OMEGA, Vol. 61(1) 53-69, 2010

EXISTENTIAL CRISIS AND THE AWARENESS OF DYING: THE ROLE OF MEANING AND SPIRITUALITY*

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ABSTRACT

An existential crisis may occur in cancer patients when they realize that their death may be imminent. We explore the ways in which patients deal with this crisis, in which the meaning of life itself is at stake. In dealing with an existential crisis, it is important to have the courage to confront the loss of meaning and security. Then, a new sense of meaning may emerge which is essentially a receptive experience of connectedness with an ego-transcending reality, such as mankind, nature, or God. This reduces existential fear and despair and leads to acceptance of "life-as-it-is," including its finitude. The article concludes with implications for healthcare workers.

INTRODUCTION

The first two authors of this article worked for over 30 years in the field of psychosocial oncology. At first they were attached to an oncology department of, respectively, a general hospital and a university hospital, followed by a center

*This study was supported by a grant from KWF [Dutch Cancer Society] and Nuts/Ohra.

doi: 10.2190/OM.61.1.c
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specialized in the counseling of cancer patients and their relatives. It struck them that between these two settings there was a clear difference in patient's requests for support. In hospital, patients were medically treated. In general they presented questions related to the physical impact of their illness, its treatment, and the immediate consequences such as managing their feelings of fear, decisions concerning treatment options, or the problem of anticipatory vomiting when going for chemotherapy. In these initial stages of the illness, short-termed and directive interventions appeared to be more adequate in dealing with feelings and related problems. Patients who visited the counseling center, however, often had already finished their medical treatment. Their request for help concerned the emotional process of the loss of meaning ("what meaning is left for the life that lies ahead of me?") and the struggle to hopefully (re)discover it. Interventions that are short-termed and directive, offering a quick release, are definitely inadequate here. In presenting their quests for meaning, patients often referred to a moment of great emotional distress in which they totally lost all anchorage: "My world collapsed." "I looked into a black hole." Similar examples were reported by Lethborg et al.: "I saw between life and death this black chasm, just completely black and you had to cross over it and you had to do it on your own" (2006, p. 36).

As in these situations where the physical survival of patients is at stake, we feel it may be justified to call this loss of anchorage a sign of an existential crisis. The severe distress of the patients we were confronted with, motivated us to study the phenomenon of the existential crisis and the way patients deal with it.

RESEARCH QUESTION

To start with, it is unclear what patients experience exactly when they are in an existential crisis and, consequently, how they deal with it. In the second place, it is unclear but paramount to know how caregivers can assist patients suffering from it. Without sufficient knowledge of and insight in the nature of the existential crisis and the dynamics of processing it, caregivers will not be able to recognize this phenomenon and know how to deal with it adequately. The result may be a serious gap in communication which can unnecessarily aggravate patients' suffering. As the literature on this subject is scarce, we intend to fill this knowledge gap in order to optimize the quality of care offered to cancer patients in an existential crisis.

METHODOLOGY

We used a specific inductive research methodology, Grounded Theory, developed by Glaser and Strauss (1967). This style of qualitative analysis includes a number of distinct features, such as theoretical sampling, making constant comparisons and the use of a coding paradigm, to ensure conceptual development and density (Strauss, 1987, p. 5). Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather

than being imposed on them prior to data collection and analysis (Patton, 1980, p. 306). The way they are generated is through systematic comparison of cases, by what Glaser and Strauss call the "constant comparative method of analysis" (Glaser & Strauss, 1967, pp. 101-116). The results are theoretically relevant when they are repeatedly present or notably absent, when comparing incident after incident.

In the Netherlands, Wester (1987; Wester & Peters, 2004) introduced and elaborated the method, from which we greatly benefited. Wester and Peters developed a computer program we used to support the administration of the analysis (Hijmans & Peters, 2002).

Concepts are the basis of analysis in Grounded Theory research. All procedures are aimed at identifying, developing, and relating concepts (Strauss & Corbin, 1990, p. 177), in our case all related to the existential crisis in oncological patients. Therefore, our research findings constitute a theoretical formulation of the reality under investigation, rather than consisting of a set of numbers. The concepts and relations between them are not only generated, but they are also provisionally tested (Strauss & Corbin, 1990, p. 24). The discovery and specification of differences among and within categories, as well as similarities, is crucially important and lies at the heart of Grounded Theory. The findings try to capture as much of the complexity in the real world as possible (Strauss & Corbin, 1990, p. 111).

Formulating theoretical interpretations of data grounded in reality provides a powerful means both for understanding the world "out there" and for developing action strategies that will allow for some measure of control over it (Strauss & Corbin, 1990, p. 9). In our last paragraph we will present our action strategies as a professional attitude for healthcare workers who intend to assist their patients in dealing with existential crisis.

Theoretical Sampling and Triangulation

Theoretical sampling is a means whereby the analyst decides on analytic grounds what data to collect next and where to find them. This process is controlled by the emerging theory (Strauss, 1987, p. 38). In our study we used different types of data such as: long interviews with 15 patients who visited the counseling center and who lived through an existential crisis; 58 written answers to open-end questions in a questionnaire; and autobiographical material of three patients in order to approach the phenomenon of the existential crisis from different angles. This strategy is known as triangulation.

Triangulation involves varieties of data, investigators, theories, as well as methodologies (Denzin, 1987, p. 294). We employed two types of triangulation. Using different data sources in which the same event occurs is a strategy to discover what concepts have in common across distinct settings. Secondly, we applied investigator triangulation: two, sometimes three, investigators analyzing

the data removes potential bias that comes from a single observer and ensures a greater reliability of observations (Denzin, 1987, p. 297).

A special case of theoretical sampling is the examination of deviant cases or contrast groups in a later phase of the research. These are exceptions to patterned regularities that are examined in order to make the analysis more sharply focused (Denzin, 1987, p. 65) and to uncover additional and relevant factors that could lead to specification or theoretical revision. We additionally interviewed nine patients without an existential crisis—who did not ask for psychological support—in the process of refining the analysis until it accounted for a majority of cases. We only included eligible patients who signed an informed consent in our study.

Sensitizing Concepts

Using sensitizing concepts is a typical strategy of theory development and verification. Beginning with vague, yet generic concepts, researchers can derive operationalizations from the subject's point of view, thus allowing the subject's meanings to be attached to a conceptual framework (Blumer, 1969; Denzin, 1978, p. 252).This means that concepts are not transformed immediately into operational definitions through an attitude scale or checklist (Denzin, 1978, p. 17). Sensitizing concepts permit the discovery of what is unique about each empirical instance of the concept while uncovering what it displays in common across many different settings. As a general reference and guidance in approaching empirical reality, sensitizing concepts also are inspired by the clinical experience and insights of the researchers (Staps & Yang, 1997), existing theories and terminology of patients (van den Hoonaard, 1997). For this study we used as sensitizing concepts: existential crisis; meaning as interpretation; meaning as experience; and spirituality. In the course of the study they were further specified by the empirical findings.

Existential Crisis

A crisis can originate when an event disturbs normal functioning to a high degree. Literature shows that in the course of an illness there may be several stressful moments that may amount to a crisis (Loscalzo & Brintzenhofeszoc, 1998). Confrontation with a so-called liminal situation (e.g., when the survival of a person itself is at stake) may cause the crisis to become an existential crisis. The awareness of one's own finitude, as so often happens in patients with cancer, creates such a liminal situation that can be accompanied by great emotional distress (Glas & Goes, 2002; Jonker-Pool, 2001).

Meaning as Interpretation

Meaning as interpretation is bestowed on subjective processes in interpretive acts (Berger & Luckmann, 1967). Interpretive meaning is an active cognitive

process in which facts and events are interpreted within an already existing system of meaning. At the same time, events are evaluated in terms of the influence they can have on this system and possibilities are calculated to reverse their possible negative consequences. In doing so, a feeling of certainty and control emerges. By producing this type of meaning, people try to (re)make and construct the world into a comprehensible and manageable reality. In this process of active meaning construction, humans position themselves as individuals in the center of their universe: everything has meaning for them. In this reality, death is unmanageable. Confronted with death, most people try to control it by denying it and project it in a distant future, beyond their existential horizon.

Meaning as Experience

It is evident that in human existence there are many things and events that cannot be understood or controlled in an active and rational way. They cannot be interpreted within an existing system of meaning and they escape the control of familiar coping strategies. To deal with these extraordinary experiences a different approach is required: a more passive attitude, being receptive to a meaning that is not rational but experiential (van Uden, 1996). This experience of meaning is characterized by a sense of connectedness, of being embedded within a larger whole (Maex, Brommer-Fogaras, & Malinowski, 1998). Experiencing oneself as part of a larger context seems to diminish the immediate threat to the existence of the individual. He perceives a new meaning in his existence, not positioning himself any longer at the center of the universe. As a consequence, one can accept that things happen beyond one's control. When this point is reached people may say: "Why should it only happen to others and not to me?"

Spirituality

Although there seems to be a great resemblance between the concepts of meaning as experience and spirituality, in our understanding spirituality enhances the concept of meaning as experience fundamentally. In our mind, spirituality is not only the experience of being passively embedded in some larger whole or higher sphere but is basically an active-passive process of relating to and often wrestling with "reality-as-it-is." This reality is greater and also different from everyday experience. It can be the awesome beauty of nature, the gruesome experience of a terminal illness, or the cruelty of life in a concentration camp (Frankl, 1971).

Characteristic of these experiences is that they cannot possibly be fitted within the familiar framework of meaning. The existential crisis as a "liminal experience" (Turner, 1969) is above all a confrontation with "the other," death, the absolute, God. Relating to the otherness of "reality-as-it-is" can be the most intense struggle an individual has to go through in his lifetime. It is definitely not passively submitting oneself to a larger whole or being taken up in a higher sphere, but very

much an active coming to terms with the realities of life and death. Jacob's struggle with the angel (god) may be a most fitting metaphor for this encounter.

Our concept of spirituality sensitized us for the intense passive-active struggle patients with cancer are going through when dealing with an existential crisis. This concept of spirituality is not necessarily limited to the belief in a god. It also includes a more secular humanistic meaning, in which mankind, nature, or cosmos play an important role (Hijmans & van Selm, 2002). The belief in God and a person's relation to him can of course be strengthened through the ordeal of an existential crisis (Haynes & Kelly, 2006), but this is definitely not the only avenue to develop one's spirituality.

RESULTS

In the following we briefly describe the nature of an existential crisis as discovered in the comparative analysis of similarities and differences among and within categories in our material. Second, we present ways in which patients deal with an existential crisis.

Characteristics of the Existential Crisis

According to our research findings the following dimensions are characteristic of the nature of the existential crisis as it manifested itself in our empirical data:

1. Awareness of finitude. The acute awareness of one's own finitude came out as the main characteristic of the existential crisis: "First I knew that one day I would die, but now through my illness I experienced that I really can die. That is a great difference."
2. Dissolving of the future. The time to live that, until then, seemed endless is suddenly very limited and restricted. What is left of the future appears threatening and alarming: "The worst for me is not having a future any more. I always hoped to have grandchildren. It will not happen to me."
3. Loss of meaning. The limitation in life expectancy causes disruption in the lifeline. Goals, especially long-term ones, lose their meaning. Dearly loved persons and things one feels connected to have to be abandoned. Religious and ideological views lose their convincing power: "What am I living for? What is the sense of the time left to me?"
4. Fear, anxiety, panic, despair. The patient becomes aware of all future threats that are awaiting him. All information, especially negative, about cancer can be retrieved and cause feelings of anxiety, panic, or anger: "I panicked, I thought I was going crazy!"
5. Loneliness. The patient may experience himself as an outsider, as "one marked by fate": "At that moment I consciously realized that I felt lonely.

That I had to go through it all by myself despite all the love and care that I felt around me."

6. Powerlessness. Patients feel powerless in relation to the course of their illness. Besides, they fear being unable to deal with the intensity of their own emotions: "I thought I can't handle this. What I felt was powerlessness. This is too much, too big, too. . . ."
7. Identity crisis. Questions arise about one's own identity. The loss of familiar identity can be aggravated by physical mutilation and dependency on others: "At that moment my whole life and my personality coincided with having cancer."

Specification of the Findings

Some interesting refinements presented themselves as exceptions to the presented patterns above. Further examination uncovered additional patterns and conditions that specify our findings as a result from the deviant or negative case analysis. The moment in which the existential crisis occurs shows different patterns. This became clear in an analysis of written answers to the open-end questions. For 53 out of 58 patients we could establish the moment in the course of the illness in which the existential crisis appeared. Based on these findings we could distinguish the following patterns, in which not so much the number as the qualitative differences count. The crisis appears:

1. Just after the first diagnosis ($N = 15$);
2. After relapse or when there was an aggravation of the illness ($N = 12$);
3. During or as a consequence of the treatment ($N = 15$);
4. During fearful expectation of the outcome of medical examination ($N = 6$);
5. Physical deterioration ($N = 3$);
6. Good news ($N = 2$).

In our group of patients with cancer who developed an existential crisis, this crisis was always preceded by an awareness of imminent death. After comparing these findings with the data of the contrast group, it turned out that awareness of personal finitude does not necessarily lead to an existential crisis. There is no existential crisis when a patient, because of his antecedents (e.g., his advanced age or former experiences with a life-threatening illness) developed a frame of meaning in which there is also room for his own finitude (i.e., his own death). Nor when a patient, because of his down-to-earth and pragmatic attitude, when confronted with his finitude, can look death in the face and accept it as a fact. Neither awareness of finitude or the existential crisis occurs in patients who consciously deny the life-threatening aspect of their illness and focus on full recovery. Apparently, they look for a solution within the pre-illness, familiar framework of meaning.

Dealing with an Existential Crisis

On the basis of our research findings we were able to demonstrate the many differences in patterns of dealing with an existential crisis. In spite of that, dimensions of cognitive meaning, the experience of meaning, and spirituality play a significant role in every patient. But the relative importance of these three dimensions may differ in every individual patient.

The Breakdown of Interpretive Meaning: a Mourning Process

We saw earlier that within the familiar system of meaning for most people, their own death is positioned in a remote future. Through the awareness of their finitude patients see their future dissolve in front of their eyes. Goals and ambitions they had no longer direct the passions of their life. Instead of looking forward to the fulfilment of their dreams and plans for the future, they now stare in a black hole. The earlier framework of meaning, with its sense of purpose and direction, is now dramatically inadequate to deal with the new reality of the approaching death. The loss of meaning, purpose, and direction is coupled with severe anxiety, fear, even panic. As they formerly shared their framework of meaning with many others, with society as a whole, they now often feel overcome with a deep feeling of loneliness. Despite all the love and care around them, they feel an outsider "marked by fate." Not being able to change this condition, including the course of their illness and the intensity of their own emotions, they feel extremely powerless. All these losses—of future, purpose in life, meaning, social integration, control of own feelings—release a deep mourning process.

In our interviews we discovered that those patients who allowed the brutal reality to penetrate into their consciousness and live through the accompanying emotions, surrendered to their mourning process and were, in this way, sincerely and adequately dealing with their existential crisis:

> On the one hand it really is terrible to realize that death has come so close to me. It is an almost suffocating sense of loneliness. On the other hand it is also something very reassuring. I am experiencing something that everybody has to go through. For me as an individual it is something absolutely unique. At the same time it is not unique at all, because at some point in life everybody has to surrender to his death.

The Experience of a New Meaning: A Healing Process

A remarkable finding of this research project was that most of the patients who had the courage to abandon the familiar framework of meaning and live through the intense emotions that come with it, at times quite unexpectedly experienced a deep connectedness with a larger whole (". . . suddenly I heard the beating of my heart and I thought: yes, it is a piece of nature that is there. And then I felt myself being part of nature . . ."). Instead of being obsessed with the future asking

themselves how much time was still left to them, they connected more with the reality of the present moment living more fully and intensely in the "here and now."

For patients feeling embedded in a "greater whole," this experience meant a deep connectedness with mankind, nature, or with a transcendental dimension like infinity or God. It also meant being deeper connected with themselves (". . . I am now more myself then ever before"). The paradox was that this being by and with themselves seemed to dissolve their sense of loneliness on a social level. Furthermore, it is remarkable that this experience of meaning reduced feelings of anxiety and panic. It generated a feeling of trust that enabled them to handle their emotions and the insecurities of the situation. By consequence, their feelings of total powerlessness and being out of control diminished. Patients experienced the "reality-as-it-is," including their finitude, as meaningful although they could not fully understand this experience rationally. Often they also found it very difficult to put it into words and they were often hesitant to talk about it. This experiential dimension of meaning cannot be evoked consciously or at will. Apart from genuinely going through a process of mourning, it often also seems to be important to seek a quiet situation, a walk through the woods or meditation, wherein such an experience of meaning may be "received."

> Meditation is now terribly important to me. I put everything aside to create time for it. . . . I don't know what it physically does for me, but it definitely has an effect on a spiritual level. Through meditation I can more deeply relax and I can make all the misery sink into the earth.

The Integration of Experiential Meaning and Interpretive Meaning: A Spiritual Process

Dealing with an existential crisis leads to the acceptance of reality as it presents itself, in which the basis for a new frame of meaning now includes a novel experience of meaning. Not only the experience of falling into a black hole, but also the sudden experience of feeling embedded in a larger whole needs to be integrated. This finding resonates with authors such as Neimeyer, who states that "in coming to terms with other serious losses in life dealing with an existential crisis requires fundamentally a meaning reconstruction" (2001, p. 1), or Hagman (2001, p. 24) who speaks about a "transformation of meanings and affects." Our finding is that the passive/receptive and active aspects of arriving at meaning are integrated in this novel experience of meaning. This integration is supported by Attig (2001, p. 34), who speaks of a simultaneous effort of "finding" and "making" meaning on the many levels of a person's existence. Consequently, patients may then abandon resistance to their own finitude, and no longer have to spend energy in denying or fighting the reality. Patients can now take practical measures to reduce consequences of their physical limitations:

> At last going to my bedroom upstairs took so much energy that at every stair I had to stop and rest. Then I realized that this was meaningless and pity for the little energy I had. Emotionally it was very difficult to decide to put my bed in the living room but at last it gave me rest, and by doing so I saved my energy that now I could use for other more relevant things. It felt good.

Aware of a shorter lifetime and fully concentrated on the here and the now, patients experience the blessings of the present as more precious. In changing priorities, behaviour will be more influenced by what is evaluated as important. This new mental balance will generate the feeling that life has more depth. Self-esteem and esteem of others will increase.

> I no longer do what I don't want to do or what I find pointless. I am more relaxed. I only do what I can and like to do. I enjoy life without looking for another person's approval or without seeking to satisfy all kinds of demands imposed upon me by others.

Apart from a fundamental reconstruction of life's meaning (Neimeyer, 2001), finding this new balance is at the same time a process of "relearning" oneself, as Attig puts it (2001, p. 40) including one's character, one's history and roles, and the identity that one finds in them. It is not surprising that many patients stated that the life-threatening illness deeply enriched their lives and their ability to love.

We should nevertheless be careful not to romanticize this process in patients. It is often a very intense and oscillating process as Stroebe and Schut (2001, p. 58) confirm, in which patients swing to and fro between two extremes: hope and anxiety, resistance and surrender, desperately clinging and letting go.

Spirituality as a Process

There are many definitions and descriptions of the concept of spirituality. It is often identified with some "higher" state of surrender in which the passive component is dominant. In our approach, spirituality is an active-passive, cognitive-experiential process of profound transformation of the person in his relation to "life-as-it-is." The bottom line of spirituality is the individual's dealing with and relating to reality itself. This description of spirituality is closely connected to the definition by Waaijman (2000). We conclude that dealing with an existential crisis as described above can essentially be labeled as an authentic spiritual process.

CONCLUSION

Dealing with an Existential Crisis: A Psycho-spiritual Process

Our comparative and cumulative research helped us to gain more insight in the process that oncological patients may go through when they are confronted with

approaching death. We also developed concepts that capture a sense of the reality patients live through during an existential crisis. Summarizing our findings:

1. For his functioning, a human being has to understand his world and bring it under his control as far as possible. This is mostly achieved by attributing some meaning to it, which is a rational activity directed by the autonomous self. The system of meaning that is constructed in that way directs the meaning of life, of the world and of events that happen within it. Within this system there is usually no place for death.
2. A life-threatening illness like cancer confronts patients with the possibility of death. In the first instance they will try to deal with it from within the existing framework of meaning. In most patients this happens first by considering the threat as temporary and the illness as curable, thinking that they will become healthy again. Then, time perspective shifts. Attention is focused on the here and now and thinking as little as possible about the future. This is an effective method to deal with the menace of death and accompanying insecurity. It is not a denial because one realizes that it can also turn out differently. One keeps it out of consciousness by concentrating on the present and the treatment.
3. When the physical condition deteriorates, a moment may occur in which one cannot deny that one will not be the same again. The changes are irreversible and death is approaching. Future is gone. The familiar framework of meaning is wrecked. This causes an existential crisis. In addition, loss of all control over the situation may cause an identity crisis. The awareness of having to let go of many things initiates a mourning process.
4. If a patient ventures to allow insecurity and the mourning process, space is created for the experiencing of meaning. When this experience manifests itself, the individual senses himself as being part of a larger whole. This reduces his fear of death. This experience of meaning cannot be consciously evocated. Nonetheless, conditions can be created that enhance the chance for it to happen.
5. If in this way patients experience a new meaning in their existence, it enables them also to cognitively attribute meaning to their new reality on the basis of a new and broader context of life, including the reality of death. The assignment of meaning and the experience of meaning are integrated at a higher level. This integration also implies a personal transformation, in which the individual lets go of his ego-centered worldview in favor of a deep sense of being embedded in a larger whole.

Model

To visualize the complex process of dealing with an existential crisis we developed a model that symbolically summarizes our results. The model shows the

process of dealing with an existential crisis as finding a middle way between extremes (i.e., integrating and transcending opposite positions). (See Figure 1).

Referring to Figure 1:

- The vertical axis in the model indicates the perspective of death in time. The bottom position (the point where the axis intersects the circle) indicates the state of consciousness and a framework of meaning in which the reality of death has no place and the individual is totally unaware of his finitude.
- The top position reflects the state of consciousness and a framework of meaning in which the reality of death takes up all place and the individual is completely overwhelmed by the awareness of personal finitude.
- The horizontal axis indicates the way of dealing with reality-as-it-is from the perspective we have on it, i.e., our psychological approach of it.

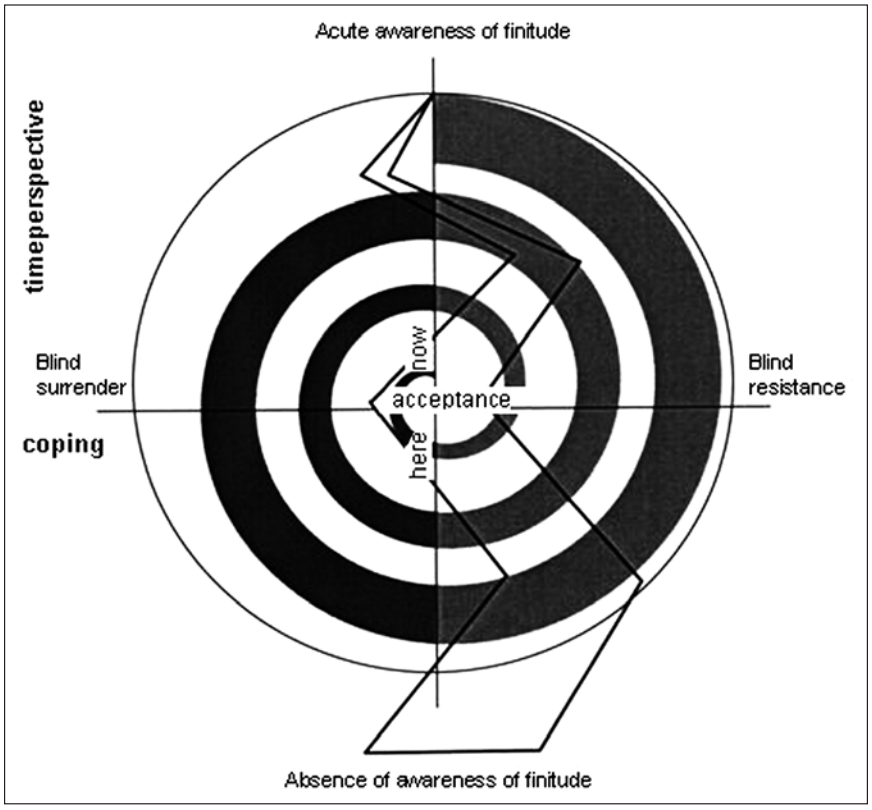

Figure 1. Dealing with existential crisis.

- The right-hand position reflects the active and possibly total control of things and events.
- The left-hand position reflects our feelings of powerlessness when confronted with things or events that one cannot control. One passively subjects himself completely to what one sees as inevitable.
- The fat arrow flashing from the bottom to the top reflects the sudden awareness of personal finitude, which can elicit the existential crisis.
- The centripetal line indicates the process of a patient in finding a new balance in his perspective on life and death and in his psychological approach that accompanies this. This, of course, is an oscillating process that in our model, ideally, runs from extremes to a mid position. The middle position reflects the state of consciousness and the framework of meaning in which the individual has integrated the extremes and has accepted reality- as-it-is. This means that in this mid position also passivity (total surrender) and activity (total control) are integrated and transcended.
- Centered in the here and now, accepting one's own death, the individual can experience the fullness of life. This can be regarded as a process of "individuation": with all the personal objectives and preoccupations gone the individual has become more himself. This is the positive lesson to be derived out of a most traumatic experience (Calhoun & Tedeschi, 2001, p. 158).

DISCUSSION

Based on a rather limited sample we have described the existential crisis and the way people deal with it as an "ideal typical" phenomenon. The implication of this is that not every cancer patient endures this process in the above described way. It also implies that patients who do undergo this process will not necessarily have to put up with it in exactly the same way.

Our purpose was discovery and elaboration. We recognized potential categories and relevant conditions but still need to validate and check out relationships between the actual data. For instance, in the first group of patients we interviewed, it struck us that all of them were able to deal with the existential crisis in a controlled way. We would like to know what patterns exist in patients who mastered the crisis in another controlled way, or those who cannot deal with it. How do we recognize and understand these patterns from within our model?

We are fully aware of the fact that we have a restricted amount of observations. To further substantiate our findings it is important that the research project is expanded to other groups of patients (different forms of cancer; progression of the illness), following the Constant Comparative Method (CCM) of Glaser and Strauss. Then we may have better judgment on the saturation of our concepts and a theoretical formulation of the reality under study.

In this research project data were collected by interviews in just one moment in time. So we can say nothing about the endurance of the changes when there is further progression of the disease. Will the changes last when the disease

aggravates? The project was too limited to build a full-fledged theoretical framework and to formulate hypotheses that can be used in quantitative research. Nevertheless our results seem very promising for further research and for clinical practice.

Some aspects of the findings were more striking than we expected. These are:

1. the many differences of moments in the course of illness in which the existential crisis manifests itself;
2. the fact that an existential crisis can even start at the moment that the patient is told that there is no more life threat;
3. the intense feeling of loneliness that can accompany the existential crisis;
4. that facing one's own finitude and going through the accompanying feelings is a condition for the experience of meaning and ultimately for acceptance;
5. the anxiety reducing aspect of the experience of meaning;
6. the ambivalence that patients show in communicating about moments of loss of meaning and of experiencing meaning. On the one hand they feel the need to talk about it and on the other hand they feel vulnerable when talking about it;
7. that for most of our patients spirituality is not linked to a religious view of life that presupposes the belief in a personal god; and
8. that spirituality leads to a higher degree of individuation in the sense that one becomes more his/her true self.

If we compare our findings with the findings of Lethborg et al. (2006), we may conclude that there is a high degree of resemblance. What they describe as the domain "experiencing the reality of advanced cancer" (p. 36) is similar to our description of the existential crisis. Their domain "living life fully with continued meaning" (p. 37) coincides strongly with our "integration of interpretive and experiential meaning." The greatest differences concern the domain "responding to the impact of advanced cancer." In our project we uncovered a process of dealing with an existential crisis in which:

1. acknowledgment of the emotions caused by the loss of meaning and the ensuing mourning process is important;
2. the new meaning presupposes a passive, receptive attitude;
3. a clear distinction can be made between the active attribution of meaning and the experience of meaning.

IMPLICATIONS FOR CLINICAL PRACTICE

In our project we also asked patients about their expectations and experiences in relation to caregivers. This yielded several points that seem to us very relevant for clinical practice. All patients answered that it is important and

supporting for them that the treating doctor or nurse show that they are knowledgeable about existential crisis and that they are aware that the patient is going through an extremely difficult process.

For dealing with an existential crisis, it is essential that caregivers realize that patients have to face and resolve the predicament of the existential crisis at their own pace to find their own answers. This implies that patients must be able to accept the fact that they do not have an answer yet and live with insecurity. For caretakers who are confronted with patients in an existential crisis, this has far reaching consequences. They have to take patients seriously and have to accept that they cannot accelerate the process, and should not react by providing answers or solutions. At such moments in the interaction they should not take up a position of professionals but of fellow-human beings who dare to share the insecurities of the patient and who express their sincere concern. Just by abstaining from interventions, but at the same time by being "present," they give the patient the necessary freedom to find his own way while telling the story of his life and trying to make sense of it.

The gift of being really present and really listen is the greatest comfort, encouragement, and consolation a caregiver can offer to his patient who, at the edge of life and death, struggles with the deepest questions about the meaning of what is happening to him.

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