to share who they are and the legacy they will leave. A clear theme in this work is the meaning and sense of significance a person’s life has, leading to the maintenance of dignity (Chochinov, 2002).

Certainly when our participants shared their transcripts with family and friends, they reported meaningful discussions about their cancer, their fears, and their appreciation of life. This brought about a sense of satisfaction and enhanced closeness. Anecdotally, in discussions with the surviving family members of these participants, now deceased, it is clear that these interview transcripts have also provided comfort in their grief.

In our quantitative study, the subgroup interviewed expressed the limiting nature of quantitative research in accessing their unique experience of cancer—when asked directly, these participants wanted to specifically share how this experience was for them. Although quantitative methods can assess certain aspects of this experience, the narrative is required in order to impact on this experience therapeutically.

#### **The Role of the Cognitive in Therapy**

In addition to the benefits from using narrative in therapy, a focus on cognitive meaning is valuable to gain and maintain a balance between positive and negative emotional states. Participants in our research used coping processes that reflected Folkman’s (1997) cognitive-meaning-based coping model, including reappraisal and revising beliefs and goals. The use of positive reappraisal described in Study 1 amplified a sense of optimism for participants. Finding benefit in their experience leads to appreciation

of and gratitude for what was meaningful. Revising beliefs promoted self-efficacy and acceptance of external support and care. And in revising goals, they aimed to live life fully. These are all cognitive-based features in that they alter a person's view of his or her experience and enables restoration of a sense of coherence.

Reestablishing a sense of coherence in this population is indeed a worthy goal of therapy. From the findings of this study it can be hypothesized that meaning moderates the assumptions forming a person's view of the world while also mediating healing needed to restore the coherent self. In the clinical setting, then, it is crucial to understand that the individual's care and appraisal of cancer needs to be tailored to the unique conceptualization of his or her cancer (Cassem, 2000; Tournier, 1957, 1965). In keeping with the previous section on the importance of narrative, understanding each patient's experience requires a curiosity about who she is and how this person's diagnosis impacts on his or her world (Cassem, 2000; Tournier, 1957, 1965).

Holland and Goen-Piels's (2000) work on a psychotherapy based on Folkman's (1997) meaning-based coping model, "Meaning Seeking Psychotherapy," incorporates the goal of finding meaning in response to an adverse situation and reducing confusion, distress, and rumination. This approach suggests that it may be useful to focus therapy in the cancer setting on the following steps: recounting of the event, initial appraisal of the event, appraisal of the event in relation to situational and global meaning, reappraisal, attainment of control, and meaning resolution (Holland & Goen-Piels, 2000). These steps work toward bridging the gap between global and situational meaning, with a focus on achieving coherence that could be incorporated into both individual and group-based interventions.

### The Role of the Existential in Therapy

*Let us ask a mountain-climber who has beheld the alpine sunset and is so moved by the splendour of nature that he feels cold shudders running down his spine—let us ask him whether after such an experience his life can ever again seem wholly meaningless.*

Frankl, 1973

The existential component of therapy has been most clearly articulated by Victor Frankl (1963). Here patients are encouraged to change attitudes to their difficulties, adapt a new perspective on identity, and to positively reinterpret the significance of their contribution to life (Zuehlke & Watkins, 1975). This

approach, which Frankl called Logotherapy, also involves techniques to shift attention away from suffering to something meaningful in the person's life, generalizing to a greater concentration on meaning in life as a whole. The effect of adversity (e.g., advanced cancer) is broached, and specific fears (e.g., of dying) are faced using the technique of "dereflection." Here patients are directed away from their presenting problem toward a search for meaning—away from their disturbance to something other than themselves (Sharf, 2000, p. 190). Participants in Study 1 described using strategies of diversion to take the focus away from their existential pain toward more meaningful aspects of their lives such as relationships, art, and nature.

Greenstein and Breitbart (2000) have published a meaning-centered group therapy for patients with advanced cancer based on principles of logotherapy. This program is intended to help participants enhance a sense of meaning, peace, and purpose even as they approach life's end. The intervention includes a mix of education, discussion, and experiential exercises that are meaning centered. Early results from this work have found that such an approach encourages patients with advanced cancer to find meaning and purpose in living until their death (Breitbart et al., 2004).

In relation to the care of cancer patients who lose meaning, there is a particular need to focus on strategies that are meaning based. Although this may sound obvious, more often than not the response to existential distress is more akin to the treatment for depression. Although untreated demoralization may indeed eventuate in depression (Kissane et al., 2001), this should not be the total focus of the care for such a patient. Interventions must include consideration of the sources of meaning in the person's life, while also taking care to assess the possibility of underlying psychiatric disorder.

### The Role of the Social in Therapy

*Being deeply loved by someone gives you strength, while loving someone deeply gives you courage.*

Lao Tsu

The ability to connect with others and to feel valued is crucial to well-being, especially in the setting of suffering. Social support boosts self-esteem and purpose. Herth's (1990, p. 1256) work with hospice patients identified that two of the three obstacles that hinder well-being include abandonment and isolation and devaluation of personhood. The importance of a patient's social world can be viewed contextually in relation to the care and support

a patient receives and in relation to the mutual impact of cancer on both patient and family and friends alike.

The social world provides the context in which meaning and purpose evolves and fundamentally influences a person's outlook and state of mind (Folkman et al., 1991, p. 249). It is also the place where emotions and inner thoughts can be shared and affective and confidant support is found. Being able to say "I am known" and "my life has importance" depends on the connections and roles a person has in his or her social world. Living with cancer can be an isolating experience in which patients can feel marginalized by their distress, loss of roles, and physical deterioration (Nekolaichuk & Bruera, 1998). The basic human longing for comfort increases in times of distress. Interconnectedness with others is a crucial component in gaining and sustaining positive emotions (Benzein & Saveman, 1998; Forbes, 1999).

A consideration of the social world in the therapeutic setting is also important in relation to the suffering experienced by the patient's social network. This notion refers to the mutual impact of cancer whereby the patient's suffering impacts on his or her family and friends, and this reciprocally impacts on the patient's suffering.

Strengthening people's skills to appraise and obtain social support in stressful situations may boost the effects of their experience on loved ones and can bridge the gap between "patient" and "carer," as well as facilitate mutual support (Folkman et al., 1991, p. 251).

Brett (2001, pp. 391, 393) shares her realization, through living with cancer, that a person can survive suffering when human connectedness prevails: "What I learned is very different from what I expected I would learn. I have learned I am loved. I learned it from old friends who stood by me and from new friends who helped in unexpected and touching ways. . . . It is only in emerging from the shimmery world of make-believe that we have a chance at finding our true selves—our strength, and with it our authentic capacity to love." This point is echoed by Frankl (1985), who referred to the power of humans who rise above misery and offer care and support to others in need: "We who lived in concentration camps can remember the men who walked throughout the huts comforting others, giving away their last piece of bread." (p. 86)

The role of family and couple therapy can be crucial to upholding the well-being of all involved in times of distress. At the very least, this is a major argument for a family meeting (or meetings at each juncture of the treatment program) as a vital dimension of a comprehensive clinical approach and, for those whose family is dysfunctional, greater attention to this

therapeutic modality. Beyond merely a family focus, various clinical responses arise as possible inclusions in interventions.

### *Support during Unpreventable Emotional Suffering*

There is much distress and suffering that arises from caring for a seriously ill family member that cannot be prevented or relieved. Support throughout the illness that includes frank discussion of side effects and tempering of unrealistic expectations can lessen any consequent emotional impact, but sometimes suffering can only be assuaged (Ferrell et al., 1991; Ferrell, 1998).

### *Preventive and Supportive Interventions*

Most well-functioning families who have become carers benefit from approaches that mobilize their inherent strengths and resources. Such interventions aim to assist families to expand and adapt their own successful problem-solving methods (Jacobs et al., 1998).

### *Interventions that Challenge Dysfunction*

Serious illness sometimes provides a timely opportunity to intervene with a dysfunctional family. Indeed, such transition points in the life cycle are fertile occasions to effect change. Hence families that challenge oncology services because of their long-term dysfunction may become amenable to help at exactly this point in their lives—the threat of death of a loved one.

In a randomized trial of family intervention during palliative care and bereavement, "challenging families" included those rigid in their structure and processes who find it difficult to accept change or those where relationships are chaotic and unstable, with distress generating psychiatric disorder such as major depressive episode (Kissane et al., 1998). This trial demonstrated the unique opportunity that exists to establish a therapeutic alliance with families in need in a manner that effectively supports their transition through the stressful experience of serious illness (Kissane, 1998; Kissane et al., 2006).

Family-centered care and the creation of communities around patients are challenging as a paradigm but a useful harness to improved quality of life—one that warrants the effort involved in easing the suffering and enhancing the meaning for all.

## **A MODEL OF CARE: MEANING IN ADJUSTMENT TO CANCER**

The goals of care and therapeutic modalities relevant to enhancing meaning and adjustment to cancer

presented here are summarized in Table 1. Such a summary cannot do justice to the intricacies involved with each clinical goal—a variety of techniques can be relevant for each. For example, the clinical goal of optimal physical care does not only refer to the need for the provision of physical symptom management but encompasses the need for connection, significance, purpose, taking a break from suffering, and so on. An intervention may include narrative therapy, meaning-based cognitive and/or existential therapy, and strengthening social supports.

Thus the model of adjustment to cancer presented here calls for a diverse clinical response that can include each of the therapeutic techniques listed above. Such a strategy echoes Blinderman and Cherny's (2005) call for the use of early palliative measures, family support, effective coping strategies, and religious belief to deal with the existential concerns of cancer patients. However, the unique aspect of this model relates to the finding that the experience of suffering and meaning for cancer patients is dynamic in nature, powered by the "will to meaning" (Frankl, 1963) and the need for consensus between what is meaningful and what is lived (Hartman & Zimberoff, 2003).

### A Clinical Example

This exploration has shown that cancer patients can move from suffering to coping to meaning and back again throughout their experience, and the clinical response must work with this process. A recent e-mail from a patient (whom we will refer to as "Meg") illustrates this process from within a therapeutic relationship and provides an example of how meaning can be used in managing disequilibrium.

Meg has been a client of the first author's for 5 years, through which time they had met with varying intensity relative to her disease stage. She now has end stage breast cancer and is experiencing many physical symptoms. In the three counseling sessions leading up to this e-mail, the use of meaning-based cognitive techniques (cognitive reappraisal through challenging automatic negative thoughts), strengthening social supports (specifically the importance of letting family and friends offer care, as Meg has been used to being the carer), and meaning-based existential techniques (through the use of journaling to process her thoughts, feelings, and purpose in life) have been discussed. In consultation with her oncologist, Meg was recently referred to a palliative care service in the community to assist in managing her pain. Meg sent this e-mail after a distressing weekend triggered by escalating pain (she has given permission for the use of this direct quote for the purposes of this article).

It's been an interesting couple of days and I've discovered a few things hardly earth shattering but useful nonetheless. Walked through the "dark forest" on Saturday night (very long night) but the light came as it always does.

Things discovered: being tired makes things worse, pain, anxiety, feeling of hopelessness and helplessness much worse. Death comes close at these times too. Practically sitting on my shoulder tapping his fingers, just waiting.

Finally just becomes tedious after a while. Luckily, the mood shifts and by dawn on Sunday, solutions were jumping up and down, "pick me, pick me . . . !

Realized:

- that getting tired (a small word to describe such an insidious feeling) takes longer to recover from and takes from many areas.
- that I have much less pain if I use drugs proactively rather than fitting it in "some time later".
- that my family and friends don't expect as much from me as I do.
- that there is no "right" way to manage the current situation. One day at a time is enough.

Those philosophies that have guided me so long still are applicable, like believing that the Universe will provide.

What else helps?—pick as many as you think, mix and match, seems to have generic applications across physical, emotional and mental states:

Walking, spend time in the garden, pat dogs, yoga, deep breathing, having a shower, clean clothes, having a cleanish house, having a cuppa, read books that affirm, reach out to people, use journal/narrative therapy (dot form is allowed, doesn't have to be War and Peace), find task focused solutions, find ways to adapt to change.

When it is hardest and I am in the middle of "the forest," it is easier if someone is with you and you need to remember that there is a light at the end. The people walking with you are walking their own journey and just walking alongside you is enough.

Focus on things to be grateful for, each day will have at least one and usually more than that—focus on today and not tomorrow—focus on what you can control—God hasn't let me down yet.

Meg illustrates the way that suffering, coping, meaning, social support and physical symptoms are all

**Table 1.** *An integrated clinical approach to locating meaning in our overall model of care*

Domains					
Suffering	Meaning	Coping	Human need	Goals of care	Therapeutic modality
The impact of cancer on the person's worldview results in the suffering encountered in living with advanced cancer.	Described as a commitment to making the most of the time left and awareness of what has been significant in life, with a determination to value these.	The attempt made to live in such a way that the focus is not totally on cancer through awareness of the need for support from others; companionship and	For connection in the midst of suffering. To make sense of current life situation.	Encouraging meaning and purpose. Acknowledging suffering.	Narrative Therapy. Meaning based cognitive therapy.
The threat of a foreshortened life.	Also reflected in relating to others, deep understanding of inner strengths, a sense of personal significance, cherished moments of beauty, peace and intimacy with loved ones, a feeling of awe about human connectedness and a union with nature.	connectedness to family, friends and health professionals; the need for a spiritual bridge to a higher being and to the earth; engaging with literature, the arts, or music; accepting the inevitability of life ending and emotional preparation for death, including leaving a "legacy" in order to be remembered.	For purpose and authenticity. For significance.	Strengthening connections with others. Optimal palliative care.	Meaning based existential therapy. Strengthening social supports and family supports or therapy.
A sense of loss of people and goals.			To "take a break" from suffering.		Physical symptom management.
The fear and isolation in facing impending death.			To have physical symptoms treated.		
Suffering is experienced as a "total pain"—in relation to physical, psychological and existential distress.	Meaning in life is experienced as a total life orientation including a person's global beliefs, spiritual beliefs and a motivation to meaning.	Meaning in life and social support are associated with lower levels of suffering in the experience of cancer.			
Factors related to suffering, especially in the context of a lack of social support, promote psychological distress and are not conducive to adjustment.	Meaning is experienced in spite of suffering in the setting of cancer.	Higher social support is associated with higher levels of meaning and lower levels of suffering in the experience of cancer.  Factors related to meaning (i.e., satisfaction with social support/ connection to others and less existential distress) promote adjustment.			



components of the cancer experience. In addition, it depicts the way that narrative, cognitive, and existential factors in addition to a strengthening of social supports and ensuring adequate physical symptom management are all important to the process of coping with cancer.

The strategies for intervention presented here offer directions rather than a model *per se*. Bringing the identified needs, clinical goals, and relevant therapeutic modalities into a response that is receptive to each patient's unique experience and social context identified in this study is the next step in this process. The therapeutic modalities suggested by these studies point to a multimodal approach that is responsive to individual needs. The clinical goals described are possible outcome measures for such an approach. Incorporating these techniques into an intervention that can be manualized and tested is the next challenge in this research.

## CONCLUSION

The key significance of our research has been in identifying not only specific factors that impact on meaning in cancer but to understand the way patients move between these factors and the weighting of the importance of management approaches. Exploring this topic from a number of perspectives has given us the opportunity to appreciate the complexity of meaning in the setting of cancer and to discover clinical directions for future intervention development.

This article speaks to the clinical complexity of the dynamic experience of suffering and meaning in cancer. Although both the joy and pain of life are components of living with this disease, it is not an experience of merely simple joy or excruciating pain. When facing the reality of one's existence, joy and meaning are alloyed with pain and suffering. Disappointment at an abbreviated life can be combined with gratitude for a life lived. Acknowledging this experience calls us to attend to both the meaning and the suffering of cancer and to encourage coping that maintains the resilience required to endure one and celebrate the other.

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