Suffering in Advanced Cancer: A Randomized Control Trial of a Narrative Intervention

Meg Wise, MLS, PhD¹, Lucille R. Marchand, BSN, MD², Linda J. Roberts, PhD³, and Ming-Yuan Chih, PhD⁴

I can be sick, but my soul isn't. There are certain things my cancer won't do. It won't touch my memories. There's no way it can touch that. I can live off of them. It's just great. It can't touch my friends. ...I still have my friends that are my spirit, hope, and courage. Cancer can't touch any of that. (Story excerpt, male, age 60)

Abstract

Background: Advanced cancer can erode patients' wellbeing. Narrative interventions have improved patients' wellbeing, but might not be feasible for widespread implementation.

Objectives: (1) Test the effects of *miLivingStory*, a telephone-based life review and illness narrative intervention with online resources and social networking, on community-dwelling advanced cancer patients' wellbeing. (2) Explore intervention use and satisfaction.

Patients and Setting: Stage III or IV cancer patients having completed initial therapy were randomized to *miLivingStory* or to an active control group, *miOwnResources*.

Data and Analysis: Primary outcomes measured at baseline, two and four months included subscales for the FACIT-Sp peace and meaning and the POMS-SF depressed, anxious, and angry mood, scored on 0–4-point Likert scales. Linear mixed modeling, controlling for baseline primary outcome scores, tested for group comparisons of repeated outcome measures. Pairwise comparisons tested for within- and between-group differences. Intervention use and satisfaction data were collected automatically and by survey.

Results: Eighty-six primarily white, female patients with high baseline wellbeing completed the study. There were no between-group differences at baseline or at two months. At four months, *miLivingStory* had a direct and positive effect for peace (2.86 vs. 2.57, $p=0.029$), a trend effect for lower depressed mood (0.55 vs. 0.77, $p=0.097$), and appeared to protect against the control group's declining wellbeing between two and four months. *miLivingStory* use was low and assessed as helpful to quite helpful.

Conclusions: Telephone-based narrative interventions hold promise in improving advanced cancer patients' wellbeing. Further testing of delivery and implementation strategies is warranted.

Keywords: cancer narratives; existential wellbeing; life review; narrative interventions

Introduction

ADVANCED CANCER is a stark reminder of our mortality and often erodes a sense of peace and meaning in life.^{1,2} Existential suffering often contributes more than physical pain to wishing for a hastened death.^{3,4} Cancer also provides opportunities to reflect on accomplishments, set goals, find meaning, and experience peace.^{5,6} In the face of advanced cancer, being at peace with oneself, others, or God is associated with resilience and personal growth⁷; its converse can manifest as depressed, anxious, and/or angry mood.⁸

Support groups and psychoeducation that provide opportunities to reflect on, voice meanings and share illness experiences have improved wellbeing among seriously ill patients.^{9,10} Expressive writing,^{11,12} and illness narratives, in traditional or new media,^{13,14} also benefit cancer patients, but the writing task takes energy, time, and skills often absent as patients juggle family and work in the face of cancer and its treatments.

Chochinov addressed this limitation for hospice in-patients with dignity therapy (DT), a life review intervention to create a legacy document for end-of-life patients. The clinician

¹Sonderregger Research Center, University of Wisconsin-Madison, Madison, Wisconsin.

²Department of Family Medicine, University of Washington-Seattle, Seattle, Washington.

³Department of Human Development and Family Studies, University of Wisconsin-Madison, Madison, Wisconsin.

⁴Department of Clinical Sciences, University of Kentucky, Lexington, Kentucky.

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elicits the patient's story through a bedside interview, participates in writing the story, and returns at least once to read and revise it per patient instructions.¹⁵ Patients receive their finalized legacy manuscript to share with loved ones.¹⁶

Multiple patient/clinician bedside interactions resulting in the delivery of a well-honed legacy manuscript are costly in today's healthcare system. To our knowledge, DT has not been implemented in nonresearch-supported clinical or community settings. The National Institute of Health calls for strategies to adapt, scale-up, and disseminate evidence-based interventions.¹⁷ Telephone,¹⁸ eHealth,^{19,20} and social networking¹⁴ are promising strategies. Our feasibility study tested *miStory*, an intervention informed both by DT and illness (or cancer) narratives for community-dwelling cancer patients.²¹ The story was elicited by telephone interview, written and delivered in paper and electronic formats along with *miStory*, a cancer resources website and story-revision tips. All patients reported benefiting from telling their story. Patients who valued *miStory* requested social networking tools, a new technology at the time.

Thus, *miLivingStory* added social networking to *miStory* for this study in which we:

- (1) Hypothesized that for advanced (Stage III or IV) cancer patients, *miLivingStory*, compared with a control group receiving online cancer resources, would:
 - (a) Increase a sense of peace and meaning, and
 - (b) Reduce depressed, angry, and anxious moods
- (2) Explored how participants used and experienced *miLivingStory*.

Methods

Interventions

miLivingStory, the treatment condition, has three components. First was a *storytelling* telephone interview with the first author (M.W.), preceded by a 20–30 minute “get-acquainted” phone call. To help participants compose their thoughts, the interviewer sent a welcoming letter and interview questions, shown in Table 1, to guide their storytelling. The interview was recorded, on average lasting one hour (range 45–124 minutes). A story manuscript was composed of the patient's words with interjections (ex: “um” and “you know”), false starts, repetitions and tangents removed, and phrases moved and transitions added to maintain narrative

TABLE 1. QUESTIONS SENT AHEAD TO HELP PARTICIPANTS PREPARE FOR THEIR STORYTELLING INTERVIEW

This is your story and you can include or exclude anything you want. Below are some questions that might guide your storytelling.

1. Say a little about your life history.
2. What were the best times in your life and why?
3. What were some difficult times and how did you get through them?
4. What are most important things you have accomplished?
5. If you feel like including it, how has cancer affected you, your family, and your life?
6. In twenty or thirty years from now, what would you want your family, friends, or loved ones to remember about you?
7. Is there anything else you'd like to add to your story?

flow and clarity. The story and a personalized cover letter describing how the story was edited were delivered by email; a paper copy, and an electronic copy on a USB drive were mailed.

Second was a password-protected *miLivingStory* website with links to online information, planning tools and support groups housed on the National Cancer Institute and the American Cancer Society websites, as well as tips on revising and sharing the story. Third, an individual password-protected social network *miLivingStory* social network provided tools to invite guests and upload the story and media. User's manuals were emailed and sent by mail.

miOwnResources, the “control” website, contained the *miLivingStory* cancer information, and support, but no story tips. A user's manual was emailed and sent by mail.

Patients, setting, and procedures

Patient eligibility included age 30 or older, diagnosis of any Stage III or Stage IV cancer, completion of initial chemotherapy, ability to provide informed consent in English, willingness to use an Internet-enabled computer (which was provided with training as needed), and not participating in other psychosocial studies. In accordance with the Health Sciences IRB, eligible patients were invited by clinicians, or by research nurses in the waiting room or while receiving chemotherapy in clinics not recruiting for other psychosocial studies. Clinicians and research nurses, using a script, described the study as a comparison between the two interventions described above and they could experience the other group's intervention at the end of the study. Patients received a brochure and the informed consent form, and if interested, signed a form giving to the first author permission to contact them for an informational and consenting interview.

After signing the consent form, participants completed a baseline survey online and were then randomized 1:1 through a random number generator in blocks of 10, reserving 5 blocks for men and 1 for minorities to assure maximum diversity. The first author called to inform participants of their random assignment. Participants were not blinded to their intervention, but were blinded as to which intervention was the control and which was the treatment condition.

Those randomized to *miLivingStory* were asked ice-breaker questions and their storytelling preferences, scheduled for the telephone interview, and registered for their website and social network. *miOwnResources* participants were registered for their website. All participants received a packet by email and by mail immediately afterward containing a letter summarizing the phone call, user's manual(s), and a link to their respective web tools. A phone call followed one week later to see how things were working and to answer any questions.

Measurements

Measurements were administered through a secure online survey at baseline, two and four months. Survey links were emailed one week before their due date. Non-responders received two reminder emails, one phone call, and one postcard to encourage completion. Participants received a thank you note with \$10 after completing each survey.

Peace and meaning were measured by those subscales of the Functional Assessment of Chronic Illness Treatments-

Spirituality (FACIT-Sp), which has performed well in intervention studies of advanced cancer patients.^{22,23} Each subscale has four statements and scored with a 5-point Likert agreement scale (0=not at all, 4=very much).^{24,25} The Profile of Mood States-Short Form (POMS-SF) subscales for depressed, angry, and anxious moods use one-word adjectives and scored on a 5-point Likert agreement scale (0=not at all, 4=extremely).²⁶ Subscales for both instruments were calculated as the mean of item scores.

miLivingStory and *miOwnResources* website usage was automatically collected. Surveys assessed story sharing and editing, use of social networking, helpfulness (0=not at all helpful, 4=very helpful) of each intervention component, and optional open-ended comments.

Data analyses

One-way ANOVA tested for between-group differences at baseline. The online survey required answers for all primary outcome items, thus resulting in no missing data. Descriptive statistics established baseline sample characteristics, as well as the use of and satisfaction with, the interventions. Linear mixed modeling, controlling for baseline scores of the primary outcomes, tested for group differences in repeated outcome measures at two and four months. Pairwise comparisons for within- and between-group differences were calculated.

Results

Figure 1 shows the recruitment and enrollment data. About 65% of potentially eligible patients were contacted in cancer clinics. Patients seen in prostate and other clinics that were recruiting for other psychosocial studies were not contacted. About one-third consented and enrolled. Reasons for nonparticipation included being too sick and not wanting to use a computer or to tell their story. From the block of 10 for minorities, 4 of 6 were randomly assigned to *miLivingStory*.

The 22% attrition rate and reasons for nonparticipation and dropout resemble other psychosocial intervention studies with advanced cancer patients.²⁷ There were no significant baseline differences between completers and dropouts.

All analyses were undertaken with the 86 participants who completed the two- and four-month survey. As per our power analysis, 80 participants were needed at four months to detect significant changes on the outcome measures with an effect size of 0.47 standard deviation and a Type I error rate of 0.05, assuming the baseline and post-test measures correlated at a magnitude of $r=0.55$.^{28,29}

Sample characteristics

As shown in Table 2, the sample was predominantly white and female, with high income and education (20% had a doctorate or a terminal degree). About 20% worked or had dependent children. Most underwent chemotherapy; slightly less than half had metastatic cancer. Nearly 80% used at least one of the many forms of complementary medicine offered at the cancer center (e.g., support groups, journaling). Cancer types not shown included 28 (33%) gynecologic, 14 (16%) breast, 12 (14%) colon/rectal, 10 (12%) liver, and 22 (26%) reported other cancers (pancreatic, throat, and hematologic). Both groups reported high peace and meaning and low depressed, angry, and anxious moods at baseline. Scores resemble those of other samples of cancer patients.^{30,31} There were no significant between-group differences in demographics or baseline primary outcome scores.

Effects on primary outcomes

Table 3 shows pairwise comparison results that include the estimated marginal mean outcome scores for the *miLivingStory* and *miOwnResources* groups controlling for baseline scores, and the mean between-group difference

FIG. 1. Enrollment and Retention by Random Group.

TABLE 2. SAMPLE CHARACTERISTICS

	<i>miLivingStory</i> n = 49	<i>miOwnResources</i> n = 37	p-value
Demographics			
Age (range 35 to 80), mean (SD)	57 (8.5)	57 (9.1)	0.917
Female, n (%) ^a	40 (82%)	28 (76%)	0.345
White, n (%)	45 (92%)	36 (97%)	—
Spouse/Partner, n (%)	36 (74%)	28 (76%)	0.744
Dependent child (ren), n (%)	7 (14%)	9 (24%)	—
Education ≥ BA/BS, n (%)	26 (53%)	17 (46%)	0.348
Work full or part time, n (%)	8 (27%)	10 (20%)	0.535
Income ≥ \$60,000, n (%)	26 (53%)	19 (51%)	0.509
Facebook, CaringBridge, MySpace, blog, n (%)	26 (53%)	18 (49%)	—
Primary outcome measures at baseline, mean (SD)			
Peace ^b	2.65 (0.81)	2.68 (0.65)	0.889
Meaning ^b	3.49 (0.57)	3.34 (0.66)	0.278
Depressed mood ^c	0.60 (0.69)	0.59 (0.44)	0.918
Angry mood ^c	0.48 (0.58)	0.51 (0.52)	0.808
Anxious mood ^c	0.74 (0.67)	1.02 (0.90)	0.107
Cancer, n (%)			
Metastatic ^d	23 (47%)	13 (35%)	0.122
Use of CAM ^d	40 (86%)	27 (73%)	0.486
Chemotherapy, recent, Baseline ^d	28 (76%)	41 (84%)	—
Chemotherapy, recent 0–2 months ^e	18 (49%)	27 (55%)	—
Chemotherapy, recent 2–4 months ^f	20 (54%)	26 (53%)	—

^aRecruited from breast and GYN clinics, but not from prostate clinic, which was recruiting for another psychosocial study.

^bAgree 0 = not at all, 1 = a little bit, 2 = somewhat, 3 = quite a bit, 4 = very much. Higher scores = Higher wellbeing.

^cAgree 0 = not at all, 1 = a little, 2 = moderately, 3 = quite a bit, 4 = extremely. Higher scores = Higher distress.

^dPast two months, baseline survey.

^ePast two months, two-month survey.

^fPast two months, four-month survey.

scores and *p*-value at two months and four months as compared with baseline. At two months, there were no significant between-group differences for any of the outcomes. At four months, *miLivingStory* had a positive effect for peace and a trending effect for lower depressed mood.

To explore the surprising effects at four months but not at two months, *post hoc* analyses examined the within-group four-month minus two-month differences, shown in Figure 2, for each outcome by randomized group. Overall, wellbeing increased in the *miLivingStory* group and declined in the

TABLE 3. PRIMARY OUTCOMES

	Primary outcome scores		Between-group differences ^a	
	<i>miLivingStory</i> n = 49 Mean (SE)	<i>miOwnResources</i> n = 37 Mean (SE)	Mean Diff (SE) ^c	p-value
Peace ^b				
2 Months	2.64 (0.89)	2.78 (0.66)	−0.14 (0.14)	0.343
4 Months	2.86 (0.84)	2.57 (0.93)	0.31 (0.14)	0.029^d
Meaning ^b				
2 Months	3.39 (0.72)	3.44 (0.62)	−0.15 (0.13)	0.266
4 Months	3.40 (0.71)	3.22 (0.83)	0.18 (0.13)	0.548
Depressed mood ^c				
2 Months	0.63 (0.73)	0.45 (0.48)	0.16 (0.13)	0.226
4 Months	0.55 (0.70)	0.77 (0.75)	−0.22 (0.13)	0.097^e
Angry mood ^c				
2 Months	0.49 (0.59)	0.47 (0.65)	0.02 (0.12)	0.888
4 Months	0.46 (0.50)	0.64 (0.79)	−0.18 (0.12)	0.119
Anxious mood ^c				
2 Months	0.79 (0.09)	0.77 (0.10)	0.02 (0.14)	0.869
4 Months	0.78 (0.73)	0.85 (0.10)	−0.07 (0.13)	0.592

Estimated marginal mean outcome scores, controlling for baseline scores.

^a*miLivingStory* minus *miOwnResources* at 2 and at 4 months, compared with baseline scores.

^b0 = not at all, 1 = a little bit, 2 = somewhat, 3 = quite a bit, 4 = very much. Higher scores = Higher wellbeing.

^c0 = not at all, 1 = a little, 2 = moderately, 3 = quite a bit, 4 = extremely. Higher scores = Higher distress.

^dSignificant at *p* < 0.05.

^eTrending at *p* < 0.10.

FIG. 2. Within-group change between 2 and 4 months.

miOwnResources group, but differences did not reach significance on most measures. For peace, *miLivingStory* scores increased significantly, but declined in the *miOwnResources* group at a near-significant level, suggesting both a protective as well as a direct and positive effect. *miLivingStory* appears to have protected against the *miOwnResources* group's significant declines in meaning and increases in depressed mood.

Intervention use and satisfaction

Table 4 shows that *miOwnResources* was used more and rated as more helpful than *miLivingStory*. Fewer than 25% of *miLivingStory* participants used their social network, but most who did invited guests. Table 5 shows that story editing increased satisfaction, while sharing did so significantly.

Discussion

We tested the effects of using a telephone interview, web-based resources, and social networking to deliver *miLivingStory* to community-dwelling advanced cancer patients. Our hypotheses were partially confirmed. *miLivingStory* at four months appears to have had a significant and direct positive effect for peace and a trending effect for depressed mood. *miLivingStory* also appeared to protect against the declines in meaning and increases in depressed mood seen in the *miOwnResources* group between the two-month and four-month surveys, but these did not reach significance.

Scores for meaning were high at baseline and remained so over time, while the converse was so for depressed, angry, and anxious mood, suggesting that a ceiling/floor effect could have

TABLE 4. PARTICIPATION IN AND SATISFACTION WITH WEB-BASED INTERVENTION COMPONENTS

Websites, cancer resources	<i>miLivingStory</i> n = 49	<i>miOwnResources</i> n = 37
Used, n (%) ^a	22 (45%)	20 (54%)
Visits, mean (range) ^a	3.27 (1–10)	4.56 (1–23)
Helpful, mean (SD) ^b	2.33 (1.41)	2.60 (1.31)
<i>miLivingStory</i> Social Network		
Used, n participants (%/49)	11 (22%)	
Hours/week used, mean (range)	1.06 (0–2)	
Invited guests, n participants (%/11)	9 (73%)	
Number of guests invited, mean (range)	9.5 (1–20)	
Number of guests who joined, mean (range)	9.0 (2–17)	
Helpful, mean (SD) ^b	2.14 (1.77)	

^aData automatically collected from websites, all other data from surveys.

^b0 = Not at all helpful, 1 = Somewhat helpful, 2 = Helpful, 3 = Quite helpful, 4 = Very helpful.

Comments:

miLivingStory is a very nice concept.

miLivingStory seems to be re-inventing the wheel. And I am not fond of the platform. It is another thing to learn. ... My mom has enough trouble with CaringBridge.

For those of us who are also working full-time jobs and caring for children and their family, it's been difficult to take time to explore this site.

TABLE 5. LIFE STORY USE AND SATISFACTION BY LEVEL OF ENGAGEMENT

<i>miLivingStory</i> , n = 49	<i>Edited story</i>			<i>Shared story</i>		
	<i>Yes</i> n = 24	<i>No</i> n = 23	<i>p-value</i>	<i>Yes</i> n = 15	<i>No</i> n = 30	<i>p-value</i>
Life Story phone interview ^a	3.00 (1.00)	2.37 (1.21)	0.090	3.00 (0.78)	2.17 (1.15)	0.018
Life Story manuscript ^a	2.46 (0.98)	1.82 (1.37)	0.070	2.80 (0.56)	1.84 (1.32)	0.010

^a0 = Not at all helpful, 1 = Somewhat helpful, 2 = Helpful, 3 = Quite helpful, 4 = Very helpful.

Negative Comments:

The phone interview was difficult. It went too long.

As I read through the edited version, I felt like I was very superficial and wanted to add so much more.

The text is not at all how I would have presented it. Perhaps I am overly sensitive, since I have a blog and write quite a bit.

Positive Comments:

I actually enjoyed the telling of my life story. I appreciated having the questions ahead of time so that I could give thought to my responses.

It helped to read My Living Story and get a perspective on my life.

My family is happy to know that my life story exists to be shared.

Very nice to tell my story and to get it in written and audio form.

Interviewer was very good. Allowed me to stay focused on my own thoughts and feelings and explore them.

I shared it with some friends. Allowed for deep and nurturing time.

I enjoyed the interview and saved the transcript. It was a positive introspective experience.

I am glad I could have done the story. I could never have done it on my own.

When you are dead and gone, it would be a great have a document like that!

To actually talk about your life and to see how it all relates having an ongoing cancer—to be put it into words, there really isn't another time to say what's on your heart.

reduced the impact of *miLivingStory*.³² By contrast, peace evidenced lower baseline scores and variability over time in both groups. These results might confirm that peace and meaning are distinct FACIT-Sp constructs, with peace representing an affective domain and more subject to change, whereas meaning representing a more stable cognitive domain.^{24,25} The absence of effects at two months might suggest that the benefits of *miLivingStory* for community-dwelling patients with advancing cancer might take time to appear, in light of the declining two-to-four-month wellbeing seen in the *miOwnResources* group.

Unlike dignity therapy, *miLivingStory* also captured the cancer (or illness) narrative to explore meanings and shifts in perspectives related to cancer. Illness narratives might contribute to an increased sense of peace in several ways.^{33,34} First, the act of storytelling can objectify cancer, thereby encouraging self-appraisal and realizing that one still has autonomy in some domains even with losses in others.^{35,36} Second, the linear structure of a story might impose order over the chaos cancer can create.³⁷ Third, a life story highlighting relationships, mastery, and values can help restore the personhood stripped by cancer.¹⁶ Fourth, stories of suffering can resonate with a deeply shared human condition and render a sense of aesthetics to one's experience.³⁸ Fifth, stories naturally express contradiction or paradox—acceptance and denial, hope and despair.³⁹ Such integration of basic dualities related to the human condition might open the person to a sense of peace, transcendence, and wisdom.^{5,40}

Use and satisfaction with the interventions

Engagement was low and satisfaction was modest for *miLivingStory* components. The telephone interview likely dampened the storytelling and effects on outcomes, compared with DT's bedside interview. Unlike DT's multiple clinician/patient interactions to elicit, read back, and co-construct the story, we provided a first draft with online tools to finalize and share the story. Some participants reported the interview and story were helpful; editing and sharing the story appeared to increase satisfaction. However, in hind-

sight, simply jumpstarting the production of a final story manuscript with tools for editing might have imposed unrealistic burden on advanced cancer patients, many of whom were working and raising children.

Social network use was low. Nearly half the sample already used another social network and was unwilling to start a new one. Consistent with socioemotional selectivity theory, several patients living with a shorter time perspective were not actively using their social network, as they were trimming their social contacts to spend more time nurturing their essential relationships.⁴¹ As technology-savvy cohorts age and face life-threatening illness, opportunities to enhance shared storytelling through social media will warrant further exploration.

Comparison with related research

Chochinov's multisite trial of DT found no significant effect on the 8-item combined peace/meaning subscale of the FACIT-Sp.³¹ The authors, as did we, reported high baseline wellbeing and challenges with measuring complex effects with simple survey instruments. However, on a study-specific scale, DT was rated significantly more meaningful than the comparator interventions. While patient satisfaction with DT was rated differently, scores were roughly comparable to our satisfaction scores. Vuksanovic found that DT had significant effects on generativity and ego-integrity compared with standard life review with no manuscript.⁴² Hall found that DT increased hope⁴³ and improved life completion and preparation. Ando in Japan found that Short-Term Life Review with collage, improved hope and the FACIT-Sp (combined peace/meaning) among patients with lower baseline scores.²³ Future research might consider measuring these additional constructs.

Limitations

Low participation and moderate attrition yielded a non-representative sample of cancer patients, thus results cannot be generalized. Like similar studies, even without recruiting in the prostate cancer clinic, men's refusal rates were

higher.^{44,45} Our study might have been underpowered. Self-report surveys might have positively biased responses; significant findings could be due to chance. The wide variation, from Stage III breast cancer to Stage IV pancreatic cancer, versus a homogeneous sample, might have reduced our ability to detect more robust effects. Storytelling might not be welcome or helpful for some patients, in light of the reasons given for refusal and attrition, disappointment among some upon learning they were randomized to *miLivingStory*, and the flat and reportorial nature of some stories.

The academic cancer center, where this study was conducted drew from a predominately white, high-income, and educated population. The requirement to use an Internet-enabled computer in a middle to older age cohort, even with the offer to provide one, might have further skewed our sample toward more educated individuals with multiple resources to address both practical and existential issues. High participation in support groups, journaling, and existential meaning-making activities might have contributed to the high baseline wellbeing.

Our active *miOwnResources* control condition might have helped patients with the same issues that *miLivingStory* was designed to address. eHealth interventions, such as the *miOwnResources* website with links to accurate online cancer information and peer support groups, have improved cancer patients' wellbeing.^{19,20} A "usual care" control group, as a third arm, might have shown greater effects for *miLivingStory* or the impact, if any, of *miOwnResources*.

Implications

Our findings, together with evidence from similar studies, suggest that life review and illness narratives show promise to reduce suffering for advanced cancer, palliative care, and end-of-life patients—and protect against the negative effects of advancing disease.

Narrative interventions might well be more robust through in-person interviews and by fully writing and editing patient stories. Paying skilled interviewer/writers, however, poses significant barriers to implementing narrative interventions in healthcare systems. The use of trained volunteers or students is worth exploring. A reminiscence intervention using trained senior volunteers reduced emotional distress and improved spiritual functioning of community-dwelling palliative care patients, compared with supportive telephone calls by research staff.⁴⁶

Sharing patient stories with clinicians could rehumanize modern medicine, and reduce physician burnout.^{47,48} The U.S. Veterans Health Administration's *My Life, My Story* quality improvement program trains volunteers to collect, write, and finalize patients' stories, and with patient approval, uploads the story to the electronic medical record which notifies the clinical team.⁴⁹ Clinicians report that reading patients' stories is worthwhile and can help them provide better care.

Conclusions

Life review/illness narrative interventions show promise to enhance advanced cancer patients' wellbeing. Future research might test *miLivingStory* among patients with lower baseline wellbeing and less use of CAM, explore in-person vs phone interview, multimedia, and video conferencing with an increasingly technology-savvy cancer patient population. Another line of research might test whether sharing patient stories with clinicians increases compassion, enriches the cli-

nician–patient relationship, and informs patient-centered palliative care. In sum, more work is needed to understand how to adjust narrative interventions to reach and improve the care and wellbeing of underserved patients with advanced cancer.

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Address correspondence to:
 Meg Wise, MLS, PhD
 Sonderegger Research Center
 School of Pharmacy
 University of Wisconsin-Madison
 2527 Rennebohm Hall
 777 Highland Avenue
 Madison, WI 53706

E-mail: mewise@wisc.edu