

The Quest for Meaning in Life in Six Patients Living with Advanced Cancer: A Qualitative Longitudinal Study

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Abstract

In this study, six individuals who were diagnosed with advanced cancer and who received home hospice care described how they found and made meaning in times of struggle with their illness—what troubled them, what made life worth living for them, how they grew spiritually in their journey, and how they strove to live authentically as they faced impending death. Their descriptions are part of a broader phenomenological inquiry on the experience of living with advanced cancer and on the changing needs and experiences over time as their health condition deteriorated. Serial, semistructured individual interviews were conducted at three different time points: onset of illness, deterioration of illness, and days before death. Despite the small sample size, the data analysed suggests that meaning making is a dynamic process, which can evolve with changes in needs and life experiences as a person's health condition deteriorates. Themes that emerged in relation to meaning in life reflect struggle—with self, with significant others, and with God or Higher Power, and between the desire to live and the readiness to die. One conclusion suggested from the data is that the (new) meanings in life made and found by dying patients have a tremendous impact on how they eventually face death. This gives a framework for clinicians to intervene and do grief work that helps patients process and integrate the meaning of illness so that they can 'live well' and that at the same time validates the need to 'die well'.

Keywords: palliative care, end of life, disease trajectory, meaning, phenomenology

Introduction

Issues of meaning in life are important to patients with a serious illness like cancer given the threat such an illness poses, the vigorous treatment measures associated with it, and the potential for confronting their own mortality that it provides. Cancer can challenge the experience of meaning in life; that is, the diagnosis and consequences of cancer can adversely affect self-perceptions, life attitudes, and individual belief systems. The threat to one's life can challenge someone's beliefs about their life and sense of well-being; patients' subjective meaning of life and even death might change during the course of an illness.

In recent years, more cross-sectional studies have been conducted on meaning in life (Erci, 2015; Tomás- Sábado et al., 2015). A classic reference on the importance of the search for meaning is Frankl (2014). Meaning has been argued to be central in human life (Frankl, 2014), and this centrality becomes prominent when individuals are challenged by traumatic life events such as life-limiting illnesses. Meaning, which is existential in nature, has to do with purpose of life (Sinclair, Pereira, & Raffin, 2006). When one is facing a life-limiting illness, one is experiencing a threat to one's own existence, and that can cause suffering, which reflects the existential dimension of life (Karlsson, Friberg, Wallengren, & Öhlén, 2014). A review of the

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literature shows that there is a relationship between meaning in life and psychological health: a loss of meaning in life is linked to increased psychological distress (Breitbart, 2003; Morita, Sakaguchi, Hirai, Tsuneto, & Shima, 2004) and hopelessness and depression (Breitbart et al., 2000), whereas an increased sense of meaning in life is linked to increased psychological well-being (Breitbart, 2003; Chochinov et al., 2004).

The striving to find meaning in life is a primary motivational force in humankind. In this sense, meaning encompasses motivation (purpose), cognition (understanding), action (behaviours), and emotional evaluation (Wong, 2012). Meaning is not only an abstract phenomenon, but more importantly, it is experienced in concrete situations. For example, the ability to make small decisions in a daily life activity could, in turn, be evaluated as ‘my life is purposeful’ (Maddi, 2012). Frequent and long-hours hospital visits and medical interventions constitute a concrete change that can affect the meaning one finds in life. Loss of one’s role as a parent or a contributing member of the society reflects an existential change that can also deeply affect the meaning one finds in life.

Existential uncertainty—of the disease trajectory, of pain, and of the dying process—has been found to prevail among patients with advanced cancer (Coyle, 2004). Multiple factors (e.g., intrapersonal, disease related, and environmental) have been found to contribute to the subjective meaning of illness perceived by a person (Coyle, 2004; Lipowski, 1970). Lipowski (1970) named eight perceived meanings of illness: challenge, enemy, punishment, weakness, irreparable loss, relief, strategy, and value. In turn, the perceived meaning of illness has an influence over the patient’s choice of coping strategies and thus the patient’s meaning and quality of life. For example, challenge is the meaning through which the patient perceives his or her disease as like any task in life, a perception which leads the patient to active and adaptive coping strategies through the use of the means and resources available. In the same vein, studies have also shown that among cancer patients certainty or even existential certainty may prevail, such as having a fresh life outlook, increased self-awareness, and new appreciation of one’s family (Corbeil, Laizner, Hunter, & Hutchinson, 2009). Conceptually, changes in meaning may include the loss of something that was meaningful previously, the creation of something new and meaningful presently, and changes in a person’s perception or reprioritization of what is meaningful in life (Breitbart, 2005; Coward & Kahn, 2005).

The present article is the result of a qualitative longitudinal study. Here, the narratives of six individuals who were living with advanced cancer and receiving home hospice care are analysed. These individuals described their perception of meaning in life and how that changed over the course of their illness. The findings reflect part of a broader phenomenological inquiry on the experience of living with advanced cancer and on the evolving needs and experiences of advanced cancer patients as the illness progresses over time. The findings also reflect on a subset of the participants of the study; 11 out of 22 participants who were approached and recruited successfully for the study. Furthermore, only six of them were followed and interviewed successfully over three time points.

Methods

Research Design

The present study is a secondary aim of a larger study about the lived experience of patients with life-limiting illness receiving home hospice care service. The fieldwork of the present study was informed by an interpretative phenomenological approach. The approach was one of discovery

and description with an emphasis on understanding participants' perceptions of meaning in life and understanding their lived experience (Creswell, 2013; Smith, Flower, & Larkin, 2009; van Manen, 1997). Qualitative, longitudinal research methods were used. The purpose of serial interviews was to examine the evolving experiences of the participants and changes in their perceptions of meaning in life over the course of their illness. Neale and Flowerdew (2003) reported that the temporal dimension of experience has an impact on the notion of hope, which is subjected to change with the progression of a disease. Conducting serial interviews also enabled development over time of a relationship and trust between the participants and the interviewer. In this way, more private accounts could emerge (Murray et al., 2009), as well as a deeper understanding of individual and contextual factors that might explain continuity or changes in the illness accounts over time (McLeod, 2003; Thomson, 2007).

Settings

Two voluntary organisations that provide home hospice care participated in this project as collaborators, and one is the largest home hospice care service provider at the national level where this study was conducted. Care was delivered through a multidisciplinary team. In most cases the team's nurse played the primary role, and most patients usually received care from the same palliative care team upon enrolment in the programme until death.

Sample

After the National University of Singapore Institutional Review Board approved this study, the home hospice care teams helped identify potential participants during their routine home visits. The care teams presented potential participants with a document package that included an invitation letter and an information sheet containing a synopsis of the study and explanation of the requirements should they agree to participate in the study. After verbal consent was obtained from the potential participants, the researcher arranged a time to visit them and explained the study face-to-face before seeking written consent.

An initial assessment was made by the healthcare team to ascertain that the potential participants met the selection criteria. Potential participants had to be patients who (a) were newly referred to palliative care, (b) were aged 55 years and above, (c) were diagnosed with advanced cancer or end-stage chronic illness, (d) had a life expectancy of six months or less, (e) lived in the community, (f) could converse in English, Mandarin, Malay, or Chinese (Hokkien or Cantonese dialects), and (g) were identified as someone who would benefit from the narrative encounter. Patients were not approached if they (a) were unable to give informed consent, (b) had strong objection to being interviewed, (c) were too ill to participate, (d) might experience unreasonable distress as a result of being interviewed, or (e) were, according to their palliative practitioners, unaware of their prognosis.

Interview Process

The author conducted interviews with five participants and was assisted in the interview of the sixth participant because Malay is not the author's native language. A series of three in-depth interviews were conducted with each participant in his or her own home. The duration of each interview was 28–84 minutes, with the average being 47 minutes. Within a series, time between each interview ranged from 37 to 140 days. The initial study protocol specified a time interval of

21 to 28 days between interviews in a series. However, as the interviews progressed, the researcher noted that some participants were rather stable in their health condition, with their health condition deteriorating at a slower rate than anticipated, while others experienced a sudden downturn. The protocol was amended, and objective indicators were used to inform the timing of the next interview. These indicators were changes in the scope of management, changes in the management of symptoms, and changes in the participant's functional status to reflect progression of the disease. The participants were informed that, if necessary, an interview could be completed in two sessions over separate days. However, none of the participants chose this option.

Each interview was audio recorded, transcribed, and reviewed before the next interview. All interviews were informal in style, with the researcher following an interview guide. An interview would typically begin with a general question about the participant's experience of living with advanced cancer and how that experience influenced his or her attitudes towards life, health beliefs, and death (e.g., *Can you share with me your illness experience? What differences did the illness experience make to your life?*). Follow-up questions were flexible and dependent on the participant's responses. The two subsequent interviews aimed to examine differences in the participant's stated meaning in life and his or her experiences as the disease progressed. In addition, demographic data (such as age, gender, religion, marital status, and living arrangement) and health-related information (such as diagnosis and length of time since acquiring the illness) were, with the patients' permission, obtained from their medical records by the staff from the respective collaborating organisations.

Data Analysis

Analysis was ongoing throughout the data collection phase in order to allow emergent themes to be considered in further rounds of interviews. The qualitative computer package QSR NVivo (version 10) assisted in this analysis. The transcripts were analysed using the framework analysis method (Gale, Heath, Cameron, Rashid, & Redwood, 2013), which was employed as an analytical approach to inductively organise the data and identify emerging themes. For the initial analysis of the data, each line of text was the unit of analysis. This was followed by coding the meaning clustered codes into conceptual categories. Finally, there was a comparative analysis where relationships between themes within cases, across cases, and across time were examined. Data management included the development of a case profile for each participant, which consisted of prominent themes identified from the participant's interview transcripts, a demographic data sheet, and field journals recorded by the author.

Attempts were made to maintain a solid data trail. Each step of the research process was documented and open to scrutiny. A coinvestigator provided an external check that the coding and themes were grounded in the narratives and that the themes derived were adequately representative of the raw data (Lincoln & Guba, 1999). In addition, member checks were also conducted with the participants during the interviews to ensure that the themes were grounded from their narratives.

Findings: Interpretative Analysis

The Participants

Twenty-two patients were identified as potential participants for the study. Eleven of these patients did not participate due to death before the interview portion of the study began, a sudden downturn of health resulting in inability to participate in interviews, deep fatigue, or not meeting the inclusion criteria. Another five patients did not complete the interview series because of fatigue, a sudden downturn of health, or death. Six patients were successfully interviewed over three time points and are the participants of the study discussed here. All of the six participants, with the exception of one, died at the completion of the study. All the interviews took place between July 2014 and January 2016. Participant demographics can be found in Table 1, and the excerpts used below were modified for grammatical accuracy, without changing the content.

Expressions of Meaning in Life

One common experience all of the six participants had was that questioning and finding meaning in life was a significant part of their cancer experience over the course of their illness. For them, meaning in life encompassed concepts of 'living day by day', having a 'normal' day, joy of life, suffering, quality of life, and blessings. Antecedents that preceded the quest for meaning in life among these participants included episodes of severe physical pain, debilitating

Table 1. Profile of participants

Characteristics	(N = 6)
Sociodemographics	
Gender	
Female	4
Male	2
Age	
56–60	1
61–65	3
66–70	1
≥71	1
Marital status	
Married	4
Single	1
Divorced/separated	1
Ethnic group	
Chinese	4
Malay	2
Religion	
Buddhist	2
Christian	1
Muslim	2
No religion	1
Living arrangement	
Alone	1
With spouse & children/grandchildren	4
With children/grandchildren	1
Medical information	
Cancer diagnosis	
Colorectal	2
Gastric	1
Lung	2
Renal	1
No. of years of diagnosis	
<1	5
2–5	0
>5	1

progression of the disease, perceived burden to family, and perceived progressive loss of social support, dignity, autonomy, sense of self-worth, and place or purpose in society.

‘Living day by day’ could mean hopelessness or a blessing. The range of meaning for the idea of ‘living day by day’ was varied, complex, and subject to the issues faced by the participants surrounding the cancer experience over time. CF2 and CF4, for example, found living day by day hopeless, especially when they had nothing to look forward to in a day.² Compared to their roles prior to the onset of disease, when they used to be busy taking care of family, gardening, and taking part in social activities, the onset of the disease brought a fundamental change to their lives: they simply passed the day doing nothing, except to feel pain and be served. They expressed their hopelessness as follows:

Life seems very uncertain. There is no hope when the disease is at this stage [advanced cancer] ... To us who are sick, living day by day seems to be just to clear the illness. (CF2)

Now that I am sick, I wake up and wait for breakfast to be served, followed by a massage by my domestic helper. Life is such now, nothing happens, nothing I can do... Now that I am sick, there is no more meaning [in life]... Nothing is important now... left only my life. (CF4)

Both CF2 and CF4 remained bleak in their life outlook towards the last days of their lives. They described their lives as ‘miserable’, ‘meaningless’, and ‘blank’:

Living day by day like this has no meaning... Time just passes blankly... without any joy of life. (CF2)

It is so miserable to live... It [life] is terrible once there is pain. If there is no pain, I can still tolerate... Of course, how could it [life] be good when you have to tolerate? (CF4)

As a contrast to the sense of hopelessness and meaningless experienced by CF2 and CF4, CM3 and MM5 counted their blessings when they were able to wake up and ‘earn’ an additional day:

Happiness is a day, unhappiness is also a day. Today is a blessing when we live through it. We will wait for tomorrow. If we live through tomorrow, it is also a blessing (CM3)

Thank God to keep my life... Every now and then, I wake up, I look at the window (*laughs*), look at the sky and [say], ‘Thank goodness I still can breathe.’ (MM5)

Both CM3 and MM5 remained positive even to the last days of their lives, which was well expressed by CM3 when he spoke regarding his perception of life and readiness for death:

When I know my condition is deteriorating, I am already mentally prepared. We as human, being happy is a day, death is also a day. The final moments only take a few seconds, don’t they? Perhaps it may take a longer time. (CM3)

The different attitudes held among CF2, CF4, and CM3 made a concrete difference in how they lived life, including how they perceived their social connectedness and their pain experiences (topics that will be discussed below).

Life is meaningful as long as one is able to lead a ‘normal’ day. The onset of illness led some participants to appreciate living a normal day. For example, MF9 shared that it was a joy to her when she was able to cook for family and see them eat, even when she could not eat herself.

² Participants are identified in this analysis using a three-character designation. The first letter designates the ethnic group (C = Chinese, M = Malay). The second letter designates male (M) or female (F). The number refers to the number assigned when the interview process began, consisting originally of 11 participants (1–11).

CM8 was happy when she was able to go for her daily exercise in the park. MM5 was very insistent about the need to maintain a sense of normalcy:

I know of people who have this type of disease. They never think so much about life. They just want to die. I said, 'You cannot think this way. You must think about daily life. You want to buy food, where are you going to get money from? You must also take care of your children and wife.' (MM5)

MM5 continued to put in efforts to lead a day as usual as his disease progressed. In fact, he learned how to 'take life easy' and be 'positive' and 'relaxed':

Life is normal. I follow my wife to NTUC [supermarket]. I go to attend wedding reception, but I avoid too crowded places... Just now I went down[stairs]to open the letter box. I felt like taking out the trash, I went out. (MM5)

Unfortunately, the ability to live a full and normal life decreased drastically when MM5 became homebound. Yet MM5 was able to find value in the life that remained, such as in his wife's unconditional support:

Nowadays, I am drowsy... I spend most of the day sleeping... [When the pain comes], I call my wife for help. I feel comfortable when my wife is beside me. Unlike the past when I did everything by myself, now I have to call on my wife. (MM5)

Joy of life created by presence of social engagement. All the participants enjoyed the presence of social support, be it their family, friends, home hospice care team, or neighbours. The joy of life created by the presence of social support was closely related to the meaning and significance of the relationship, meeting the need for the patient to remain socially connected and mentally strong, or perhaps to offset the darkness of the cancer experience itself.

MF9 expressed the importance of family and social support in helping her cope with cancer positively—that is, by forgetting about being sick and by knowing that others still 'remembered' her:

All my family support [me]. My sister, my friend, my husband, all support me. Family support is important. My friends come to visit me every week [which] makes me happy. We just eat, never think of illness. Happy, eat, happy, eat. (MF9)

To MF9, her husband was her key pillar of strength, and she expressed her desire for him to remain as her pillar of strength till her death:

I hope he will never be fed up but take care of me until I die... He stopped work to take care of me (*praises Allah*)... I feel very loved and that makes me strong. (MF9)

CF2 emphasized the importance of care and concern from the people that she knows, be they her family, church groups, or palliative care team. To her, the care and concern shown created a sense of security:

I want care and love so that I can become slightly more cheerful... not so bored... There is a sense of warmth in the loving care, and the heart will feel comforted. (CF2)

However, in her final days, CF2 lamented on the lack of care and concern from her family. She hoped she could die quietly, without any worries, but had no opportunity to explore the topic of death with her family.

I hope my ending is quiet... without any worry... [I hope to talk with my family about my death] but they don't sit down to listen... This [talking about my death] is very important and I am brooding over it. (CF2)

The importance and fortune of having good friends was mentioned by CM3 and CM8. For example, CM3 was grateful that his friends brought him food and visited him at home when they learned that he was too weak to step out of the house. The ability to have friends who could

speak to him so honestly and caringly touched CM3 deeply too:

I have a group of friends [from cycling hobby group] who pooled together 500 dollars for me. They advised me, 'Please don't be angry. With this disease, please don't save money but eat what you can'. I listened and felt that their words made sense and were very reasonable. (CM3)

Life is suffering when one is in pain. Pain was a common experience faced by all the participants, but the pain seemed generally manageable with the opioid prescribed by the home hospice care team. However, pain frequently became an issue and more severe as the disease progressed rapidly. CF4 reacted strongly to the escalating pain, which also reflected her emotional vulnerability:

I was not feeling well recently and that day, I was having great pain, so much so that I was very depressed ... wept in grief ... felt so pitiful ... in so much pain that I felt helpless... I really felt like dying in those few days. (CF4)

CF4 went on to describe further grief from when she could not recognize her only daughter during those painful days:

I could not recognize my daughter in those few days... I ate the painkillers the whole day and thus became confused... I asked my daughter 'Who are you?'... thought she is someone else... I was very heartbroken when I could not recognize my own child. (CF4)

Changes that took place as the disease progressed rapidly and suffering intensified led CF4 to alter what could be hoped for—from hoping for a cure in the initial phase to hoping for a quick death when pain was intolerable.

Impact of self-worth and autonomy on the perceived quality of life. Whether life was viewed as pitiful or satisfying was closely related to perceived autonomy and self-worth. For example, CF4 described how the onset of illness lowered her quality of life and self-worth:

I cannot go anywhere. You see, I need to be held by the hand even to the doorstep. You see, it is so pitiful... need to rely on people... cannot be done by myself. (CF4)

On the other hand, CM3 remained independent in his daily living activities, which enabled him to maintain a certain quality of life.

When I observed others, how else could I feel troubled? Some of their conditions are worse than me. At least, I can still walk and cycle, others need to sit on wheelchair. (CM3)

However, CM3's situation changed when he became weaker as the illness deteriorated. He went out of the house less frequently. Similar changes were also echoed by CF2, CF4, MM5 and MF9.

Almost all of the participants expressed fear of becoming a burden to their family as their disease deteriorated rapidly. One common experience was the need for assistance in personal care such as toileting and bathing due to weak legs or the risk of fall. This affected their mood, as reflected by CM3:

When I want to go to the toilet, I need some help... so my mood is low and confused... I need to call for help when I want to get down from the bed. (CM3)

CF4 described her fear of falling again and lamented that there was no choice but to get used to being helped:

There is no other way; you need to like it [being dependent] even if you don't. If I could do it myself, I would have done it myself. (CF4)

Life is blessed by grace of God or Higher Power. Religion was an important pillar of spiritual

strength for many of the participants. It was through religion that they sought ‘spiritual comfort’, ‘spiritual sustenance’, or ‘peace’, and found a religious support network. Through religious chanting or recitations, which became more frequent as the disease progressed, they found relief from pain and peaceful sleep. In fact, religion seemed a tremendous source of support for the participants towards the final phase as their social life became much more limited, such as when they were homebound or when they received fewer visitors. For some, God or Higher Power was both the ‘reason’ for illness and the ‘source of hope’ for a blessed future with or without the illness.

MM5 described how his conversations with Allah helped him transition from questioning ‘Why me?’ to acceptance, which in turn helped him cope and live his life positively:

I wake up around 5:30 in the morning. I pray, talk to my God, talk to my Allah. You see, I cannot complain to my wife every now and then, I don’t want to give her difficulties. I don’t have others to listen to me. My two sons are not around... When I pray I just talk (*laughs*)... by talking to my Allah, I can ease my problem, you see. That makes me happy. (MM5)

MM5 went on to elaborate how religion has transformed him into a new identity that he could not see when he was well.

Last time [when I was well], I would just go out, not to be asked where I want to go. I really had this type of attitude. But now I got this type of disease [advanced cancer], I know how grateful it is. [My] Allah makes [me] sick so that I know what is happening to [me]... [He] teaches me something ... I should be humble. (MM5)

Discussion

The intent of this qualitative longitudinal study was to explore the human and existential dimensions of living with advanced cancer: that is, the journey six patients undertook when they struggled with finding meaning in life, recognizing their impending death and uncertainty of the dying process and what life would be like before death. The journey of finding and making meaning in their lives was a dynamic, nonlinear process closely associated with the progression of their disease, the meaning of illness within their contexts, and their appraisals of their quality of life in relation to their independence and social connectedness. For a person living with advanced cancer, a primary paradox is present in the desire to live and the inevitability of death. This paradox is particularly present when pain is involved, which can be one of the antecedents to a desire for hastened death (Coyle & Sculco, 2004).

‘Relationships’ is a common theme in palliative care research on patients’ experiences (Haug, Danbolt, Kvigne & Demarinis, 2015; Jassim & Whitford, 2014; McTiernan & O’Connell, 2015), and the same is true for the findings discussed above. For the elderly participants in this study, the significance of close relationships gave them meaning in life. Although the elderly participants were frail and vulnerable, they were actively searching for meaning, perhaps even hope, in life through relationships—with self, spouse, children, grandchildren, relatives, friends, and God or Higher Power. The social factor was essential to the participants’ quality of life; it was important for the participants to continue feeling valued and part of the community. A study by Karlsson et al. (2014) reported that existential uncertainty was alleviated when patients were able to socialize with family and friends. The inability to have such functioning relationships made it difficult for the patients to manage the existential uncertainty (Karlsson et al., 2014). This research supports the concept of ‘social death’ coined by Sudnow (1967).

‘Continuity’ is another central theme discussed in the findings. Continuity refers to the

ability to undertake the same normal, daily but meaningful activities as before the illness struck and the ability to maintain the same framework in relation to meaning. The results show that the participants had a desire to live as normally as possible, to be 'remembered' and needed, and to occupy themselves with some meaningful activities. These abilities could be found mainly in three areas: (a) daily functioning at home such as cooking for the family and looking after one's spouse, children, and grandchildren; (b) spending time with close relationships; and (c) being involved in certain meaningful activities such as religious activities for some. Perhaps the sense of continuity provided the participants with a sense of assurance, security, and participation, especially when they had little time left.

The third central theme that emerged from the findings is 'dialectical awareness'; that is, the participants' existential experiences evidenced the awareness and appreciation of opposition, or systematic and yet continuously changing reality (Swales & Heard, 2009). Different types of dialectical meanings were found among the participants, which concur with other existing findings. For example, the participants were reported to hold opposing realities, such as life and impending death (Benzein, Nordberg, & Saveman, 2001; Sand, Olsson & Strang, 2009), existential certainty and uncertainty, such as the uncertainty of suffering (Saeteren, Lindström, & Nåden, 2010), and self-sufficiency and dependency (Allen, Haley, Harris, Fowler, & Pruthi, 2011).

There are limitations in this study. One key limitation is the small sample size. In palliative care, the patients' personal accounts are essential components in understanding the experience of living with advanced cancer. Unfortunately, the lack of energy and strength to participate in serial, narrative interviews is a genuine issue of concern. Thus, the results may not be transferrable to other dying people or those who lack the energy and strength to share. Nevertheless, the narrative in itself has been reported to have a healing effect on patients (Romanoff & Thompson, 2006). The other limitation is the analytical approach adopted in the study. Presentation of the findings using thematic analysis gives them the appearance of 'snapshots' of single time points. Future studies may want to consider using the case study approach in which findings could be presented on a participant basis with the entire trajectory across all three time points.

Conclusion

The findings underscore that meaning is central in human life, and this centrality becomes prominent when individuals are challenged by traumatic life events such as life-limiting illness. Many patients with cancer report changes in how they experience meaning in life, as they are confronted with life limitations and recognizing themselves as vulnerable and mortal. One conclusion suggested by the findings is that while death and loss are not optional in human life, how we make meaning of them is. This concept provides a framework for clinicians to intervene and do grief work that helps patients process and integrate the dialectical meaning of illness—through the process of change and acceptance—so that they can 'live well' while also having the need to 'die well' validated. Support needs to be given through sensitivity and respect in order to help patients and their families cope with the loss constructively and achieve a new equilibrium, with the ultimate goal of helping patients not only live and die well but also with authenticity.

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