Exploring Hope and Healing in Patients Living With Advanced Non-Small Cell Lung Cancer

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Lung cancer is the second most commonly diagnosed cancer in Canada (Canadian Cancer Society [CCS], 2012). An estimated 85%–90% of lung cancers are classified as non-small cell lung cancer (NSCLC), with almost half of patients with NSCLC presenting with advanced disease at the time of diagnosis (CCS, 2012). Advanced disease refers to NSCLC that has spread locally (stage IIIb) or distally (stage IV) to the lymph nodes or other tissues and organs (CCS, 2012). The five-year survival rates are poor at 13% and 19% for men and women, respectively (CCS, 2012).

Unsurprisingly, 43%–50% of patients with lung cancer experience psychological distress, surpassing the rates associated with all other diagnoses (Cooley, Short, & Moriarty, 2003; Tishelman et al., 2005; Zabora, BrintzenhofeSzoc, Curbow, Hooker, & Piantadosi, 2001). That distress has been linked to a number of cancer- and treatment-related factors that have been found to negatively affect the patients’ social, physical, and spiritual well-being and quality of life (Akin, Can, Aydiner, Ozdilli, & Duran, 2010; Fan, Filipczak, & Chow, 2007; Thompson, Solà, & Subirana, 2005). Such distress also has been associated with poor adherence to treatment and low satisfaction with care, contributing further to poor health and survival outcomes (Graves et al., 2007; Kaasa, Mestekaasa, & Lund, 1989; Kukull, McCorkle, & Drievers, 1986).

Although the terms are sometimes used interchangeably and their definitions overlap, distress is not a synonym of suffering but rather one of its components. Psychological distress is a predictor of suffering in patients with cancer (Wilson et al., 2007). Suffering has also been reported at all phases of the cancer trajectory and significantly affects patients’ ability to cope with advanced disease (Chio et al., 2006; Ferrell & Coyle, 2008). One of the first to explore the affective experience of suffering, Cassel (1982) deplored the separation of mind and body, which he felt contributed to suffering being given scant attention as it was unjustly relegated to the realm of the mind, thereby giving it less credibility within medicine. Cassel (1982) posited that suffering is experienced by the whole person and occurs when the “impending destruction of the person is perceived” and lasts until the threat has passed or until the person can restore a new sense of integrity (p. 640). This suffering occurs in any of the multiple facets of the person (e.g., physical, emotional, social, spiritual) (Cassel, 1982).