

Original Article

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An adaptation of meaning-centered psychotherapy integrating “essential care”: A pilot study

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Abstract

Introduction. There is a growing interest in the emotional state of cancer patients. The main objective of this pilot study is to assess the feasibility, acceptability, and preliminary efficacy of Meaning-Centered Psychotherapy and Essential Care (MCP-EC) in patients with advanced cancer compared with usual psychological support. We define “Essential Care” as the promotion of patient care and self-care through the recall of good care experiences and discussion of the concepts: responsibility, self-compassion, kindness, and attitude.

Method. Pilot, single-center, and prospective study of 30 patients with advanced cancer and emotional distress. Our adaptation consisted in three session Meaning-Centered Psychotherapy-Palliative Care, plus a fourth session named “Essential Care”. The study was carried out in two phases. First, 20 patients were randomized to one of the two arms: individual MCP-EC (experimental, $n = 10$) or usual psychological supportive (control, $n = 10$). In a second phase, 10 patients were assigned consecutively to Group MCP-EC ($n = 10$). All patients were evaluated at baseline (pre-) and post-intervention with questionnaires for socio-demographic data and clinical scales.

Results. Nineteen patients completed the 4 sessions of MCP-EC, 9 individual format and 10 group format. Usual supportive intervention was delivered to 10 control patients. Total 28 patients completed pre- and post-treatment evaluations. There were no pre- vs. post-differences in the evaluations of the control group. In the experimental group, significant pre- vs. post-differences were found in EQ-5D-3L, HADS, FACIT, DM, HAI, SCS-SF, and TD questionnaires. These results indicated that MCP-EC reduced anxiety and depression symptoms, hopelessness, demoralization, as well as increased spiritual well-being and sense of meaning. Participants were satisfied and found the MCP-EC intervention positively.

Conclusions. This pilot study suggests that the MCP-EC has feasibility, acceptability, and preliminary efficacy reducing the emotional distress in advanced cancer patients. Larger studies are warranted to clarify the strengths and limitations of this psychotherapy.

Introduction

The diagnosis of advanced cancer represents a situation of threat and uncertainty for patients and their families (Gil et al., 2010; Holland, 2013). Oncological patients often express feelings of hopelessness, a desire for hastened death, and high levels of anxiety and depression associated with the loss of meaning in life (Gil and Breitbart, 2013; Breitbart, 2017). Those existential concerns notably increase the complexity of comprehensive care in patients with advanced cancer. It is therefore of paramount importance to develop new intervention models able to achieve the management of both physical and psychosocial symptoms (Holland, 2013).

The Meaning-Centered Psychotherapy (MCP) model developed by William Breitbart has shown efficacy in treating patients with advanced cancer (Breitbart et al., 2010, 2012, 2015, 2018; Gil and Breitbart, 2013). MCP was developed and showed to be effective in both a Group Format and in an Individual Format (consisting of 8 group sessions or 7 sessions in individual format), based on enhancing a sense of meaning and purpose in life of patients with advanced cancer. It was inspired by the work of Viktor Frankl, founder of logotherapy,

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and author of the book “Man’s Search for Meaning” (Frankl, 1946). An abbreviated version of MCP tailored to the needs of palliative care patients (MCP-PC) appears to be feasible, acceptable, and has the potential to help patients better cope with the challenges inherent in confronting death and dying (Rosenfeld et al., 2016; Masterson et al., 2017).

For this study, we have designed a brief psychotherapy adapting the short version of MCP for Palliative Care by adding a fourth session called “Essential Care,” whose objectives are the care and self-care of the patient, the establishment of a care plan between the patient, his/her family and the health team, through the recollection of care experiences, and a discussion of the concepts of responsibility, self-compassion, kindness, and attitude to face advanced cancer (Breitbart, 2017).

Through a prospective intervention, we aimed to reduce the emotional distress associated with an advanced oncological disease by promoting or maintaining a sense that one’s life has meaning, as well as the capacity for self-compassion and care.

The main objective of this pilot study is to assess feasibility, acceptability, and preliminary efficacy of a Meaning-Centered Psychotherapy-Palliative Care and Essential Care (MCP-EC) in patients with advanced cancer compared with a usual psychological supportive intervention. Changes at the level of emotional distress were evaluated through measurement instruments validated in the Spanish population.

Materials and methods

Participants

Patients with a diagnosis of advanced cancer were recruited from the Medical Oncology Department of the Clinical University Hospital in Zaragoza (Spain) between April 2017 and December 2018. All participants had a histologically proven diagnosis of advanced (unresectable stage III or stage IV) and incurable cancer (oncologist’s criteria). In addition, patients had to be evaluated by the Psycho-oncology Unit for presenting emotional distress. All were over 18 years of age with an Eastern Cooperative Oncology Group (ECOG) Performance Status equal to or less than 2.

Ethical considerations

The study was approved by the Aragón Research Ethics Committee (CEICA). Patients were interviewed and informed about the project in a first session with a member of the research team. All participants were Spanish-speaking, read and signed the informed consent after resolving any doubts that might arise.

Procedures

The pilot study was carried out in two separate phases. Figure 1 shows the design, summary, and detail of the complete study.

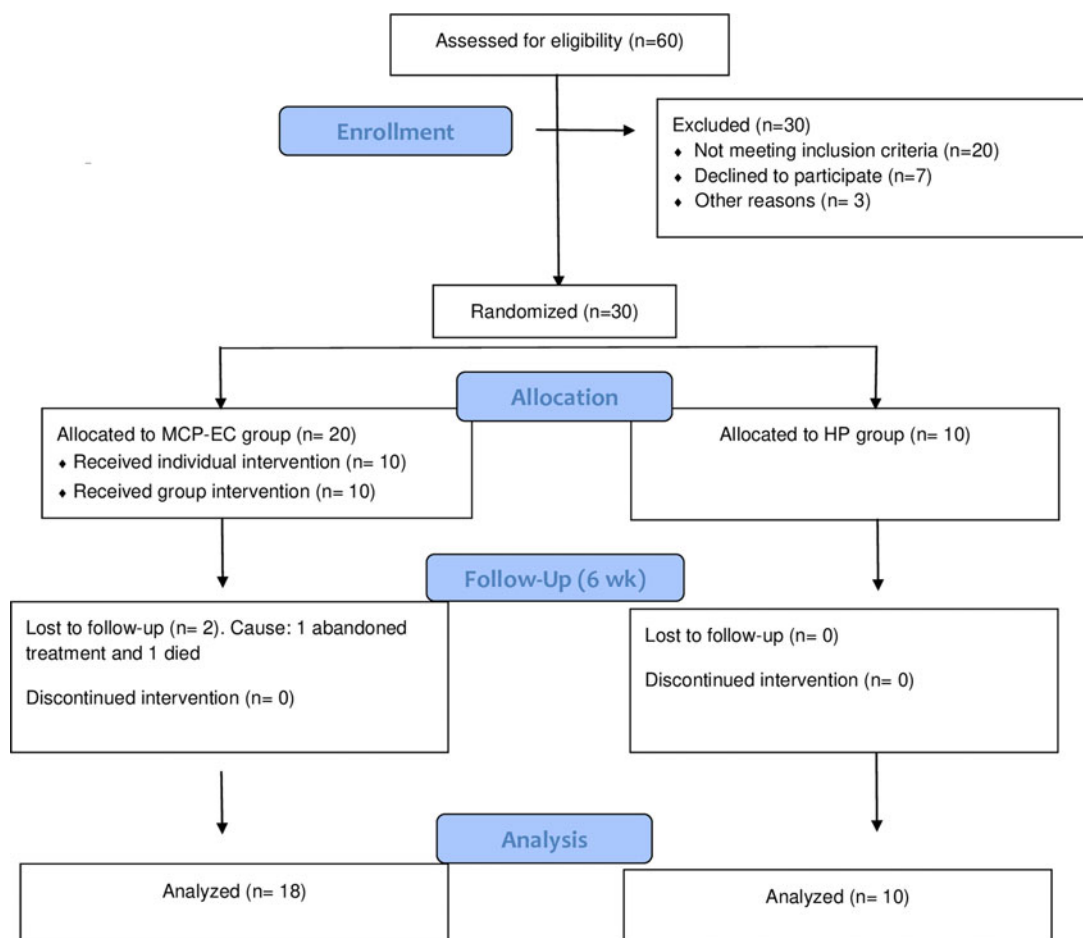


Fig. 1. Flowchart of the study.

A single-center and prospective study with 20 patients diagnosed with advanced cancer. First, the patients were randomized to one of the two arms of the study; experimental arm: Individual MCP-EC ($n = 10$) or control arm: routine care and usual supportive psychological intervention in medical reviews ($n = 10$). The patients were assigned randomly and consecutively following a balanced assignment process using EPIDAT 4.0 software with two groups of equal size. In a second phase, 10 patients were assigned consecutively to Group MCP-EC ($n = 10$).

Control group

The control group received usual care in the form of individual supportive psychological intervention. A first visit was carried out to conduct a psychological and emotional assessment of the patient as well as to assess the distress in each case, the need for psychotropic therapy, in addition to indicating general guidelines for coping with cancer. At a follow-up visit, two weeks after signing the informed consent, patients were asked their cancer-related concerns, but no structured psychological intervention was performed. None of the control participants followed additional psychotherapy during the four-week course of the study.

MCP-EC intervention

MCP-EC consisted of four individual consecutive sessions (one per week) with a duration depending on the functional capacity of the patient (approximately 45 min each). The sessions were led by the psychiatrist of the Psycho-Oncology Unit (Tirso

Ventura MD, PhD). In each meeting, a dialogue was established between the patient and the therapist focused on aspects related to the MCP developed by William Breitbart. Different didactic exercises, discussion topics and experiential tasks were carried out in each session. All of them were videotaped (with the prior signed permission of the patients) and took place in a private room, the Psycho-Oncology office, located in the area of the Psychosomatic Unit of the Clinical University Hospital in Zaragoza (Spain).

In the “Essential Care” session, we follow the same structure as in the MPC sessions (Breitbart and Poppito, 2014a, 2014b). The objective of this session is to promote care and self-care and establish a care plan between the patients, their family, and the health-care team. This session offers the possibility of having a relative or close friend of the patient attend to participate in the care plan. Following the same methodology as in the CCM sessions, we defined and discussed with the patient concepts of care, self-care, responsibility, self-compassion, kindness, and attitude to face advanced cancer. As experiential task, we asked the patients to tell us about an experience of good care in their life, as well as how they take care of themselves and how they would like to be cared for (Supplementary material).

Table 1 shows the detail, content, and objective of the four sessions that were developed in our intervention.

A second phase was carried out with 10 patients ($n = 10$) who were consecutively recruited and assigned in two groups of five patients who followed the Group MCP-EC. The therapy included a total of four consecutive weekly sessions (approximately 60 min each), with the same structure applied to the individual psychotherapy sessions. All sessions were videotaped (with the prior

Table 1. Meaning-Centered Psychotherapy and Essential Care (MCP-EC): work plan

Session 1	Introduction of Psychotherapy. Cancer and Meaning
• Objective	Presentation of the patient, biography, and oncological history. Introduction of psychotherapy, definition of meaning, and concept of sources of meaning. Approach of the self-understanding and the experience of the meaning in life.
• Tasks	Explore identity and values before and after cancer diagnosis. Identify meaningful moments in your life. Offer read “Man’s Search for Meaning” by Viktor Frankl.
Session 2	Sources of meaning
• Objective	Recognition and exploration of different sources of meaning: • experiential (e.g., love, beauty, and humor) • creative (e.g., roles, responsibility, and accomplishments) • attitude (e.g., facing life’s limitations).
• Tasks	Identify limitations or difficulties in life. Explore the ability to cope with obstacles such as cancer. Recognize the courage and commitment to live despite adversity.
Session 3	Historical sources of meaning
• Objective	Exploration of the historical sources of meaning as well as the concept of legacy in the past, present, and future.
• Tasks	Identify experiences that have left a mark on the patient’s life. Reflect on the most significant achievements in his life. Value learning or hopes for the future.
Session 4	Essential care
• Objective	Promote care and self-care and to establish a care plan between the patient, their family, and the healthcare team. This session offers the possibility of attending a relative or close friend of the patient to participate in the care plan.
• Tasks	Reflect an experience of good care in your life. Value responsibility, self-compassion, kindness. Attitude: Upright, Whole, Careful. How would you like to take care of yourself and be cared for? How would you like us to help you?

signed permission of the patients), for an external evaluator to assess whether the key points of each session had been addressed.

Measurements

In both groups, evaluations were carried out using a number of questionnaires and scales at two different timepoints: baseline or pre-intervention (before the start of MCP-EC or usual psychological support) and post-intervention (one week after last MCP-EC session or five weeks after the completion of the baseline evaluation in the control group).

The scales or questionnaires used were the following: questionnaire of sociodemographic and clinical data: EQ-5D-3L, Quality-of-Life Questionnaire (Badia et al., 1999), Functional Assessment of Chronic Illness Therapy of Spiritual Well-being Scale (FACIT; Brady et al., 1999; Peterman et al., 2014; Spanish validation of Cella et al., 1998), Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983; Spanish validation of Tejero et al., 1986), Self-Compassion Scale-Short Form (SCS-SF; Spanish validation of García-Campayo et al., 2014), Hopelessness Assessment in Illness Scale (HAI; Rosenfeld et al., 2011), Demoralization Scale (DM; Kissane et al., 2004), and the Distress Thermometer (DT; Roth et al., 1998; Tuinman et al., 2008; Spanish validation of Martínez et al., 2013). All the evaluation instruments used in the study are adapted and validated for the Spanish population, except HAI and DM.

The criteria used to assess the feasibility of our study were the percentage of patients who complete the four sessions, and the percentage of patients who answer all the questionnaires under study.

Patients in the MCP-EC arm, both in individual and group format, also received a Post-Therapy Assessment Questionnaire (PTAQ) to evaluate the acceptability of the new intervention. This questionnaire was developed with the collaboration of F. Gil, and consists of 13 items assessing the usefulness and satisfaction with the received therapy (Figure 3).

Statistical analysis

Patients' characteristics and clinical outcomes were summarized for each treatment group using descriptive statistics. Data were described as mean (standard deviation) or the number of cases (percentages) and compared using the χ^2 test with Yates correction for categorical variables and two-sample *t*-test for continuous variables. Paired sample *t*-tests were used when subjects were measured twice. All analyses were performed with R version 4.0.3 and the appropriate packages using an alpha level of 0.05.

Results

Our pilot study included 30 patients ($n = 30$) with a diagnosis of advanced cancer and emotional distress. 73% of the cases were women ($n = 22$) and the mean age was 55.3 years (range: 36–71). Table 2 shows the sociodemographic and clinical characteristics of the sample.

Of the 30 patients included, 20 patients received MCP-EC of whom 10 patients received the psychotherapy in an individual manner, while 10 patients received group psychotherapy. Of the 10 patients who received individual psychotherapy, 9 of them completed all sessions and questionnaires (1 of them dropped out of therapy by choice). All patients (10) who received group

psychotherapy completed the sessions. However, only 9 completed the questionnaires (1 could not complete the post-intervention questionnaire due to death).

All patients completed the baseline assessment that included the sociodemographic and clinical data questionnaire, the EuroQoL quality-of-life questionnaire (EQ-5D-3L), and six scales that measured emotional distress and/or spiritual well-being (FACIT, HADS, SCS-SF, HAI, DM, and DT).

Table 3 shows the results obtained in the baseline evaluation with the six previously mentioned scales that measured emotional and spiritual variables. There were no significant differences between groups (control and MCP-EC) in any of the scales or parameters assessed in this baseline evaluation. All the patients presented emotional discomfort or distress in the baseline (pre-treatment). Patients in both groups scored equally high ($p = 0.866$ for the difference between groups) with respect to anxiety and depression according to the HADS scale. DM scale showed a high demoralization (score equal to or greater than 11) without significant differences between treatment groups ($p = 0.698$). DT reflected a similar emotional distress in both treatment arms (global score equal to or greater than 4) with nonsignificant differences between groups ($p = 0.271$). In a similar trend, the rest of the scales and questionnaires that evaluated parameters of hopelessness, spiritual well-being, and self-compassion did not show significant differences between groups at the baseline.

The second evaluation was carried out post-treatment in both groups. This evaluation was completed by 28 study patients. Two patients from the psychotherapy group did not fulfill the post-intervention questionnaires: one left the study and one died.

Figure 2 shows the variation between the pre- and post-treatment evaluations for some key parameters.

Compared to baseline, the routine care for four weeks in the control group did not notably change the post-treatment scores in the evaluations carried out. HADS, FACIT, HAI, and SCS-SF scales showed a trend toward improved emotional well-being, although nonstatistically significant. Only the DT showed less distress in the post-intervention evaluation of patients in this group ($p = 0.011$ for the comparison pre- vs. post-treatment).

MCP-EC was applied in 20 patients (10 in individual format and 10 in group format). In both groups, the patients received the four sessions with the same format and content. We did not observe differences between both groups neither in sociodemographic and clinical characteristics nor in the baseline assessment of emotional state and distress before treatment (Supplementary tables). Consequently, we merged both groups in the analyses carried out hereinafter.

MCP-EC group showed significant differences between pre- and post-treatment. Thus, the EQ-5D-3L scale scored higher in the post-intervention evaluation, related to better quality of life ($p = 0.042$). MCP-EC also decreased the HADS scale, both in the depression (HADS-D) and anxiety (HADS-A) sub-scales ($p < 0.001$), as well as the DM ($p = 0.005$) and HAI ($p < 0.001$). A similar trend toward greater spiritual well-being was observed in the FACIT scale after MCP-EC ($p = 0.007$). Self-compassion, measured by the SCS-SF, also increased after psychotherapy ($p = 0.029$). Lastly, the Distress Thermometer also showed a decrease in emotional distress after MCP-EC in all patients ($p = 0.006$).

Our results show a statistically significant benefit of MCP-EC over the control group in all the evaluations post-intervention. The higher differences were observed using the HADS, FACIT, DM, and HAI scales.

Table 2. Sociodemographic and clinical characteristics

	All (n = 30)	Control (n = 10)	MCP-EC (n = 20)	p
Sex				0.682
Women	22 (73.3%)	8 (80%)	14 (70%)	
Men	8 (26.7%)	2 (20%)	6 (30%)	
Age (years)	55.3 (9.30)	56.0 (8.89)	54.9 (9.71)	0.760
Nationality				1.000
Spain	26 (86.7%)	9 (90%)	17 (85%)	
Other	4 (13.3%)	1 (10%)	3 (15%)	
Place of residence				0.029
Urban	22 (73.3%)	10 (100%)	12 (60%)	
Rural	8 (26.7%)	0 (0%)	8 (40%)	
Marital status				0.335
Single	4 (13.3%)	2 (20%)	2 (10%)	
Married	22 (73.3%)	8 (80%)	14 (70%)	
Divorced	4 (13.3%)	0 (0%)	4 (20%)	
Education level				0.429
Primary	10 (33.3%)	5 (50%)	5 (25%)	
Secondary	2 (6.67%)	1 (10%)	1 (5%)	
Technical/Higher Secondary	11 (36.7%)	2 (20%)	9 (45%)	
University	7 (23.3%)	2 (20%)	5 (25%)	
Religion				0.481
Practicing Catholic	11 (36.7%)	3 (30%)	8 (40%)	
Non-practicing Catholic	10 (33.3%)	5 (50%)	5 (25%)	
Agnostic	4 (13.3%)	0 (0%)	4 (20%)	
Non-believer—Atheist	3 (10%)	1 (10%)	2 (10%)	
Other	2 (6.67%)	1 (10%)	1 (5%)	
Smoking status				1.000
Non-smoker	9 (30%)	3 (30%)	6 (30%)	
Previous smoker	16 (53.3%)	5 (50%)	11 (55%)	
Smoker	5 (16.7%)	2 (20%)	3 (15%)	
Previous psychotherapy	3 (10%)	0 (0%)	3 (15%)	0.532
Tumor location				0.662
Lung	10 (33.3%)	3 (30%)	7 (35%)	
Breast	10 (33.3%)	4 (40%)	6 (30%)	
Gynecological tumor	2 (6.67%)	0 (0%)	2 (10%)	
Gastrointestinal	2 (6.67%)	2 (20%)	0 (0%)	
Kidney	2 (6.67%)	1 (10%)	1 (5%)	
Urothelial	1 (3.33%)	0 (0%)	1 (5%)	
Brain	1 (3.33%)	0 (0%)	1 (5%)	
Soft tissue	1 (3.33%)	0 (0%)	1 (5%)	
Unknown origin	1 (3.33%)	0 (0%)	1 (5%)	
Tumor histology				0.440
Squamous/epidermoid carcinoma	3 (10%)	0 (0%)	3 (15%)	
Adenocarcinoma	15 (50%)	6 (60%)	9 (45%)	

(Continued)

Table 2. (Continued.)

	All (n = 30)	Control (n = 10)	MCP-EC (n = 20)	p
Small cell or neuroendocrine carcinoma	5 (16.7%)	2 (20%)	3 (15%)	
Lobular carcinoma	1 (3.33%)	1 (10%)	0 (0%)	
Other	6 (20%)	1 (10%)	5 (25%)	
Tumor stage				
IV (advanced)	30 (100%)	10 (100%)	20 (100%)	
Line of Therapy				
No treatment	1 (3.33%)	1 (10%)	0 (0%)	0.476
First line	16 (53.3%)	4 (40%)	12 (60%)	
Second line	6 (20%)	2 (20%)	4 (29%)	
Third line or later	7 (23.3%)	3 (30%)	4 (20%)	

Data are expressed as the number of cases (%).

MCP-EC: Meaning-Centered Psychotherapy and Essential Care.

p: p-value for the comparison between groups.

PTAQ was administered 2 months after completing the Group MCP-EC and 3 months after completing the Individual MCP-EC psychotherapy (n = 20): 13 responded (5 patients in MCP-EC individual and 8 patients in MCP-EC group); 6 had died and 1

dropped out in the first session. Patients were asked to rate their responses to the patient satisfaction questionnaire on scale ranging 0, 1, 2, or 3 (not at all, a little, quite a bit, a lot), with higher scores indicating greater satisfaction (Figure 3). We reviewed the results of the MCP-EC in six patients who died before completing the PTAQ and they too showed improvement in their scores on the emotional distress scales with statistically significant differences ($p < 0.05$) in the following scales and questionnaires: HADS, DS, HAI, FACIT, and SCS-SF.

Table 3. Baseline (pre-intervention) evaluation according the scales/questionnaires used

Scale—Questionnaire	Control (n = 10)	MCP-EC (n = 20)	p
HADS (total)	19.8 (8.64)	19.2 (7.42)	0.866
Anxiety	11.4 (5.19)	10.2 (4.10)	0.533
Depression	8.40 (4.09)	9.05 (4.76)	0.702
FACIT (total)	28.8 (9.84)	28.6 (6.96)	0.944
Meaning and peace	20.9 (4.95)	20.6 (4.91)	0.877
Faith	7.90 (5.57)	7.95 (4.84)	0.981
Demoralization scale (total)	13.9 (8.76)	15.2 (6.75)	0.698
Meaning and purpose	6.40 (4.53)	6.30 (3.99)	0.953
Distress and coping	7.50 (4.43)	8.85 (3.17)	0.404
Hopelessness Scale—HAI questionnaire	6.90 (3.38)	7.40 (3.76)	0.717
Self-compassion Scale (SCS-SF) (total)	18.1 (4.72)	17.5 (3.93)	0.744
Self-kindness/ Self-judgment	5.90 (2.18)	6.00 (1.41)	0.897
Common humanity/ Isolation	6.65 (1.53)	5.83 (1.43)	0.172
Mindfulness/ Over-identification	5.55 (1.59)	5.70 (1.96)	0.824
Distress Thermometer (global)	6.75 (2.10)	5.80 (2.29)	0.271

Data are expressed as mean (standard deviation).

MCP-EC: Meaning-Centered Psychotherapy and Essential Care.

p: p-value for the comparison between groups.

HADS, Hospital Anxiety and Depression Scale; FACIT, Functional Assessment of Chronic Illness Therapy; HAI, Hopelessness Assessment in Illness; SCS-SF, Self-compassion Scale-Short Form.

Discussion

The present pilot study was designed to assess the feasibility, acceptability, and preliminary efficacy of a brief psychotherapeutic intervention (MCP-EC), compared to usual clinical care, to address the psychosocial needs of patients with advanced cancer.

The study intervention (MCP-EC) consisted of four consecutive weekly sessions. Nineteen of the 20 patients (95% of the experimental group) were able to attend and complete all sessions. Only one of the individual psychotherapy patients decided to drop out of the study after the first session, which translates into a great compliance and a high adherence to this psychological treatment. This demonstrates the feasibility of the intervention and the high adherence to psychological treatment with a minimal loss of patients attending the sessions. This adherence rate is higher than that obtained in the pilot study of individual psychotherapy focused on sense (Breitbart et al., 2012) in which 65% completed the post-treatment evaluation. Post-treatment evaluations were compared with baseline evaluations for each subject and 28 of the 30 patients, including control group, completed the study (93%). The methodology was designed following the recommendations of pilot studies on meaning-centered psychotherapy (Gil and Breitbart, 2013; Breitbart, 2017). Our data suggest that the selection of participants, number of sessions and the intervention model can be important to ensure compliance and adherence to therapy and subsequent evaluation. In summary, the rate of patients who complete the four sessions (95%) and the rate of patients who answer all the questionnaires under study (93%), demonstrates the feasibility of the intervention, one of the main objective of this pilot study.

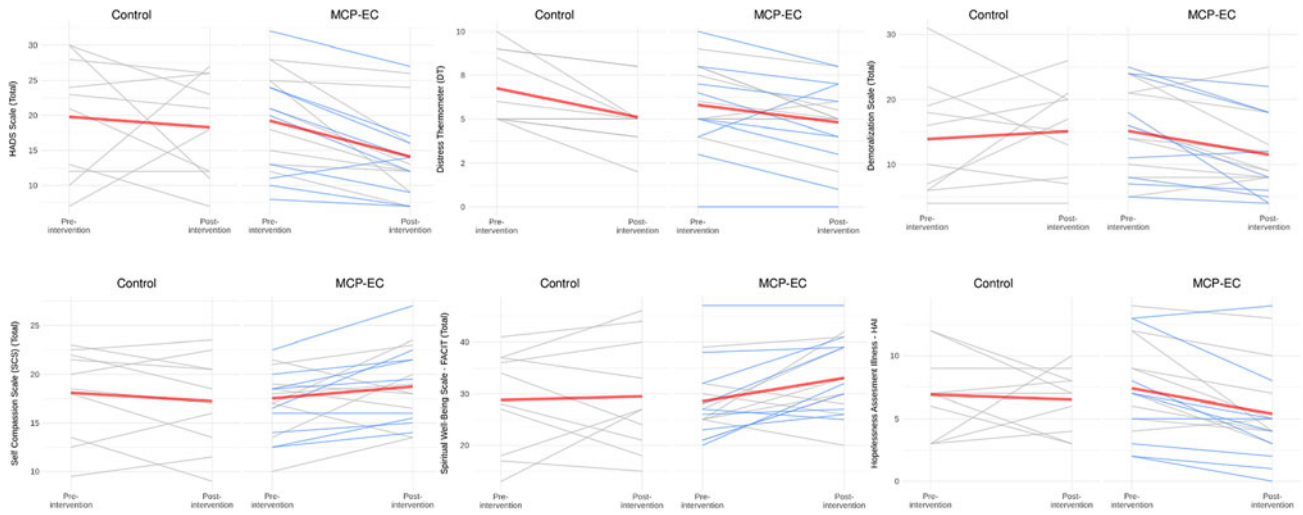


Fig. 2. Comparison of pre- and post-treatment evaluation in both treatment groups. Thin lines represent the individual variation for each individual patient. The red line represents the mean variation for the treatment group. Blue lines indicate patients who underwent group psychotherapy, while grey lines indicate individual psychotherapy.

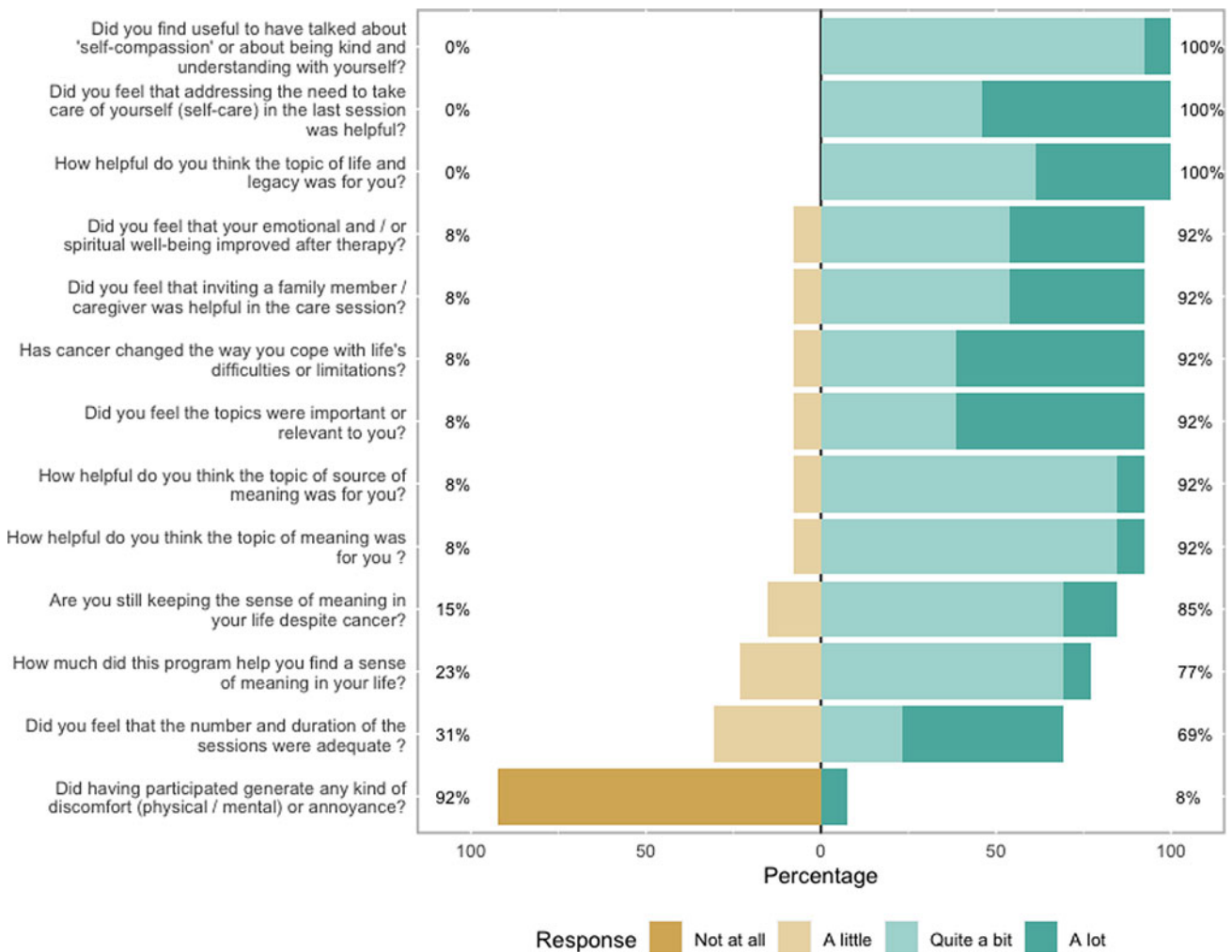


Fig. 3. Patients response to post-therapy assessment questionnaire (PTAQ).

PTAQ assesses acceptability by asking if patients found satisfaction and usefulness of the applied therapy. In the MCP-EC, the mean score was 2.1. Our results were similar to those reported by Gil et al. (2018), with mean scores ranging from 2.1 (MCP-PC) to 2.4 (Standard Counseling and MCP-compassionate palliative care groups). It should be noted that, in our pilot study, six patients were unable to complete the PTAQ because they had died when the questionnaire was administered 2 months after completing the Group MCP-EC and 3 months after completing the Individual MCP-EC psychotherapy. This loss in response to the PTAQ questionnaire due to the death of six patients may indicate the clinical severity of the patients studied, who nevertheless expressed an improvement in emotional distress at the end of therapy on the HADS, DS, HAI, FACIT, and SCS-SF.

Despite the impact on these patients, emotional distress has been underestimated, due to the importance of their somatic pathology and the lack of adequate therapeutic resources (Holland, 2013). In our sample ($n = 30$), all patients presented emotional distress at baseline evaluation (pretreatment). There were no significant differences between the two groups (control vs. MCP-EC) in any of the scales or parameters assessed. This indicates that the patient selection and randomization were adequate and the emotional state before performing the intervention was similar in both groups.

Our baseline assessment of the HADS, HAI, DT scales showed greater emotional distress in our patients compared with other studies in advanced cancer using similar methodology (Breitbart et al., 2012, 2015, 2018). We postulate that the profile of the participants in our study is associated with increased emotional distress due to the greater severity of the oncologic pathology; all stage IV subjects (100%), of whom 90% were receiving active oncologic treatment. Yet, despite the greater severity, our MCP-EC intervention was able to improve the emotional distress associated with advanced cancer.

We are aware that we have used many questionnaires in this pilot study, but we wanted to test how they work in patients with advanced cancer, since many scales are used to detect emotional distress in general cancer patients. Further studies are needed to evaluate the intercorrelation between different instruments, as well as validation studies to determine different cut-off points on these instruments as other authors have reported (Trask et al., 2002; Graham-Wisener et al., 2021).

No significant differences were found in the control group regarding the scales performed before and after the intervention. Usual supportive care had no emotional impact in our sample. This highlights the need to develop new interventions aimed at managing emotional distress, beyond the usual supportive psychological intervention.

On the other hand, the results of the MCP-EC treatment were very different. All evaluations performed showed a reduction in anxiety, depressive symptoms, hopelessness, and demoralization while increasing spiritual well-being and enhancing sense of meaning. These results are in line with pioneering studies of MCP in both individual and group formats (Breitbart et al., 2012, 2015; Gil et al., 2018) which reported improvement in emotional well-being and quality of life with a greater reduction in feelings of depression, hopelessness, and desire to hasten death. Our results hence demonstrate the preliminary efficacy of a psychological intervention focused on meaning and care in the emotional state, in a similar way to those previous studies.

Our study also supports the incorporation of family members and close friends to participate in the care plan as well as the

inclusion of “essential care” construct in meaning-centered psychotherapy. In the fourth session, named “Essential Care,” the patient was offered the possibility of having a family member or trusted person present. Of the 20 patients, only one patient attended this last session alone. Our results suggest that the participation of a “trusted caregiver” in the MCP-EC may positively influence the feasibility, acceptability, and efficacy of this psychotherapeutic intervention (Figure 3). As has been published in other studies, the inclusion of constructs as compassion, self-compassion, care, self-care, kindness can integrated better after working on the constructs of MCP (attitude, courage, commitment, and others) (Breitbart, 2017; Gil et al., 2018).

In summary, this pilot study confirms the feasibility, acceptability, and preliminary efficacy of the MCP-EC and supports the creation and implementation of tools and protocols of brief emotional intervention in the usual clinical practice of caring in patients with advanced cancer.

Study limitations

The main limitation of the study was the reduced sample size. Nevertheless, as an initial pilot study, it was based on the methodology of previous studies with similar or even smaller samples. Despite being a small sample, the intervention has proven to be feasible and accepted by the participating subjects.

We also consider a limitation of the study that the individual and group MCP participants are combined into one intervention group. The 10 patients who participated in group psychotherapy were not randomized, but were recruited consecutively. However, they met all the study criteria and did not show statistically significant differences in either the sociodemographic data, the pretreatment scales, or in the post-treatment scales, compared to the first 20 patients who were randomized.

Conclusion

This pilot study suggests that MCP-EC is feasible, acceptable, and reduces emotional distress in patients with advanced cancer, comparing this approach with usual support care. Our results are consistent with the literature published to date. However, more research is needed in larger samples to evaluate the efficacy of MCP-EC intervention.

All this points to the need to develop and apply brief psychotherapeutic interventions in routine clinical practice in patients with cancer to maintain the meaning of life, integrating concepts of care, to improve the psychosocial distress associated with advanced illness.

Supplementary material. The supplementary material for this article can be found at <https://doi.org/10.1017/S1478951521001486>.

Conflict of interest. The authors declare no conflict of interest.

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