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# Strategic Therapy in Palliative Care


## Abstract

So far, only a few publications have addressed psychotherapy with palliative care patients. This article first describes the growing field of palliative medicine and its central paradigm, quality of life. Then an overview of frequent clinical symptoms is provided, and therapeutic approaches originating in the first (behavioral) and second (cognitive) waves of behavior therapy are outlined. However, the main foci of this present work are the approaches of the third wave behavior therapies: We will concentrate on their key concepts, such as mindfulness, acceptance, values, and meaning-in-life, and their intersection with existing psychotherapies for palliative care patients. We will also clarify the role of Strategic Brief Therapy in inpatient settings. The introduced concepts will be theoretically integrated into a "hot-cool" perspective. Finally, a case vignette will illustrate our approach.

**Keywords:** Palliative care, behavior therapy, acceptance, mindfulness, values, meaning in life

## 1. Introduction

Excepting some theoretical and preliminary clinical work, psychotherapeutic interventions for patients at the end of life rest on very scant conceptual and research bases. While the idea of hospice – providing shelter, food, and assistance to travelers, the poor, the sick, and the dying – has existed since Christianity's incipience, the modern hospice movement did not begin until Dame Cicely Saunders (1918-2005) opened St. Christopher's Hospice in London in 1967. From here, the idea of palliative care was disseminated within England and in other countries. In 1975, the first palliative care unit opened its doors at Montreal's Royal Victoria Hospital. In Germany, the first initiatives and associations that contributed to the promotion and acceptance of the hospice idea did not emerge until the 1980s. In 1985, the "Christophorus-Hospiz-Verein" [Christophorus-Hospice-Association] was founded in Munich and became the first association that contained the term "hospice" in its name. In 1992, the "Bundesarbeitsgemeinschaft Hospiz" [Federal Hospice Committee] organized, and in 1995 the "Deutsche Gesellschaft für Palliativmedizin" [German Association for Palliative Medicine] was founded, which unites physi-

cians and other professional groups to jointly work toward development and progress in palliative medicine (RADBRUCH & ZECH, 2000). At present, the number of inpatient and outpatient caregiver services is increasing rapidly. Concurrently, there is a great need for evidence-based research concerning areas of pain and symptom management, ethical and legal issues, as well as the development and research of psychotherapeutic interventions.

In Germany, the term *hospice* denotes a care facility in charge of pain therapy and symptom management. Usually, hospices have an independent organizational structure and are managed by nursing professionals. Medical care is most often provided by local community rather than in-house physicians. Eligible care receivers are seriously ill individuals with terminal and progressive diseases who do not require inpatient treatment in a hospital, but for whom outpatient care at home is not an option. Care is provided for weeks or months, usually until the patient dies. In contrast, a *palliative care unit* is an independent, hospital-associated, or integrated facility that targets optimal symptom management with interdisciplinary or multi-professional teams supervised by a physician. The average duration of stay is approximately 14 days. The primary goal is the patient's discharge to home-based care. If such care is impossible, continued inpatient care, in a hospice for example, is arranged.

The World Health Organization *defines* palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (http://www.who.int/cancer/palliative/definition/en – URL accessed on March 28, 2006). Clearly, an increase in the quality of life of patients as well as their families is palliative medicine's central concern. Its task is not only the alleviation but also the prevention of suffering. The underlying view of human beings equally considers physical, psychosocial, and spiritual aspects of an individual's life.

## 2. Improvement of Quality of Life as the Task of Palliative Care

Quality of life has become an important concept in healthcare, especially in palliative care. The growing number of publications over the past 20 years reflects the research activities in the field. While "quality of life" is the topic of many studies and most health-related research includes quality of life measures, there is *no consensus of definitions* regarding quality of life. It is widely recognized that quality of life is a complex and idiographic construct that changes in response to illness (BAUSEWEIN, unpublished; CARR & HIGGINSON, 2003; RICHARDS & RAMIREZ, 1997). A variety of dimensions contribute to quality of life, such as pain and other symptoms, physical and cognitive functioning, psychological and social functioning, functioning in one's roles, and spiritual wellbeing (RICHARDS & RAMIREZ, 1997). The significance of attitudes and expectations is expressed in Calman's (1984) definition of quality of life termed "Calman Gap" (quality of life = patients' achievements minus patients' expectations).

Several *concepts* and tools help to understand quality of life, e.g. health-related or subjective quality of life measures. Many instruments for measuring specific domains of quality of life have been developed and validated. However, the exact nature and composition of factors that influence quality of life and therefore must be considered in its measurement are still unclear. For example, we recognize that many patients obtain high quality of life scores when impaired physical functioning and serious illness are present (BAUSEWEIN, unpublished). We also do not know how quality of life changes over time, e.g., as a progressive disease advances. Most publications on quality of life take snapshot measures at only one point in time and do not show the course of quality of life across time.
However, in recent years a new construct termed *response shift* has emerged, which could provide a better means to understanding how people perceive their quality of life and how they cope with health-related or other life changes. Response shift is defined as "a change in the meaning of one's self evaluation of a target construct as a result of recalibration, change in values and reconceptualization" (SPRANGERS & SCHWARTZ, 1999, p. 1508).

The *Schedule for Meaning-in-Life Evaluation* (SMiLE, FEGG ET AL., submitted, http://www.meaninginlife.info) offers one way to measure response shift. The SMiLE is a respondent-generated measure of individual meaning-in-life and assesses three aspects. It asks subjects:
(1) To name three to seven domains that they judge to be important to their individual meaning-in-life.
(2) To rate their current level of satisfaction in each of these domains using a seven-point Likert scale (range, -3 to +3);
and
(3) To rate the importance of each of their chosen areas using a eight-point adjectival scale (range, 0 to 7).

To obtain a total individual meaning-in-life score (SMiLE Index, 0–100, with higher scores reflecting higher individual meaning in life), relative weight and current satisfaction are multiplied for each domain and the results are summed. For analysis, raw scores can be grouped into categories such as family, partner, leisure activities, health, finances, etc. Repeated measures within subject demonstrate that the SMiLE detects response shift, defined as the redefinition or re-conceptualization of some domains as a function of contextual changes in patients' lives (cf. case vignette).

## 3. Psychological Symptoms in Palliative Care Patients

The prevalence data characterizing the psychological difficulties encountered by seriously ill and dying individuals correlate with the patient population, the measurement methods, and the progression of the disease (BREITBART ET AL., 1995).

**Table 1. The prevalence of psychological symptoms as a function of disease progression (Pouget-Schors & Degner, 2002; Schwarz & Krauß, 2000).**

| | Curative | Palliative | Final |
|---|---|---|---|
| Depressive symptoms | 25-50% | 77% | |
| Anxiety disorders | 1-44% | 9-33% | |
| Generalized anxiety disorder | | 1.1% | |
| PTSD | 5-22% | | |
| Adjustment disorders | | 7.5% | |
| Fatigue | | 84%* | 60-80% |
| Neuropsychological symptoms | | 19.8-44% | 61% |
| Suicidality | 0.2% | | 0.003% |

* After radio or chemotherapy.

A construct of special significance in palliative care is the *fear of death*. On the one hand, this fear of death is determined by biological variables that serve self-preservation. On the other hand, it is a function of interpersonal experiences and social learning (e.g., models of coping with death and dying in the parental home, in the public sphere, and in the media). Florian and Mikulincer (2004) proposed a theoretical model that identifies three dimensions of the fear of personal death. These dimensions refer to the intrapersonal, interpersonal, and transpersonal meanings that people may attach to their own death. The intrapersonal dimension specifies the consequences of death for one's own mind and body, such as failure to accomplish important life goals and decomposition of the body. The interpersonal dimension relates to the possible impact of death on one's interpersonal life, such as the termination of close relationships, the failure to care for loved ones, and the possibility of being forgotten. The transpersonal dimension includes a person's beliefs about the hereafter and the transcendental nature of his or her existence, such as uncertainty about what to expect in the hereafter or the possibility of punishment.

*Terror management theory (TMT)* assumes that humans cope with their fear of death via two cultural anxiety-buffering mechanisms: (1) the belief in a cultural worldview and (2) the esteem that is derived from meeting the standards of that worldview (Greenberg et al., 1997, Joireman & Duell, 2005). All cultural worldviews provide their constituents with a sense of enduring meaning and a basis for perceiving oneself as a person of worth within the world of meaning to which one belongs. By meeting or exceeding individually internalized standards of value, norms, and social roles derived from the culture, people transcend their fear of death and hence maintain psychological equanimity despite their knowledge of their own mortality. Effective terror management thus requires (1) faith in a meaningful conception of reality (the cultural worldview) and (2) the belief that one is meeting the standards of value prescribed by that worldview (self-esteem). Self-esteem-related psychological resources, such as hardiness

(FLORIAN ET AL., 2001) and secure attachment styles (MIKULINCER ET AL., 2003) have been found to reduce the effects of mortality salience manipulations. Also close relationships serve as a fundamental buffer of existential anxieties (MIKULINCER ET AL., 2004).
Furthermore, KISSANE ET AL. (1997) described *demoralization* in the terminally ill, which they characterized as a syndrome distinct from depression. It consists of the triad of hopelessness, loss of meaning, and existential distress. Patients with this syndrome are more likely to commit suicide or wish to hasten death (KISSANE & KELLY, 2000).

When treating psychological disorders and their effects on patients' social environment in general and on partnership and family in particular, one must consider that the vital threat posed by the disease and its treatment may overshadow all other behavioral domains (*mental centralization*; FEGG & FRICK, 2003).

## 4. Classical Behavior Therapeutic Approaches

According to KANFER ET AL. (2000), assessment in behavior therapy consists of an analysis of the behavior patterns to be modified (target analysis), the conditions that generated and maintained these patterns (problem analysis), and the means by which the desired changes will be effected with a particular individual (therapy planning). Different interventions, outlined below, may be appropriate for the treatment of patients with serious physical illnesses.
Involving family members in the patients' treatment and, if necessary, providing family members with separate psychotherapeutic support is of special importance in this area of psychotherapy more than in any other. Especially in the USA, structured group intervention programs are available to cancer patients (FAWZY & FAWZY, 2000, SPIEGEL & CLASSEN, 2000, SPIEGEL ET AL., 2000): psychotherapists cooperate with physicians, nurses, social workers, counselors, and self-help groups within a multi-layered psychosocial oncology network. In many cases, psychopharmacological interventions may be indicated as well. Recommendations and guidelines can be found in BAUSEWEIN ET AL. (2005).
From a behavioral therapeutic perspective, the following interventions may be considered (HÄRTL & SCHREINER, 2005):
The term *exposure treatment* subsumes a heterogeneous group of behavioral therapeutic interventions that constitute first-line treatments for anxiety disorders. Systematic desensitization and exposure with response prevention are counted among them. In its original conception, systematic desensitization, applicable to surgery or before chemo and radiotherapy, consists of three components: (1) Relaxation training; (2) construction of an individualized fear hierarchy; (3) exposure to the individual items while relaxing. The latter may be practiced in sensu, in the patient's imagination, or in vivo, through the actual encounter with or presentation of fear-producing situations.

Exposure techniques imply the presentation of the situation that is feared by the patient. The presentation of the fear-producing situation can occur in small steps (graduated exposure) or begin with the most feared item (flooding). Response prevention denotes the prevention of avoidance behavior to enable the patient's habituation to the fear-producing situation. Exposure usually lasts for at least 30 minutes; however, the patient's experience of fear reduction is critical. The classically conditioned, anticipatory gagging reflex that was elicited by the sight of the clinic in which chemotherapy had produced nausea and which therefore was avoided by the patient, provides an example of the applicability of exposure with response prevention to the care setting.

*Operant methods* serve to increase desired behavior or to decrease undesired or disruptive behavior. Shaping involves the systematic reinforcement of successive approximations to the target behavior. An example is a child with cancer whose ability to play alone should be increased to prepare him or her for a long inpatient hospital stay. First, independent play is reinforced by the therapist. Alternatively, opportunities for positive reinforcement of the child's behavior can be generated by prompting (support via verbal or physical assistance that directs attention to the target behavior), fading (the stepwise reduction of assistance) and backward chaining (the establishment of a complex behavioral chain by reinforcing the last link first). Before using positive reinforcement, reinforcers that are effective for the individual patient must be identified. These are then presented contingently by the therapist, family members, or by the patient him or herself (self-reinforcement). Behavioral activation and positive reinforcement are implemented especially with depressed patients. The patient's day is structured with an activity schedule; the frequency of activities is increased; and particularly those activities that may have self-reinforcing effects are targeted.

Effective communication by the patient with family members, physicians, and care staff may be promoted with the help of *role plays* focusing on posing questions, articulating needs, or expressing emotions, for example. The therapists and patients jointly plan the role plays, analyze their component parts, engage in debriefing with concrete suggestions, and practice generalization to everyday life. Video feedback is useful, for positive and problematic behavioral sequences may be replayed repeatedly and modified, if necessary. Role plays are also amenable to group settings. Role-play techniques are a basic component of self-assertiveness training. Modeled social situations are trained during role play with video feedback, and subsequently trained via in vivo exercises. Self-assertiveness training is particularly indicated for those patients who have a negative body or self-image following surgery or medical therapy.

JACOBSON'S (1996) Progressive Relaxation is suggested for *relaxation training*. Patients first learn to notice and to discriminate different degrees of tension in their striated (voluntary) musculature to be able to relax these muscle groups at a later time. Patients also receive detailed instructions about the interaction of physiological and mental tension or relaxation. In a prede-

termined sequence, different muscle groups are contracted for 5 s and then relaxed for 10 s. Daily home practice, mostly assisted by audio tapes, is assumed. Progressive relaxation training may occur in individual as well as in group sessions. It has been shown to reduce nausea, vomiting, and other psycho-physiologically adverse effects of chemotherapy in cancer patients (MOLASSIOTIS ET AL., 2002). The procedure may also be applied to pain, depression, or anxiety. For this reason, Progressive Relaxation Training may be termed the "aspirin of psychotherapy", for it seems to be applicable in a plethora of areas where it produces non-specific effects.
Controlled breathing is probably the most versatile of all the relaxation techniques. It is easy to learn, may be used in almost any situation, and may be helpful for controlling all adverse symptoms. However, for patients with breathing difficulties this technique may be contraindicated (TURK & FELDMAN, 2000).
In *attentional training*, guided imagery may be used to enhance patients' ability to use all their sensory modalities (i.e., vision, audition, olfaction, gustation, and tactation) and thereby increase their engagement. The therapist may ask the patient to imagine scenes, such as a pleasant day at the beach. Such practice can be of assistance for patients by providing them with opportunities to try a range of different scenes in order to learn to use all their senses and to generate a set of images that is of particular use for them (TURK & FELDMAN, 2000). In attentional training, different methods are described (FERNANDEZ & TURK, 1989): (1) Those that focus on the environment rather than on the body; (2) neutral images; (3) dramatized images including the pain or discomfort component; (4) pleasant images; and (5) rhythmic activity.

A technique that must be viewed with caution given recent research results is *thought stopping*, a covert conditioning procedure. Patients learn to disrupt their ongoing negative thinking with a loud "Stop", further enhanced by noise from clapping their hands or hitting the table. Patients are also taught to engage in predetermined positive self-verbalization. However, research participants who were instructed to suppress a thought in this fashion showed an increase in the frequency of the suppressed thought compared to participants who did not receive such a suppression instruction (CLARK ET AL., 1991, GOLD & WEGNER, 1995).
*Stress Inoculation Training* (SIT) is a procedure that aims at general stress management. An initial didactic phase focuses on an analysis of the problem and a formulation of a plausible explanatory model. In the following practice phase, an alternative new behavior is tested under induced and controlled stress conditions. The application phase involves the implementation of the learned coping skills in everyday life. Especially with seriously ill patients who are hospitalized for longer durations, SIT may be used strategically. In this context, the elaboration and written formulation of an emergency plan is also helpful.
The different procedures of *cognitive therapy* require that the therapist and the patient work together to analyze the patient's dysfunctional, mostly automatic thought patterns. The identification of the patient's core assumptions is facilitated by extensive self-monitoring of automatic negative thoughts to illustrate the connection between these thoughts and the patient's emo-

tions. A typical daily diary consists of a brief description of the problematic situation and of the accompanying emotions and thoughts. The dialog with the therapist challenges the patient's typical dysfunctional thoughts and replaces them with appropriate ones (cognitive restructuring). Typical cognitive errors are overgeneralization (e.g., "This nausea will never stop."), arbitrary inferences (e.g., "I lived wrong, that's why I am sick."), personalization ("Our friends are not calling anymore because I'm sick."), dichotomous thinking (e.g., "I'm a failure.") and selective minimization or maximization (e.g., "The nurse was unfriendly today; she does not like me."). Their modification can be prompted with different cognitive techniques. In the Socratic dialog, the therapist directs the patient's attention to heretofore neglected aspects of the situation, to earlier experiences that contradict the present situation, or to alternative interpretations. The patient may also be prompted to supply "rational" answers and alternative thoughts. For example, a patient with a dysfunctional, subjective theory of his or her disease may be asked to list all variables that could have possibly contributed to the cancer. The technique of hypothesis testing requires the patient to examine the accuracy, completeness, and logic of his or her thoughts by gathering experiential data, evaluating them, and drawing conclusions. Nevertheless, recent evidence suggests that some of the theoretical assumptions underlying this procedure may have to be revised (Teasdale et al., 1995; Teasdale, 1999).

Numerous clinical studies have investigated the efficacy of the interventions described in the preceding paragraphs. However, studies in the area of palliative medicine are few and far between. Results from psycho-oncological research to date have been promising (Holland, 2002, Kidman & Edelman, 1997, Spirito et al., 1988).

## 5. "Third wave"-therapies and other modern psychotherapy methods

From the behavior analytic as well as the cognitive influences in behavior therapy, the third wave of behavior therapy – following the purely behavioral ("classical") and the cognitive phases – has emerged in recent years (Hayes, 2004; Sonntag, 2005). It consists of Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), Dialectical Behavior Therapy (DBT; Linehan, 1996), Integrative Behavioral Couples Therapy (IBCT; Jacobson & Christensen, 1996), Integrative Family Therapy (IFT; Greco & Eifert, 2004), the Cognitive Behavior Analytic System of Psychotherapy (CBASP; McCullough, 2000), Mindfulness-Based Cognitive Therapy (MBCT; Segal et al., 2002), Behavioral Activation according to the late Neil Jacobson (Martell et al., 2001) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2004).
The primary aspects of these therapeutic orientations (e.g., mindfulness, acceptance, values) are essential in the psychotherapeutic treatment of palliative care patients; on the one hand, the progression of the disease is inevitable; on the other hand, the time for a psychotherapeutic intervention targeting modification is often limited. Especially in this existentially signifi-

cant life situation, questions as to the meaning in life and its values become increasingly important. So far, however, an integration of "third wave" therapies into psycho-oncology, palliative medicine and hospice work has not occurred. For this reason, the following section will detail the core concepts of these therapies and other related topics and thereby generate a first approximation to new therapy methods in the areas of psycho-oncology, palliative medicine, and hospice work.

Of course, foci must be selected: therefore, we will restrict our discussion to the following concepts: (a) mindfulness; (b) acceptance (with ACT as an example) and (c) values. Then we will broaden our approach to include as a theme (d) the meaning-in-life, which is of major significance for seriously ill patients.

Many of these constructs have a long historical tradition, e.g., the concept of mindfulness originated in Buddha's teachings. It is the core principle of the Buddhist "Theravada" tradition (i.e., the way of the elders; SCHMIDT, 2004). Other concepts were adopted from philosophy: It is important to further elaborate their foundations, as new impulses for present-day research may be gained from a thorough understanding of these concepts' long and extensive tradition.

### *(a) Mindfulness*

*Mindfulness* has been described as "paying attention in a particular way: on purpose, in the present moment and non-judgmentally" (KABAT-ZINN, 1984; KABAT-ZINN, 1990; TEASDALE ET AL., 1995). The essence of mindfulness is to be fully aware of one's experience in each moment, equally open to whatever the moment has to offer, and free of the domination of habitual, automatic, cognitive routines that are often goal-oriented and – in one form or another – related to wanting things to be different to what they are (TEASDALE, 1999). Mindfulness may include qualities like non-judging, non-striving, acceptance, patience, trust, openness, letting go, gentleness, generosity, empathy, gratitude, and loving-kindness (SHAPIRO ET AL., 2002). Unfortunately, the defining criteria and operationalization procedures for mindfulness have not yet been determined (BISHOP, 2002).

KABAT-ZINN (1990) developed a structured group intervention termed *Mindfulness-Based Stress Reduction* (MBSR). MBSR typically consists of 8 to 10 weekly group sessions, with one session being a full-day "retreat". In formal mindfulness practice, the participants sit quietly in an erect and dignified posture and attempt, non-strivingly, to maintain attention on a particular focus, commonly on their own breathing. When their attention wanders from the breath to the thoughts and feelings that inevitably arise, the participants acknowledge and accept these thoughts or feelings, let them go, and redirect their attention back to the breath. This procedure is repeated many times, whenever the participants notice that their attention has wandered. In informal practice, participants apply the same approach as often as possible during their typical day, bringing the attention back to the "here and now", using a focus on the breath as an "anchor" whenever they notice that attention has been diverted. These meditation techniques are used to develop a perspective on thoughts and feelings so that they are recognized

as mental events rather than as aspects of the self or as necessarily accurate reflections of reality. BISHOP'S (2002) literature review summarizes the efficacy studies conducted so far and concludes that considerable methodological problems necessitate more methodologically precise studies of MBSR's effects.

Based on MBSR, TEASDALE ET AL. (1995) developed *Mindfulness-Based Cognitive Therapy* (MBCT) for the treatment of depression. MBCT is a theoretically driven group intervention program that combines the attentional control training and implicit modification of affect-related schematic mental models of MBSR with aspects of Beck's cognitive therapy for depression. It is explicitly designed to foster a decentered relationship to negative thoughts ("thoughts are not facts"). Techniques to change belief in specific negative thoughts or assumptions are not included (TEASDALE, 1999).

### *(b) Acceptance and Commitment Therapy (ACT)*

ACT is based on an analysis of language from a functional contextual perspective (HAYES & WILSON, 1994, HAYES ET AL., 2004). This "analysis suggests that it is common for humans to regard some of their own private reactions (e.g., physiological sensations, affect, cognitive evaluations, and perceptions) as aversive and to make attempts to modify or eliminate these reactions. In general, however, attempts to control such aversive private events tend to be ineffective and paradoxically result in more of the same thoughts and emotions that the individual was trying to avoid in the first place. In many instances, the individual may manage to achieve some short-term relief from these noxious thoughts, feelings, or sensations; however, this short-term relief often is associated with additional long-term difficulties" (e.g., substance abuse, physically avoiding people, places, or things that evoke the emotion; CALLAGHAN ET AL., 2004, p. 196). ACT emphasizes acceptance as an essential skill that aids in moving clients toward their specified values. The goals of ACT are "to help the client recognize the ineffectiveness of experiential avoidance and to develop a new, more effective repertoire for experiencing painful thoughts and feelings. This new repertoire is always based on the client's personal set of values and goals for therapy." (CALLAGHAN ET AL., 2004, pp. 196-197)

The acronym *FEAR* describes ACT's explanatory model for human suffering:

- *Fusion.* The descriptors of private events are cognitively fused with the person. For example, the statement, "I *am* depressed," denotes a state of being and thus fuses the person with the descriptor ("depressed"). A statement such as, "I am a person who presently has a feeling that could be described as 'depression'," would be more precise.
- *Evaluation.* Evaluation may serve to label experiential avoidance. The goal, however, is to be present in the here and now.
- *Avoidance.* Avoidance of unpleasant private events: ACT encourages their acceptance.
- *Reasons.* Individuals constantly give reasons for private and public events. Experiential avoidance may result from the confusion of reasons with causes.

The acronym ACT summarizes the ACT approach:

- *Accept your reactions and be present!* This means that actively accepting a situation, an emotion, etc., *as it is* presents an alternative to experiential avoidance. Feeling *better* is not at the heart of the matter, but becoming better at *feeling* is.
- *Choose a valued direction!* Giving one's life a value-oriented direction that is experienced as worthwhile.
- *Take action!* Denotes engaged behavior: Choosing a valued direction is the first step, actually moving one's feet into the direction is the second.

SONNTAG (2005) provides a concise overview of ACT. Its therapeutic process consists of the following phases:

1. In the *first* phase, clients are brought into contact with the reality that previous struggles to control their inner experiences have been unsuccessful (HAYES ET AL., 2004). "Creative hopelessness" is generated, which forms the starting point for a new beginning. A variety of metaphors, detailed in HAYES ET AL. (2004), are employed to initiate an experientially oriented therapeutic process.
2. In the *second* phase, clients are helped to see that not only their previous struggles to control private events have been unsuccessful but that these struggles have actually made matters worse.
3. The *third* phase of ACT further increases acceptance.
4. The *fourth* phase of ACT focuses on the "discovery of the self." HAYES ET AL. (2004) differentiate the conceptualized self, ongoing self-awareness, and the observing self.
   - *The conceptualized self:* "We humans do not merely live in the world, we live in the world as we interpret it, construct it, view it, or understand it. […] Clients have told stories, formulated their life histories, defined their dominant attributes, compared their attributes to those of others, constructed cause and effect relations between their histories and attributes, and so on. […] The conceptualized self can create severe problems." (HAYES ET AL., 2004, p. 192f)
   - *Ongoing self-awareness:* From a behavior analytic perspective, awareness is the continuously ongoing verbal responding prompted by one's own behavior. Rather than focusing on the specific content of self-knowledge, ACT promotes flexible and functional aspects of self-knowledge (HAYES ET AL., 2004).
   - *The observing self* is the location that remains after all content has been subtracted. "For example, notice what is consistent in answers to the questions 'What happened to you yesterday?' 'What did you see?' 'What did you eat?' […] The 'I' that is referred to is not just a physical organism, it is also a locus, place, or perspective." (HAYES ET AL., 2004, p.195f).

The juxtaposition of conceptualized and observer selves and the promotion of self as a perspective serve to undermine the fusion with the conceptualized self.

5. Values come to the fore in the *fifth* phase: Clients learn to formulate their own values and begin to orient their lives toward them.
6. Finally, the *sixth* phase of ACT involves securing a commitment from the client and implementing behavior change strategies.

There are multiple studies reporting the effectiveness of ACT with a number of populations (Callaghan et al., 2004; Hayes et al., 2006). So far, clinical psychotherapy outcome studies with palliative care patients have not been conducted. Presumably, some aspects of the intervention would have to be modified.

### *(c) Values*

SCHWARTZ AND BILSKY'S (1987) circumplex model of human values, empirically tested with more than 40,000 participants worldwide (SCHWARTZ & BILSKY, 1990; SCHWARTZ ET AL., 2001), has not received much attention in psychotherapy. Ten motivationally distinct domains were derived from sets deemed representative of universal human requirements and validated in cross-cultural research projects (SCHWARTZ & BILSKY, 1990). Each value domain was defined in terms of its central goal (that is, the desired end state to which it is directed).

Values are cognitive representations of goals or motivations that are important to people. They can be described as emotionally and cognitively relevant principles guiding people's lives


**Figure 1. Theoretical model of structure of relations among 10 value constructs (Schwartz et al., 2001)**

(ROKEACH, 1973). Values are closely connected to needs. However, while needs are not evaluated as "good" or "bad," values always have a positive connotation. As a transsituational reference system, they offer orientation and influence behaviour (ROCCAS ET AL., 2002). Values are relatively stable and conceptually related to personality characteristics. However, they are different constructs: Traits refer to what people are like, values to what people consider important. There is some evidence that, while traits have stronger influence on behavior over which individuals have little cognitive control, values affect behavior under more voluntary control.

Following Schwartz's value theory, it has been demonstrated that patients with *self-transcendent* values (universalism, benevolence), who are concerned about global contexts ("macro worries"), are more likely to be satisfied in their subjective well-being than patients with "micro worries" who are concerned with *self-enhancement* values (power, achievement, hedonism; Boehnke et al., 1998). Another differentiation is between the value domains *openness to change* (self-direction, stimulation, hedonism) and *conservation* (security, conformity, tradition). Confirming Terror Management Theory, it has been shown that proselfs are more likely than prosocials to endorse self-transcendent values under mortality salience (GÄRLING, 1999, JOIREMAN & DUELL, 2005). In palliative care patients, there also is a shift towards self-transcendence (FEGG ET AL., 2005). Compared with healthy adults, palliative care patients scored significantly higher in benevolence and lower in self-enhancement values. Conservation values (security, conformity, tradition) were correlated with higher levels of individual quality of life.
Values present both resources and difficulties in psychotherapy. Reflecting on lived values or on opportunities and capacities for behavior in the service of one's values may create experiences that counter suffering and illness. However, values may become problematic (a) when they cannot be lived because of situational constraints or a lack of necessary skills, for example; and (b) when conflicts between core values and core needs arise.

### *(d) Meaning-in-Life*

Many seriously ill patients question the meaning of their disease, the (remaining) meaning in their life and regarding their future. Questions as to how to maintain meaning in one's life or how to restore it gain in significance. For this reason, we extend the third wave therapies to include this component. The following paragraphs will outline a few positions on the topic "meaning-in-life".
Questioning the "meaning in one's life" must be distinguished from questioning the "meaning *of* life" (e.g., Leibniz' question: "Why is there something rather than nothing?"). For pragmatic reasons, psychotherapy focuses on the discovery of personal meaning *in* one's life. Questions as to the meaning of existence in general are more appropriately addressed by philosophy. However, one may assume that both kinds of meaning are required for effective coping with suffering, illness, and death (WONG & FRY, 1998).

The construct "meaning-in-life" has only recently entered *clinical research*. MOADEL ET AL. (1999) surveyed cancer patients and assessed their most important needs: 40% of the patients needed help discovering meaning in their life. MEIER ET AL. (1998) found that 47% of the physicians who had granted at least one request for assisted suicide cited the patients' "loss of meaning in their lives" as a reason for the request. Furthermore, BRADY ET AL. (1999) showed that cancer patients who reported a high degree of meaning in their lives were able to better tolerate severe physical symptoms than patients who reported lower scores.

FRANKL'S (1976) achievement was to draw attention to the significance of existential questions for psychotherapy. His personal history as a survivor of the Nazi concentration camps led him to develop *logotherapy*, which subsequently underwent multiple extensions and modifications (LÄNGLE ET AL., 2005). Frankl defines "meaning" as the manifestation of values, which occurs via three main paths: Creativity (e.g., work, deeds, dedication to causes), experience (e.g., art, nature, humor, love, relationships, roles), and attitude (one's attitude toward suffering and existential problems). Some of Frankl's basic concepts include: "1. Meaning of life – life has meaning and never ceases to have meaning even up to the last moment of life, meaning may change in this context but it never ceases to exist. 2. Will to meaning – the desire to find meaning in human existence is a primary instinct and basic motivation for human behavior. 3. Freedom of will – we have freedom to find meaning in existence and to choose our attitude to suffering" (BREITBART, 2002, pp. 7-8).

WONG (1998b) summarized the criticisms raised against logotherapy: The main weakness of logotherapy is that its principles are stated in philosophical terms or in metaphor. This vagueness precludes scientific analysis. Another common critique of logotherapy is that it overemphasizes values and spirituality. The third criticism alleges that Frankl's writings are faithfully proclaimed by many of his disciples as if they were "the sacred scriptures". Within the logotherapy movement, there seems to be little evidence of critical self-examination and creative tension.

Contrary to Frankl's approach and to existential therapy, Maslow (1943) assumes that individuals' needs are organized hierarchically. His *hierarchy of needs* consists of five levels: physiological needs; needs for safety; needs for belonging/love; needs for esteem; and, finally, self-actualization.

The four lower levels are grouped together as "deficiency needs", while the top level is referred to as "being needs". While our deficiency needs must be met, our being needs are continually shaping our behavior. The basic concept is that the higher needs in this hierarchy only come into focus once all the needs that are lower down in the pyramid are mainly or entirely satisfied. GASIET'S (1981) approach, postulating a hierarchical organization of physiological core needs, fundamental interpersonal needs, and needs for social status and meaning, is similar. ALLPORT (1955) differentiates between deficiency and growth motives. Growth motives include long-range purposes and striving toward distance and goals.

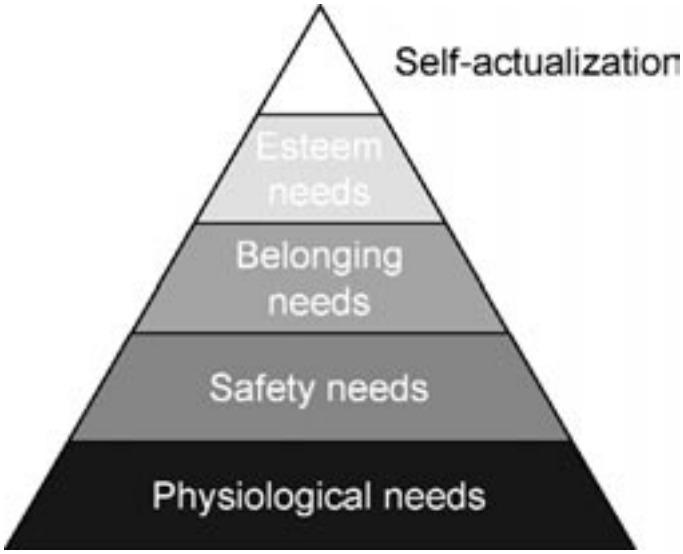


**Figure 2. Maslow's (1943) Pyramid of Needs.**

ANTONOVSKY'S (1997) salutogenesis focuses on what allows people to maintain or restore their health in the presence of persistent burdens and stressors. He coined the term *sense of coherence* to describe a global attitude that expresses the degree to which a generalized, lasting, and dynamic feeling of trust, composed of comprehensibility, manageability und meaningfulness, is present.

The *classical coping model* according to LAZARUS AND FOLKMAN (1984) was expanded to include a meaning component. FOLKMAN AND GREER (2000) speak of meaning-based coping, when unachievable goals are abandoned and new ones are formulated, which then seem to become worthwhile or achievable.

*Giving meaning to negative events* in times of crisis may constitute a form of control. It may help the person to make sense of these negative events and bolster his or her self-worth (FEGG, 2004, HILBERT, 1984, SNYDER & PULVERS, 2001, TAYLOR, 1983). Several authors (e.g., DEVOGLER & EBERSOLE, 1981; EBERSOLE & DEPAOLA, 1987; EBERSOLE & DEPAOLA, 1989; ERIKSON, 2003; TAYLOR & EBERSOLE, 1993) propose a dependence between the questions for meaning and a person's developmental level or age cohort. JANOFF-BULMAN AND YOPYK (2004) describe two different concepts of meaning: one revolving around *comprehensibility*, the other around *significance*. In the aftermath of an extreme, negative life event questions arise about the comprehensibility of the event. There is a human need for a "comprehensible, meaningful and just world" (LERNER, 1980). Positive illusions of control or influence over one's own fate (TAYLOR, 1989) may constitute physically healthy individuals' basis for mental health. On the other hand,

a meaningless world, in the sense of a random, incomprehensible world, is one that induces intense anxiety and dread. Coping processes following a diagnosis of a serious illness involve moving from a blanket perception of randomness and uncontrollability to attempts to minimize these views. Importantly, the literature also points to a potentially positive impact of traumatic life events on meaningfulness. The term "posttraumatic growth" reflects this new attention to the "benefits" of victimization (CALHOUN & TEDESCHI, 2001; TEDESCHI ET AL., 1998). Between 75 and 90% of victims gain in strength through suffering and report a greater appreciation of life, particularly in life domains such as close relationships, nature, and spirituality (Tedeschi et al., 1998). Survivors reprioritize what is important to them: They make conscious choices about how to live their newly valued lives.

Although the importance of meaning has been repeatedly emphasized, there is no agreed-upon *definition of meaning*. Even the nature and the number of the domains that may comprise or influence meaning is unclear: BAUMEISTER (1991) lists four[1]; REKER AND WONG (1988) twelve[2] sources of meaning. One has the impression that other authors do not differentiate (a) meaning-of-life from meaning-in-life, (b) comprehensibility as meaning, (c) comprehensibility as a relation among events, and (d) meaning as a consequence of a value-directed life, etc.

Meaning-in-life probably occurs on different levels. Baumeister and Vohs (2002) distinguish lower and higher levels: *Low levels* involve concrete, immediate, and specific meanings, whereas high levels invoke long time spans and broad concepts. A shift upward to a *higher level* of meaning is typically experienced as a very positive event that brings satisfaction and pleasure. But a happy life and a meaningful life do not seem to be the same thing. BAUMEISTER (1991) reviewed evidence showing that having children reduces parents' happiness and life satisfaction, but that this loss of happiness may be compensated by an increase in meaningfulness. It would be excessive to conclude that happiness and meaningfulness are opposites. Rather, meaning may be necessary but not sufficient for happiness (BAUMEISTER & VOHS, 2002).

REKER ET AL (1987) view meaning-in-life structurally as an idiographic, *three-dimensional construct* composed of cognitive, motivational, and affective components. The cognitive component consists of the individually constructed value system within which people deem themselves and their environment meaningful. Motivationally, it implies the selection and the pursuit of activities and goals, which seem worthwhile within the individual's value system. Finally, the affective component encompasses feelings of contentment and fulfillment, evoked by the

[1] 1. Need for purpose, 2. values, 3. sense of efficacy, 4. self-worth.

[2] 1. Meeting basic needs (e.g. food, shelter, safety), 2. leisure activities or hobbies, 3. creative work, 4. personal relationships (familiy or friends), 5. personal achievement (education or career), 6. personal growth (wisdom or maturity), 7. social and political activism (e.g. peace movement, antipolluation campaigns), 8. altruism, 9. enduring values and ideals (truth, goodness, beauty, justice), 10. traditions and culture (heritage, ethnocultural association), 11. legacy (leaving a mark for posterity), 12. religion.

achievement of goals and by a positive attitude toward life. The cognitive component provides a basis for the motivational and affective components as well.
Meaning-in-life can be defined as an "individually constructed, culturally based cognitive system that influences an individual's choice of activities and goals, and endows life with a sense of purpose, personal worth, and fulfillment" (WONG & FRY, 1998, p. 406-407).
It is hypothesized that authentic personal meaning involves all three elements. The absence of any one element will undermine personal meaning. Subsequently, WONG (1998a) added additional components: social (comprising love, caring, relationship) and personal categories (comprising intelligence, education).

## 6. Psychotherapy in Palliative Care

A small but growing literature is developing on psychotherapeutic interventions for palliative care patients. We will limit our discussion to those interventions that are based on the principles described in the preceding sections.
CHOCHINOV (2003) defines *dignity* as a multifactorial construct which incorporates physical, pychological, spiritual, and social aspects of the illness experience. A factor analysis suggested six dimensions describing aspects of the dying patients' experience (HACK ET AL., 2004): Pain, intimate dependency, hopelessness/depression, informal support network, formal support network, quality of life. In a qualitative analysis (CHOCHINOV ET AL., 2002b), three major categories emerged: Illness-related concerns, a dignity conserving repertoire, and a social dignity inventory. Loss of dignity is associated with both psychological and symptom distress, heightened dependency needs, and loss of will to live (CHOCHINOV ET AL., 2002a).
In *Dignity Psychotherapy* (CHOCHINOV, 2002), patients are offered the opportunity to speak of issues they hold to be most important, such as recounting aspects of their life they feel most proud of, things they feel are or were most meaningful, the personal history they would most want remembered; or words they might provide in the service of helping to look after their family and friends, such as hopes, wishes, or directives for those they will soon leave behind. Dignity psychotherapy sessions are taped, transcribed, edited for clarity, and quickly returned to the patient. Dignity therapy is found to increase purpose, dignity, and the will to live. It reduces depressive symptoms and is helpful also for the family (CHOCHINOV ET AL., 2005).
*Meaning-Centered Group Psychotherapy* (MCGP) is designed to help patients with advanced cancer to sustain or enhance a sense of meaning, peace and purpose in their lives (BREITBART, 2002; BREITBART ET AL., 2004; GREENSTEIN, 2000; GREENSTEIN & BREITBART, 2000). The eight-week MCGP program (one one-and-a half hour session per week) includes the following sessions: 1. Summary of concepts of meaning and sources of meaning. 2. Cancer and meaning. 3 and 4. Meaning derived from the historical context of life. 5. Meaning derived from attitudinal values. 6. Meaning derived from creative values and responsibility. 7. Meaning derived through experiential values. 8. Termination and feedback.

MCGP uses a mixture of didactics, discussion, and experiential exercises that focus on particular themes related to meaning and advanced cancer. With this manualized group intervention, patients are assigned readings and homework tailored to each session's theme, which is then discussed in the following session. Participants must be willing to help create meaning, both for themselves and for the other group members. The intervention aims to help expand possible sources of meaning by teaching the philosophy of meaning on which the intervention is based; by group exercises and homework for each individual participant; and by open-ended discussion, which may include interpretive comments from group leaders (Breitbart, 2002).

The following approaches are not limited to palliative patients: In *Meaning-Centered Counseling* MCC (WONG, 1998b), key concepts of existential psychology and logotherapy are translated into cognitive processes that can be operationalized and subjected to empirical research. MCC affirms that with proper counseling, all individuals can learn to live with dignity, meaning, and purpose even when they believe their lives are not worth living because of suffering or loss of dignity. MCC is "a hybrid from an unlikely marriage between existential psychotherapy and cognitive/behavior psychology" (p. 403). Specific therapeutic goals include: (a) Help clients to gain insight about their core values, deep-seated beliefs, existential concerns, and the inner workings of their minds; (b) help clients to clarify their values and have clearer ideas of what they really want in life; (c) equip clients with the necessary skills to cope effectively with life's many demands; (d) provide social validation and establish meaningful relationships.

KEYES AND COLLEAGUES (2002) distinguish subjective and psychological wellbeing. *Subjective wellbeing* encompasses a global evaluation of life in terms of contentment and balance of positive and negative affect. *Psychological wellbeing* concerns existential life questions and comprises six dimensions: Self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (RYFF & SINGER, 1996). The *Psychological Wellbeing Scales* measures these dimensions and shows differences regarding age, gender, and cultural factors (RYFF & KEYES, 1995, RYFF & SINGER, 1996), personality (SCHMUTTE & RYFF, 1997), aging (HEIDRICH & RYFF, 1993), life changes (KLING ET AL., 1997, KWAN ET AL., 2003) and difficult life events (RYFF ET AL., 1998).

Based on this multidimensional model FAVA ET AL. (1998) developed *Wellbeing Therapy,* which aims at enhancing the patient's mental wellbeing with techniques from cognitive behavioral therapy (FAVA & RUINI, 2003). This kind of therapy is used for affective disorders, among others (FAVA ET AL., 1998), for relapse prevention in depression (FAVA ET AL., 1998), and for psychosomatic problems (FAVA, 1999).

## 7. Strategic Brief Therapy and Strategic Functional Family Therapy

Strategic Brief Therapy (SULZ, 1994) is of multifaceted interest in palliative care: first, the formulation of a survival strategy aids the patient in his or her individual relationship formation; moreover, Strategic Functional Family Therapy (SULZ & HEEKERENS, 2002) provides a valuable approach for addressing the often challenging relationship issues among family members in an inpatient context.

A core concept of the Strategic Brief Therapy is the *survival strategy* (SULZ, 2001) which contains the following logic:

*"Only if I (observable behavior) … and as long as I never (avoidance of emotion) … may I preserve (fulfillment of core needs) … and may I prevent (avoidance of putative consequences of emotion) …"*

Aspects related to approach and avoidance connect the survival strategy to motivational schemata. Survival strategies have the following characteristics (SULZ, 1994):

(a) Unjustified generalizations (mistaking particulars for the whole)
(b) Dichotomous thinking (either/or, "and" – as a third solution – does not exist)
(c) Flawed causal reasoning (e.g., my behavior will cause my dad to leave us)
(d) Mistaking thoughts and feelings for actual events (e.g., if I feel I hate him and I have the thought to kill him, this will happen)
(e) Overestimating other people's power (e.g., he does not need me; he is far superior to me)
(f) Underestimating one's own power (e.g., I won't be able to live without him or without his positive attention).

Survival strategies are mostly implicit, unarticulated and unconscious. While such a rule may have contributed to surviving and maintaining the homeostasis at an earlier childhood developmental level, it has become dysfunctional in adulthood. Difficult situations lead to symptom development, which prevents a revision of the survival strategy based upon actual experience. Therapy aims at an explicit formulation of the survival strategy and subsequent testing of the strategy against reality, in the sense of empirical hypothesis testing (WRIGHT & BECK, 1986) via action that deliberately counters the strategy.

When working with palliative care patients, it is important to know the implicit survival strategy as it concerns the building of reciprocal relationships (GRAWE, 1992). Upon conducting a vertical behavioral analysis (CASPAR & GRAWE, 1982), the more superordinate plans of the patient are identified and his or her identity goals are met in a complementary or alternative fashion. The following table gives a summary of self-concept, worldview, core motives, behavioral patterns, and survival strategy of some clinically frequent personality types. For a more comprehensive treatment, the reader is referred to SULZ (1994) and FYDRICH (2001). The complementary relationship formation is primarily focused on the core motives that underlie the respective personality style.

Table 2. Complementary relationship building: Outline of self-concept, worldview, core motives, behavioral patterns, and survival strategies of selected personality styles. Adapted from Fydrich (2001) and Sulz (1994).

| Personality Style | Self-concept (Schemata) | Image of others (Schemata) | Core motives | Behavioral patterns | Survival strategy |
|---|---|---|---|---|---|
| **Borderline** | Instable, fickle, autonomous and yet dependent, spontaneous, vulnerable, complicated, worthless, unlovable | Unreliable, uncaring, exploiters, focused on their own advantages. Hurtful but also supportive. Absolutely necessary. Life-saving. | Avoid emptiness and emotional pain. Seek out absolute acknowledgment and unconditional acceptance. | Search for help, make demands, seek closeness, maintain distance, impulsivity (e.g., self-injurious and parasuicidal behavior, temper tantrums). | Only if I completely engage in good and emotionally intensive relationships, and as long as I never trust these relationships but take the smallest signs of hurt as a reason for separation, may I preserve the hope to find a thoroughly good relationship one day and may I prevent being alone and bereft, internally empty. |
| **Histrionic** | Dazzling, extraordinary, enchanting, impressive | Seducible, to be impressed, admirer, potentially affirming | Looking for affirmation, showing and spontaneously expressing distinctiveness, being the center, demonstrating one's worth | Theatrical, charming, clearly demonstrating emotions, avoiding "shadows" | Only if I exaggerate my emotions and my expressions and as long as I never convey an unvarnished reality, never leave the stage and initiative to others, may I maintain sufficient attention, attraction, and thereby control others, and I may I prevent disappointment, abuse, and dependence. |
| **Narcissistic** | Extraordinary, unique, self-confident, entitled to special privileges, superior | Subordinate, servant, admirer | Getting the admirationand the special treatment to which you are entitled | Boasting, competing, manipulating, using others, being the center of attention | Only if I am always magnificent and super and manage to gain the world's affirmation and admiration, and as long as I am never second class or mediocre, may I preserve attention, respect, and the hope for love and may I prevent becoming nothing and withering while being ignored. |

Table 2. Complementary relationship building: Outline of self-concept, worldview, core motives, behavioral patterns, and survival strategies of selected personality styles. Adapted from Fydrich (2001) and Sulz (1994).

| Personality Style | Self-concept (Schemata) | Image of others (Schemata) | Core motives | Behavioral patterns | Survival strategy |
|---|---|---|---|---|---|
| **Insecure** | Vulnerable, self-critical, socially awkward, inferior, incapable | Critical, humbling, superior, competent | Hiding one's flaws and weaknesses | Reservation, avoidance of social situations, silence, self-criticism | Only if I never say anything wrong, never express my own wishes, and as long as I never deny others' demands, provoke others' displeasure, rather if I am silent, may I preserve a chance to belong and may I prevent rejection. |
| **Dependent** | Devoted, loyal, faithful, weak, insecure in decision-making, alone, helpless | Strong, caring, helping, knowledgeable, competent | Must have others available; avoiding mistakes | Tying others to oneself; showering them with praise; subordinating oneself; being silent and self-critical | Only if my thoughts, feelings, and actions correspond to the wishes of my attachment figure, and as long as I never allow incompatible needs to emerge, may I preserve the protection, the warmth, and the closeness and may I prevent avoid loss. |
| **Compulsive** | Responsible, precise, careful, dutiful, competent | Careless, incapable, unrestrained, making mistakes | Perfectionism; maintaining control; others should be perfect as well | Following the rules to a tee; controlling; evaluating; criticizing and punishing; having great expectations (toward self and others) | Only if I check the effects of my behavior with regard to meeting a standard of perfection, and as long as I am never imprecise, untidy, unclean, careless, may I preserve control over the effects of my behavior and may I prevent irreparable damage through my aggressive impulses. |
| **Passive-aggressive** | Independent, autonomous, vulnerable, critical | Pushy, incompetent, controlling, demanding, domineering | Unwilling to surrender control; maintaining autonomy; protecting oneself from exploitation | Passive resistance; rule breaking; seeking approval; becoming unapproachable | Only if I am always internally opposing authority and as long as I am never openly aggressive, and if I only compromise as much as absolutely necessary, may I preserve my autonomy and also the opportunity for goodwill and may I prevent open conflict and rejection. |

*Strategic functional family therapy* (SULZ & HEEKERENS, 2002) is based on MINUCHIN'S (1981) structural approach, HALEY'S (1977) strategic view of family homeostasis, and ALEXANDER AND BARTON'S (1976) functional analysis of family patterns.
MINUCHIN (1981) categorized family structures with regard to their internal (intra-familial) and external boundaries (between family and environment) and identified four common forms of dysfunction:

1. Enmeshment (extreme closeness, diffuse boundaries between individuals),
2. Overinvolvement (as a form of excessive responsiveness and boundary transgression),
3. Rigidity (strong resistance to any form of change), and
4. Conflict avoidance (mostly by one member of the parental dyad).

The target of therapy is the restoration of clear boundaries and the hierarchy as well as the communication of effective problem-solving strategies.
While HALEY (1977) points to the stabilizing effects exerted by mental and psychosomatic symptoms on the family homeostasis, ALEXANDER AND BARTON (1976) investigate the instrumentality of the familial (i.e., problematic) behavioral patterns and focus individual therapy on discovering novel behavioral alternatives that might fulfill the same function as the dysfunctional behavior or the symptom. Similarly to the individual level, *family survival strategies* may also be formulated on the level of the family system, where they encompass the core family needs, the core family anger, the core family anxiety, and family behavioral patterns (SULZ & HEEKERENS, 2002):
*"Only if the family always (behavioral patterns of use to the family) … and if the family never (avoidance of patterns harmful to the family) … the family can maintain (core family need) … and the family can avoid (avoidance of a core family threat) …."*

The strategic functional family therapy focuses on the individual, on the family subsystems (e.g., parents-children, male-female, etc.), and on the family as a whole with regard to the functional and dysfunctional behavioral patterns that may appear on the intra-familial level on the one hand and in interaction with the environment on the other. Especially in an inpatient context, conflict-laden relationships are frequently experienced: Already protracted conflict situations as well as those partially exacerbated by the stress and the role strain connected with the life situation place a considerable burden on the therapeutic team. It is often helpful to understand these conflicts in the context of the family survival strategies as defined during team sessions and supervisions. Analogously to working with the survival strategy on the individual level, relationship building complementary to the survival strategy of the family may significantly reduce the problematic behavioral patterns.

In the case of *dysfunctional family communication*, i.e., ambiguous or self-contradictory messages or the avoidance of particular content or the erroneous decoding of unambiguous mes-

sages, the promotion of open communication or specialized communication training is indicated. Often, family members assume to protect each other by disregarding or discounting the terminality of a family member's medical condition. In clinical practice, an open family conversation is almost always experienced as a relief, for the energy required for avoiding a particular situation does not have to be expended anymore. Specialized communication training may also be conducted to improve communication: This training consists of psychoeducational elements with concrete instructions and practical exercises (SCHULZ & VON THUN, 2001).

If a *disruption in the family homeostasis* has occurred, e.g., because a family member fell ill, the following therapeutic strategy is recommended: (a) after having analyzed the homeostasis of all individuals, subsystems, and family systems, the individual as well as the family survival strategies are formulated. (b) Through role-play or other scenic presentation, each family member is able to experience the effects of his or her effort to maintain the homeostasis on other members of the family. Special attention is given to the consequences of the changed role constellation due to a family member's illness. (c) The other's response attempting to restore or maintain his or her homeostasis may further displace the family homeostasis from equilibrium. (d) For this reason, alternatives for generating a new homeostasis are worked out. (e) These solutions are presented and jointly discussed. (f) Repeated role-plays or scenic presentations test the effects of the novel homeostatic effort. (g) Over time, the jointly achieved result is examined. Subsequent sessions work on further improvement.

## 8. Theoretical Foundation: A "hot-cool"-Perspective

SULZ (1994) views the *homeostatic effort* as the central principle governing humans. He differentiates a voluntary from an autonomous mentality: The voluntary mind is our conscious sensing, perceiving, feeling, thinking, and behaving. It is governed by the autonomous mind, which treats our conscious mental apparatus "as a puppeteer would treat a marionette" (SULZ, 2001). Analogous terms are experiential and rational systems (EPSTEIN, 1993) or implicit and explicit systems (GRAWE, 1998). Homeostasis is achieved through self-regulation, i.e., through organization without external directed control. This occurs through self-reinforcement (see automatic reinforcement, HAYES ET AL., 2004). Moment-to-moment positive (reinforcing) and negative (weakening) feedback processes generate a dynamic equilibrium. Concurrently, new order parameters emerge that in turn generate stable equilibrium states (SULZ, 2003).
METCALFE & JACOBS (1996) proposed a two-system framework for understanding the process of self-control or "willpower" in the delay of gratification paradigm (MISCHEL & EBESEN, 1970): an emotional, hot system and a cognitive, cool system. The amygdala-based emotional, *hot system* is largely under "stimulus control", characterized by direct rapid automatic triggering, conditioned responding, inflexibility, stereotyping, and affective primacy. In contrast, the hippocampus-based cognitive *cool system* is the locus of cognitive mediational processes, gener-

ating thoughtful reflective reactions. It is narrative, recording autobiographical events, complete with their spatial-temporal context, giving knowledge about sensations and emotions, thoughts, actions, and context into an ongoing narrative that is coherent, goal sensitive, and strategic. It is argued that the evolutionary adaptive value of the hot system comes from allowing quick fight-or-flight responses under threat conditions without the need for time to think (METCALFE & JACOBS, 1996). Such an emergency system can become maladaptive, however, if activated indiscriminately in situations that require patience and reflective, strategic behavior.
Normally, encoding in the two systems is thought to operate in parallel, with the cool system encoding the contextual panorama and the hot system contributing a "highlighting" of the specifically fear-provoking (or emotional) aspects of the experience. Although at relatively low levels of stress, the two systems work together, hot-system processing begins to dominate the cool system as stress levels and negative arousal increase. The hot system and the cool system seem to respond differently to increasing stress. "The cool system shows a non-monotonic response to increasing stress, much like the classic Yerkes-Dodson-Law. At low levels of stress, mineralocorticoid receptors in the hippocampus produce an increase in responsivity, but at higher levels of stress the successive occupation of glucocorticoid receptors, in addition to the mineralocorticoid receptors, causes the hippocampus to become less responsive, and eventually, at extremely high levels, dysfunctional." (METCALFE & JACOBS, 1996 , p. 2). Exposure to chronic stress has been shown to be correlated with volume decreases in the hippocampus (SAPOLSKY, 1996). In contrast, the hot system shows a simple increase in responsivity to increasing stress (MCGAUGH, 1989).

The differential reactivity of these two systems in the presence of stress explains the necessity to activate problems within therapy, one of the change processes according to Grawe (1998): for only at a moderate arousal level is the cool-system sufficiently activated to develop novel problem-solving strategies or to allow a recoding of distressing material (e.g., in trauma therapy). A purely rational disputation in a completely relaxed state, in contrast, does not lead to any change. Clinical experience raises the question whether increasing stress actually prompts a completely linear increase in the activity of the hot-system, as postulated. Exposure with response prevention demonstrates a different experience: After having spent sufficient time in the stress or fear-producing situation, habituation occurs, i.e., the arousal level decreases. It would be helpful to empirically test Metcalfe & Jacobs' (1996) system in this regard.

"Thus, effective self-regulation hinges on being able to access cooling mechanisms to attenuate negative arousal and suppress hot system activation when needed" (MISCHEL & AYDUK, 2002, p. 115). For this reason, especially the frequently extremely stressful situations of palliative care patients require a sufficiently large arsenal of "*cooling strategies*": Among those are – as described above – directed attention techniques (RODRIGUEZ ET AL., 1989, LEVY ET AL., 2001), mindfulness, values work, meaning-in-life, and spirituality. The hot system comprises

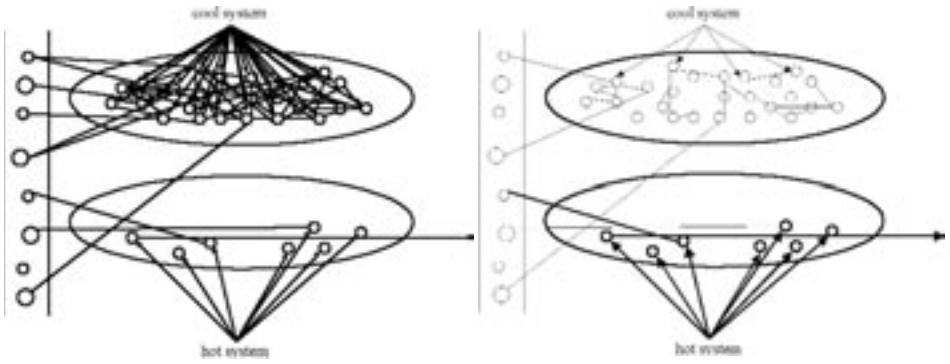

**Figure 3: The cool and the hot systems during low and extreme stress (cf. Metcalfe & Mischel, 1999, p. 15).**
**The left panel shows the hot/cool systems under low levels of stress. The right panel shows the effects of extreme stress as seen with many palliative care patients: The hot system is hyperresponsive, whereas the cool system is becoming dysfunctional. Both systems show so-called "hot spots" (i.e., fragments of feeling unconnected to other hot spots) and cool representations (differentially intercorrelated).**

survival strategies (SULZ, 1994) and motivational schemata (GRAWE, 1998). The findings of AYDUK ET AL. (2002) support the adaptive value of activating a cooling strategy under hot, arousing conditions that otherwise elicit automatic, hot-system responses.

In summary, many of the described techniques and interventions of "third-wave" therapies (e.g., mindfulness, acceptances, values work) as well as meaning-in-life, spirituality, and survival strategies can be categorized into the "hot-cool" perspective. Cooling strategies help palliative care patients to compensate for the hyperactivity of the hot system. In general, there is a considerable need for the development of psychotherapeutic interventions specialized for palliative care patients. Most of the treatment programs described in the preceding paragraphs are still in development, and the evidence for their use is too sparse to recommend any of these programs for daily clinical practice. Interventions for family members are also needed, for the impending death of their family member or partner may thrust them into a critical life situation.

## 9. Case Vignette

A 53-year-old patient approached me some time ago and said, "I need new ideas and strategies, so bad news won't affect me anymore." She had been diagnosed with a malignant lymphoma a few months ago and, according to the doctors, had only a few months to live. She said she would like to process the terminality of her illness and develop perspectives that

allowed her to meaningfully live out her remaining time. For quite some time she had felt some pressure on her heart, but the results from a previous medical examination had been unremarkable.

During assessment of the patient's history, it was noteworthy that the patient always considered herself too small with regard to her physical size of 156 cm. She did not go to college ("That's not necessary for women"), unlike her brother who became an historian and whom she "always looked up to and admired." Her mother was emotionally withdrawn. The patient reported having had a positive and friendly relationship with her father.

Christine, as I choose to call this patient, showed the following *survival strategy*: "Only if I am consistently friendly, lively, in motion, and if I never show my anger unmasked or am at rest, then I can maintain sufficient attention and interest and can avoid loneliness and disappointment."

There were no known physiological or physical preexisting conditions. The functional pressure on Christine's heart had occurred previously, several years ago when her daughter entered a relationship with a man who abused alcohol and had lost his job in the course of his substance use disorder: Christine had feared that her daughter could "socially drift" or get pregnant by the man. As the relationship fell apart, Christine's problem also remitted.

During her *mental health assessment*, Christine reported discomfort and distressing thoughts of death and dying, feelings of loneliness and strong feelings of tension and arousal. In personal interactions, she was very friendly and attentive. *Diagnostically*, an adjustment disorder (F43.2) was warranted; the criteria for a somatization disorder were not met.

The patient identified as her current *resources*: her relationship with her husband, with whom she had had a very long loving relationship; generally her family, which included a son and his family in addition to the now adult daughter; the family home, where she felt safe; her creativity (pottery and painting) as well as her engagement in the Catholic Church.

A *SMiLE* was administered and repeated at three different points in time (in two-month intervals). The family domain (including the children in addition to the husband) was the most important area and even had increased by the time of the fourth assessment. Physically defined power (e.g., bicycling, gardening, etc.) was named only during the first two assessments and was then replaced by mental power (e.g., inner balance, gaining strength from religion). Employment was important only at the first assessment point, then leisure activities became increasingly importance. Health was only mentioned during the first three visits. Finally, cultural activity constituted an additional domain (especially reading and listening to music). Across visits, creativity (pottery and painting) constituted a consistently important domain for meaning in life.

This simple example illustrates that three of the initially named domains were replaced in the course of the repeated assessments (employment, health, and power). Domains that required activity and effort lost their importance as the tumor progressed. The importance of family clearly increased. If – as is the practice in numerous questionnaires – only the physical function had been assessed across time, one would conclude that the patient's quality of life had continually decreased as her illness progressed. However, a consideration of the patient's con-

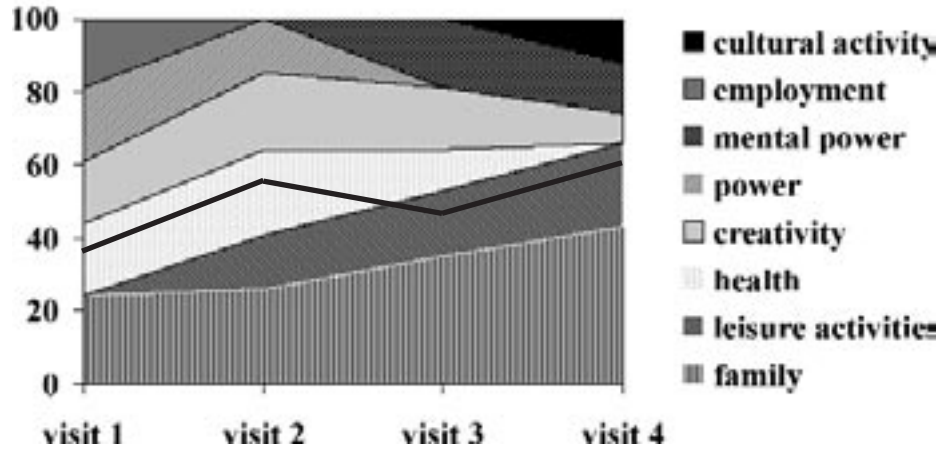


**Figure 4. The patient's individual meaning in life as therapy progressed.**
**The diagram depicts the relative importance of five domains relevant to the patient's individual meaning in life, which sum to 100%. Furthermore, the global index of individual meaning in life is presented. The figure does not indicate the patient's contentment in any of these domains.**

tentment with each domain even indicates a slight increase in the patient's overall meaning in life in the course of therapy (as shown by the thick line in Figure 4).

Similarly, the patient's *values* were formulated by using the exercise "What do you want your life to stand for" described in HAYES ET AL. (2004). Christine considered the question, "Who am I and who do I want to be", and how she wanted her family members to remember her: What she wished her husband to think of her after death, and what she wanted her children, relatives, and friends to remember about her. The "Schwartz Value Survey" was also completed. The following image emerged on her values disk (Figure 5).

*Self-direction*, as independence, autonomy, and personal control, was predominant, followed by universalism and benevolence. The survival strategy had already indicated Christine's striving for autonomy and her heightened activity level. This also related to her high level of creativity. *Benevolence* was also strongly pronounced and had been expressed for years with Christine's social engagement with diverse charities. In addition to other people's wellbeing, she was especially concerned with the wellbeing of the family members closest to her, for whom she greatly cared. Finally, *universalism* also showed a special emphasis: Christine's engagement in "fair trade" also encompassed an interest in equality and understanding of minority populations. Additionally, she worried about ecological nutrition and a careful treatment of nature.


**Figure 5. The patient's value domains**

The strongly pronounced *self-transcendence* of the patient is demonstrated by many seriously ill patients close to death (FEGG ET AL., 2005) of by experimental participants during conditions of mortality salience (JOIREMAN & DUELL, 2005). However, a one-sided orientation of the value structure might become evident too: If the value disk would be thrown like a Frisbee, its flight would be extremely unsteady or it would even crash because of the displacement of its gravitational point. A stabile flight path requires a symmetric form and a balanced, even distribution of mass (cf. Hauke in this issue). Therefore, the therapeutic work determined which values could be found in the neglected domains of "self-enhancement" and "conservation" and could be strengthened.

It became evident that the patient neglected herself through her lively, consistently active behavior pattern. After empirical tests of the previously formulated and defined survival strategy had weakened the old patterns step-by-step, Christine was able to permit herself the domain "hedonism": Enjoying, pampering herself, and being pampered by others. Here, the "little school of taking pleasure" was combined with other exercises from "Euthymic Therapy" (LUTZ, 2000). Another domain that gained in importance was "safety". This domain is particularly important for seriously ill patients, for they often experience an extreme loss of control due to their illness. For the patient, religion and the unconditional support of her family provided the sources of security and stability.

One further aspect of the patient's survival strategy was addressed in therapy: Her avoidance of anger and rage. Role-plays as well as repeated empirical hypothesis testing taught Christine to contact her avoided feelings and to express them appropriately, e.g., to her partner but also to her doctors. She began to ask for more emotionality from her husband: She reported feeling livelier and rediscovering her "sassy" side.

Immediately at the start of therapy, *mindfulness training* was initiated: Christine began to sit mindfully for ten minutes three times per day. She was instructed to focus on her breath and to observe her thoughts, feelings, physical reactions, memories, and internal images during this time. This practice was supported by audio-CDs. Moreover, Christine took regular lessons with a yoga teacher.
In a behavioral therapeutic context, it was rather unusual that the patient reported several *dreams*, which were discussed with her. In my opinion, one of these dreams is related to the patient's progression in mindfulness practice and demonstrates the increasing activity of the observing self:

> Masses of snow fall
> From a window I observe gigantic masses of snow that crash into unknown depths. The snow forms silent clouds, almost similar to the smoke columns of Aetna erupting at this time, only in the opposite direction. Then I turn to a window in a right angle to the left and see a huge roof avalanche plunging. I do not feel any fear in the presence of these events, but I have the feeling that I have been walking around in different rooms for a while. It is not cold, and I have food.

When anxiety emerged, the following thought helped her to manage her anxiety: "I view my illness as an adventure. My life is my adventure." She actively processed death and dying: She read the "Tibetan Book of Living and Dying", while she also began to consciously enjoy her last summer together with her husband and experienced phases of intense vitality: "I awoke this morning with an urgent thought: I want to live, live, LIVE, LIVE, live, live, LIVE LIVE LIVELIVELIVELIVELIVE ……!!!!!!!!!!!!!!!!!! The wish to let go with dignity is still present, still is there, but it is far away " (one of the patient's emails to the therapist).
When the fear of death grew stronger, she practiced *breathing techniques* that she learned in prenatal classes: She tried not to counter the fear, to breathe into it and not to engage in resistance. She commented this practice as follows: "I attempt to become a willow bending in the wind and not the pine that breaks."
Music became more important to her as well: "Since I peacefully have listened to Beethoven's piano sonata 'The Hunt', I tend to compare my mood to it. Although I still had a chemo day ahead of me, I was touched by the light and joyful flowing of the melody and I related it to all

levels of my inner life. That is, I feel quite well and cheerful … and I find my path acceptable, even if it is a bit crazy."

Christine learned to pay more attention to self-care and to *reduce excessive responsibility*: For example, her sister-in-law took over caring for Christine's demented mother. Christine took more frequent breaks, which led to a clear reduction of her somatoform heart problems.

In addition to being able to express anger and to reduce her responsibilities, Christine deliberately implemented breaks for serenity and recovery. The value work produced increases in her ability to enjoy/hedonism (concerning her partnership as well as her experience of nature) and in security through her family's support and her spirituality. She developed several anxiety management strategies, did not avoid fear, and integrated mindfulness training into her everyday life.

When the disease progressed and Christine became physically weaker, the continuity of the psychotherapeutic work was maintained by conducting home visits. Christine passed away peacefully in the presence of her family.

## References


- Alexander J & Barton C (1976) Behavioral systems therapy for families. In: Osons D (Hg.) *Treating relationships.* Graphic, Lake Mills.
- Allport G (1955) *Becoming: Basic considerations for a psychology of personality.* Yale University Press, New Haven (CT).
- Antonovsky A (1997) *Salutogenese*. Dgvt-Verlag.
- Ayduk O, Mischel W & Downey G (2002) Attentional Mechanisms linking Rejection to Hostile Reactivity: The Role of "Hot" Versus "Cool" Focus. *Psychological Science* 13(5):443-448.
- Baumeister R (1991) *Meanings of life*. Guilford, New York.
- Baumeister R & Vohs K (2002) The Pursuit of Meaningfulness in Life. In: Snyder C & Lopez S (Hg.) *Handbook of Positive Psychology.* Oxford University Press, Oxford New York, 2002, pp. 608-618.
- Bausewein C (unpublished) *Response Shift*, München.
- Bausewein C, Remi C, Twycross R & Wilcock A (2005) *Arzneimitteltherapie in der Palliativmedizin*. Urban & Fischer bei Elsevier, München.
- Bishop S (2002) What Do We Really Know About Mindfulness-Based Stress Reduction? *Psychosomatic Medicine* 64:71-84.
- Blackledge J & Hayes S (2001) Emotion Regulation in Acceptance and Commitment Therapy. JCLP/In Sesseion: *Psychotherapy in Practice* 57(2):243-255.
- Boehnke K, Schwartz S, Stromberg C & Sagiv L (1998) The structure and dynamics of worry: Theory, measurement, and cross-national replications. *Journal of Personality* 66(5):745-782.
- Boss M (1979) *Existential foundations of medicine and psychology*. Jason Aronson Inc, Trenton (NJ).
- Brady M, Peterman A, Fitchett G, Mo M & Cella D (1999) A case for including spirituality in quality of life measurement in oncology. *Psycho-Oncology* 8:418-428.

- Breitbart W (2002) Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer. *Support Care Cancer* 10(4):272-280.
- Breitbart W, Bruera E, Chochinov H & Lynch M (1995) Neuropsychiatric Syndromes and Psychological Symptoms in Patients with Advanced Cancer. *Journal of Pain & Symptom Management* 10(2):131-141.
- Breitbart W, Gibson C, Poppito S & Berg A (2004) Psychotherapeutic Interventions at the End of Life: A Focus on Meaning and Spirituality. *Can J Psychiatry* 49:366-372.
- Calhoun L & Tedeschi R (2001) Posttraumatic growth: The positive lessons of loss. In: Neimeyer R (Hg.) *Meaning reconstruction and the experience of loss.* American Psychological Association, Washington DC, 2001, pp. 157-172.
- Callaghan G, Gregg J, Marx B, Kohlenberg B & Gifford E (2004) FACT: The Utility of an Integration of Functional Analytic Psychotherapy and Acceptance and Commitment Therapy to Alleviate Human Suffering. *Psychotherapy: Theory, Research, Practice, Training* 41(3):195-207.
- Calman K (1984) Quality of life in cancer patients – an hypothesis. *Journal of Medical Ethics* 10:124-127.
- Carr A & Higginson I (2003) Are quality of life measures patient-centred? In: Carr A, Higginson I & Robinson P (Hg.) *Quality of life.* BMJ Books, London, 2003, pp. 19-30.
- Caspar F & Grawe K (1982) Vertikale Verhaltensanalyse (VVA). Analyse des Interaktionsverhaltens als Grundlage für die Problemdefinition und Therapieplanung. In: Bommert H & Petermann F (Hg.) *Diagnostik und Praxis-Kontrolle in der Klinischen Psychologie*. DGVT, Tübingen, 1982.
- Chochinov H (2002) Dignity-conserving care: A new model for palliative care. *JAMA* 287:2253-2260.
- Chochinov H (2003) Thinking Outside the Box: Depression, Hope, and Meaning at the End of Life. *Journal of Palliative Medicine* 6(6):973-977.
- Chochinov H, Hack T, Hassard T, Kristjanson L, McClement S & Harlos M (2002a) Dignity in the terminally ill: A cross-sectional, cohort study. *Lancet* 360(9350):2026-2030.
- Chochinov H, Hack T, Hassard T, Kristjanson L, McClement S & Harlos M (2005) Dignity Therapy: A Novel Psychotherapeutic Intervention for Patients Near the End of Life. *J Clin Oncol* 23(24):5520-5525.
- Chochinov H, Hack T, McClement S, Kristjanson L & Harlos M (2002b) Dignity in the terminally ill: a developing empirical model. *Soc Sci Med* 54:433-443.
- Clark D, Ball S & Pape D (1991) An experimental investigation of thought suppression. *Behavior Research and Therapy* 29:253-257.
- Clark L & Watson D (1991) Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology* 100:316-336.
- DeVogler K & Ebersole P (1981) Adults' meaning in life. *Psychological Reports* 49(1):87-90.
- Ebersole P & DePaola S (1987) Meaning in life categories of later life couples. *Journal of Psychology: Interdisciplinary and Applied* 121(2):185-191.
- Ebersole P & DePaola S (1989) Meaning in life depth in the active married elderly. *Journal of Psychology: Interdisciplinary and Applied* 123(2):171-178.
- Epstein S (1993) Emotion and self-theory. In: Lewis M & Haviland J (Hg.) *Handbook of Emotions*. Guilford, New York, 1993.

- Erikson E (2003) *Identität und Lebenszyklus*. Suhrkamp.
- Fava G (1999) Well-being therapy: Conceptual and technical issues. *Psychotherapy and Psychosomatics* 68(4):171-179.
- Fava G, Rafanelli C, Cazzaro M, Conti S & Grandi S (1998) Well-being therapy. A novel psychotherapeutic approach for residual symptoms of affective disorders. *Psychol Med* 28(2):475-480.
- Fava G & Ruini C (2003) Development and characteristics of a well-being enhancing psychotherapeutic strategy: well-being therapy. *J Behav Ther Exp Psychiatry* 34(1):45-63.
- Fawzy F & Fawzy N (2000) Psychoedukative Interventionen bei Krebspatienten. In: Larbig E & Tschuschke V (Hg.) *Psychoonkologische Interventionen*. Ernst Reinhard Verlag, München, 2000, pp. 151-181.
- Fegg M (2004) *Krankheitsbewältigung bei malignen Lymphomen. Evaluation und Verlauf von Bewältigungsstrategien, Kausal- und Kontrollattributionen vor und 6 Monate nach Hochdosischemotherapie mit autologer Blutstammzelltransplantation*. Ludwig-Maximilians-Universität, München.
- Fegg M & Frick E (2003) Psychoonkologische Aspekte hämatopoetischer Stammzellentransplantation. In: Oduncu F, Schroth U & Vossenkuhl W (Hg.) *Organtransplantation, Organgewinnung und -verteilung, Perspektiven.* Vandenhoeck & Rupprecht, Göttingen, 2003.
- Fegg M, Wasner M, Neudert C & Borasio GD (2005) Personal Values and Individual Quality of Life in Palliative Care Patients. *Journal of Pain and Symptom Management* 30:154-159.
- Fegg MJ, Kramer M, L'hoste S & Borasio GD (submitted) *The Schedule for Meaning in Life Evaluation (SMiLE): Validation of a new instrument in meaning-in-life research.*
- Fegg MJ, Kramer M, Bausewein C, Stiefel F, Borasio GD (submitted) *Meaning in Life in the Federal Republic of Germany: Results of a representative survey.*
- Fernandez E & Turk D (1989) The utility of cognitive coping strategies for altering pain perception: a meta-analysis. *Pain* 38:123-135.
- Fischer C (1982) Existential therapy. In: Corey G (Hg.) *Theory and practice of counseling and psychotherapy*. Brooks/Cole Publishing, San Francisco (CA), 1982, pp. 67-75.
- Florian V & Mikulincer M (2004) A Multifaceted Perspective on the Existential Meanings, Manifestions, and Consequences of the Fear of Personal Death. In: Greenberg J, Koole S & Pyszczynski T (Hg.) *Handbook of Experimental Existential Psychology.* Guilford, New York, 2004, pp. 54-70.
- Florian V, Mikulincer M & Hirschberger G (2001) An existentialist view on mortality salience effects: Personal hardiness, death-thought accessibility, and cultural worldview defense. *British Journal of Social Psychology* 40:437-453.
- Folkman S & Greer S (2000) Promoting psychological well-being in the face of serious illness: when theory, research and practice inform each other. *Psycho-Oncology* 9(1):11-9.
- Frankl V (1976) *Man's search for meaning*. Pocket, New York.
- Frankl V (1982) *Ärztliche Seelsorge*. Kindler, München.
- Fydrich T (2001) Motivorientiertes Indikations- und Interventionsmodell für die kognitive Verhaltenstherapie bei Persönlichkeitsstörungen (MIIM). *Psychotherapie* 6(2):247-255.
- Gärling T (1999) Value priorities, social value orientations, and cooperation in social dilemmas. *British Journal of Social Psychology* 38:397-408.

- Gasiet S (1981) *Menschliche Bedürfnisse. Eine theoretische Synthese*. Campus.
- Gold D & Wegner D (1995) Origins of ruminative thought: Trauma, incompleteness, nondisclosure, and suppression. *J Appl Soc Psychol* 25:1245-1261.
- Grawe K (1992) Komplementäre Beziehungsgestaltung als Mittel zur Herstellung einer guten Therapiebeziehung. In: Margraf J & Brengelmann J (Hg.) *Die Therapeut-Patient-Beziehung in der Verhaltenstherapie*. Röttger-Verlag, München, 1992, pp. 215-244.
- Grawe K (1998) *Psychologische Therapie*. Hogrefe, Göttingen.
- Greco L & Eifert G (2004) Treating parent-adolescent conflict: Is acceptance the missing link for an Integrative Family Therapy? *Cogn Behav Pract* 11:305-314.
- Greenberg J, Solomon S & Pyszczynski T (1997) Terror management theory of self-esteem and cultural worldviews: Empirical assessments and conceptual refinements. *Advances in Experimental Social Psychology* 29:61-139.
- Greenstein M (2000) The House That's on Fire: Meaning-Centered Psychotherapy Pilot Group for Cancer Patients. *American Journal of Psychotherapy* 54(4):501-511.
- Greenstein M & Breitbart W (2000) Cancer and the Experience of Meaning: A Group Psychotherapy Program for People with Cancer. *American Journal of Psychotherapy* 54(4):486-500.
- Hack T, Chochinov H, Hassard T, Kristjanson L, McClement S & Harlos M (2004) Defining Dignity in Terminally ill Cancer Patients: A Factor-Analytic Approach. *Psycho-Oncology* 13:700-708.
- Haley J (1977) *Direktive Familientherapie. Strategien für die Lösung von Problemen.* Pfeiffer, München.
- Härtl K & Schreiner M (2005) Verhaltenstherapie. In: Sellschopp A, Fegg M, Frick E, Gruber U, Pouget-Schors D, Theml H, Vodermaier A & Vollmer T (Hg.) *Manual Psychoonkologie. Empfehlungen zur Diagnostik, Therapie und Nachsorge*. Zuckschwerdt, München, 2005, pp. 50-56.
- Hayes S (2004) Acceptance and commitment therapy and the new behavior therapies: Mindfulness, acceptance, and relationship. In: Hayes S, Follette V & Linehan M (Hg.) *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition*. Guliford Press, New York, 2004, pp. 1-29.
- Hayes S, Luoma J, Bond F, Masuda A & Lillis J (2006) Acceptance and Commitment Therapy: Model, processes and outcomes. *Behaviour Research and Therapy* 44(1):1-25.
- Hayes S, Strosahl K & Wilson K (2004) *Akzeptanz- und Commitment Therapie. Ein erlebnisorientierter Ansatz zur Verhaltensänderung*. CIP-Medien, München.
- Hayes S & Wilson K (1994) Acceptance and commitment therapy: Altering the verbal support for experiental avoidance. *The Behavior Analyst* 17:289-303.
- Heidrich S & Ryff C (1993) Physical and mental health in later life: The self-system as mediator. *Psychology and Aging* 8(3):327-338.
- Hilbert R (1984) The accultural dimensions of chronic pain: Flawed reality construction and the problem of meaning. *Social Problems* 31:365-378.
- Holland J (2002) History of psycho-oncology: overcoming attitudinal and conceptual barriers. *Psychosomatic Medicine* 64(2):206-221.
- Jacobson E (1996) *Entspannung als Therapie. Progressive Relaxation in Theorie und Praxis.* Pfeiffer bei Klett-Cotta, Stuttgart.

- Jacobson N & Christensen A (1996) *Integrative couple therapy: Promoting acceptance and change*. W. W. Norton, New York.
- Janoff-Bulman R & Yopyk D (2004) Random Outcomes and Valued Commitments. In: Greenberg J, Koole S & Pyszczynski T (Hg.) *Handbook of Experimental Existential Psychology*. Guilford Press, New York, 2004, pp. 122-138.
- Joireman J & Duell B (2005) Mother Teresa Versus Ebenezer Scrooge: Mortality Salience Leads Proselfs to Endorse Self-Transcendent Values (Unless Proselfs Are Reassured). *Personality and Social Psychology Bulletin* 31(3):307-320.
- Kabat-Zinn J (1984) An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: theoretical considerations and preliminary results. *Gen Hosp Psychiatry* 4:33-47.
- Kabat-Zinn J (1990) *Full catastophe living: using the wisdom of your body and mind to face stress, pain, and illness.* Delta, New York.
- Kanfer F, Reinecker H & Schmelzer D (2000) *Selbstmanagement-Therapie: Ein Lehrbuch für die klinische Praxis.* Springer, Berlin.
- Keyes C, Shmothkin D & Ryff C (2002) Optimizing Well-Being: The Empirical Encounter of Two Traditions. *Journal of Personality and Social Psychology* 82(6):1007-1022.
- Kidman A & Edelman S (1997) Developments in psycho-oncology and cognitive behavior therapy in cancer. *Journal of Cognitive Psychotherapy* 11(1):45-62.
- Kissane D, Bloch S, Miach P, Smith G, Seddon A & Keks N (1997) Cognitive-existential group therapy for patients with primary breast cancer-techniques and themes. *Psycho-Oncology* 6(1):25-33.
- Kissane D & Kelly B (2000) Demoralization, depression and desire for death: problems with the Dutch guideline for euthanasia of the mentally ill. *Aust NZ J Psychiatry* 34:325-333.
- Kling K, Ryff C & Essex M (1997) Adaptive changes in the self-concept during a life transition. *Personality and Social Psychology Bulletin* 23(9):981-990.
- Kohlenberg R & Tsai M (1991) *Functional analytic psychotherapy*. Plenum Press, New York.
- Kwan C, Love G, Ryff C & Essex M (2003) The role of self-enhancing evaluations in a successful life transition. *Psychology and Aging* 18(1):3-12.
- Längle A, Görtz A, Probst C, Probst M, Lopatka C, Kubin M & Steinert K (2005) Wie wirksam ist existenzanalytische Psychotherapie: ein Projektbericht zur Existenzanalyse. *Psychotherapie-Forum* 13(2):54-60.
- Lazarus RS & Folkman S (1984) *Stress appraisal and coping*. Springer, New York.
- Lerner M (1980) *The belief in a just world: a fundamental delusion.* Plenum Press, New York.
- Levy S, Ayduk O & Downey G (2001) Rejection sensitivity: Implications for interpersonal and intergroup processes. In: Leary M (Hg.) *Interpersonal Rejection*. Oxford University Press, New York, 2001, pp. 251-289.
- Linehan M (1996) *Dialektisch-Behaviorale Therapie der Borderline-Persönlichkeitsstörung.* CIP-Medien, München.
- Lutz R (2000) Euthyme Therapie. In: Margraf J (Hg.) *Lehrbuch der Verhaltenstherapie.* Band 1: Grundlagen – Diagnostik – Verfahren – Rahmenbedingungen. Springer, Berlin, 2000, pp. 447-463.

- Martell C, Addis M & Jacobson N (2001) *Depression in the context: Strategies for guided action.* W. W. Norton, New York.
- Maslow A (1943) A Theory of Human Motivation. *Psychological Review* 50:370-396.
- May R (1961) *Existential psychology.* Random House, New York.
- McCullough J (2000) *Treatment of chronic depression: Cognitive behavioral analysis system of psychotherapy.* Guilford Press, New York.
- McGaugh J (1989) Involvement of hormonal and neuromodulatory systems in the regulation of memory storage. *Annual Review of Neuroscience* 12:255-287.
- Meier D, Emmons C, Wallenstein S, Quill T, Morrison R & Cassel C (1998) A national survey of physician-assisted suicide and euthanasie in the United States. *New Engand Journal of Medicine* 338(17):1193-1201.
- Metcalfe J & Jacobs W (1998) Emotional memory: The effects of stress on "cool" and "hot" memory systems. In: Medin D (Hg.) *The psychology of learning and motivation: Vol. 38. Advances in research and theory*. Academic Press, San Diego, 1998, pp. 187-222.
- Metcalfe J & Jacoby W (1996) A "Hot-System/Cool-System" View of Memory under Stress. *PTSD Research Quarterly* 7(2):1-3.
- Metcalfe J & Mischel W (1999) A Hot/Cool-System Analysis of Delay of Gratification: Dynamics of Willpower. *Psychological Review* 106(1):3-19.
- Mikulincer M, Florian V & Hirschberger G (2003) The existential function of close relationships: Introducing death into the science of love. *Personality and Social Psychology Review* 7:20-40.
- Mikulincer M, Florian V & Hirschberger G (2004) The Terror of Death and the Quest for Love. An Existential Perspective on Close Relationships. In: Greenberg J, Koole S & Pyszczynski T (Hg.) *Handbook of Experimental Existential Psychology*. Guilford, New York, 2004, pp. 287-304.
- Minuchin S (1981) *Praxis der strukturellen Familientherapie.* Lambertus, Freiburg.
- Mischel W & Ayduk O (2002) Self-Regulation in a Cognitive-Affective Personality System: Attentional Control in the Service of the Self. *Self and Identity* 1:113-120.
- Mischel W & Ebesen E (1970) Attention in delay of gratification. *Journal of Personality and Social Psychology* 16:329-337.
- Moadel A, Morgan C, Fatone A, Grennan J, Carter J, Laruffa G, Skummy A & Dutcher J (1999) Seeking meaning and hope: Self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. *Psycho-Oncology* 8:378-385.
- Molassiotis A, Yung H, Yam B, Chan F & Mok T (2002) The effectiveness of progressive muscle relaxation training in managing chemotherapy-induced nausea and vomiting in Chinese breast cancer patients: A randomised controlled trial. *Supportive Care in Cancer* 10(3):237-246.
- Piaget J & Inhelder B (1981) *Die Psychologie des Kindes.* Fischer, Frankfurt.
- Pouget-Schors D & Degner H (2002) Erkennen des psychosozialen Behandlungsbedarfs bei Tumorpatienten. In: Sellschopp A, Fegg M, Frick E, Gruber U, Pouget-Schors D, Theml H, Vodermeier A & Vollmer T (Hg.) *Manual Psychoonkologie. Empfehlungen zur Diagnostik, Therapie und Nachsorge.* Zuckschwerdt, München, 2002, pp. 30-36.

- Radbruch L & Zech D (2000) Definition, Entwicklung und Ziele der Palliativmedizin. In: Aulbert E & Zech D (Hg.) *Lehrbuch der Palliativmedizin*. Schattauer, Stuttgart New York, 2000, pp. 1-11.
- Reker G, Peacock E & Wong P (1987) Meaning and purpose in life and well-being: a life-span perspective. *J Gerontol* 42(1):44-49.
- Reker G & Wong P (1988) Aging as an individual process: Towards a theory of personal meaning. In: Birren J & Bengston V (Hg.) *Emergent theories of aging.* Springer, New York, 1988, pp. 220-226.
- Richards M & Ramirez A (1997) Quality of life: the main outcome measure of palliative care. *Palliative Medicine* 11(2):89-92.
- Roccas S, Sagiv L, Schwartz SH & Knafo A (2002) The Big Five personality factors and personal values. *Personality and Social Psychology Bulletin* 28(6):789-801.
- Rodriguez M, Shoda Y, Mischel W & Wright J (1989) *Delay of gratification and children's social behavior in natural settings.* Eastern Psychological Association, Boston, 1989.
- Rokeach M (1973) *The nature of human values.* Free Press, New York.
- Ryff C & Keyes C (1995) The structure of psychological well-being revisited. *J Pers Soc Psychol* 69(4): 719-727.
- Ryff C & Singer B (1996) Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics* 65(1):14-23.
- Ryff C, Singer B, Love G & Essex M (1998) Resilience in adulthood and later life: Defining features and dynamic processes. In: Lomranz J (Hg.) *Handbook of aging and mental health: An integrative approach.* Plenum Press, New York (NY), 1998, pp. 69-96.
- Sapolsky R (1996) Why stress is bad for your brain. *Science* 273:749-750.
- Schmidt S (2004) Mindfulness and Healing Intention: Concepts, Practice, and Research Evaluation. *The Journal of Alternative and Complementary Medicine* 10(S1):7-14.
- Schmutte P & Ryff C (1997) Personality and well-being: Reexamining methods and meanings. *Journal of Personality and Social Psychology* 73(3):549-559.
- Schulz von Thun F (2001) *Miteinander Reden. Kommunikationspsychologie für Führungskräfte.* Rowohlt, Reinbek.
- Schwartz S, Melech G, Lehmann A, Burgess S, Harris M & Owens V (2001) Extending the cross-cultural validity of the theory of basic human values with a different method of measurement. *Journal of Cross-Cultural Psychology* 32(5):519-542.
- Schwartz SH & Bilsky W (1987) Toward a universal psychological structure of human values. *Journal of Personality and Social Psychology* 53(3):550-562.
- Schwartz SH & Bilsky W (1990) Toward a theory of the universal content and structure of values: Extensions and cross-cultural replications. *Journal of Personality and Social Psychology* 58(5):878-891.
- Schwarz R & Krauß O (2000) Palliativmedizin – psychologische Therapie. *Internist* 41:612-618.
- Segal Z, Williams J & Teasdale J (2002) *Mindfulness-based cognitive therapy for depression: A new approach for preventing relapse.* Guilford Press, New York.
- Shapiro S, Schwartz G & Santerre C (2002) Meditation and Positive Psychology. In: Snyder C & Lopez S (Hg.) *Handbook of Positive Psychology.* Oxford University Press, Oxford New York, 2002, pp. 632-645.

- Snyder C & Pulvers K (2001) Dr. Seuss, the coping machine, and 'Oh, the places you will go.' In: Snyder C (Hg.) *Coping and copers: Adaptive processes and people.* Oxford University Press, New York, 2001, pp. 3-29.
- Sonntag R (2005) Akzeptanz- und Commitment-Therapie. Ein Beitrag zur dritten Welle der Verhatenstherapie. *Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie* 10(2): 157-181.
- Spiegel D & Classen C (2000) *Group therapy for cancer patients: A research-based handbook of psychosocial care.* Basic Books, New York.
- Spiegel D, Stein S, Earhart T & Diamond S (2000) Group Psychotherapy and the Terminally Ill. In: Chochinov H & Breitbart W (Hg.) *Handbook of Psychiatry in Palliative Medicine.* Oxford University Press, New York, 2000, pp. 241-252.
- Spira J (2000) Existential psychotherapy in palliative care. In: Chochinov H & Breitbart W (Hg.) *Handbook of psychiatry in palliative medicine.* Oxford University Press, New York, 2000, pp. 197-214.
- Spirito A, Hewett K & Stark L (1988) The application of behavior therapy in oncology. *Adv Psychosom Med* 18:66-81.
- Sprangers M & Schwartz C (1999) Integrating response shift into health-related quality of life research: a theoretical model. *Social Science & Medicine* 48(11):1507-1515.
- Sulz S (1994) *Strategische Kurzzeittherapie – Wege zur effizienten Psychotherapie.* CIP Medien, München.
- Sulz S (2001) *Von der Strategie des Symptoms zur Strategie der Therapie. Gestaltung von Prozess und Inhalt in der Psychotherapie.* CIP Medien, München.
- Sulz S (2003) Prozessuale und inhaltliche Therapiestrategien. In: Leibing E, Hiller W & Sulz S (Hg.) *Lehrbuch der Psychotherapie für die Ausbildung zur/zum Psychologischen PsychotherapeutIn und für die ärztliche Weiterbildung.* Band 3: Verhaltenstherapie. CIP-Medien, München, 2003, pp. 103-122.
- Sulz S & Heekerens H Editors (2002) *Familien in Therapie. Grundlagen und Anwendung kognitiv-behavioraler Familientherapie.* CIP-Medien, München.
- Taylor D (1989) *Positive Illusions*. Basic Books, New York.
- Taylor S (1983) Adjustment to threatening events. A theory of cognitive adaptation. *Am Psychol* 38:1161-1173.
- Taylor S & Ebersole P (1993) Young children's meaning in life. *Psychological Reports* 73(3):1099-1104.
- Teasdale J (1999) Emotional processing, three modes of mind and the prevention of relapse in depression. *Behavior Research and Therapy* 37(S1):53-77.
- Teasdale J, Segal Z & Williams J (1995) How does cognitive therapy prevent depression relapse and why should attentional control (mindfulness) training help? *Behavior Research and Therapy* 33:25-39.
- Tedeschi R, Park C & Calhoun L Editors (1998) *Posttraumatic growth: Changes in the aftermath of crisis.* Erlbaum, Mahwah (NJ).
- Turk D & Feldman C (2000) A Cognitive-Behavioral Approach to Symptom Management in Palliative Care. In: Chochinov H & Breitbart W (Hg.) *Handbook of Psychiatry in Palliative Medicine.* Oxford University Press, New York, 2000, pp. 223-239.

- van Dereusen E (2002) *Existential counseling and psychotherapy in practice.* Sage publications, London.
- van Kaam A (1967) Counseling and psychotherapy from the viewpoint of existential psychology. In: Arbuckle D (Hg.) *Counseling and psychotherapy: an overview.* McGraw-Hill, New York, 1967.
- Wong P (1998a) Implicit Theories of Meaningful Life and the Development of the Personal Meaning Profile. In: Wong P & Fry P (Hg.) *The Human Quest for Meaning. A Handbook of Psychological Research and Clinical Applications*. Erlbaum, Mahwah (NJ), 1998a, pp. 111-140.
- Wong P (1998b) Meaning-Centered Counseling. In: Wong P & Fry P (Hg.) *The Human Quest for Meaning. A Handbook of Psychological Research and Clinical Applications.* Erlbaum, Mahwah (NJ), 1998b, pp. 395-435.
- Wong P & Fry P Editors (1998) *The Human Quest for Meaning. A handbook of psychological research and clinical applications.* Lawrence Erlbaum Associates, Mahwah (NJ).
- Wright J & Beck A (1986) Kognitive Therapie der Depression. In: Sulz S (Hg.) *Verständnis und Therapie der Depression*. Ernst Reinhardt, München, 1986.
- Yalom I (1980) *Existential psychotherapy*. Basic Books, New York.


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