Supportive Care in Cancer

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Review Article

Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer

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Abstract. Existential and spiritual issues are at the frontier of new clinical and research focus in palliative and supportive care of cancer patients. As concepts of adequate supportive care expand beyond a focus on pain and physical symptom control, existential and spiritual issues such as meaning, hope and spirituality in general have received increased attention from supportive care clinicians and clinical researchers. This paper reviews the topics of spirituality and end-of-life care, defines spirituality, and suggests measures of spirituality that deal with two of its main components: faith/religious beliefs and meaning/spiritual well-being. These two constructs of spirituality are reviewed in terms of their role in supportive care. Finally, a review of existing psychotherapeutic interventions for spiritual suffering are reviewed and a novel meaning-centered group psychotherapy for advanced cancer patients is described.

Keywords. Cancer - Meaning - Spirituality - Psychotherapy

Introduction

As the discipline of Palliative Medicine matures throughout the world, it is becoming more apparent that concepts of adequate palliative care must be expanded in their focus beyond pain and physical symptom control to include psychiatric, psychosocial, existential, and spiritual domains of end-of-life care (Table 1) [*6*, *8*, *13*, *67*, *61*]. While pain and physical symptoms are indeed distressing to cancer patients with advanced disease, the fact remains that symptoms relating to psychological distress and existential concerns are even more prevalent than pain and other physical symptoms [*60*]. Integrating spirituality and issues of meaning and faith into the supportive care of cancer patients with advanced disease is now an essential component of optimal supportive care. This paper reviews the issues of

spirituality and meaning in the supportive care of advanced cancer patients and presents a novel psychotherapy intervention based on a meaning-centered approach greatly influenced by the work of Viktor Frankl.

Table 1. Existential and spiritual issues at the frontier of supportive care

Desire for death
Requests for assisted suicide
Demoralization syndrome
Hopelessness
Loss of meaning
Suffering
Dignity
Acceptance
Will to live
Insight into prognosis
Spirituality
Intervention development

Spirituality and end-of-life care

Measures to address physical, psychological and spiritual domains of end-of-life care have been identified as priorities both by medical professional organizations and by cancer patients themselves. In a recent Institute of Medicine (IOM) report (1997) entitled, "*Approaching Death: Improving Care at the End of Life*," the IOM identified the domains of quality end-of-life care from the professional perspective [*32*]. These domains included: (1) overall quality of life; (2) physical well-being and functioning; (3) psychosocial well-being and functioning; (4) spiritual well-being; (5) patient perception of care; and (6) family well-being and functioning. Singer et al. [*68*] conducted an extensive qualitative study of cancer patients' perspective on what domains of end-of life care were most important to them. Puchalski and Romer [*61*] have advocated incorporating a "spiritual history" into standard medical history taking, particularly for patients with advanced cancer or other life-threatening diseases. Such a spiritual history, they believe, provides clinicians with a framework that will help them, both in understanding their patients more fully, and in beginning to address some of the spiritual needs that are so important during supportive cancer care (Table 2). Domains of quality end-of-life care from the patient perspective include: (1) receiving adequate pain and symptom control; (2) avoiding inappropriate prolongation of dying; (3) achieving a sense of spiritual peace; (4) relieving burden; and (5) strengthening relationships with loved ones. In a Gallup Poll on "Spiritual beliefs and the dying process" [*40*], 40% of the U.S. public said that if they were dying it would be "very important" to have a doctor who is spiritually attuned to them. The greatest concerns for 50-60% of those questioned when they think of their own deaths are: (1) not being forgiven by God; (2) not reconciling with others; and (3) dying while removed or cut off from God or a higher power. Moadel et al. [*56*] surveyed 248 cancer patients in New York City and asked them what their most important needs were. Fifty-one percent said they needed help with overcoming fears, while 41% needed help to find hope, 40% needed help to find meaning in life, 43% needed help to find peace of mind, and 39%

needed help to find spiritual resources. In a sample of 162 Japanese hospice inpatients, psychological distress was related to meaninglessness in 37%, hopelessness in 37%, and loss of social role and feeling irrelevant in 28%. Finally, Meier et al. [*55*] found, in a national survey of North American physicians, that among the reasons physicians cited as given by patients requesting assisted suicide, pain and physical symptom distress accounted for 52%; however, "loss of meaning in life" accounted for 47% of the requests for suicide. Clearly, from the perspectives of patient and physician alike, issues of spirituality are essential elements of quality end-of-life care.

Table 2. Taking a spiritual history. Adapted from [*61*]

F - Faith or beliefs	
F	What is your faith or belief?
F	What things do you believe in that give meaning to life?
F	Do you consider yourself spiritual or religious?
I - Importance and influence	
I	Is it important in your life?
I	What influence does it have on how you take care of yourself?
I	How have your beliefs influenced your behavior during this illness?
C - Community	
-	Are you part of a spiritual or religious community?
C	Is this of support to you?
C	Is there a person or group of people whom you really love or who is/are really important to you?
A - Address	
A	How would you like me, your health care provider, to address these issues in your care?

Defining and measuring spirituality as a construct of faith and meaning

A definition of "spirituality" may be helpful at this point. Puchalski and Romer [*61*] define spirituality as that which allows a person to experience transcendent meaning in life. Spirituality is a construct that involves concepts of "Faith" and/or "Meaning", according to Karasu [*45*] and Brady et al. [*5*]. Faith is a belief in a higher transcendent power, not necessarily identified as God, and not necessarily through participation in the rituals or beliefs of a specific organized religion; faith in a transcendent power may identify this power as being external to the human psyche or internalized; it is the relationship and connectedness to this power, or spirit, that is an essential component of the spiritual experience and is related to the concept of meaning. Meaning, or having a sense that one's life has meaning, involves the conviction that one is fulfilling a unique role and purpose in a life that is a gift; a life that comes with a responsibility to live up to one's full potential as a human being and, in so doing, being able to achieve a sense of peace, contentment, or even transcendence through connectedness with something greater than one's self [*36*]. Viewing spirituality as a construct composed of faith and meaning is reflected in a widely utilized measure of spiritual well-being recently developed by the group that developed the FACT or FACIT systems of measuring quality of life; it is called the FACIT Spiritual Well-Being Scale [*5*, *59*]. The FACIT Spiritual Well-Being Scale generates a total score as well as two subscale

scores, one corresponding to Faith and a second corresponding to Meaning/Peace.

The "faith" component of spirituality is most often associated with religion and religious belief, while the "meaning" component of spirituality appears to be a more universal concept that can exist in religious or nonreligiously identified individuals.

Faith/religious beliefs and end-of-life care

There has been great interest in the health outcome effects, and the role of faith and religious beliefs in palliative care [*3, 47, 48, 54 , 69*]. Sloan et al. [*69*] concluded in their review of the literature that evidence of an association between religion and health was weak and inconsistent, and that it was premature to promote faith and religion as adjunctive medical treatments. A review of the literature on the relationship between religion and depression [*54*] suggests that individuals with high levels of religious involvement, organizational religious involvement, religious salience, and intrinsic religious motivation are at a lowered risk for depression, while private religious activity and particular religious beliefs have no correlation to depression. Elderly men who use religious beliefs or practices as a means of coping with physical illness appear to be less depressed than their nonreligious peers [*47*]. Researchers theorize that religious beliefs may play a part in helping patients to construct a meaning for the suffering inherent in illness, which may in turn facilitate acceptance of their situation [*48*]. Importantly, recent studies have found that religion and spirituality generally play a positive part in patients' coping with illnesses such as cancer or HIV [*3, 5, 57*]. Promoting religion, faith, or specific religious beliefs or rituals (e.g. prayer, belief in an afterlife) in an effort to deal with patients' spiritual concerns or suffering at the end-of-life has met with limited acceptance among health care providers and is not universally applicable to all patients. Mangans and Wadland [*65*] suggest that there is a great discrepancy between physicians and patients on such issues as belief in God, belief in an afterlife, regular prayer, and feeling close to God, with physicians endorsing such beliefs or practices less than half as often as patients (none greater than 40%). Interventions based on the "Meaning" component of spirituality are therefore likely to have more universal applicability and acceptance by health care providers as well as patients.

Meaning/spiritual well-being and end-of-life care

Park and Folkman [*58*] reviewed the concepts of "meaning" in the context of stress and coping, and described conceptual models for meaning in relation to traumatic events and coping. They describe meaning as a general life orientation, as personal significance, as causality, as a coping mechanism, and as an outcome. Meaning has been assessed in terms of reevaluating an event as positive, answering the question of why an event occurred, or "Why me?," enumerating ways in which life has changed, sometimes in a positive way, because of an event, and stating the extent to which one has "made sense of" or "found meaning in" an event[*2, 33 , 35, 36, 37, 38, 80, 81*]. Park and Folkman [*58*] also describe two levels of meaning, termed global meaning and situational meaning, and review the process of "meaning making" that highlights the critical role of reappraisal in the coping process. Thus, positive psychological changes and an improved sense of meaning in life have been associated with cancer illness and bone marrow transplantation, for instance [*2*]. The cancer literature is replete with accounts of positive life change and positive reappraisals of the value and meaning of life *25, 49, 80*]. Frankl viewed suffering as a potential springboard, both to having a need for meaning and for finding it [*35, 36*]. The diagnosis of a terminal illness may be seen as a crisis in the fullest sense of the word - an experience of distress or even despair that may in itself offer an opportunity for growth and meaning, as one learns to cope. Perhaps one of the important distinctions between Park and Folkman's conceptualization of meaning as global or situational, and Frankl's concept of the term meaning in logotherapy is that for Frankl, meaning is a state. Either one has a loss of sense of meaning and

purpose in life (as many terminally ill cancer patients do when they become demoralized and see no value in living out the remaining weeks of their lives, as described by Kissane et al. [*46*]), or one has a sustained or even heightened sense of meaning, purpose, and peace, which allows one to value the time remaining even more intensely and to make a positive appraisal of events.

Several recent studies utilizing the FACIT Spiritual Well-Being Scale (FACITSWBS) as a measure of spirituality, faith and meaning have shed some light on the importance of these concepts in end-of-life care. Brady et al. [*5*] found that cancer patients who reported a high degree of meaning in their lives (as measured by the FACITSWBS meaning/peace subscale) were able to tolerate severe physical symptoms to a greater degree than patients who reported lower scores on meaning/peace. Patients with a high sense of meaning reported high satisfaction with their quality of life despite pain and fatigue to a greater degree than patients with a low sense of meaning. Breitbart's group [*9, 57*] has demonstrated a central role for spiritual well-being and meaning, in particular as a buffering agent, protecting against depression, hopelessness and desire for hastened death among terminally ill cancer patients. While spiritual well-being (as measured by the FACITSWBS) serves as a general positive influence in terms of diminishing the incidence of depression, hopelessness and desire for death, it is the score on the Meaning/Peace subscale of the FACITSWBS that has the most significant effect on these issues. These findings are significant in the face of what we have come to learn about the consequences of depression and hopelessness in cancer patients. Depression and hopelessness are associated with poorer survival in cancer patients [*84*] and dramatically higher rates of suicide, suicidal ideation and desires for hastened death and interest in physician-assisted suicide [*5, 9, 15, , 16*]. Kissane et al. [*46*] have described a syndrome of "demoralization" in the terminally ill, which Kissane proposes is distinct from depression and consists in a triad of hopelessness, loss of meaning, and a desire for death. These data suggest the critical need for the development of interventions for terminally ill cancer patients that address depression, hopelessness and loss of meaning and impact on desire for death, demoralization, and what many palliative care practitioners [*67*] refer to as "spiritual suffering."

Interventions for spiritual suffering at the end of life

With the exception of some theoretical and preliminary clinical work in the areas of self-transcendence and logotherapy (described in detail below), very little work has been conducted on psychotherapy interventions for spiritual suffering or distress at the end of life. Palliative care practitioners themselves have begun to deal with the issue of spirituality in the dying and interventions for spiritual suffering [*61, 67*]. Rousseau [*67*] in fact outlined an approach for the treatment of spiritual suffering, which was composed of the following steps: (1) controlling physical symptoms; (2) providing a supportive presence; (3) encouraging life review to assist in recognizing purpose, value, and meaning; (4) exploring guilt, remorse, forgiveness, reconciliation; (5) facilitating religious expression; (6) reframing goals; (7) encouraging meditative practices, focusing on healing rather than cure. Rousseau, an experienced palliative care practitioner practicing in the Southwest of the U.S., has presented an approach to spiritual suffering that has an interesting blend of basic psychotherapeutic principles common to many psychotherapies. Psychotherapeutic techniques that are particularly adaptive to psychotherapy with the dying, such as life narrative and life review (as originally described by Viederman [*83*]) are also included. Finally there is a heavy emphasis on facilitating religious expression and confession that may in fact be extremely useful to many patients, but is not applicable to all patients and not necessarily an intervention that many clinicians feel comfortable providing. What Rousseau's work suggests is that it is critically necessary to develop new, novel psychotherapeutic interventions aimed at improving spiritual well-being and sense of meaning while diminishing hopelessness, demoralization, and distress at this time and at this stage in the development of palliative medicine and end-of-life care in the U.S. Such interventions can be implemented as individual or group psychotherapy interventions. Group psychotherapy interventions may in fact be

even more effective and powerful than individual psychotherapies for cancer patients. Below is a description of group psychotherapy interventions for cancer patients, including spiritually based interventions, and a description of a novel "meaning-centered group psychotherapy" intervention that our group in the Department of Psychiatry and Behavioral Sciences of Memorial Sloan-Kettering Cancer Center has begun to implement and study empirically [*42*].

Traditional Group Psychotherapy Interventions for Cancer Patients

There is clear evidence that group psychotherapy interventions for cancer patients are efficient in terms of time and financial cost, and also highly effective in improving quality of life, reducing psychological distress, anxiety and depression, improving coping skills, and reducing symptoms such as pain and nausea and vomiting [*28*, *29*, *79*]. While group psychotherapy interventions for cancer patients have been applied mostly in newly diagnosed or relatively early-stage cancer patients, several studies have demonstrated significant quality of life, mood, coping and symptom control benefits for patients with advanced, metastatic cance, and even for dying patients [*26*, *27*, *31*, *34*, *41*, *52*, *71*, *72*, *74*, *75*, *76*, *77*, *79*, *87*]. The group psychotherapy intervention format is felt by some investigators to be equally effective as or even more effective than individual psychotherapy interventions (*10*, *11*, *20*, *86*). Group interventions may offer benefits not available in individual settings, such as: a sense of universality; sharing a common experience and identity; a feeling of helping oneself by helping others; hopefulness fostered by seeing how others have coped successfully; and a sense of belonging to a larger group (self-transcendence, meaning, common purpose).

The role of cancer support groups has traditionally been to provide basic information, provide support, facilitate emotional expression and teach coping skills [*28*, *29*]. However, a more careful examination of the content of the cancer group psychotherapy intervention literature reveals that many interventions have either implicit or explicit existential and spiritual elements that may have an important role in the benefit conveyed by these interventions [*21*, *42*]. Very few cancer group psychotherapy intervention trials have specifically addressed existential or spiritual themes or outcomes (e.g., self-transcendence, meaning, spiritual well-being) as their main focus. Rather, cancer group psychotherapy intervention trials fall predominantly into the following categories: (a) patient education/psycho-education interventions (e.g. [*1*, *10*, *24*, *44*, *85*]); (b) supportive-expressive interventions (e.g., [*27*, *75*, *78*, *86*); and (c) cognitive-behavioral interventions (e.g. [*23*, *30*, *46*, *82*]).

Despite these categorizations, the interventions noted above often cover a broad range of pragmatic and/or existential issues, combining psycho-education, coping skills, symptom control, support, emotional expression and existential concerns. Spiegel’s supportive-expressive group psychotherapy for women with metastatic breast cancer was adapted from Yalom and Spiegel’s existential supportive-expressive group intervention and maintains a significant existential element. A major element of supportive-expressive group therapy for metastatic breast cancer patients includes "detoxifying" death by direct discussion of death anxiety and other fears regarding facing death, which can result in positive life changes [*46*, *73*] combined aspects of Spiegel’s model with a cognitive intervention. Topics for discussion included grief work, coping skills, mastery, cognitive reframing, and the re-ordering of priorities.

Spiritual/self-transcendent/logotherapy group psychotherapy in cancer

A relatively small, but growing, literature is developing around group psychotherapy for cancer patients that is based on nontraditional, alternative, spiritually based interventions grounded in theoretical perspectives ranging from yoga, meditation and Buddhist philosophy (e.g,. [*51*]) to those based on concepts and theories of self-transcendence [*12*, *21*, *43*], and those based on Viktor Frankl's logotherapy [*50* , *62*, *88*]. The majority of this psychotherapy intervention work has utilized the related concepts of "self-transcendence" and "meaning" as developed by such theoreticians as Viktor Frankl [*35*, *36*, *37*, *38*] and Pamela Reed [*63*, *64*, *65*, *66*].

Self-transcendence is only one element in Frankl's theory of man's will (instinct) to meaning, and he describes self-transcendence as an inherent characteristic of humans to connect with that which is greater than one's own individual concerns and needs, and through this, in part, finding or making meaning in one's life [*35*, *36*, *37*, *38*]. Reed [*63*, *65*] described self-transcendence within the framework of lifespan developmental theory, and defines self-transcendence as a characteristic of developmental maturity in which a person experiences the expansion of self-boundaries and an orientation toward broadened life perspectives and activities. Advancing age and life-threatening illness such as cancer can be stimuli for expansion of one's previous concepts of self-boundaries that can lead to changes in personal life purpose and meaning. While overlap exists between the concepts of "self-transcendence" as developed by nurse theoreticians (e.g. [*20*, *83*,]) and Frankl's logotherapy, it is clear that self-transcendence is merely one aspect of a more complex theoretical and clinical framework developed by Frankl as a means to understanding man's will to meaning and utilizing meaning (having a sense of meaning and purpose in life) as a psychotherapeutic technique and goal as developed in logotherapy.

Self-transcendence has been shown, primarily in the nursing literature, to be associated with indicators of well-being and mental health in older adults, women with breast cancer, women with AIDS, gay men with AIDS, and older men with prostate cancer [*12*, *17*, *18*, *19*, *20*, *21*, *66*]. Two recent pilot studies have examined self-transcendence in women with breast cancer [*21*] and prostate cancer [*12*]. Chin-A-Loy and Fernsler performed a descriptive study of a convenience sample of 24 men with prostate cancer who were already attending a general cancer support group. They examined the degree of self-transcendence in this sample, using Reed's Self Transcendence Scale (STS), and examined correlates. Overall, the men scored high on the STS, and no significant correlations were found between age, duration of cancer or education. The STS alpha coefficient of internal consistency reliability was lower than that found in previous studies in women with breast cancer. The 15 STS items (see below in the "Rationale" section for a description of the 15 STS items) were examined individually for rates of endorsement. Interestingly, the item "accepting death as a part of life" had one of the lowest rates of endorsement. Several subjects wrote in comments on the STS indicating the role of spirituality and meaning in their coping with cancer, indicating that the STS may not be the ideal tool to capture issues of meaning and spirituality in patients with advanced cancer. This study in men with prostate cancer was quite preliminary and did not represent an intervention aimed at increasing self-transcendence. It also pointed out potential limitations of the STS as a measure useful in a population of advanced cancer patients. Coward [*21*] conducted the only pilot support group intervention for women with breast cancer that utilizes self-transcendence theory and is designed to facilitate self-transcendent views and perspectives to enhance emotional and physical well-being. Women (*N*=16) who had recently been diagnosed with breast cancer participated in a 90-min support session that met weekly for 8 weeks. Specific activities intended to facilitate the self-transcendence process in this nurse-led group included: values clarification, problem solving, assertive communication skill training, feelings management, pleasant activity planning, constructive thinking,

and relaxation training. In addition, promotion of mutual support among group members and the sharing of experiences was fostered by the group leaders. Measures of self-transcendence included the STS and the Purpose in Life (PIL) test [*22*]. While self-transcendence was positively correlated with measures of emotional well-being, there was no statistically significant difference in scores on the STS and PIL before and after intervention (although mood state and functional performance status were improved after the intervention).

The application of logotherapy to medically ill populations is extremely limited, and there have been no group psychotherapy interventions conducted with cancer patients utilizing logotherapy. Lazer [*50*] conducted logotherapeutic support groups for patients with cardiac disease. No significant assessment of the impact of these groups was conducted. Quirk [*62*], outlined an 8-week "Logogroup" course consisting of didactics, experiential exercises, and homework aimed at enhancing a sense of meaning. This intervention was not applied in a medically ill population and not evaluated in any systematic fashion. Finally, Zuehlke and Watkins [*88*] adapted individual logotherapy to patients with terminal illnesses (primarily cancer), who met for six individual 45-min sessions over a 2-week period. The treatment provided was logotherapy, whose premise is that failure to find meaning in life results in psychological distress. As a therapeutic intervention, the logotherapist helps the patients discover for themselves who they are, how they wishes to interpret their present individual situation, and what they want to become. Importance is placed on the individual's acceptance of the freedom to change his/her attitude to the difficulties experienced, to develop a new perspective on their identity, and to reinterpret the significance of his life's contributions in a positive way. The logotherapeutic steps undertaken included: (1) enhancing rapport with therapist; (2) eliciting sources (e.g. activities, relationships) that provided meaning in each patient's life; (3) focusing on the impact of illness; (4) dealing with the fear of dying using the technique of dereflection; and finally (5) enhancing a sense of closure with significant others in life as death approached. Patients who participated (N=6) experienced a stronger feeling of purposefulness and meaningfulness than controls (N=6), as measured by the PIL test.

Meaning-centered group psychotherapy for advanced cancer patients

The importance of spiritual well-being, and the role of "meaning" in particular, in moderating depression, hopelessness and desire for death in terminally ill cancer and AIDS patients stimulated our research group at Memorial Sloan-Kettering Cancer Center to focus new efforts on developing nonpharmacologic (psychotherapy) interventions that can address such issues as hopelessness, loss of meaning and spiritual well-being in patients with advanced cancer at the end of life. This effort led to an exploration and analysis of the work of Viktor Frankl and his concepts of logotherapy or meaning-based psychotherapy [*35*, *36*, *37*, *38*]. While Frankl's logotherapy was not designed for the treatment of cancer patients or those with life-threatening illness, his concepts of meaning and spirituality clearly, in our view, had applications in psychotherapeutic work with advanced cancer patients, many of whom seek guidance and help in dealing with issues of sustaining meaning, hope, and understanding cancer and impending death in the context of their lives.

Frankl's main contributions to human psychology have been to raise awareness of the spiritual component of human experience and the central importance of meaning (or the will to meaning) as a driving force or instinct in human psychology. As a psychiatrist who survived Auschwitz, his insights have been widely shared. Some of Frankl's basic concepts include:

(1)
Meaning of life - life has meaning and never ceases to have meaning even up to the last moment of life, meaning mat change in this context but it never ceases to exist.
(2)
Will to meaning - the desire to find meaning in human existence is a primary instinct and basic motivation for human behavior.
(3)
Freedom of will - we have the freedom to find meaning in existence and to choose our attitude to suffering.
(4)
The three main sources of meaning in life are derived from creativity (work, deeds, dedication to causes), experience (art, nature, humor, love, relationships, roles) and attitude - the attitude one takes towards suffering and existential problems.

Frankl felt there were three inevitable existential problems: suffering, death and guilt (existential guilt about the fact that one never lives up to one's potential). Other basic ideas include the concept that life is a gift and that we have a responsibility to live life to the fullest; meaning occurs in the historical context of an individual, his family, his people, humankind.

The novel intervention we call "Meaning Centered Group Psychotherapy," or MCGP, is based on the concepts described above and the principles of Viktor Frankl's logotherapy and is designed to help patients with advanced cancer to sustain or enhance a sense of meaning, peace and purpose in their lives even as they approach the end of life. We have conducted a series of pilot group psychotherapy interventions utilizing this meaning-centered approach in a cohort of advanced cancer patients [*42*] in order to establish the feasibility, practicality, applicability and acceptance of such an intervention, and are now beginning to conduct a controlled trial of MCGP. We have been able to manualize an 8-week (one 1 1/2 h session per week) Meaning-Centered Group Psychotherapy intervention, which utilizes a mixture of didactics, discussion and experiential exercises focused around particular themes related to meaning and advanced cancer. The session themes include:

Session 1
Concepts of meaning and sources of meaning
Session 2
Cancer and meaning
Session 3
Meaning and historical context of life
Session 4
Storytelling, life project
Session 5
Limitations and finiteness of life
Session 6
Responsibility, creativity, deeds
Session 7
Experience, nature, art, humor
Session 8
Termination, goodbyes, hopes for the future

Patients are assigned readings and homework that are specific to each session's theme and are utilized in each session. While the focus of each session is on issues of meaning/peace and purpose in life in the face of advanced cancer and a limited prognosis, elements of support and expression of emotion are inevitable in the context of each group session (but limited by the focus on experiential exercises,

didactics and discussions related to themes focusing on meaning).

Conclusion

Addressing spiritual issues in end-of-life care for cancer patients has become a priority in the optimal delivery of ideal palliative care in the United States. Spiritual needs, in particular issues related to maintaining a sense of meaning, peace and hope in the face of advancing cancer, have been identified as priorities by both patients and professionals alike. There is a compelling need for the development of novel and innovative psychotherapeutic interventions for advanced cancer patients, to help them deal with the spiritual suffering, demoralization, hopelessness and loss of meaning that is so common (up to 17% of terminally ill cancer patients have a significant desire for a hastened death [9].

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