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Death Concerns Among Individuals Newly Diagnosed with Lung Cancer

Rebecca Lehto, PhD¹ and Barbara Therrien, PhD²

¹ Michigan State University College of Nursing, East Lansing, MI

² University of Michigan School of Nursing, Ann Arbor, MI

Abstract

Confronting the reality of death is an important challenge for individuals facing life-threatening illness such as lung cancer, the leading cause of cancer death. Few studies, however, document the nature of death-related concerns in individuals newly diagnosed with lung cancer. The aims of this exploratory study were to examine unsolicited death-related concerns among newly diagnosed individuals, and to determine if age, gender, marital status, stage of disease, type of treatment, presence of co-morbid conditions, and Veteran status were related to extent of death concerns. A mixed method approach was used to examine death concerns in 73 individuals newly diagnosed with non-small cell lung cancer. Seven categories related to death were identified: psychological preparation; time left; impact; behavioral preparation; acceptance; cancer death experiences; and post-death. Stage of disease and Veteran status were factors that were related to increased numbers of death-related content. Findings demonstrate that death concerns are varied, primarily negative, and are relevant to the person facing a new lung cancer diagnosis, thus highlighting the importance for health care providers to assess, discuss, and listen for death concerns in the acute care setting.

Keywords

death; lung cancer; worry; concerns; cognitive structure

Confronting death has been identified as a critical, but also a challenging cognitive and emotional task for individuals facing a life-threatening illness such as lung cancer (Kubler-Ross, 2002), the leading cause of cancer death in the United States (Jemal et al., 2009). Although lung cancer carries a poor prognosis, few empirical studies address the nature of death-related concerns among newly diagnosed individuals with lung cancer. This dearth of knowledge is significant particularly as it pertains to individuals with localized disease, a group whose five-year survival rates have steadily increased in recent years (Sugimura & Yang, 2006). Although almost 70% of all lung cancer cases are diagnosed with locally advanced or metastasized disease, survival estimates for localized disease range from 43 to 69% at five years (Lee et al., 2008; Molina, Yang, Cassivi, Schild, & Adiel, 2008). Unresolved death-related concerns often underlie neuroses and contribute to diminished psychological adaptation, although managing the reality of death and related concerns are also associated with enhanced meaning and the construction of authentic purposeful lives (Yalom, 2008). Given the life-threatening nature of a new lung cancer diagnosis, recognizing the presence and nature of death-related concerns is of importance to health care providers in their efforts to appropriately deliver satisfactory and comprehensive care for individuals in acute treatment settings. The purpose of this exploratory study is to address

this research gap in the acute care literature by examining the frequency and content of unsolicited death concerns among individuals with early stage disease. Such information will assist health care providers who provide emotional support and respond to the psychosocial needs of patients in the early stages of the disease process.

Humans are unique in that they must live and learn to adapt with the awareness of their own mortality. Terror management theory posits that the awareness of death, or mortality salience, has specific effects on human behavior. Extensive research has shown that increased conscious and unconscious death awareness can differentially activate behavioral responses to the threat of death (Goldenberg & Arndt, 2008). Unconscious heightened death arousal leads to behaviors associated with self-esteem preservation and adherence to cultural knowledge, whereas conscious heightened death awareness leads to active engagement and health-oriented behaviors, both of which are aimed at reducing the threat associated with heightened death awareness (Goldenberg & Arndt, 2008). Unexpected diagnoses of life-threatening illnesses such as cancer leave individuals vulnerable to disruptive existential concerns and profound emotional upheaval (Blinderman & Cherny, 2005; Moene, Bergbom, & Skott, 2006; Westman, Bergenmar, & Andersson, 2006). Further, the illness context presses the death construct upon individuals, many of whom may not have had even a rudimentary cognitive structure of personal death prior to the diagnosis.

Much of the research that has examined death concerns among individuals living with life-threatening illness has been conducted from a palliative care perspective in patients with a terminal diagnosis at the end of life. Findings from this body of research identify that many chronically ill individuals who are facing death have multiple unmet needs, many of which stem from providers who have difficulties discussing end of life needs and death (Fitzsimmons et al., 2007; McSkimming et al., 1999). There is general consensus that existential concerns are significant issues among individuals facing terminal disease regardless of cultural origins and type of life-threatening illness (LeMay & Wilson, 2008; Henoeh & Danielson, 2009). Individuals who struggle with finding meaning and purpose from life, and have concerns about the past, future concerns about death, and religious worry suffer from existential distress, a despairing condition that can increase desire for death and foster suicidal ideation. For individuals who are able to resolve their existential concerns, end of life may be time of psychological growth, deepening relationships with others, and an enhanced sense of self (LeMay & Wilson, 2008).

Less research has examined death concerns in individuals facing life-threatening diagnoses in the acute care treatment setting. A qualitative study conducted among women and men who had undergone curative treatment for breast and prostate cancer found that all participants raised the topic of death. The death concerns related to loved one's reactions, what would happen following death, and faith in God as a source of security (Westman et al., 2006). Although there is limited inquiry related to death concerns in acute care, a vast empirical foundation documents psychological distress, particularly anxiety and depression, among individuals diagnosed with life-threatening illness (Jacobsen & Jim, 2008). For individuals with lung cancer, a group shown to have higher illness burden, lowered quality of life, and high psychological distress compared with survivors of other cancers (Schag, Ganz, Wing, Sim, & Lee, 1994; Sugimura, & Yang, 2006), the lack of research that has systematically addressed death and existential concerns is particularly glaring. Among newly diagnosed lung cancer patients, psychosocial issues were of higher concern than physical symptoms, and were the least likely to be managed effectively by the health care team (Hill, Amir, Muers, Connelly, & Round, 2002).

Unresolved death concerns in the face of a life-threatening stressor such as lung cancer may be one factor that increases psychological distress and contributes to difficulties with

adjustment and adaptation. Thus, a thorough examination of the nature and extent of death concerns is an important first step that will identify areas for further assessment and needs for enhanced support. Little is known about factors such as age, gender, co-morbidities, type of treatment, and extent of disease that may be associated with higher death concern among individuals newly diagnosed with lung cancer. The purposes of this exploratory study were to examine contents of unsolicited death-related concerns among individuals primarily diagnosed with early stage lung cancer who were preparing for aggressive treatment. A second purpose was to determine if age, gender, marital status (presence of support), stage of disease, type of treatment (surgery vs. radiation and/or chemotherapy), presence of co-morbid conditions, and Veteran status (potential exposures to combat) were related to death-related concerns in the identified sample.

Method

Participants

Participants were 73 adults with a confirmed diagnosis of non-small cell lung cancer who were awaiting treatment and were volunteers of two pilot studies conducted at a Midwestern VA and a University outpatient clinic. Eligibility criteria included that participants were 21 years of age or older, and have a new diagnosis of non-small cell lung cancer. Participants were excluded if they had a known previous history of cancer, documented cognitive or psychiatric disorder, or a history of a debilitating illness such as advanced cardiac, respiratory, or renal disease that would complicate study participation. Further, participants were excluded if they were taking anti-anxiety medication.

The mean age was 64.98 ± 9.28 (range 47 – 83), and the mean education was 12.74 ± 2.28 (range 8–20) years. Most participants were men, $n = 52$ (71%), Caucasian, $n = 68$ (93%), and married $n = 43$ (59%). The sample was almost evenly divided between non-Veterans ($n = 37$, $n = 51\%$) and Veterans ($n = 36$, 49%). Most of the individuals were diagnosed with either stage I ($n = 33$, 45%) or II ($n = 33$, 45%) disease, but seven participants (10%) were diagnosed with staged IIIa disease. Most of the sample was eligible for surgery with curative goals ($n = 55$, 75%), and 18 (25%), including 11 individuals with early stage disease, were to receive radiation and/or chemotherapy. As expected from an older sample with lung cancer, most ($n = 58$, 79%) had at least one co-existing medical condition (hypertension, diabetes, chronic obstructive pulmonary disease, musculo-skeletal problems such as arthritis) with 48 ($n = 66\%$) having a history of two or more of the above-mentioned conditions.

Materials

Data derived for this study are based on findings from semi-structured interviews that used the Conceptual Cognitive Map (3CM) methodology (Kearney & Kaplan, 1997). Cognitive maps are mental models that are schematic of individuals' cognitive representation of a specific situation or problem. Cognitive maps guide the capacity for incorporating and interpreting new information, for learning, for making decisions, and for setting goals by influencing what information is attended to and how it is perceived (Kaplan & Kaplan, 1981). Contents of cognitive maps that are readily accessible and come easily to mind are those that are the most salient, meaningful, and concerning to the individual. In line with reasoning, they would be the most important for health care providers to identify and address when in contact with individuals who are newly diagnosed with life-threatening illness.

The 3CM is an established open-ended method for assessing cognitive structures and processes, and was implemented in this study to gain information about individual

perceptions and concerns relative to the new diagnosis of lung cancer (Kearney & Kaplan, 1997). The standard procedure entailed asking participants to think about and write down the important issues that came to mind about the new diagnosis. Content items were coded for affect by the participant with a plus (+) if it was perceived as positive and with a minus (−) if it was perceived as negative. Participants then organized the individual items into groups that were meaningful, thus producing clusters that were representative of a descriptive content category. The 3CM content formed a visual representation of the individual's current state of mind, and provided basis for speculation about underlying cognitive structures. There were no constraints placed on the number, organization, or time committed to developing the cognitive maps (Kearney & Kaplan, 1997).

Procedure

Scientific review and IRB committees at the respective institutions approved all study procedures. Participants were approached at time of treatment planning following diagnosis and written informed consent was obtained. Participants completed questionnaires and the semi-structured interview as a part of two pilot studies aimed at understanding worry and illness perceptions in early-stage lung cancer. All testing occurred during scheduled outpatient clinic visits in quiet private areas, most generally in consultation rooms. All participants agreed to complete the 3CM. The interviews generally were completed within 15 minutes. However, there was individual variability in the amounts of time taken to collect the 3CM data as some individuals had few and others had more extensive contents to report.

3CM findings were analyzed using a mixed-methods approach. Descriptive statistics were used to characterize the sample and to quantify the interview findings. Two independent nurse scientists analyzed, summarized, and coded content to assure inter-rater reliability of the coding scheme. Content analyses allowed categorization based on groups of related phrases and words. The researcher summed negative and positive items. In addition to death contents, future disease fears and spiritual and/or religious issues were also examined because of the content relevance to concerns about death. Future disease fears related to the threat of metastasis or treatment failure may stem from associations with the imminence of death. Further, religious contents can serve as a buffer to manage and offset death concerns (Pyszcynski, Greenberg, Solomon, Arndt, & Schimel, 2004).

Results

All these newly diagnosed individuals reported significantly more negative coded contents (4.67 ± 3.62 , range 0 – 13) than positive coded contents (2.22 ± 2.53 , range 0 – 12), $t(72) = 4.26$, $p < .005$. Over half of present participants identified death concerns ($n = 39$, 53.4%). Table 1 presents the numbers of positive and negative contents, numbers of future disease fears, and spiritual and/or religious contents between those ($n = 39$) who had death contents and those who had no death contents ($n = 34$). Although death contents were primarily coded as negative, some were also coded as positive and/or neutral. Individuals with death concerns had significantly more negative coded contents, $t(72) = -3.81$, $p < .005$, and more future disease fears, $t(72) = -2.31$, $p < .05$, compared to individuals with no death contents (Table 1). Individuals with death content reported significantly more negatively coded than positively coded items in their 3CM maps, $t(38) = 4.52$, $p < .005$. In contrast, individuals with no death content reported negatively and positively coded contents that were not significantly different.

Researchers identified seven death content categories: psychological preparation ($n = 25$, 64%); time left to live/loss ($n = 12$, 31%); impact of death on loved ones ($n = 12$, 31%); behavioral preparation ($n = 9$, 23%); death acceptance ($n = 9$, 23%); experiences with others who have died of cancer ($n = 7$, 18%); and post-death ($n = 4$, 10%). Death contents

that were coded positive primarily stemmed from the death acceptance, behavioral preparation, and post-death categories (Table 2).

Future disease fears included concerns about an uncertain future, the potential for cancer spread, tumor location, and disability. Although the future disease contents do not address death specifically, they reflect heightened awareness of the life-threatening nature and association with death that diagnosis of cancer conferred. A total of 48 individuals (66%) cited at least one future disease concern. Participants primarily coded future disease concerns negatively.

Contents related to spirituality and/or religion included religious affiliation, perceived higher order or purpose to life, and behaviors such as prayer and meditation. These contents are closely aligned with cultural management of death and the cognitive integration of a major life event into a larger perspective (Yalom, 2008). A total of 16 individuals (22%) cited at least one spirituality and/or religious concern, and all were coded positively. See Table 3 for future disease concerns and spirituality and/or religious concerns.

Men ($M = 1.17 \pm 1.32$) and women ($M = .76 \pm .89$), and unmarried ($M = 1.23 \pm 1.10$) and married individuals ($M = .93 \pm 1.30$), were not significantly different in death contents. There were significant differences in numbers of death contents among individuals with stage I ($M = .89 \pm 1.08$), stage II ($M = .91 \pm 1.01$), and stage IIIa disease ($M = 3.2 \pm 1.6$), $F(1, 72) = 10.4, p < .005$. Scheffe's post hoc test showed that those with stage IIIa disease identified significantly more death contents than those with stage I and II disease, who were not significantly different. Those who were to receive radiation and/or chemotherapy ($M = 1.33 \pm 1.18$) were not significantly different in death contents compared with those who were to receive surgery ($M = .96 \pm 1.23$). Individuals with co-morbid health conditions ($M = 1.12 \pm 1.27$) were not significantly different in death contents compared with individuals without co-existing health conditions ($M = .80 \pm 1.01$). Veterans had significantly higher death contents ($M = 1.44 \pm 1.38$) compared with non-Veterans ($M = .68 \pm .91$), $t(72) = -2.81, p < .05$.

Discussion

Responding to a new diagnosis and the need for treatment of lung cancer, a major life-threatening illness, is challenging and requires significant adjustments in multiple life domains. Although it is well recognized that heightened death awareness has implications for health-related behaviors and adaptation among healthy individuals, there has been little inquiry on the nature of death concerns among individuals facing life-threatening illness in the acute care setting. In this study of individuals facing recent diagnosis of lung cancer who were preparing for treatment, more than half cited death-related concerns, more than half cited future disease-related concerns, and about one-fifth cited spirituality/religious concerns. These findings indicate the prevalence of death awareness and concern among individuals preparing for treatment in the acute phase of illness.

The death content groups demonstrate the individualized nature of the cognitions associated with death. Psychological preparation, the most frequently cited type of death content, were largely aversive and reflective of active grappling with the reality of death and a conscious awareness that the treatment might not be effective. Further, psychological preparations indicate the abruptness of the threat and early integration of a personal death construct into cognitive structures.

Time left to live and loss contents reflected the finitude of life and include concerns about life expectancy, leaving family, and loss associated with not seeing grandchildren grow.

There is pain and reflection in these death contents. Death contents in this category reflect grief associated with recognition of personal death and actual and impending losses.

Concerns about the impact of personal death on loved ones and the wider community included no longer being present as chief provider, finding care for pets, and concerns about how one's personal death would affect family. These contents reflect cognitions about the negative consequences of personal death on important others.

Behavioral preparation death contents were active strategies taken to ensure that important life matters were in order in case of death. Cognizant of the possibility of not surviving surgery or disease sequelae, participants who expressed this concern indicated that a priority was to reduce financial and legal burden on survivors. Some reported making funeral and burial arrangements. Others indicated the importance of gaining a power of attorney that could act in their behalf if they were no longer able to make independent health care or legal decisions. Such activities demonstrate their concrete action plans for managing these concerns. Given that a few of the behavioral preparation contents were also coded as positive, there may be peace of mind associated with having end-of-life affairs in order. Further, although these behavioral strategies do not reduce vulnerability to death, they assist in managing the enormity of the subjective threat (Goldenberg & Arndt, 2008).

Death acceptance contents often were reflective, such as "you think of death, which I accept." Individuals who cited death acceptance appeared to have previously contemplated and cognitively integrated the reality of personal death prior to the current diagnosis of lung cancer. Acceptance also included trusting God and maintaining hope.

Past experiences with friends or family members who had died of cancer indicate that the new cancer diagnosis activated these memories. Memories could be influential in priming current perceptions about death, and even thoughts and images about personal death from lung cancer. Participants coded these contents negatively.

Comparatively fewer death contents related to post-death, e.g., ideas about afterlife. These death contents reflect cultural learning and beliefs about death and its meaning. Post-death contents were largely positive, and reflected perceptions that personal death is not an end in and of itself.

In addition to death concerns, the majority of the sample, including many who did not cite specific death concerns, had future disease fears indicating heightened awareness of the life-threatening nature of the diagnosis and the looming possibility of death. Future disease fears reflect the recognition of personal vulnerability, the seriousness of the illness, and uncertainties about whether the disease is terminal.

Over one-fifth of present participants cited spiritual and/or religious content, many of which suggested tangible support from a religious community. Belief in a positive afterlife, perception that life is determined by power(s) greater than the self, and surrender to an uncertain and unknowable future may be stabilizing forces for managing death-related concerns.

Age, gender, marital status, type of treatment, and presence of co-morbid conditions were not related to extent of death concerns. Notably, most individuals in this study were older, currently married, men who had experience with health care problems. Other groups may respond differently. Present individuals who were diagnosed with stage IIIa, relatively more advanced cancer, were more likely to report death content than those whose cancer was less advanced. These more advanced cancer individuals may have recognized that long-term survival odds were not optimistic. Alternatively, these individuals may have been

experiencing more physical symptoms, a factor that undermines personal defenses against death awareness (Goldenberg & Arndt, 2008). Lung cancer that is most amenable to curative treatment is diagnosed when individuals are asymptomatic, a factor associated with why the disease is generally detected at advanced stages (Fossella, Komaki, & Putnam, 2003). Still another possibility is that the participants with stage IIIa disease may have experienced a longer diagnostic and staging work-up prior to the initiation of treatment. A longer pre-treatment time interval would increase the likelihood of having occasion to reflect on important implications of a life-threatening diagnosis.

Veterans, who represented about one-half of the study's participants, were significantly more likely to cite death contents than non-Veterans. Many Veterans had previous combat training and also military experiences in war environments. One explanation for the increased death content in this group is that previous military experiences, including combat situations, forced the personal death construct into many of these participants' awareness long before the current diagnosis of lung cancer. Such exposures would increase conscious access to death-related thought in the face of a new life-threatening context.

Given the life-threatening enormity of a lung cancer diagnosis, the individuals who did not cite death contents are also an important group to consider. Issues such as denial, avoidance, comfort with disclosure, and personal efforts to remain strong may have offset willingness to cite death as a concern (Vos, Putter, van Houweelingen, & de Haes, 2008). Studies from the terror management perspective have found that self-esteem buffers against the activation of conscious death thoughts. Unconscious awareness of death, however, may boost defensive responses supportive of self-esteem such as over-optimism, increase affinity to belief-relevant cognitive structures, and incite behaviors that promote self-esteem (Goldenberg & Arndt, 2008). Thus, individuals who cited more positive contents in their cognitive maps may not have had conscious access to death-related thoughts.

Findings from this study indicate that the cognitive process of managing the reality of death begins during the acute phases of illness for many individuals. However, patients who are receiving treatment for early-stage lung cancer may not have death concerns addressed because health care providers are focused on curative management. Kubler-Ross (2002), in her seminal work on death and dying, identified cognitive integration stages that symbolized individual steps towards accepting a terminal prognosis. In focused interviews of individuals facing life-threatening illness and their families, both patients and kin voiced perceptions that health professionals focus on physical and medical interventions, and are uncomfortable discussing death (McSkinning et al., 1999). Little research has examined provider strategies that might lead to management and reconciliation of death concerns among individuals facing procedures such as surgery during acute treatment. Addressing death and identifying domains of death concern can help identify links to content areas that health care professionals can use to determine individualized needs for intervention. Death concerns were not specifically solicited in the reported study, yet death was on many individuals' conscious minds. Individuals may have difficulties concentrating on necessary treatment information if they are thinking about death-related concepts such as how much time they have left. In the acute care context, inquiring about death-related concerns may be uncomfortable for the provider who may be concerned that such discussions would increase psychological distress. However, scheduling a few extra minutes in the context of a trusting relationship would allow time for the provider to assess for these concerns as part of the psychosocial screening process. Assessment strategies, such as a less formalized version of the approach used in this study, are non-burdensome, not time-intensive, and permit the individual to identify perceptions that are most important. Individuals who are distressed about their families, have unresolved grief, and experience high levels of negative affect secondary to death-related concerns may benefit from targeted mental health assistance to

offset the risk for depression during this highly stressful time. Providers can provide tangible support by locating resources to assist with end of life affairs such as estate management and finances.

Certain limitations of the study must be acknowledged. The amount of time spent on the map exercise was not recorded, a factor that could influence extent of content in the individual submissions. Further, there were likely individualized preferences in terms of disclosure and comfort with the method. Another limitation is the small convenience sample with imbalanced gender ratio and a lack of ethnic and cultural diversity. Further, the cross-sectional design precludes the ability to determine how death content may change following treatment and over the survivorship continuum. More research with a larger and more diverse sample of newly diagnosed individuals with lung cancer that follows the illness trajectory over time is warranted. Such research would provide information on relationships between death-related concerns and subsequent illness adaptation.

Individuals with newly diagnosed lung cancer experience concerns that are not only related to the physical disease and the proposed medical and surgical management, but are also related to death and vulnerability. The study demonstrates that death concerns are varied, primarily negative, and are relevant to the person facing lung cancer in the earliest phases of illness. Given what is known about high psychological distress among individuals with cancer following diagnosis, the findings emphasize the importance of health care providers being comfortable in assessing, discussing, and listening to concerns about death. Individuals facing a serious diagnosis should feel assured that death thoughts and concerns are normal, sense that discussions about death are permissible, and believe that acute care team members are willing to engage themselves in this territory. Given the potential rewards for patients when identified sources of concern and vulnerability are faced and managed in terms of reduced psychological distress, improved quality of life, and self-directed adaptation; exploring and addressing death concerns in the early phases of illness is an investment well spent.

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Table 1

Descriptive Statistics of Death Contents Group (n = 39) and No Death Contents Group (n = 34)

Demographics	Death contents (n = 39) (Mean ± SD) (min – max)	No death contents (n = 34) (Mean ± SD) (min – max)
Age	65.59 ± 8.81 (50 – 82)	64.29 ± 9.89 (47 – 83)
Education Years	12.74 ± 2.48 (8 – 18)	12.74 ± 2.06 (8 – 20)
Gender	males = 29 (74%) females = 10 (26%)	males = 23 (68%) females = 11 (32%)
3CM Findings		
Number of Death Contents	1.97 ± 0.99 (1 – 6)	-
Number of Negative Coded Contents	6.05 ± 3.43** (0 – 13)	3.09 ± 3.21** (0 – 12)
Number of Positive Coded Contents	2.46 ± 2.83 (0 – 12)	1.94 ± 2.10 (0 – 7)
Number of Disease Fear Contents	2.41 ± 2.04* (0 – 7)	1.41 ± 1.65* (0 – 5)
Number of Spiritual and/or Religious Contents	.59 ± 1.14 (0 – 4)	.24 ± .61 (0 – 2)

*
p < .05;**
p < .005.

Table 2

Types of Death Contents

Death Concerns	Examples
Psychological preparation	<p>I am prepared for death but do not want it (–)</p> <p>Death is positive, death from lung cancer is negative (–)</p> <p>1½ years without treatment: on life/death threshold (–)</p> <p>Death: too early in life, I have more to offer, don't think it is my time to die (–)</p> <p>Death and combat are the same (–)</p> <p>Life or early death? (+/–)</p> <p>Am I too old for this to be of value, 82 years (–)</p>
Time left to live death/Loss	<p>I wonder how much time I might have on this earth (–)</p> <p>Will be dead within 5 years without treatment (–)</p> <p>I won't live to see my grandchildren born (–)</p> <p>How much longer do I have to live? (–)</p> <p>Leaving my family (–)</p>
Impact of death on loved ones	<p>If it is incurable, how do I prepare loved ones? (–)</p> <p>Will my family be able to keep our home if I die? (–)</p> <p>How will my children deal with it if I die? (–)</p> <p>Who will care for my dog if this is terminal? (–)</p> <p>What will happen to her (wife) after I am gone? (–)</p>
Behavioral preparation	<p>Funeral arrangements (–)</p> <p>Get affairs in order (–)</p> <p>Have made will, arrangements, burial, anything related to death (–)</p> <p>Make sure estate is together, will (+)</p>
Death acceptance	<p>Ready to go (+/–)</p> <p>I accept death (+)</p> <p>My time has come (+)</p> <p>Sense that God will take me when he is ready (+)</p>
Experiences with others who died from cancer	<p>My wife died of lung cancer last year (–)</p> <p>I have 3 siblings dead from cancer (–)</p> <p>Thoughts about pain, had cousin that died from cancer (–)</p>
Post-death contents	<p>After-life? (+)</p> <p>Had peace throughout. Know I would not die (+)</p>

Table 3**Future Disease Fears and Spiritual/Religious Contents**

	Examples
Future Disease Fear contents	<p>They said it was a little spot, how big is a little spot? (–)</p> <p>What types of treatment and how will I respond? (–)</p> <p>I'm afraid to learn that my tumor has spread (–)</p> <p>If I have to have chemo, I'll lose my hair and feel sick (–)</p> <p>The unknowns are the hardest to deal with (–)</p> <p>Can I be cured (–)</p> <p>Will it go through my body? (–)</p> <p>Why did they wait so long- will it affect my treatment? (–)</p> <p>Is long term helpful or not, I do not know (–)</p> <p>Has cancer gotten to lymph nodes? (–)</p> <p>Tumor is right next to my heart (–)</p> <p>Instead of a benign cyst, it was cancer in my lung (–)</p>
Spiritual and/or religious contents	<p>The power of prayer from so many people is awesome (+)</p> <p>I know that I have a guardian angel that allowed my disease to be diagnosed early (+)</p> <p>If you believe as I do, pray-he is there for you (+)</p> <p>Thankful for a strong faith and church community</p> <p>(Catholic) (+)</p> <p>Trust in God (+)</p> <p>I will be putting my life in the hands of the good Lord (+)</p> <p>Give your burdens to God and I did (+)</p> <p>Had peace throughout (+)</p> <p>Rosary and prayer, eases tensions and worry (+)</p>