12 Meaning-Centered Group Psychotherapy

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12.1 Introduction

A famous Talmudic question asks: ‘What is truer than the truth?’ The answer: ‘The story.’ This, dear reader, is the story of Meaning-Centered Group Psychotherapy (MCGP), at least in abbreviated form.

Like many clinical interventions in our field of psycho-oncology, Meaning-Centered Psychotherapy (MCP) arose from a need to deal with a challenging clinical problem, that of despair, hopelessness and desire for hastened death in advanced cancer patients who, in fact, not suffering from a clinical depression [1], but rather confronting an existential crisis of loss of meaning, value and purpose in the face of a terminal prognosis. While our group ultimately demonstrated that desire for hastened death in the presence of a clinical depression could be reversed with adequate antidepressant therapy [2], no effective intervention appeared available for loss of meaning and hopelessness in the absence of clinical depression.

Inspired primarily by the works of Viktor Frankl [3–6] and further informed by the contributions of Irvin Yalom [7], our research group adapted Frankl’s concepts of the importance of meaning in human existence (and his ‘logotherapy’), and initially created MCGP, intended primarily for advanced cancer patients. The goal of the intervention was to diminish despair, demoralisation, hopelessness and desire for hastened death by sustaining or enhancing a sense of meaning, even in the face of death. While MCP relies heavily on Frankl’s concepts of meaning, its sources and related resources to re-connect with meaning in the midst of suffering, MCP also incorporates fundamental existential concepts and concerns that do not directly focus on meaning, but are clearly related to the search for, connection with and creation of meaning. MCGP is an eight-week intervention, composed of didactics and experiential exercises, designed to help patients understand the importance of meaning to diminish despair near the end of life.

12.2 Background

As we deepen our understanding of the psychosocial needs of palliative care patients, it is apparent that our present concepts of adequate care must be expanded beyond simple pain and physical symptom control to include psychiatric, psychosocial, existential and spiritual domains of care [8–12]. While physical symptoms are indeed distressing, those relating to psychological distress and existential concerns are even more prevalent than pain and other physical symptoms [13]. Acknowledging the psychological and spiritual domains of end-of-life care are clear priorities for both medical professionals and patients themselves.

12.2.1 Defining Spirituality as a Construct of Meaning and/or Faith

The Consensus Conference on Improving Spiritual Care as a Dimension of Palliative Care defined
spirituality as ‘the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred’ [14]. Others have defined spirituality as a construct that combines concepts of meaning and religious faith [15, 16]. 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. This comes with a responsibility to live to one’s full potential as a human being; in so doing, one gains a sense of peace, contentment or even transcendence, through connectedness with something greater than one’s self [4]. Faith is a belief in a higher transcendent power, not necessarily, but typically, identified as God, and usually, but not necessarily, through participation in the rituals or beliefs of a specific organised religion. The faith component of spirituality is most often associated with religious belief, while the meaning component appears to be a more secular and potentially universal concept that can exist in religious or non-religiously identified individuals.

### 12.2.2 Spiritual Well-Being/meaning and Its Impact on Psychosocial Outcomes in Advanced Cancer

There has been great interest in the impact of faith and religious beliefs on health outcomes [17–21]. Religion and spirituality generally play a positive role in patients’ coping with illnesses such as cancer or HIV [17, 22, 23]. However, the link between religion and health is weaker than that between spirituality/meaning and health outcomes [24, 25]. Importantly, researchers theorise that religious beliefs may help patients construct meaning in suffering inherent to illness, which may in turn facilitate acceptance of their situation [19].

There is extensive evidence for the significance of spiritual well-being at the end-of-life. For example, Singer and colleagues found that ‘achieving a sense of spiritual peace’ was a domain that was most important from the patients’ perspective [26]. Moosel and colleagues reported that 51% of patients wanted help overcoming fears, while 41% needed help finding hope, 40% the meaning in life, 43% peace of mind and 39% spiritual resources [27]. Among Japanese hospice inpatients, psychological distress was related to meaninglessness in 37%, hopelessness in 37% and loss of social role and feeling irrelevant in 28% [28]. Finally, Meier and colleagues noted that ‘loss of meaning in life’ accounted for 47% of the requests for assisted suicide [29]. Clearly, spirituality is an essential element of quality end-of-life care.

Several studies expand on the importance of these concepts. A high degree of meaning corresponds with higher satisfaction with quality of life and better tolerance of severe physical symptoms [30]. Our research group [1, 23] demonstrated the central role for spiritual well-being (i.e. meaning) as a buffering agent, protecting against depression, hopelessness and desire for hastened death. We also found that spiritual well-being was significantly associated with end-of-life despair, even after controlling for the influence of depression [31]. Similarly, Yanez and colleagues found that increases in meaning/peace significantly predicted better mental health and lower distress, whereas increases in faith did not [32].

Depression, hopelessness and loss of meaning are associated with poorer survival [33] and higher rates of suicide, suicidal ideation and desire for hastened death [1, 34–37]. Additionally, hopelessness and loss of meaning predict desire for death, independently of depression [1]. There is a critical need for psychosocial interventions that address loss of meaning as a mechanism for improving psychosocial outcomes (e.g. quality of life, depression, anxiety, hopelessness, desire for death and end-of-life despair).

### 12.3 Theoretical Conceptual Framework Underlying Meaning-Centred Psychotherapy

#### 12.3.1 Frankl’s Concepts of Meaning

Frankl’s logotherapy was not designed for the treatment of cancer patients or those with life-threatening illness. His main contribution to human psychology was 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 human instinct. Basic concepts related to meaning, proposed by Frankl and adapted for MCP in the cancer setting include:

1. **Meaning of life** – life has and never ceases to have meaning, from the first moment through to the very last. Meaning may change through the years, but it never ceases to exist. When we feel our lives have no meaning, it is because we have become disconnected from such meaning, rather than because it no longer exists.

2. **Will to meaning** – the desire to find meaning in existence is a primary motivating force in
Table 12.1  Frankl’s sources of meaning

| Creativity | Engaging in life through work, deeds, causes, artistic endeavours, hobbies, and so on. Examples include our career/job, volunteer work, involvement with church/synagogue, political and social causes. |
| Experience | Connecting with life through love, relationships, nature, art and humour. Examples include our family, children, loved ones, the sunset, gardening, beaches, museums, playing with pets, and so on. |
| Attitude | Encountering life’s limitations by turning personal tragedy into triumph, things we have achieved despite adversity, rising above or transcending difficult circumstances. Examples include achieving an education despite personal/financial challenges, overcoming grief/loss, persevering through cancer treatment, and so on. |
| History | Legacy given (past), lived (present) and left (future). Examples include our story, our family history, the history of our name, our accomplishments and whatever we hope to leave behind. |

our behaviour. Human beings are creatures who innately search for and create meaning in their lives.

3. **Freedom of will** – we have the freedom to find meaning in life and to choose our attitude towards suffering. We have the responsibility to discover meaning, direction and identity. We must respond to the fact of our existence and create the ‘essence’ of what makes us human.

4. **Sources of meaning**. Meaning in life has specific and available sources (Table 12.1). The four main sources of meaning are derived from creativity (work, deeds, dedication to causes), experience (art, nature, humour, love, relationships, roles), attitude (the stance one takes towards suffering and existential problems) and legacy (meaning exists in a historical context, thus legacy – past, present and future – is a critical element in sustaining or enhancing meaning).

Drawing from these principles, MCGP enhances patients’ sense of meaning by helping them to capitalise on the various sources of meaning in their lives. Enhanced meaning is conceptualised as the catalyst for improved quality of life, reduced psychological distress and despair. Specifically, meaning is viewed as both an intermediary outcome, as well as a mediator of change.

12.3.2 **Meaning-Focused Coping**

More recently, Park and Folkman [38] described helpful conceptual models for meaning in relation to traumatic events and coping, which seem relevant to the theoretical framework of MCP and MCGP. They describe meaning as a general life orientation, as personal significance, as causality, as a coping mechanism and as an outcome. Critically important is their concept of meaning-based coping, assessed in terms of reevaluating an event as positive, answering the question of why or ‘Why me?’, enumerating ways in which life changed (sometimes for the positive) because of an event, and appreciating that one has ‘made sense of’ or ‘found meaning’ in these circumstances [3–6, 39–42]. Park and Folkman [38] also describe two levels of meaning: global meaning and situational meaning. Unlike this conceptualisation of global or situational, Frankl viewed meaning as a state; individuals can move from feeling demoralised and as if their lives hold no value (see Kissane [37]), to recognising personal meaning and purpose, which allows them to value even more intensely the time remaining. Conceptualising meaning as a state subject to change suggests its potential responsiveness to intervention. Frankl also viewed suffering as a potential springboard, both for having a need for explanation and for finding meaning [3, 4]. Hence, 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.

12.3.3 **Concepts Central to Existential Philosophy and Psychology**

Underlying the development of MCP and MCGP are concepts central to existential philosophy, psychology and psychiatry, developed by such pioneers as Kierkegaard, Nietzsche, Heidegger, Sartre and Yalom [7, 43–46]. Much of the psychotherapeutic work is richer when the therapists are well grounded in the basic theories of existential philosophy and psychotherapy. Important concepts include: freedom, responsibility, choice, creativity, identity, authenticity, engagement, existential guilt, care, transcendence, transformation, direction, being unto death, being and temporality and existential isolation. These existential concepts richly inform the intervention and are utilised primarily to reinforce the goals of MCP related to the search for, connection with and creation of meaning.

12.4 **Target Groups of Patients**

MCGP, as it has been developed and shown to be effective in clinical trial to date, has been targeted
towards advanced cancer patients with poor prognosis. Patients with physical limitations sufficient to preclude participation in outpatient group psychotherapy (as indicated by a Karnofsky Performance Rating below 50 [47]) are not suited for this intervention. The efficacy of MCGP in improving patients' spiritual well-being and sense of meaning, and decreasing anxiety and desire for death, makes it particularly appropriate for patients who are experiencing at least moderate distress, (as indicated by a score of 4 or higher on the Distress Thermometer, NCCN Clinical Practice Guidelines in Oncology [48]), predominantly in the areas of emotional problems and spiritual/religious concerns.

12.5 Main Themes and Format of the Therapy

MCGP is an eight-week (1 1/2 hour weekly sessions) group intervention, which uses a mix of didactics, discussions and experiential exercises that are centred around particular themes related to meaning and advanced cancer (Table 12.2). The intention is to sustain or enhance a sense of meaning and purpose by teaching patients how to use the breadth of possible sources of meaning as coping resources through a combination of: (i) instructed teaching on the concepts of meaning; (ii) group experiential exercises to enhance learning, followed by homework for practice; and (iii) group leader-facilitated discussion aimed at reinforcing the importance of re-connecting to sources of meaning and using these as resources. Other existential concepts, such as freedom, responsibility, authenticity, existential guilt, transcendence and choice are incorporated into session content as these themes arise. Elements of support and expression of emotion are inevitable in each session (but are limited by the psycho-educational focus of MCGP).

The following is an overview of each session, including the experiential exercises used to facilitate discussion and deepen understanding.

### 12.5.1 Session 1: Concepts and Sources of Meaning

The first session involves introductions of each group member and an overall explanation of the group's goals. Patient introductions include biographical/demographic information, as well as their expectations, hopes and questions relating to the group. The session concludes with a discussion of what meaning means to each participant, stimulated by an experiential exercise which helps patients discover how they find a sense of meaning and purpose in general, as well as specifically in relation to having been diagnosed with cancer. As an adjective to the group, all patients are given a copy of Frankl's 'Man's Search for Meaning' [4] as a means of facilitating each patient's understanding of the main themes of the intervention.

#### 12.5.1.1 Session 1: Experiential Exercise

List one or two experiences or moments when life has felt particularly meaningful to you — whether it sounds powerful or mundane. For example, it could be something that helped you get through a difficult day, or a time when you felt most alive. And say something about it.

<table>
<thead>
<tr>
<th>Session</th>
<th>MCGP</th>
<th>Content</th>
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<tr>
<td>1</td>
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<td>Introductions of group members; introduction of concept of meaning and sources of meaning; experiential exercise; homework</td>
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<tr>
<td>2</td>
<td>Cancer and meaning</td>
<td>Identity – before and after cancer diagnosis; experiential exercise; homework</td>
</tr>
<tr>
<td>3</td>
<td>Historical sources of meaning (legacy: past)</td>
<td>Life as a legacy that has been given (past); experiential exercise; homework</td>
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<td>4</td>
<td>Historical sources of meaning (legacy: present and future)</td>
<td>Life as a legacy that one lives (present) and gives (future); experiential exercise; homework</td>
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<td>Confronting limitations imposed by cancer, prognosis and death; experiential exercise; introduction to legacy project; homework</td>
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<td>6</td>
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<td>Experiential sources of meaning: connecting with life</td>
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<td>8</td>
<td>Transitions: reflections and hopes for the future</td>
<td>Review of sources of meaning, as resources, reflections on lessons learned in the group, experiential exercise on hopes for the future</td>
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12.5.2 Session 2: Cancer and Meaning

The emphasis of session 2 is the linking of identity as a central element of meaning. The session begins as a continuation of sharing meaningful experiences, as well as a detailed explanation of what, or who, made these experiences meaningful. Identity, as a component of meaning, is addressed through the experiential exercise in which patients are asked to respond to the question 'who am I?' This exercise provides the opportunity to discuss pre-cancer identity and roles, and then how cancer has affected their identity and what they consider to be meaningful in their lives.

12.5.2.1 Session 2: Experiential Exercise

'Identity and Cancer'

1. Write down four answers to the question, 'Who am I?' These can be positive or negative, and include personality characteristics, body image, beliefs, things you do, people you know, and so on. For example, answers might start with, 'I am someone who _____', or 'I am a _______'.

2. How has cancer affected your answers? How has it affected the things that are most meaningful to you?

The following MCGP excerpt exemplifies the type of interaction that occurs between group members and leaders during the Session 2 Experiential Exercise:

PATIENT 1: I am a daughter, a mother, a grandmother, a sister, a friend and a neighbour. I attempt to respect all people in their views, which sometimes can be difficult. I represent myself honestly and frankly without being offensive, or at least I try. And my philosophy is to do unto others as they have done unto you. I'm somebody who can be very private and not always share all my needs and concerns. I also have been working on accepting love and affection and other gifts from other people. I'm more of a caregiver than someone who gets care from others. I don't like to receive care, but I'm beginning to, actually... this may be the one thing that my illness has caused me to mull over. That I'm more accepting of people wanting to do things.

GROUP LEADER: Thank you. That's really interesting. I want to make some comments, but first let's hear from someone else. Patient 2, would you like to go?

PATIENT 2: Well in terms of pre-cancer, I'm my niece's loving aunty whom she currently adores... she's seven, I'm not sure how long that will last, but right now, that's really important to me, and it's brought

my brother and me closer. I'm active and am always ready for an adventure. All my friends knew I was a 'yes, let's do it, person', enthusiastic, open. I'm a young adult librarian, with a real connection to the teens. I really loved working with them, especially on the advisory council; I really just loved it, and sometimes would stay very late with them, into the night. I was just, really... connected... I ran around a lot and I was rarely home before 11 p.m. My friends always asked why I wasn't home more. It wasn't that I didn't like home, it's just that I wanted to be out, experiencing life. I also love concerts and I danced. And I dated; I was the essence of positive, a very good friend. I'm really proud of that.

(Several other patients discussed their responses to this exercise)

GROUP LEADER: Thanks. Do you have any questions for each other about the things that you said? Were there any commonalities that you noticed?

PATIENT 1: I guess the commonality that most of us spoke about, is being a member of a unique group, a family and for most of us, that was in the top position. That was most important.

PATIENT 2: I have a comment but I don't know if it's what you're asking for. Patient 1 was talking about being a giver, but that it's basically hard for her to receive. I've had friends who are like that and it's frustrating to want to give to a person like you, but you also don't want to take people's wishes lightly... I know I'm probably speaking out of turn for all of your friends, who want to be generous back to you.

PATIENT 1: Most of them have been, because they, you know, sit me down and do what they want to do. I guess most of my good friends are very strong willed people like me and they listen and do for the most part what they want. And I don't get offended for the most part.

GROUP LEADER: It was actually quite striking... that there were many similarities in what you all shared about your identities pre-cancer. For many people, the first, the most important source of your identity, had to do with your love relationships, family relationships, your role in a family, being a daughter, father, an aunt, being a member of immediate family. So it's from these connections that we derive meaning in life, through our connectedness with people we love. And often they are members of our family. And, often, these are our sources of identity, as a member of a family, as a father, an aunt...

PATIENT 1: These roles are also a source of pain.

GROUP LEADER: Yes, that can be true, but they are also clearly a source of meaning. Do you remember
which source of meaning? It’s the ‘experiential’ source of meaning. Through love, through connectedness with people. ... Someone made a comment that Patient 3 didn’t mention this source of meaning. Patient 3, you said something interesting. You said you’ve been alone too long. But you also said that you’re a loyal friend, loyal as a puppy and a good lover. So for you, love is very relevant too. You derive a sense of meaning through friendship and romantic love. Those are all similar, all love, right? Let me ask you something, Patient 3, did you leave out being a son, or a family member, for a specific reason?

PATIENT 3: Well, I never knew my dad. I didn’t really know my mother until I was older. And I have a brother and a sister, but I’m not close to either of them. So, in a way, my job became more of my family, the people I worked with, people in recovery, they were my family. Because I became more connected to them. But outside of that, no ... no real family. So in a sense, family has been a disappointment, pain. So everyone talks about family reunions, I don’t have that. That’s not a part of my life.

GROUP LEADER: So again this idea comes up that the things that give us meaning, like love and relationships and family, are also potential sources of pain. We have to be aware of that, don’t we! The other thing I heard that was common in the responses, besides love and connectedness to other people, is connectedness to other kinds of experiences in life, like dancing, and Patient 4, you were talking about baking, cooking ... so it’s not just relationships with people, it’s relationships to the world, and being in nature, and engaging in pleasurable things, like dancing and eating. And in addition to that, several people talked about their identity coming from what they did for work, being a nurse, a lawyer, a librarian ... your work, these are creative sources of meaning, because we derive meaning through things we create, the work we do in our lives. And you added something interesting, Patient 1, that had to do with ... I think I would use the word compassion ... It had to do with caring for other people?

PATIENT 1: Well, you know, you talked about our professions, but I didn’t actually talk today about my professional life, I didn’t say anything about being a nurse or a health care provider, but I talked about being caretaker. A caretaker, in general, to the people in my life.

GROUP LEADER: Exactly. So this creative source of meaning doesn’t just come from a job you get paid to do, but from the person you create in the world. You’ve created a person who is loving, giving and caring. You’ve created a virtue, a value, compassion is important, caring for others is important. So it’s not just the job you do, but the kind of person you become and create in the world, and what values that represents, that is meaningful to you. That’s all part of ‘creative’ sources of meaning.

12.5.3 Sessions 3 and 4: Historical Sources of Meaning

Sessions 3 and 4 focus on giving each patient a chance to share their life story with the group, which helps them to better appreciate their inherited legacy and past accomplishments while still elucidating current and future goals. The theme of Session 3 is ‘Life as a legacy that has been given’ via the past, such as legacy given through one’s family of origin. The facts of our lives that have been created by our genetics and the circumstances of our past are discussed in terms of how they have shaped us and perhaps motivated us to transcend limitations. Session 4 focuses on ‘Life as a legacy that ones lives and will give’, in terms of patients’ living legacy, and the legacy they hope to leave for others. The Session 3 experiential exercise helps patients to understand the ways in which their pasts have shaped what they find meaningful, and the Session 4 exercise fosters a discussion of future goals, no matter how small. As a homework assignment after Session 4, patients are asked to tell their life story to a loved one(s), highlighting experiences that have been a source of meaning and pride for them, and things they wished they might have accomplished but have yet to do.

12.5.3.1 Session 3: Experiential Exercise ‘Life as a Legacy That Has Been Given’

When you look back on your life and upbringing, what are the most significant memories, relationships, traditions, and so on, that have made the greatest impact on who you are today?

For example: Identify specific memories of how you were raised that have made a lasting impression on your life (e.g. your relationship with parents, siblings, friends, teachers, etc.) What is the origin of your name? What are some past events that have touched your life?

12.5.3.2 Session 4: Experiential Exercise ‘Life as a Legacy That You Live and Will Give’

1. As you reflect upon who you are today, what are the meaningful activities, roles or accomplishments that you are most proud of?
2. As you look towards the future, what are some of the life-lessons you have learned along the way that you would want to pass on to others? What is the legacy you hope to live and give?

12.5.4 Session 5: Attitudinal Sources of Meaning

This session examines each patient’s confrontation with limitations in life and the ultimate limitation – our mortality and the finiteness of life. The focus is on our freedom to choose our attitudes towards such limitations and find meaning in life, even in the face of death. In discussing the experiential exercise, group leaders emphasise one of Frankl’s core theoretical beliefs, that by choosing our attitude towards circumstances that are beyond our control, (e.g. cancer and death), we may find meaning in life and suffering, which will then help us to rise above or overcome such limitations. One of the more critical elements of this session involves the experiential exercise in which patients are asked to discuss their thoughts, feelings and concepts of what constitutes a ‘good’ or meaningful death. Common issues that have arisen include where patients prefer to die (e.g. at home in their own bed), how they want to die (e.g. without pain, surrounded by family), and what patients expect takes place after death, funeral fantasies, family issues and the afterlife. This exercise is designed to detoxify the discussion of death and to allow for a safe examination of the life they have lived and how they may be able to accept that life. Inherent in these discussion are issues of tasks of life completion, forgiveness and redemption. At the end of session 5, patients are presented with the ‘Legacy Project’, which integrates ideas presented in treatment (e.g. meaning, identity, creativity and responsibility), in order to facilitate the generation of a sense of meaning in light of cancer. Some examples of Legacy Project include creating a legacy photo album or video, mending a broken relationship or undertaking something the patient has always wanted to do but has not yet done.

12.5.4.1 Session 5: Experiential Exercise ‘Encountering Life’s Limitations’

1. Since your diagnosis, are you still able to find meaning in your daily life despite your awareness of the finiteness of life? (If yes, how? If no, what are the obstacles?)

2. During this time, have you ever lost a sense of meaning in life – that life was not worth living? (If yes, please briefly describe.)

3. What would you consider a ‘good’ or ‘meaningful’ death? How can you imagine being remembered by your loved ones? (e.g. what are some of your personal characteristics, the shared memories or meaningful life events that have made a lasting impression on them?)

12.5.5 Session 6: Creative Sources of Meaning

Session 6 focuses on ‘Creativity’ as a source and resource of meaning in life. One important element of the experiential exercises deals with the issue of ‘Responsibility’ (our ability to respond to the fact of our existence, to answer the question, ‘what life have we created for ourselves?’). Each patient is asked to discuss what their responsibilities are, as well as for whom they are responsible. Any unfinished business or tasks patients may have is also examined. This discussion invites group members to focus on the task at hand, as opposed to focusing only on their suffering. Additionally, by attending to their responsibility to others, meaning may be enhanced by the realisation that their lives transcend themselves and extend to others.

12.5.5.1 Session 6: Experiential Exercise ‘Engaging in Life Fully’

1. Living life and being creative requires courage and commitment. Can you think of time(s) in your life when you’ve been courageous, taken ownership of your life or made a meaningful commitment to something of value to you?

2. Do you feel you’ve expressed what is most meaningful to you through your life’s work and creative activities (e.g. job, parenting, hobbies, causes)? – If so, how?

3. What are your responsibilities? Who are you responsible to and for?

4. Do you have unfinished business? What tasks have you always wanted to do, but have yet to undertake? What’s holding you back from responding to this creative call?

12.5.6 Session 7: Experiential Sources of Meaning

Session 7 focuses on discussing experiential sources of meaning, such as love, beauty and humour. While creative and attitudinal sources of meaning require more
of an active involvement with life, experiential sources embody more of a passive or even sensory engagement with life. Patients explore moments and experiences when they have felt connected with life through love, beauty and humour. Often, the discussions highlight how these sources of meaning become particularly important for patients since their cancer diagnosis. Feelings concerning the group’s upcoming termination are discussed in preparation for the final session.

12.5.6.1 Session 7: Experiential Exercise
‘Connecting with Life’
List three ways in which you ‘connect with life’ and feel most alive through the experiential sources of:
LOVE: BEAUTY: HUMOUR:

12.5.7 Session 8: Transitions
The final session provides an opportunity to review patients’ Legacy Projects, as well as to review individual and group themes. Additionally, the group is asked to discuss topics such as: (i) How has the group been experienced? (ii) Have there been changes in attitudes towards your illness or suffering? (iii) How do you envision continuing what has been started in the group? The experiential exercise that ends this session focuses on answering the question, ‘What are your hopes for the future?’

12.5.7.1 Session 8: Experiential Exercise
‘Group Reflections and Hopes for the future’
1. What has been like for you to go through this learning experience over these last eight sessions? Have there been any changes in the way you view your life and cancer experience having been through this process?
2. Do you feel like you have a better understanding of the sources of meaning in life and are able to use them in your daily life? If so, how?
3. What are your hopes for the future?

12.6 Key Therapist Techniques in the Application of MCGP

12.6.1 Group Process Skills and Techniques
MCGP is essentially a group intervention, and as such, attention to basic tenets of group process and dynamics remains important. Co-facilitators must be cognizant of group etiquette, especially in terms of working together as co-facilitators, attending to and promoting group cohesion and facilitating an atmosphere that is conducive to productive exchanges between patients. While MCGP is not intended to be primarily a supportive group intervention, elements of support are in fact quite inevitable, but are not intentionally promoted or specifically fostered.

12.6.2 Psycho-Educational Approach: Didactics and Experiential Exercises to Enhance Learning
MCGP is also essentially an educational intervention. The goal of MCGP is to have patients understand the concept of meaning, and its importance, particularly as one faces a terminal illness, and the ultimate limitation of death. Additionally, MCGP strives to have patients learn about sources of meaning in order for them to become resources in coping with advanced cancer. This educational process is achieved primarily through a set of brief didactics which introduce each session, followed by an experiential exercise designed to link learning of these abstract concepts with patients’ own emotional experiences. Patients each share the content of their experiential exercises, and the process of experiential learning is reinforced through the comments of co-facilitators and patients, as well as through the identification of commonalties among patients’ responses.

12.6.3 A Focus on Meaning and Sources of Meaning as Resources
MCGP is designed to have patients learn Frankl’s concepts of meaning and to incorporate these sources of meaning as resources in their coping with advanced cancer. In each session, the co-facilitators listen carefully for and highlight content shared by patients that reflect sources of meaning. Co-facilitators identify meaningful moments described by patients, and also draw attention to meaning shifts when patients begin to incorporate the vocabulary and conceptual framework of meaning into the material they share. An emphasis is also placed on the importance of the patient’s ability to shift from one source of meaning to another, as selected sources of meaning become unavailable due to disease progression. A specific technique used to facilitate this process is called ‘Moving from ways of doing to ways of being’. This refers to helping patients to become aware that meaning can be derived in more passive ways. For example, patients can still be good fathers even if
they cannot go out to the backyard and play ball with their sons, by being fathers in less action-oriented ways, such as sitting and talking about their son's life goals and fears, and through expressing affection. In MCGP, it is also important for co-facilitators to be aware of the 'co-creation of meaning' between group members. All present are 'witnesses' or repositories of meaning for each other, and are thus part of a meaningful legacy created by the group as a whole.

12.6.4 Incorporating Basic Existential Concepts and Themes

A central concept in MCGP is that human beings are creatures. We create key values and, most importantly, we create our lives. In order to live fully, we must create a life of meaning, identity and direction. 'Detoxifying death' through the therapeutic stance and attitude of the co-facilitators is an important technique utilised throughout MCGP. Co-facilitators speak openly about death as the ultimate limitation that causes suffering and for which meaning can still be derived through the attitude that one takes towards suffering (e.g. transcendence, choice). Another technique, the 'existential nudge', occurs when co-facilitators gently challenge the resistance of patients to explore difficult existential realities, such as the ultimate limitation of death or existential guilt.

12.7 Case Example

Allen is a 56 year old gay man who has worked in the advertising field for 30 years. His work is fast paced, taxing and consuming. While he enjoyed his work, he had begun to think of doing other things in recent years that may be more fulfilling. However, such feelings were usually overtaken by fears of what he would do with his life and what identity he would subsequently have. He has had a long and satisfying relationship with his partner of many years, a relationship in which Allen finds great solace and comfort.

His initial battle with cancer began 16 years ago, when he was diagnosed with thyroid cancer. The subsequent surgeries left him with significant scarring of his neck, which impacted his self-image and sense of self. He stated, 'I felt like a fish that had been filleted.' Despite this, he felt he had overcome cancer and that the 'battle was won'. However, a routine examination three years ago revealed advanced prostate cancer. Allen stated that this 'completely overwhelmed me. I felt crushed'. He began to experience anxiety and depression, and to question the value of fighting this battle once again. His current life felt empty and meaningless in the face of his new cancer; he felt alone and 'singed out' by having to face this challenge again. Allen began seeing a psychiatrist for help with his mood symptoms, and hence his referral to MCGP.

After the first session, Allen reported that he felt 'overwhelmed by all these other people with cancer'. He considered ending the group, but discussed this with his psychiatrist and decided to stick it out. He was relieved when other group members shared similar feelings, and he felt more connected to them. He no longer felt as alone and now, in addition to the support of his psychiatrist, he had people who understood his experience of facing cancer and possible death.

As the group progressed, Allen began to alter his world view significantly. He began to view the pressures of work, which had seemed so compelling and all-consuming, as being secondary to his own needs and quality of life. His long-standing desire to leave his work began to take on a new intensity. Session 6, which focuses on patients' feelings of responsibility to themselves and others, as well as any unfinished business, was an important turning point for Allen. 'I used to be so afraid of what I would do and who I would be. But I've battled cancer twice! If I can fight these kinds of fights, those fears really seem to pale. My work was important for me. But it's the "me" that counts here. Me and my partner count so much more.' Such a change is a good example of the type of cognitive re-structuring in the face of illness that often occurs. Allen's shift of taking into account not only himself, but his partner as well, illustrates this session's goal of enhancing patients' sense of meaning through the realisation that their lives transcend themselves and extend to others as well.

For his 'Legacy Project', Allen resolved to accomplish two goals. The first was to finish his employment and put his available resources into his relationship. The second was to begin the process of renovating his home, something he and his partner had wanted to do, but his illness had delayed until now prevented from occurring. Allen related that he used to think, 'I'm dying. Why bother?' His new outlook on life and his illness allowed him to view his remaining time as precious and worthy of investment. In addition, he came to the realisation that despite the anxieties and pain his illness caused, he still lived and therefore he should carry on living to the end. 'Until I go, I'm still here. Why should I stop experiencing the simple joy of still existing? I won't let it rob me of that.'

At the conclusion of the group, Allen reported that he felt it to have been of great value to him. 'I would
not have seen the purpose or even the possibility of making these changes without this group and all of you.' At the two-month follow-up we conduct with patients, Allen had indeed carried out the twin goals of his 'Legacy Project'. He felt an enhanced sense of meaning in his life, and was finding it easier to cope with his illness.

12.8 Key Challenges in Application of MCGP

The key challenge in applying MCGP in an advanced cancer population is related to inflexibility, which is innate to a weekly group intervention that requires regular attendance at a specified day and time. MCGP also has specific themes that are covered weekly, with a logical progression of content as the sessions unfold. Therefore, attending all sessions is desirable. Research with palliative care populations suffers from attrition due to illness, death, conflicts with scheduling chemotherapy, diagnostic tests, other doctor appointments and brief hospitalisations. Our trials of MCGP have had attrition rates as high as 50% (interestingly, the rate is the same for Supportive Psychotherapy).

12.9 Overview of Evidence on Efficacy

Early research by Yalom, Spiegel and colleagues demonstrated that a one-year supportive-expressive group psychotherapy, which included a focus on existential issues, decreased psychological distress and improved quality of life [49–51]. More recent studies have described short-term interventions that included a spiritual or existential component, including individually-based approaches [36, 52–54]. However, results are inconsistent in their effects on depression, anxiety and desire for death. More importantly, specific aspects of spiritual well-being and meaning were not consistently targeted as outcomes. Thus, despite the seeming importance of enhancing one’s sense of meaning and purpose, few clinical interventions have been developed that attempt to address this critical issue.

A randomised controlled trial of MCGP [55] demonstrated its efficacy in improving spiritual well-being and a sense of meaning, as well as in decreasing anxiety, hopelessness and desire for death. Ninety patients were randomised to either eight sessions of MCGP or Supportive Group Psychotherapy (SGP). Of the 55 patients who completed the eight-week intervention, 38 completed a follow-up assessment two months later (attrition was largely due to death or physical deterioration). Outcome assessments included measures of spiritual well-being, meaning, hopelessness, desire for death, optimism/pessimism, anxiety, depression and overall quality of life.

Results demonstrated significantly greater benefits from MCGP compared to SGP, particularly in enhancing spiritual well-being and a sense of meaning. Treatment effects for MCGP appeared even stronger two months after treatment ended, suggesting that benefits not only persist, but may grow over time. Patients who participated in SGP failed to demonstrate any such improvements, either post-treatment or at the two month follow-up assessment.

12.10 Service Development and Future Directions

While MCGP is effective for patients with advanced cancer, it is demanding, inflexible and associated with significant attrition. We therefore developed the more flexible individual format, Individual Meaning-Centred Psychotherapy (IMCP). IMCP has proved to be equally effective, but allows for flexibility in time and place (e.g. office, bedside or chemo suite) for scheduling sessions, and has significantly reduced attrition and enhanced rates of intervention completers [56]. We are currently adapting and testing MCP for other cancer populations, (e.g. early stage cancer, cancer survivors) as well as for oncology care providers [57]. Additionally, we are developing briefer forms of IMCP that can be applied to hospice populations.

12.10.1 Training

Clinicians can be readily trained to deliver MCP through one-day workshops and supervision sessions. Its psycho-educational format as a structured intervention makes mastery more straightforward, although the experience that well trained therapists bring is invaluable.

12.10.2 Manuals

Both formats of MCP – MCGP and IMCP – have been manualised, with manuals developed both for therapists and patient participants. By the end of 2011, these manuals, along with a textbook on MCP, will be available and published through Oxford University Press.

12.11 Summary

MCGP and IMCP have been developed by W. Breitbart and colleagues in the Department of Psychiatry and Be Cancer...
Acknowledgement

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Recommended Reading


References


