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Narrating family support and psychological adaptation among patients with advanced cancer in a Chinese cultural context: an exploratory secondary qualitative narrative analysis

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Abstract

Purpose

Palliative care is fundamentally centered on empathy, reflection, and humanized communication. While family support is vital in family-centered cultures, literature often conceptualizes it in rigid, categorical terms, rarely addressing the relational trajectories that guide clinical narrative communication.

Aim

To explore how advanced cancer patients narratively experience family interactions in relation to psychological adaptation, and to provide a culturally situated interpretive framework for family-sensitive palliative care.

Design:

A secondary qualitative narrative analysis using a narrative-interpretive approach and categorical-content analysis on a previously collected narrative dataset regarding spiritual health.

Setting/Participants:

Five patients with advanced cancer receiving palliative care within a specialist care setting in Macao.

Results

Four recurrent narrative patterns were identified: (1) shared emotional containment in family relationships; (2) recognition of enduring family roles; (3) co-constructed meanings of illness within family dialogue; and (4) intergenerational continuity and legacy-oriented narration. Participants described family support not just as practical assistance, but as a crucial relational context through which distress was eased, personal identity was sustained, and illness was integrated into a broader life narrative.

Conclusions

This secondary narrative analysis refines the understanding of family support by demonstrating its dynamic organization alongside psychological adaptation in a Chinese cultural context. By highlighting the authentic inner voices and reflexive trajectories of these narratives, the findings offer an essential framework to guide healthcare professionals in conducting narrative-informed, humanized communication that fosters the positive meaning of family.

Highlights

1. Palliative nurses function as "family narrative facilitators and witnesses" within clinical environments, enacting narrative nursing principles through relational care.
2. The narrative nursing pathway is enacted in palliative wards via four interconnected stages: externalization, reconstruction, witnessing, and transmission—corresponding to the four relational adaptation processes identified in this study.
3. This theoretically grounded approach demonstrates how family support enhances psychological adaptation in advanced cancer patients through specific relational processes rather than generic emotional comfort.
4. A relational adaptation framework is proposed, conceptualizing family as simultaneously operating as affective regulator, identity mirror, interpretive partner, and continuity vessel.

Introduction

Psychological distress is pervasive among patients with advanced cancer, manifesting as anxiety, depression, existential suffering, and disrupted sense of self [1, 2]. Family support has consistently been identified as a protective factor associated with improved emotional adjustment, reduced depressive symptoms, and enhanced quality of life[3, 4]. However, the existing literature predominantly conceptualizes family support through categorical frameworks—classifying it into emotional, instrumental, informational, and appraisal dimensions[5, 6]) often grounded in the stress-buffering model [7], which posits that social support mitigates the health impact of stressful events. While these frameworks clarify what is provided and that it is protective, they do not illuminate how relational interactions within families reshape patients' psychological adaptation over time.

This process-level gap is particularly consequential. Understanding the relational processes through which family support operates—rather than merely cataloguing its types—is essential for designing family-centered interventions that go beyond resource provision[8]. Yet the majority of prior research relies on cross-sectional correlational designs that link support variables to outcome measures without explicating the temporal, interactive pathways connecting them [9, 10]. How family relationships reorganize emotional regulation, sustain identity continuity, and facilitate existential meaning-making in the trajectory of advanced illness remains largely unexplored.

This gap is especially salient in Chinese cultural contexts. In Chinese family systems, illness is experienced collectively rather than individually[11]. Confucian values of filial piety position caregiving as a moral obligation that shapes intergenerational relational dynamics[12]. The concept of relational self means that identity and emotional regulation are fundamentally embedded in family bonds rather than located solely within the individual[13]. Consequently, the processes through which family support shapes adaptation may operate differently—and more centrally—than models derived from Western individualistic frameworks suggest. A culturally situated investigation is therefore needed to capture these relational dynamics authentically.

Narrative inquiry offers a methodologically coherent approach to addressing this gap. Narrative theory posits that individuals make sense of disruptive experiences by integrating them into evolving life stories, and that this meaning-making is inherently relational—shaped through dialogue with significant others[14]. A narrative lens enables researchers to trace how patients reconstruct illness meaning within family relational environments over time, moving beyond static snapshots to capture dynamic processes of adaptation[15].

This study therefore advances current understanding by conceptualizing family support as a relationally embedded narrative process described by patients as shaping psychological adaptation. The study aimed to explore how patients with advanced cancer narratively construct the role of family support and to identify relational processes through which family interactions shape psychological adaptation within a Chinese cultural context.

Methods

Analytic orientation

The purpose of the secondary analysis was not to generate a formal explanatory model or to claim exhaustive coverage of family processes in advanced cancer. Rather, it aimed to develop a focused interpretive account of recurrent narrative patterns within a small set of information-rich cases. Attention was given to how participants organized their accounts of illness, family relationships, emotional coping, and future-oriented reflection, and to how these elements were narratively linked to adaptation. The resulting framework is therefore heuristic and culturally situated, intended to clarify patterns of meaning within these narratives rather than to establish sequential, universal, or causal stages.

Study Design

This study adopted a qualitative narrative research design grounded in constructivist epistemology. Narrative inquiry was selected because of its capacity to illuminate how individuals construct meaning from illness experiences within relational and temporal contexts [16,17]. The specific analytic approach was the categorical-content model described by Lieblich, Tuval-Mashiach, and Zilber (1998)[16], which enables systematic categorization of narrative content segments while preserving the contextual integrity of each participant's story. This approach was suited to identifying recurring relational patterns described by participants as associated with psychological adaptation in patients with advanced cancer.

This study represents a secondary theoretical analysis. Although family narratives were not the sole focus of the original data collection, substantial relational content was present within the interviews. The analytic aim of the present study differs from the prior publication[18] in its exclusive focus on family-mediated relational meaning-making processes. All transcripts were reanalyzed in their entirety for this purpose.

Secondary analysis of qualitative data is methodologically appropriate when the original dataset contains sufficient depth and relevance to address a distinct research question [19,20]. The current analysis differs from the prior publication in its exclusive analytic focus on family relational processes that facilitate psychological adaptation—a dimension not examined in the original study, which addressed narrative nursing practices and spiritual care processes.

This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [21] (see Supplementary File).

Setting and Participants

Five participants were recruited from the palliative care unit of Kiang Wu Hospital in Macao between March and May 2025 using purposive sampling. The clinical, sociodemographic, and cultural characteristics of the sample are detailed in Tables 1 and 2.

Inclusion criteria:

1. Pathologically confirmed advanced carcinoma, classified as TNM clinical stage III–IV.
2. Age ≥18 years.
3. Awareness of cancer diagnosis.
4. Ability to communicate verbally in Cantonese or Mandarin.
5. Capacity to provide informed consent.

Exclusion criteria:

1. Severe psychiatric disorder (e.g., psychotic features, active suicidal ideation).
2. Severe depressive symptoms as indicated by PHQ-9 score >15 [22] .
3. Cognitive impairment affecting sustained interview participation.

Given the narrative depth required to examine relational processes and temporal transitions in illness experience, the sampling strategy prioritized informational richness over numerical breadth [23]. Five participants were included—a sample size consistent with narrative inquiry studies seeking in-depth, case-oriented analysis [17]. Sampling concluded when cross-case analysis revealed no additional recurring relational patterns within this homogeneous sample. Given the small and culturally homogeneous sample, the intention was conceptual elaboration rather than theoretical saturation in a grounded theory sense. [23,24].

All participants reported high perceived family support and no family conflict (Table 1). This homogeneity reflects the clinical reality of the recruitment setting—a palliative care unit where family involvement is normatively high—and limits the transferability of findings to contexts where family support is absent or conflictual.

Data Collection

Semi-structured narrative interviews were conducted between March and May 2025. Each interview lasted 45–60 minutes and took place in a private room within the palliative care unit. All interviews were conducted in Cantonese by the first author (WL), audio-recorded, and transcribed verbatim.

Interview guide development. A semi-structured interview guide comprising 12 questions was developed informed by the FICA framework (Faith, Importance, Community, Address) [25] and the literature on psychological adaptation, meaning-making, and relational support in advanced cancer [26,27] (see Supplementary File for the complete guide). FICA served as a sensitizing structure to facilitate broad exploration of spiritual beliefs, perceived meaning, relational networks, and coping practices; it was not applied as an analytic framework.

The guide was reviewed by two hospice care experts for relevance and cultural sensitivity, and pilot-tested with two patients meeting inclusion criteria (not included in the final sample). Minor wording refinements were made to enhance narrative openness and reduce directiveness.

Questions particularly relevant to the current analysis included:

- "Would you mind telling us how you felt and what you thought from the time you were diagnosed with cancer until now, when you are at the hospice centre?" (Q1)
- "What do you think makes your life worth living?" (Q4)
- "Is there someone or a group of persons that you really love or that are really significant to you?" (Q5)

During interviews, follow-up probes were used to explore specific relational episodes, emotional turning points, and the perceived role of family interactions in participants' psychological adjustment. For example, when participants mentioned family members, the interviewer probed further with questions such as "Can you tell me more about how your family responded at that time?" or "How did that interaction affect how you were feeling?" Field notes were recorded after each interview to document emotional tone, nonverbal cues, and relational dynamics observed during the encounter.

Data Analysis

Data analysis followed the categorical-content approach [16] and proceeded in five stages:

1. **Holistic reading**: Each transcript was read multiple times in its entirety to develop a global understanding of the narrative arc, emotional trajectory, and relational context.
2. **Extraction of meaning units**: Narrative segments pertaining to family interactions, relational episodes, and psychological transitions were identified and extracted as meaning units.
3. **Inductive categorical coding**: Meaning units were organized into inductively derived categories reflecting patterns in how family relational interactions influenced psychological experience.

4. **Identification of relational processes**: Categories were examined for recurring relational patterns that participants narratively linked to perceived psychological shifts. A relational pattern was retained when: (a) it appeared in at least three of five cases; (b) participants explicitly described a perceived psychological shift; and (c) the narrative linked the family interaction to that shift. This criterion was applied to enhance analytic transparency rather than to establish causal inference. This triple criterion reduced the risk of overinterpretation from isolated narrative excerpts.
5. **Cross-case comparison** : Identified processes were compared across all five cases to examine variation, contextual conditions, and narrative consistency.

Analysis was conducted on the original Cantonese transcripts by the first author (WL) to preserve linguistic and cultural nuance. Coding and categorical decisions were independently reviewed by the corresponding author (ZL), with discrepancies resolved through discussion until consensus was reached. Illustrative quotations were translated into English by the first author and verified by the corresponding author to ensure translational accuracy while retaining idiomatic meaning.

Researcher Reflexivity and Trustworthiness

Researcher positionality. The first author (WL) is a registered nurse with over 10 years of clinical experience in the palliative care unit where data were collected, and holds a Master's degree in Nursing with a research focus on spiritual well-being in advanced cancer patients. This dual role as clinician-researcher may have facilitated rapport and trust, enabling participants to share sensitive narratives with greater depth. However, it also introduced potential influence through pre-existing clinical relationships, perceived dependency, or social desirability. The research team maintained reflexive awareness of assumptions regarding family-centred cultural values in Chinese society and actively examined alternative interpretations during analysis.

Strategies to enhance rigor: [28,29]

- *Reflexive journaling*: The first author maintained a reflexive journal documenting positionality concerns, emotional responses, and evolving interpretive decisions after each interview and analytic session.
- *Peer debriefing*: Regular debriefing sessions were held with two senior qualitative researchers, focusing on analytic decisions, category boundaries, and alternative interpretations.
- *Member reflections*: Participants were invited to review and comment on preliminary interpretive summaries. Rather than seeking verification of "accuracy," these reflections served as opportunities for participants to add nuance or raise divergent perspectives .
- *Audit trail*: All analytic decisions, coding iterations, and thematic evolution were documented systematically .
- *Thick description*: Findings are presented with detailed contextual information and extensive participant quotations to support transferability judgments by readers.

- *Triangulation*: Credibility was strengthened through triangulation between interview data, field notes, and theoretical interpretation .

Ethical Considerations

Ethical approval was obtained from the Ethics Committee of Kiang Wu Hospital (Approval No.: KWH 2025-013). The study was performed in accordance with the 1964 Declaration of Helsinki and its later amendments. Written informed consent was obtained from all participants prior to data collection. Participants were informed of their right to withdraw at any time without affecting their clinical care. Given the emotionally sensitive nature of end-of-life narratives, emotional distress was actively monitored during interviews, and a referral pathway to hospital psychological services was established. Pseudonyms are used throughout to protect participant identity.

Findings

Five participants (three men and two women; age range 65–77 years) described their illness experiences as deeply embedded within family relationships. Analysis suggested that participants described family support not merely as instrumental assistance but as a relational context within which emotional regulation, identity continuity, and existential meaning were narratively reorganized. Four interrelated relational processes were identified, each associated with a discernible psychological transition. Table 3 summarizes the cross-case distribution of these processes.

1. Shared emotional containment in family relationships

Initial cancer diagnosis was described as a moment of emotional disintegration characterized by fear, helplessness, and anticipatory grief. Participants did not experience these emotions in isolation; rather, distress was co-experienced and modulated within family interactions. This process was evident across all five cases.

Family presence functioned as an affective stabilizer. Participants described emotional relief not simply because relatives offered comfort, but because emotional burdens were redistributed within the relational field. Shared crying, mutual reassurance, and silent companionship created what may be understood as emotional co-regulation—a process through which one person's affective state was regulated through synchronization with the emotional composure of another.

One participant described his darkest period of hospitalization, where family daily visits and the anticipation of new family life collectively prevented emotional collapse:

My children treat me very well; they visit me every day and bring me food. My daughter is seven months pregnant—I tell her she doesn't need to come so often. (Ba014) Life is just about living. For the sake of survival—my granddaughter is about to be born, my youngest son is about to get married—there's no reason to die so soon. Being alive and able to care for yourself—that is life's meaning. It's that simple. (P2, age 65) (Ba003)

Another participant described how the constant companionship of family members during treatment and hospitalization provided her greatest source of spiritual comfort:

My husband, daughter, and daughter-in-law always accompany me to follow-ups and treatments. They are truly wonderful. (Da002) Family's daily greetings and companionship are my greatest spiritual comfort. (P4, age 77) (Da006)

Similarly, P5 described family as a stabilizing force that sustained him throughout the illness trajectory:

My children are very supportive now. Ever since I got this illness, my family has been behind me, holding me up. (P5, age 76) (Ea003)

Across cases, emotional stability emerged not from individual coping strategies alone but from synchronized relational adjustment. Family members' consistent physical presence, calm demeanor, and practical caregiving collectively constituted a relational environment within which acute distress was contained.

This process marked the first psychological transition: from acute psychological fragmentation toward affective containment.

2. Recognition of enduring family roles

As treatment progressed, physical deterioration threatened participants' established family roles—as providers, decision-makers, and mentors. However, rather than relinquishing identity, participants actively reinterpreted their positions within the family system. This process was identified in all five cases.

Role reaffirmation took several forms. Some participants emphasized continued involvement in family responsibilities and value transmission. Others asserted agency through the acknowledgment that their life duties had been fulfilled—a realization enabled by family members who respected their contributions and continued to validate their enduring significance. For instance, P2 articulated satisfaction with having fulfilled his paternal role, maintaining identity as a responsible provider:

Actually, I've done well in every role. Once you have a family, you have responsibilities—at the very least, you provide for your three children through university. After that, they are on their own. As long as you do right by others and do right by society, you can live with a clear conscience. (P2, age 65) (Ba003)

P1 described how her grandson's reciprocal care during her chemotherapy validated her enduring role as a grandmother—the very relationship she had invested in years earlier now sustained her identity through illness:

My daughter and son-in-law used to be busy with work, so I often looked after my grandson and encouraged him. Everyone thought he was naughty, without any future. But now he has been admitted to medical school. When I vomit during chemotherapy, he even helps me clean up—he visits me every day. So I feel I did well as a grandmother and in looking after children. (P1, age 76) (Aa015)

P4 reflected on the fulfillment of her family roles, affirming her identity as a dutiful wife and mother even as illness progressed:

After work, I always took care of the household—cooking meals, looking after the family. I managed to fulfill the roles of a good wife and a good mother, and I was filial too. (P4, age 77) (Da006)

Furthermore, P3 expressed a settled sense of completed parental duty, which preserved his self-concept as a responsible father despite physical decline:

There is nothing I truly regret in life. Everyone dies eventually. My children have grown up—there is nothing to worry about. (P3, age 70)

P5 affirmed that building a family from nothing—despite being an adopted child from a poor background—constituted his life's central achievement:

In the beginning, I had no one to rely on, and my family was poor. But I built a family of my own through my own hard work, and I consider that a true success. (P5, age 76) (Ea035)

Even when physically dependent, participants maintained symbolic authority or relational responsibility. Family members' behaviors were critical in this process: when relatives continued to seek advice, express respect, or defer to the participant's judgment, patients interpreted this as validation of enduring identity. Through ongoing relational acknowledgment, participants preserved continuity between pre-illness and post-diagnosis self-concepts. Illness did not erase identity; it required renegotiation within family structures.

This process facilitated a second psychological transition: from identity disruption to role continuity.

3. Co-constructed meanings of illness within family dialogue

Participants' narratives revealed that meaning-making was dialogic rather than solitary. Interpretations of illness were shaped through conversations, shared memories, and collective reinterpretation of suffering. This process was identified in four of five cases (P1, P3, P4, P5), though the specific interpretive frameworks varied.

Some families framed illness as a life trial or karmic destiny, others as a stage of natural aging, and still others through the lens of scientific compliance. These frameworks were not imposed unilaterally; they evolved through family dialogue. P1 reframed her diagnosis from a personal failure to a cosmic alignment supported by collective care:

At first, I felt like a failure for getting this illness. But when the universe chooses you out of 1.4 billion people, you just have to accept it. Yet, looking back, so many people have been helping me all along. I have medications to treat it and a place to stay during my treatment. I truly have so much to be grateful for. (P1, age 76) (Aa001/Aa005)

This perspectival transformation was not achieved in isolation. P1 described a specific turning point that was initiated by family action—her in-law took her on a trip—which opened the psychological space for meaning reconstruction:

The turning point was when my in-law took me on a trip to the Guanyin temple at Nanhai. Seeing the open environment, my perspective shifted. Actually, many things in life are already arranged by heaven—why be so self-destructive? Blaming heaven and others is pointless. When my son was ill, I did my best to bring him for treatment and care for him. Perhaps the mother-son bond was simply meant to be shorter. One can only accept destiny. (P1, age 76)

While some participants drew on cosmological frameworks, others conceptualized their journey through scientific compliance and pragmatic acceptance—though this collectively sustained optimism was often severely tested by medical setbacks. P4 shared the emotional volatility of navigating a sudden relapse, a process she endured with family accompaniment:

When I was first diagnosed, I couldn't help but ask, 'Why me? Why do I have this illness when everyone else is fine?' I felt so suffocated and scared. But after a while, I realized I had to face reality and trust in science. I tried to stay optimistic, thinking that maybe I could be the lucky one. So, I accepted the treatments and took it one step at a time. Things were supposed to be fine, and my spirits were lifting, but then—out of nowhere—it relapsed. Now, I just have to let things take their natural course. (P4, age 77) (Da001/Da002)

This reframing was sustained through continued family encouragement, including from her elderly mother and grandchildren:

I still have my 90-year-old mother in Xinhui. When she learned I was ill, she encouraged me to face it with optimism. (Da005) My grandchildren call me every day to ask how I am, saying they miss me very much—that makes me so happy. (P4, age 77) (Da005)

In contrast to the emotional turbulence caused by medical uncertainty, other families normalized the illness as an inevitable stage of natural aging, co-constructing a narrative of calm acceptance within the marital dyad:

When I was diagnosed, my wife was devastated—it hit her like a bolt from the blue. But I didn't feel anything special. If I'm sick, I'm sick. People get sick eventually, and I didn't overthink it. After all, we only live once. Life is like running a marathon: some finish the full course, while others only run half. Everyone has their own journey. (P3, age 70) (Ca006)

Within the marital relationship, P3's calm framing served as a dialogic counterpoint to his wife's distress, and together the couple co-constructed a shared narrative of philosophical acceptance. This extended to a broader sense of contentment rooted in their shared life:

The world is changing so fast that we can't chase after everything. My life has already been good enough, and we must learn to be content with what we have. (P3, age 70) (Ca018/Ca022)

P5, while characteristically understating his emotional needs, acknowledged that family support formed the relational foundation upon which his optimistic orientation rested:

Always face difficulties positively—don't overthink things. Optimism has its advantages. (P5, age 76) (Ea027)

Importantly, shifts in meaning corresponded with discernible psychological transitions—from anger to acceptance, from despair to reflective calm. Illness became incorporated into a broader life story rather than remaining a disruptive rupture.

This process represented a third psychological transition: from existential threat to narrative integration.

4. Intergenerational continuity and legacy-oriented narration

As prognosis awareness increased, participants increasingly oriented toward generativity—the concern for establishing and guiding the next generation. Rather than focusing solely on impending death, they emphasized transmitting values, advice, and emotional reassurance to younger family members. This process was identified in all five cases.

Family support facilitated this orientation by creating opportunities for storytelling, reconciliation, and symbolic inheritance (e.g., moral teachings, family traditions). Within these intergenerational dialogues, participants utilized explicit behavioral mandates to impart foundational principles of relational integrity:

This is exactly how I teach my grandchild: your main goal in life must be to study hard and do well in school. At the same time, always treat others—whether they are friends, family, or anyone else—with genuine sincerity. If you aren't being sincere, what is the point of it all? (P1, age 76) (Aa002)

Remarks about familial duty were portrayed not as limiting burdens, but as necessary principles for achieving long-term social responsibility and personal peace:

Once you have a family, you must shoulder the responsibility. At the very least, you provide for your three children through college. After that, they are on their own. As long as you do right by others and do right by society, you can live with a clear conscience. (P2, age 65) (Ba003/Ba007)

Participants described a sense of relief when they believed their life responsibilities had been fulfilled. Overcoming socioeconomic adversity to establish a stable household served as a primary anchor for existential peace:

In the beginning, I had no one to rely on, and my family was poor. But I built a family of my own through my own hard work, and I consider that a true success. (P5, age 76) (Ea035)

Similarly, the tangible products of decades of physical labor provided an enduring sense of personal productivity and familial provision:

My work brought me the greatest sense of fulfillment. For 30 years, I made so many woolen sweaters with my own two hands to be exported for people to wear. Relying on myself, I was able to earn a living and provide for my entire family. (P3, age 70) (Ca008)

Furthermore, professional dedication to the development of younger generations extended this sense of fulfillment beyond the immediate family unit into the broader community:

Back when I worked at the daycare, I poured my heart into caring for the children, training and encouraging them. As a result, most of them got accepted into excellent schools. (P1, age 76) (Aa004)

Ultimately, the aggregation of these accomplishments culminated in a generalized state of contentment, centering on the successful scaffolding of their descendants' futures:

What I am most proud of is having established a family and raised three children through university. The people I am most grateful to are my parents and my wife—especially my wife, who took such good care of the household. Looking after three children was truly hard work. (P2, age 65)

Legacy formation reduced anxiety surrounding mortality by situating death within an ongoing family trajectory. Anticipated separation was transformed into perceived continuity: death was reframed not as relational termination but as transition within collective memory.

This marked the fourth psychological transition: from mortality awareness to intergenerational continuity.

Integrative Synthesis

Across participants' narratives, these four relational patterns were described as overlapping rather than strictly sequential. Participants often described emotional stabilization as occurring alongside efforts to maintain valued roles by providing affective stability as a precondition for identity work; role continuity facilitated dialogic reconstruction by preserving the agentive position from which meaning could be negotiated; reconstructed meaning supported generativity by providing a coherent narrative foundation upon which legacy could be constructed. Recursive feedback was also observed: generativity conversations retroactively strengthened emotional stability, and dialogic reconstruction reinforced role identity.

Across cases, family functioned as:

- an **affective regulator** (absorbing and redistributing emotional distress),
- an **identity mirror** (reflecting and validating the patient's enduring self),
- a **meaning-making partner** (co-constructing interpretive frameworks for suffering), and

- a **continuity vessel** (carrying forward the patient's values beyond death).

Cultural values emphasizing filial responsibility, collective identity, and family cohesion shaped the activation and expression of these processes within the Macao Chinese context.

The Relational Adaptation Framework

A conceptual framework of relational adaptation is synthesized from the four identified patterns (Figure 1). Shared emotional containment provides initial affective stabilization following diagnostic shock. Stabilization enables role reaffirmation, which preserves identity continuity despite functional decline. Identity continuity facilitates dialogic reconstruction, allowing illness to be integrated into a coherent life narrative. Narrative integration then supports generativity and legacy orientation, transforming mortality awareness into intergenerational continuity.

Rather than proceeding unidirectionally, these processes interact bidirectionally and recursively. In this conceptual representation, psychological adaptation is depicted as relationally organized within narrative accounts. Figure 1 presents a conceptual model derived from narrative analysis. The model represents interpretive synthesis rather than empirically tested causal pathways. Adaptation was narrated as an ongoing relational reorganization rather than a discrete endpoint embedded within family interaction patterns.

This framework differentiates between support as resource provision and support as relational process. The distinction lies not in the type of assistance provided, but in the dynamic co-construction of emotional regulation, identity continuity, and existential meaning within family interaction. This process-oriented perspective extends beyond categorical models of social support toward a process-level understanding of how families facilitate psychological adaptation in advanced illness (Figure 1).

Discussion

This study explored how family support shapes psychological adaptation among patients with advanced cancer in [a city in Southern China] using a narrative analytic lens. Rather than functioning solely as emotional or instrumental assistance, family support operated through relational processes that reorganized affect, identity, and existential meaning. Four interrelated relational processes were identified: emotional co-regulation, role reaffirmation, dialogic reconstruction, and generativity-oriented continuity. These findings suggest that, within this sample, adaptation was frequently described as relationally mediated rather than solely intrapsychic embedded in family systems and cultural expectations.

This study proposes a conceptual distinction between support as resource provision and support as relationally embedded narrative practice. The distinction lies not in the type of assistance provided, but in the dynamic co-construction of emotional regulation, identity continuity, and existential meaning within family interaction. This process-oriented perspective extends beyond categorical models of social

support toward an understanding of how families actively facilitate psychological adaptation in advanced illness.

Shared emotional containment in family relationships

Participants described initial distress as relationally shared rather than individually contained. This aligns with family systems perspectives[30], which conceptualize emotional states as circulating within relational units. In this study, family presence, composure, and routine interaction were described as stabilizing influences. Rather than demonstrating that support “buffers” stress in a linear sense, the findings suggest that patients narrated emotional adjustment as occurring within relational fields. For nursing practice, attention to family members’ emotional preparedness may therefore be relevant when supporting adaptation.

Recognition of enduring family roles

Illness-related functional decline threatened established family roles; however, participants described identity continuity when family members continued to acknowledge their authority or contribution[31]. This finding resonates with narrative identity scholarship, which emphasizes the preservation of core self-themes across life disruption. Identity was not maintained through independence alone but through relational recognition[32]. Clinically, overprotection may unintentionally accelerate identity erosion by limiting role participation.

Co-constructed meanings of illness within family dialogue

Meaning-making was described as dialogic rather than solitary. Families co-constructed interpretive frameworks—whether grounded in destiny, pragmatism, or philosophical acceptance—that enabled illness to be incorporated into broader life narratives[33]. Rather than demonstrating causal transformation, the findings illustrate how participants retrospectively linked shared conversations to shifts in acceptance[34]. Structured family dialogue may therefore support narrative integration.

Intergenerational continuity and legacy-oriented narration

As prognosis awareness increased, participants oriented toward generativity and legacy transmission. This pattern is consistent with generativity theory and dignity-related frameworks [35, 36] ; however, in this study generativity emerged organically within family interaction rather than as a therapist-led intervention. Participants described reduced distress when they perceived responsibilities as fulfilled and values as transmissible. In family-centered cultures, such continuity may hold particular existential significance.

Integrative Conceptualization

Together, these findings offer a culturally situated conceptualization of adaptation as narratively embedded within family relational contexts. Rather than proposing universal mechanisms, the study

presents a conceptual model derived from interpretive synthesis. The model invites future longitudinal and dyadic research to examine how relational processes unfold across diverse contexts.

Cultural Context

Findings must be interpreted within the sociocultural context of [a city in southern China], characterized by strong family-centred norms and moral obligations toward intergenerational care. Filial responsibility and collective decision-making shaped relational dynamics and meaning negotiation across all five cases. The prominence of fate-related interpretive frameworks ("heaven's arrangement," "destiny"), the centrality of family duty fulfillment as a source of existential peace, and the emphasis on intergenerational transmission all reflect Confucian-influenced cultural values that privilege relational harmony and collective identity over individual autonomy.

The processes identified may manifest differently in more individualistic cultural contexts where personal autonomy, self-determination, and independent coping are more highly valued. In such contexts, family involvement in meaning-making may be experienced as intrusive rather than supportive, and identity continuity may be anchored more in professional achievement or personal pursuits than in family roles. Thus, transferability should be approached cautiously, with attention to how cultural values shape the activation, expression, and effectiveness of relational adaptation processes.

Clinical Implications

While exploratory, these findings provide heuristic implications for palliative nursing practice. The relational adaptation framework identified in this study carries several implications for palliative care nursing practice:

1. **Family as co-regulatory partners.** Palliative care should involve family members as active participants in emotional regulation processes. Assessing family members' emotional preparedness and capacity for calm presence may be as clinically relevant as assessing patient symptom burden.
2. **Role preservation assessment.** Clinicians should assess whether patients retain meaningful roles within their family systems, and whether well-intentioned caregiving inadvertently eliminates opportunities for role participation. Simple interventions—such as encouraging families to continue seeking patients' opinions or involving patients in household decisions—may preserve identity continuity.
3. **Facilitated family dialogue.** Structured family conversations that create space for shared narrative reframing may enhance adaptive meaning reconstruction. Life review sessions that include key family members may activate the dialogic reconstruction process.
4. **Legacy-building opportunities.** Structured opportunities for value transmission and storytelling may reduce existential distress by supporting the naturally occurring generativity process. This may include assisted letter-writing, recorded messages for future generations, or facilitated intergenerational conversations about family values.

Interventions that focus solely on symptom control without attending to relational narrative processes risk overlooking critical adaptation processes.

Limitations

This study has several limitations. First, it is a secondary analysis of interviews originally conducted to explore spiritual health broadly rather than family processes specifically. As a result, the scope and depth of the present interpretation were shaped by what participants spontaneously disclosed about family within the original interview context. Second, the analysis drew on a small number of information-rich cases from a single palliative care setting in Macao, which limits transferability. Third, the participants were older adults and all described family relationships that were broadly supportive; therefore, the findings may not reflect the experiences of younger patients or those facing family conflict, absence, or ambivalence. Finally, because the analysis is interpretive and narrative in nature, the proposed framework should be understood as a culturally situated heuristic account rather than a generalizable explanatory model. Future primary studies specifically designed around family processes are warranted, particularly those incorporating larger and more diverse cohorts to examine how varying relational dynamics—including conflict, estrangement, or ambivalence—shape psychological adaptation at the end of life.

Conclusion

Family support in advanced cancer functions not merely as assistance but as a relational meaning-making system that reorganizes emotional stability, identity continuity, and existential orientation. In this exploratory study, psychological adaptation was narratively described as unfolding within family-mediated relational contexts—emotional co-regulation, role reaffirmation, dialogic reconstruction, and generativity-oriented continuity—rather than through individual coping alone.

The conceptual model generated here may serve as a starting point for future empirical and cross-cultural research examining relational dimensions of adaptation in advanced illness. For nursing practice, these findings position palliative nurses as facilitators of relational adaptation processes—creating conditions for family emotional co-regulation, preserving patients' meaningful roles, facilitating shared meaning-making conversations, and supporting intergenerational legacy transmission.

Declarations

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Declaration of Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT Author Statement

Waichi Lo: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writing - original draft.

Zhimin Luo: Conceptualization, Methodology, Formal analysis, Writing - review & editing, Supervision, Project administration.

Ethics Approval and Consent to Participate

The study received approval from the Ethics Committee of Kiang Wu Hospital in southern city in China (Approval No.: KWH2025-013), and all participants provided their written informed consent. We certify that the study was performed in accordance with the 1964 Declaration of Helsinki and later amendments.

Declaration of Generative AI and AI-assisted Technologies in the Writing Process

During the preparation of this work, the author(s) used Claude (Anthropic) in order to assist with manuscript revision, including structural reorganization, refinement of argumentation, and language editing. After using this tool, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

References

1. Guo W, Liu X, Zhang L, et al. Dyadic spiritual coping in patients with advanced cancer and their family caregivers: an actor-partner interdependence model analysis. J Pain Symptom Manage. 2025;69:483–95. https://doi.org/10.1016/j.jpainsymman.2025.02.007.
2. Philipp R, Walbaum C, Koch U, et al. Existential distress in advanced cancer: a cohort study. Gen Hosp Psychiatry. 2025;94:184–91. https://doi.org/10.1016/j.genhosppsych.2025.02.023.
3. Chen C, Sun X, Liu Z, et al. The relationship between resilience and quality of life in advanced cancer survivors: multiple mediating effects of social support and spirituality. Front Public Health. 2023;11:1207097. https://doi.org/10.3389/fpubh.2023.1207097.
4. Vodermaier A, Linden W. Social support buffers against anxiety and depressive symptoms in patients with cancer only if support is wanted: a large sample replication. Support Care Cancer.

2019;27:3589–91. https://doi.org/10.1007/s00520-019-04737-w.

5. Cipolletta S, Marzorati C, Orsolini M, et al. The role of social support in the experience of informal caregivers of cancer patients: an umbrella review. Psychooncology. 2026;35:e70430. https://doi.org/10.1002/pon.70430.
6. Kwon JY, Johnson KL, Haase KR, et al. Patterns of social support among older adults with cancer and associations with patient-reported outcomes: a latent class analysis. J Geriatr Oncol. 2025;16:102157. https://doi.org/10.1016/j.jgo.2024.102157.
7. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. Psychol Bull. 1985;98:310–57. https://doi.org/10.1037/0033-2909.98.2.310.
8. Driessen HPA, Bakker EM, Rietjens JAC, et al. A qualitative study on redefining normality in relatives of patients with advanced cancer. Cancer Med. 2024;13:e7211. https://doi.org/10.1002/cam4.70151.
9. Devuyst P, Leiter RE, Milliken A, et al. Narrative identity at the end of life: a qualitative analysis of dignity therapy interviews from an existential perspective. BMC Palliat Care. 2025;24:269. https://doi.org/10.1186/s12904-025-01876-2.
10. Helgeson VS, Cohen S. Social support and adjustment to cancer: reconciling descriptive, correlational, and intervention research. Health Psychol. 1996;15:135–48. https://doi.org/10.1037/0278-6133.15.2.135.
11. Bao S, Chen Y. Choice, struggle, and resilience: the experience of pre-loss grief among Chinese family caregivers of cancer patients. BMC Palliat Care. 2025;25:24. https://doi.org/10.1186/s12904-025-01976-z.
12. Bedford O, Yeh KH. The history and the future of the psychology of filial piety: Chinese norms to contextualized personality construct. Front Psychol. 2019;10:100. https://doi.org/10.3389/fpsyg.2019.00100.
13. Markus HR, Kitayama S. Culture and the self: implications for cognition, emotion, and motivation. Psychol Rev. 1991;98:224–53. https://doi.org/10.1037/0033-295X.98.2.224.
14. Charon R. Narrative Medicine: Honoring the Stories of Illness. New York: Oxford University Press; 2006.
15. Agom DA, Neill S, Allen S, et al. Construction of meanings during life-limiting illnesses and its impacts on palliative care: ethnographic study in an African context. Psychooncology. 2019;28:2201–9. https://doi.org/10.1002/pon.5208.
16. Lieblich A, Tuval-Mashiach R, Zilber T. Narrative Research: Reading, Analysis, and Interpretation. Thousand Oaks: Sage; 1998.
17. Polkinghorne DE. Validity issues in narrative research. Qual Inq. 2007;13:471–86. https://doi.org/10.1177/1077800406297670.
18. Lo W, Luo Z. Narrative-based study of spiritual health in advanced cancer patients: insights from Macao's cultural context with broader implications for Asia and beyond. BMC Palliat Care. 2026;25:10. https://doi.org/10.1186/s12904-025-01946-5.

19. Heaton J. Reworking Qualitative Data. London: Sage; 2004.
20. Long-Sutehall T, Sque M, Addington-Hall J. Secondary analysis of qualitative data: a valuable method for exploring sensitive issues with an elusive population? J Res Nurs. 2011;16:335–44. https://doi.org/10.1177/1744987110381553.
21. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19:349–57. https://doi.org/10.1093/intqhc/mzm042.
22. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16:606–13. https://doi.org/10.1046/j.1525-1497.2001.016009606.x.
23. Palinkas LA, Horwitz SM, Green CA, et al. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Adm Policy Ment Health. 2015;42:533–44. https://doi.org/10.1007/s10488-013-0528-y.
24. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52:1893–907. https://doi.org/10.1007/s11135-017-0574-8.
25. Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. J Palliat Med. 2000;3:129–37. https://doi.org/10.1089/jpm.2000.3.129.
26. Deng XM, Hounsri K, Lopez V, et al. Family experiences, needs, and perceptions in home-based hospice care for patients with terminal cancer: meta-synthesis and systematic review. JMIR Cancer. 2025;11:e71596. https://doi.org/10.2196/71596.
27. Iannopollo L, Cristaldi G, Feltrin A. Self-Narrative in a Therapeutic Group Pathway for Cancer Patients: Discussion of the Group Narrative Psychotherapy Intervention Initiated at the Veneto Institute of Oncology: IOV IRCCS of Padua. Behav Sci. 2024;14:376. https://doi.org/10.3390/bs14050376.
28. Carter N, Bryant-Lukosius D, DiCenso A, et al. The use of triangulation in qualitative research. Oncol Nurs Forum. 2014;41:545–7. https://doi.org/10.1188/14.ONF.545-547.
29. Tracy SJ. Qualitative quality: eight big-tent criteria for excellent qualitative research. Qual Inq. 2010;16:837–51. https://doi.org/10.1177/1077800410383121.
30. Shahinbana M, Jensen JF. Utilizing Bowen Family Systems Theory as a Medical Family Therapist to Promote Biopsychosocial-Spiritual Health Across Clinical Settings. Fam J. 2026;34:280–90. https://doi.org/10.1177/10664807251396946.
31. Adler JM, Lodi-Smith J, Philippe FL, et al. The incremental validity of narrative identity in predicting well-being: a review of the field and recommendations for the future. Pers Soc Psychol Rev. 2016;20:142–75. https://doi.org/10.1177/1088868315585068.
32. McAdams DP. Narrative identity. In: Schwartz SJ, Luyckx K, Vignoles VL, editors. Handbook of Identity Theory and Research. New York: Springer; 2011. pp. 99–115.
33. Park SR, Cho M, Jung HY, et al. A Qualitative Study of Family Centrality in Modified Dignity Therapy Experiences Among Korean Patients With Advanced Cancer: KCSG-PC22-10. J Korean Med Sci.

2026;41:e11. https://doi.org/10.3346/jkms.2026.41.e11.

34. Needle JS, Friebert S, Thompkins JD, et al. Effect of the family-centered advance care planning for teens with cancer intervention on sustainability of congruence about end-of-life treatment preferences: a randomized clinical trial. JAMA Netw Open. 2022;5:e2221512. doi.org.
35. Erikson EH. Childhood and Society. New York: Norton; 1950.
36. Julião M, Sobral MA, Johnston B, et al. A Portuguese trial using dignity therapy for adults who have a life-threatening disease: Qualitative analysis of generativity documents. Palliat Support Care. 2022;20:189–95. https://doi.org/10.1017/S1478951521000754.

Tables

Table 1 to 3 are available in the Supplementary Files section.

Figures

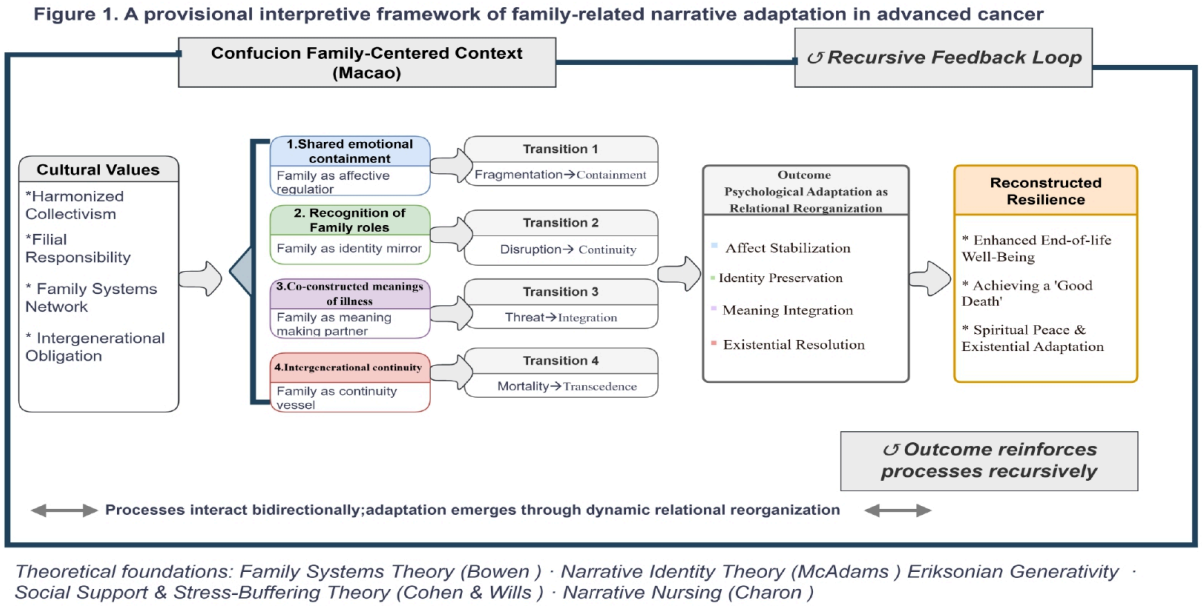

Figure 1

This figure summarizes four recurrent narrative patterns identified in the secondary analysis: shared emotional containment in family relationships, recognition of enduring family roles, co-constructed meanings of illness within family dialogue, and intergenerational continuity and legacy-oriented narration. The patterns are not intended to represent fixed stages, causal mechanisms, or a universal

sequence. Rather, they provide a heuristic, culturally situated summary of how participants in this study linked family experiences to psychological adaptation.

The right panel depicts the integrated outcome—psychological adaptation conceptualized as relational reorganization—culminating in reconstructed resilience, which encompasses enhanced end-of-life well-being, achievement of a "good death," and spiritual peace. The recursive feedback loop (↺) denotes that adaptive outcomes reinforce and reshape the ongoing relational mechanisms.

Color coding distinguishes the four thematic domains: blue = emotional; green = identity; purple = meaning; red/pink = existential. The model is designed to be interpretable in grayscale printing.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Table1.docx
- Table3.docx
- COREQChecklist.docx
- Table2.docx