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Adapting Meaning-Centered Psychotherapy for the palliative care setting: Results of a pilot study

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Abstract

Aims—To establish preliminary evidence for the feasibility, acceptability, and utility of an abbreviated version of Meaning-Centered Psychotherapy tailored to the needs of palliative care patients in the final weeks or months of life.

Background—Surprisingly, few mental health interventions have specifically targeted the psychological needs of palliative care patients, when physical comfort seems to take precedence over mental health and emotional needs. Yet the need for mental health services targeting these patients is clear, as one in three palliative care patients experience clinically significant depression and an equal proportion experience clinically significant anxiety.

Design—This pilot study used an open-label design to assess the feasibility, acceptability, and perceived utility of Meaning-Centered Psychotherapy–palliative care, a brief intervention that focuses on enhancing meaning at the end of life.

Setting/participants—A total of 12 patients admitted to a palliative care hospital for supportive care consented to participate in the study.

Results—Of the 11 patients that began treatment (one patient died before the first session), 8 completed the three-session intervention. Patients expressed positive feedback about the structure, focus, and length of the intervention, but varied in precisely which elements they found most helpful.

Conclusion—An abbreviated version of Meaning-Centered Psychotherapy tailored to the needs of palliative care patients (Meaning-Centered Psychotherapy–palliative care) appears to be feasible, acceptable, and has the potential to help patients better cope with the challenges inherent

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in confronting death and dying. Further research, with larger and more representative samples, is needed in order to clarify the strengths and weaknesses of this approach.

Keywords

Psychotherapy; mental health; spirituality; advanced cancer; coping

The psychosocial needs of cancer patients are critical components of cancer care across the illness trajectory.^{1,2} The need for mental health services for targeting patients at the end of life is particularly striking, as one in three palliative care patients experience clinically significant depression and an equal number experience significant anxiety symptoms.³ Furthermore, the emotional, psychological, and spiritual needs of palliative care patients greatly impact quality-of-life.⁴ The importance of spiritual well-being in particular has emerged in research from diverse countries and cultures (e.g. Europe and Asia).^{5–7} This growing literature has highlighted the lack of meaning and purpose in life as a key element of the existential distress that often accompanies a diagnosis of terminal illness or deterioration in physical functioning. Several psychotherapy approaches have been developed for patients with cancer, some of which have focused squarely on existential and spiritual concerns. These treatment approaches have covered a range of illness types and disease stages, but surprisingly few have specifically targeted patients in the final weeks or months of life.

One intervention developed specifically to address psychosocial and existential distress in terminally ill patients is Chochinov's Dignity therapy.⁸ This intervention consists of two sessions, one eliciting the patient's life history and hopes for their loved ones and a second in which a narrative based on that interview is provided to the patient, who can edit the document and add content. In their initial feasibility study, most participants responded favorably to this intervention and reported significantly less suffering and depression following the feedback session. However, a subsequent randomized, controlled trial (RCT) comparing dignity therapy to a brief client-centered therapy or treatment as usual demonstrated very modest results.⁹ Although patients receiving dignity therapy reported greater perceived benefit and satisfaction, there were no differences across treatment groups on self-report measures of quality-of-life, depression, anxiety, or spiritual well-being. Notwithstanding these modest results, dignity therapy has grown in popularity, with several publications describing its application to novel settings and populations.^{10–13} Ando et al.^{14,15} developed a very similar treatment approach, short-term life review (STLR). This intervention also consists of an initial interview focusing on important memories, relationships, and messages for younger generations that is used to create an album that is reviewed with the patient in a second session. An RCT demonstrated that terminally ill cancer patients who received STLR showed greater increases in spiritual well-being, sense of hope, and preparedness for death compared to patients who received two sessions of general support.¹⁵

Nissim et al.¹⁶ described positive results from another brief intervention for advanced cancer patients, Managing Cancer and Living Meaningfully (CALM). Comprising three to six sessions spread over a 3-month period, CALM focuses on four domains: symptom

management and communication with health care providers, changes in self and relations with close others, spiritual well-being and sense of meaning, and advance care planning. However, their pilot study was marked by substantial attrition, with only 17 of the original 26 participants completing three or more sessions and only 10 (38%) providing feedback after completion of the study. Lo et al.¹⁷ also found high rates of attrition in their trial of CALM in 50 Canadian palliative care patients, but patients who completed treatment reported significant fewer symptoms of depression and death anxiety, and significantly better overall quality of life.

Several interventions have also targeted psychological distress in palliative care patients, but without a focus on spiritual or existential issues. Anderson et al.¹⁸ conducted a small pilot study ($N = 11$) of cognitive behavioral therapy (CBT) for anxiety and depression in hospice patients. Although the intervention was generally well received, the authors noted that the CBT technique of challenging negative thoughts may be inappropriate for many terminally ill patients, as their negative thoughts tend to be realistic. In addition, many patients were unable to fulfill desired goals due to physical limitations. Galfin et al.¹⁹ described an RCT comparing a “guided self-help intervention” (involving visualizing pleasant memories for 10 min/day) to a wait-list control group. They found significant reductions in anxiety among patients who completed the intervention but no improvement in depression or overall quality of life. However, these interventions do not address the spiritual or existential issues that are critical to patients approaching the end of life.²⁰

A handful of interventions have also targeted spiritual and existential issues in patients with advanced cancer, though not targeting those in the final weeks of life.^{21,22} One approach that has generated strong findings is Breitbart and colleagues’^{23–26} Meaning-Centered Psychotherapy (MCP). Grounded in Viktor Frankl’s Logotherapy,^{27,28} MCP was designed to help patients with advanced cancer sustain or enhance a sense of meaning, peace, and purpose in their lives. Several RCTs of MCP in both individual and group formats have demonstrated significant improvement in spiritual well-being, quality-of-life, depression, hopelessness, and desire for death for patients living with advanced cancer.^{24–26} Given the apparent effectiveness of MCP for advanced cancer patients in an ambulatory care setting, we adapted this intervention for use in an inpatient palliative care setting, for patients rapidly approaching the end of life. This study was designed to assess whether a brief version of MCP could be successfully implemented in an inpatient palliative care facility and to generate preliminary data for additional adaptations or modifications. A secondary goal was to help clarify which aspects of MCP were most salient for terminally ill cancer inpatients.

Method

Participants

A total of 12 terminally ill cancer patients were recruited from an inpatient palliative care hospital. Patients admitted to this facility have a life expectancy of less than 6 months, but the average time to death is 4–6 weeks. Patients in this facility receive aggressive palliative care but do not receive “curative” treatments. All participants were English-speaking, diagnosed with terminal cancer, and were sufficiently cognitively intact to be able to provide informed consent. Prospective participants were referred by the treating physician if they

were cognitively intact enough to engage in treatment. Prospective participants met with a research assistant who described the procedures, risks, and benefits and elicited written informed consent. The study was approved by the institutional review boards (IRBs) of all participating institutions.

Procedures

Following informed consent, all participants were asked to complete the study measures, including a socio-demographic questionnaire, the distress thermometer (DT),²⁹ and the Hospital Anxiety and Depression Scale (HADS).³⁰ Medical history was elicited from the patient's medical record. Table 1 presents the demographic and clinical characteristics of study participants. All patients were assigned to one of the three study therapists, all of whom were doctoral students in clinical psychology that had been trained in MCP. Study therapists also received supervision from a licensed clinical psychologist with extensive experience delivering MCP in both individual and group formats. Because participants were extremely ill, sessions were delivered in the patient's private room, typically at the bedside, and the length of each session was tailored to the patient's functional capacity (approximately 45 min). Following the third (final) session, patients completed a brief questionnaire eliciting their perceptions of the intervention and its utility.

Meaning-Centered Psychotherapy, palliative care version

The Meaning-Centered Psychotherapy–palliative care (MCP-PC) treatment manual was developed by the same research team that developed the group and individual versions of MCP. The goal of MCP-PC was to extract the most salient elements from the treatment while maintaining the integrity of the approach, and in particular, the emphasis on developing or bolstering a sense of meaning and purpose in life. In order to accommodate the level of impairment typical of palliative care patients, we limited the number of individual treatment sessions to three and re-organized the content within each session such that the most essential material was covered early in the session (in case physical limitations required that a session be abbreviated).

The first MCP-PC session addressed the person's own understanding of meaning and experience of meaning in his or her life. Topics included a discussion of meaningful moments in the person's past, their identity before and after being diagnosed with cancer, and aspects of their history that have impacted their values and identity. At the end of the session, the patient was presented with an optional "connectedness" exercise in which they were encouraged to tell their story to a loved one or friend. Session two addressed sources of meaning, including experiential (e.g. love, beauty, and humor), creative (e.g. creating a meaningful life through roles and accomplishments), and attitudinal sources (e.g. facing life's limitations). In this session, patients were asked to reflect on which of these sources of meaning they still draw upon despite the limitations imposed by their illness. The session ended with another optional exercise in which the patient was invited to take notice of creative sources of meaning in his or her life and to reflect on how it makes them feel. The third and final MCP-PC session focused on finding meaning through courage and commitment, living one's legacy, and finding a sense of peace. The exercises focused on identifying times in the past in which the patient was courageous, and how they might draw

from these experiences now, while hospitalized and severely ill. The patient was also invited to discuss their legacy and what they hope to impart on the world. The session ended by summarizing and processing what the experience of treatment has been like for the patient. Of note, coding of session transcripts by a clinician who had not provided treatment demonstrated a very high level of adherence to the treatment manual (data available upon request).

Results

Of the 12 patients who consented to participate, 11 initiated treatment (one died before the first session, but after completing the baseline study measures). Eight patients completed the three-session intervention and the post-treatment questionnaire; three were unable to complete treatment due to physical and/or cognitive deterioration but no one requested to discontinue treatment. Responses to the post-treatment questionnaire are summarized in Table 2. Patient feedback was encouraging, with no patients reporting that the intervention was distressing (mean = 0.25, standard deviation (SD) = 0.5). Of the eight participants who completed treatment, six indicated that the intervention was *not at all* distressing, while two indicated that it was *slightly* distressing. Participants also appeared satisfied with the length of treatment, with most indicating that it was *not at all* too short (mean = 0.50, SD = 0.9). Two participants found treatment *somewhat* too short, while the remainder ($n = 6$) indicated *not at all*. Conversely, few patients perceived the intervention as too long (mean = 0.75, SD = 1.2); one person responded *somewhat* and another *quite a bit*.

Participants generally felt positive about the content of the intervention. In their response to the intervention, four of the eight “completers” indicated that treatment was “quite a bit” or “very much” helpful in finding a sense of meaning (mean = 2.50, SD = 0.9); only one patient responded “slightly” to this question and none responded “not at all.” However, there was more disparity in the precise elements of treatment that were perceived as helpful. For example, when asked about the helpfulness of discussions of *historical sources of meaning*, two participants circled “10” (extremely helpful), one circled “2” (with a “1” indicating that the topic was *not at all* helpful), and four participants gave more moderate responses (circling “5” or “6”). Responses to the question about *creative sources of meaning* were even more varied, with three participants indicating that the topic was very helpful (“10”) and two indicating that it was not at all helpful (“1”). The most uniformly well-received topic was *courage and commitment*, with a mean rating exceeding 7.0 and only one participant indicating a score below “5” on the 1–10 rating scale (“3”).

The MCP-PC protocol is exemplified by a case vignette (see Appendix 1). The vignette describes the treatment of an elderly man with terminal cancer, who had little support and a moderate degree of distress. Like several of the individuals treated in this pilot study, this patient found some aspects of the treatment particularly salient whereas others were less so. Nevertheless, the potential for meaningful change is clear from this case.

Discussion

This study's primary goals were to establish the feasibility and acceptability of a brief version of MCP specifically geared toward the needs of patients in the final weeks or months of life (MCP-PC). By pilot testing this intervention with terminally ill patients, our research team amassed critical data upon which to refine the intervention, develop a treatment manual, and begin planning for a more extensive and systematic evaluation of MCP-PC. The results of this pilot study provide support for these goals, as patients were generally satisfied with the content of the intervention, as well as its length and intensity. However, they also highlighted the importance of delivering this intervention in a more flexible way, to maximize effectiveness and minimize patient burden. It was especially noteworthy that, despite the challenges inherent in exploring potentially sensitive topics at the end of life, only two patients reported feeling "a little" distressed and those patients still expressed positive feelings about the intervention on the whole.

An unexpected finding from this pilot study was the variable responses to different treatment elements. Patients typically identified one or two elements of the treatment as highly relevant, whereas other elements seemed less salient. Yet precisely which elements of treatment were viewed as most relevant varied considerably across patients. These findings highlight the need for an individualized approach to MCP, particularly in a setting where time is limited. Allowing patients to guide the treatment focus within sessions (e.g. choosing whether to focus more on experiential, creative, or attitudinal sources of meaning) allows for some degree of individualization, while still maintaining an adequate degree of standardization across patients. However, determining the optimal method for tailoring treatment will require continued exploration, as patients may not be able to predict in advance which aspects of MCP will be most important.

Notwithstanding the challenges inherent in developing an abbreviated psychotherapy for patients at the end of life, these findings provide preliminary support that MCP-PC offers a feasible and potentially beneficial approach for helping patients manage the psychological distress associated with terminal illness. The potential utility of this approach is particularly appealing given the importance of issues related to meaning and spiritual well-being across diverse cultures.^{6,31,32} If subsequent research supports these preliminary data, the potential for widespread use with palliative care patients worldwide is substantial. There are, of course, many limitations in a pilot study such as this one, including the small and non-random sample and the lack of systematic outcome data on changes in psychological or general distress. Further research with larger and more representative samples, a randomized design, and systematic outcome data is needed to better understand the strengths and weaknesses of MCP, as well as its overall utility in reducing distress. Nevertheless, these findings are encouraging and provide a strong foundation for a more rigorous analysis of MCP-PC in a population that still lacks systematic and effective mental health interventions.

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Appendix 1

Case vignette

Mr J was an 83-year-old African-American man who had been recently diagnosed with advanced prostate cancer and admitted to the hospital for palliative care. He had never married, had no children, and described himself as “a loner.” Mr J had previously worked as an actor, but supported himself through freelance work. Mr J had no visitors in the hospital and reported only occasional telephone calls with a cousin. Prior to the intervention, Mr J rated his overall distress as 6 (on the distress thermometer (DT)) but endorsed few symptoms of depression or anxiety (Hospital Anxiety and Depression Scale (HADS) total score = 6).

During his first session, a prominent theme that emerged was the adversity he had faced throughout much of his life. He recalled having grown up during the Great Depression and described vivid memories of his experiences during race riots and instances of racism while he served in the Army. He expressed regret about not leaving behind a legacy. However, he recounted many connections he had made with other people throughout his life and conceptualized these connections as a primary source of meaning for him.

During the second session, when love was introduced as an experiential source of meaning, Mr J focused the strained relationships he had experienced, particularly with his father. He described having struggled with his homosexuality as a young man and noted that he had never discussed his sexual orientation with his father. In response to this discussion, Mr J resonated to the meaning-centered psychotherapy (MCP) concept of courage and commitment and in particular the courage needed to create a meaningful life despite adversity. The therapist focused on his sharing of painful memories and framed this disclosure as a source of meaning (i.e. connecting to another person), which Mr J found comforting.

The final session focused on how Mr J could draw on his past experiences of meaning to face each day in the hospital and continue to connect with others. Mr J was intrigued by this idea and seemed open to exploring it further. As the therapy ended, Mr J described feeling a sense of peace and comfort, despite his illness.

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What is already known about the topic?

- The prevalence of clinically significant anxiety, depression, and existential despair among terminally ill patients is extremely high.
- To date, few empirically supported mental health interventions exist that address psychological and existential distress exist and for patients in the last weeks or months of life.
- Meaning-Centered Psychotherapy (MCP), developed by Breitbart and colleagues, has demonstrated powerful treatment effects in reducing psychological distress in patients with advanced cancer.

What this paper adds?

- This pilot study describes an adaptation of MCP for the treatment of distress in palliative care patients.
- This paper presents the first pilot data regarding the feasibility, acceptability, and potential utility of MCP in a palliative care setting.
- These results lay the foundation for future, systematic research examining the strengths and limitations of MCP in targeting end-of-life distress.

Implications for practice, theory, or policy

- The potential utility of brief psychotherapies for patients approaching the end of life is critically important for palliative care providers.
- Despite the potentially sensitive nature of exploring end-of-life topics with terminally ill patients, no patients reported adverse reactions to this intervention.
- MCP appears to hold promise as an effective intervention in the last weeks of life.

Table 1

Participant characteristics.

Gender	
Male	7 (58%)
Female	5 (42%)
Race/ethnicity	
White/non-Hispanic	6 (50%)
African-American	4 (33%)
Hispanic	2 (17%)
Primary cancer site	
Gastrointestinal	3 (25%)
Prostate	2 (17%)
Lung	2 (17%)
Uterine	2 (17%)
Other	3 (17%)
Missing	1 (8%)
Age (mean (SD); range)	66.9 (10.7); 46–83
Years of education	14.3 (2.3); 10–18

SD: standard deviation.

Table 2

Post-treatment participant feedback ($N = 8$).

Question	Mean (SD)	Individual participant scores							
		1	2	3	4	5	6	7	8
How much did this program help you <i>find a sense of meaning</i> in your life despite having cancer? ^a	2.50 (0.9)	2	3	3	1	4	3	2	2
Do you feel the topics were important or relevant to you? ^a	2.62 (0.9)	3	3	3	2	4	1	3	2
Did you feel it was too long? ^a	0.75 (1.2)	0	0	0	2	3	1	0	0
Did you feel it was too short? ^a	0.50 (0.9)	0	0	0	2	2	0	0	0
Was it difficult to participate because you felt too tired or ill? ^a	0.87 (1.5)	2	0	0	0	4	1	0	0
Overall, was completing this intervention a <i>positive</i> experience? ^a	3.13 (0.8)	3	3	4	3	4	4	2	2
Was participating in this intervention <i>distressing</i> in any way? ^a	0.25 (0.5)	1	0	0	0	0	0	0	1
How helpful do you think the topic of <i>meaning</i> was for you? ^b	5.86 (1.6)	5	6	7	3	10	6	8	6
How helpful do you think the topic of <i>historical sources of meaning</i> was for you? ^b	6.38 (2.8)	5	6	10	2	10	5	8	5
How helpful do you think the topic of <i>experiential sources of meaning</i> was for you? ^b	6.29 (3.6)	1	7	X ^c	2	10	10	8	6
How helpful do you think the topic of <i>creative sources of meaning</i> was for you? ^b	6.50 (3.8)	1	6	10	1	10	10	8	6
How helpful do you think the topic of <i>attitudinal sources of meaning</i> was for you? ^b	6.88 (2.9)	10	7	5	1	10	7	8	7
How helpful do you think the topic of <i>courage and commitment</i> was for you? ^b	7.14 (2.4)	8	7	10	3	X ^c	9	8	5
How helpful do you think the topic of <i>life and legacy</i> was for you? ^b *	6.29 (3.0)	1	8	10	4	9 ^c	7	8	6

SD: standard deviation.

^aPossible range: 0–4.

^bPossible range: 0–10.

^cSubject did not respond to this item.