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Navigating the Cancer Journey: The Dynamic Interplay of Existential, Relational, and Structural Factors Across the Illness Trajectory

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ABSTRACT A cancer diagnosis constitutes a profound biopsychosocial crisis. This systematic narrative review synthesises psycho-oncological literature to propose the Dynamic Socio-Existential (DSE) Model, an integrative framework addressing a critical gap in understanding psychological adaptation. The findings reveal that adaptation is a non-linear, dynamic process shaped by the continuous interplay of three systems, namely, the existential (internal meaning-making), the relational (interpersonal support), and the structural (cultural and economic context). Crucially, the nature of this interplay evolves across the illness trajectory. The study concludes that effective support must be phase-specific and multifocal, simultaneously targeting existential distress, relational dynamics, and structural barriers to significantly enhance patient well-being.

INTRODUCTION

Cancer and Its Deep-rooted Issues

The concepts of health and well-being have long transcended the mere absence of disease, evolving into multifaceted constructs encompassing physical, mental, and social completeness (World Health Organisation 1948). Academically, well-being is increasingly recognised as a dynamic state of equilibrium, challenged and redefined by life's adversities. A cancer diagnosis constitutes an ontological rupture, a profound crisis that fractures an individual's sense of self, future, and place in the world (Kissane and Al-Asady 2015). It is a global malady, with the GLOBOCAN 2022 report estimating 20 million new cases and 9.7 million deaths annually, figures projected to rise sharply, making it a leading cause of mortality and morbidity worldwide (Sung et al. 2021). However, its grip extends far beyond epidemiology; it is a biopsychosocial crisis that ensnares the mind as fiercely as it does the body.

The pervasive perception of cancer as a "death sentence" triggers a cascade of emotional and mental reactions that can be as debilitating as the physical symptoms. For instance, the initial phase is often marked by intense anxiety and a search for control, where a patient's coping style, such as a high-monitoring approach, can significantly influence their diagnostic distress (Bronner et al. 2018). As the illness trajectory unfolds, patients continuously navigate shifting challenges, for example, long-term survivors frequently grapple with perceived cognitive impairment and the lingering effects of their coping efforts (Davelaar and Garbanati 2023), while those with advanced disease face the immense challenge of managing symptom burden through various coping behaviours (Dev et al. 2024). While a robust body of literature highlights the critical roles of coping strategies and support ecosystems, a significant gap persists. Much of the research examines these elements in isolation or within a single phase of illness, failing to capture the fluid and iterative process of psychological adaptation. For example, a study on young adults highlighted that their coping strategies are uniquely tested by the profound changes and uncertainty during active treatment, a challenge distinct from those faced by older adults (Lie et al. 2018; Hernández et al. 2019). Furthermore, the cultural lens is often treated as a variable rather than as a fundamental framework for understanding. Recent studies underscore that coping is not a universal process but is deeply embedded in cultural and religious contexts, whether it is the

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use of religious coping in secular Sweden (Ahmadi and Ahmadi 2017), the role of religiosity for Arab-Palestinian women (Almuhtaseb et al. 2020), or the spiritual coping mechanisms observed in families of children with cancer in Malaysia (Chong et al. 2023).

The Research Argument and Theoretical Rationale

While the psycho-oncological literature has made significant strides in identifying key components of adaptation related to cancer, such as coping strategies, social support, and more recently, financial toxicity and cultural considerations, a critical limitation persists. Much of this research remains artificially siloed, examining these elements in isolation or treating them as static variables within a single phase of the illness trajectory. This article argues that this fragmented approach fundamentally fails to capture the true nature of psychological adaptation to cancer. The researchers contend that adaptation is not a linear progression through stages nor the sum of independent factors. Rather, it is a non-linear, dynamic process of continuous negotiation. This negotiation occurs across multiple domains as follows:

- **Internally,** the individual negotiates between terror and hope, between the urge to fight and the need to accept, and between their pre-illness identity and a new, emerging self. This is evident in the struggle with intolerance of uncertainty and the quest for coping self-efficacy, which are crucial for managing the self-perceived burden of the disease (Eyni and Mousavi 2023).
- **Relationally,** they negotiate needs for dependence and autonomy, for open communication and protective silence, within their network of family, partners, and clinicians. This is exemplified by the complex dynamics of dyadic coping, which can significantly influence the emotional functioning of both patients and their partners (van Roij et al. 2022), and by the way fear of recurrence can inhibit disclosure between couples (Soriano et al. 2021).
- **Structurally,** they negotiate with systemic forces, cultural narratives about illness, the crushing weight of financial toxicity, and the barriers of an often-impermeable healthcare system, that actively enable or constrain their capacity to cope. The association between shared decision-making, financial toxicity, and the need for specific coping actions powerfully illustrates how structural factors directly shape patient experiences (Liu et al. 2024).

The prevailing, more static models cannot adequately explain why a coping strategy that is effective in one phase becomes maladaptive in another, or how a structural barrier like poverty can directly cripple an individual's existential search for meaning and poison their family relationships. There exists a significant gap in the literature for a synthesising framework that moves beyond listing influential factors to instead model the dynamic and recursive interplay between them over time.

This gap is the central problem this manuscript addresses. The following section will introduce the proposed framework, the Dynamic Socio-Existential (DSE) Model, designed specifically to provide this integrative lens and overcome the limitations of current siloed approaches.

Structure of the Manuscript

Following this introduction, the manuscript is structured to first detail the systematic methodology employed for the literature review. It then presents the theoretical foundations of the proposed Dynamic Socio-Existential (DSE) Model, explicating its three core systems. The subsequent sections are organised thematically according to this model wherein Part I explores the Existential System (meaning, coping, spirituality), Part II analyses the Relational System (dyadic, familial, and clinical support), and Part III investigates the Structural System (culture, inequity, financial toxicity). A synthesis chapter then integrates these findings into a novel, phase-based model of adaptation, illustrating how the interplay of systems evolves across the illness trajectory. The paper concludes with a discussion of the core findings, the utility of the DSE model, and its implications for future research, clinical practice, and policy.

Research Questions

The following questions guide this study:

1. How do the dominant emotional reactions and coping strategies of cancer patients evolve across distinct phases of the illness

trajectory (diagnosis, active treatment, survivorship, advanced/metastatic disease)?
2. What are the primary support mechanisms availed and received at each phase, and how do they interact with individual coping efforts?
3. How is the very definition and experience of "Quality of Life" reconfigured by patients at each phase of their illness?
4. How do cultural and contextual factors permeate and shape these coping, support, and QoL assessment processes?

Research Objectives

The primary objectives of this study are to:
1. Conduct a systematic synthesis of current literature to construct a phase-specific model of psychological adaptation to cancer.
2. Critically analyse the interplay between individual coping mechanisms and external support systems at each phase.
3. Map the evolution of the concept of Quality of Life from a pre-diagnosis baseline to an end-of-life state of peace and acceptance.
4. Propose an integrative framework for clinicians and researchers to assess and intervene in the psychosocial dimensions of cancer care in a more targeted and effective manner.

By addressing these questions and objectives, this article aims to contribute a nuanced, holistic framework to the field of psycho-oncology, underscoring the imperative to view the cancer journey not just as a medical battle but as a profound human experience of crisis, adaptation, and meaning-making.

MATERIAL AND METHODS

Study Design

This study employed a systematic narrative review methodology to develop the Dynamic Socio-Existential (DSE) Model of Cancer Adaptation. This design was selected to synthesise a diverse and complex body of psycho-oncological literature into a novel, coherent theoretical framework. The approach allows for the integration of findings from qualitative, quantitative, and mixed-methods studies to develop higher-order conceptual themes and model the dynamic relationships between them (Whittemore and Knafl 2005; Green et al. 2006). The review was conducted and reported in accordance with the PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta Analyses extension for Scoping Reviews) guidelines to ensure rigour and transparency (Tricco et al. 2018).

Search Strategy and Initial Literature Identification

A targeted search strategy was designed to capture a wide spectrum of psycho-oncological literature relevant to the DSE model's core domains of existential, relational, and structural.

- *Sources:* The search was conducted exclusively through the online platforms of four major academic publishers known for their strong portfolios in social sciences, medicine, and psychology.
- *Publishers and Yield***:** The initial search yielded a total of 140 publications, distributed as follows:
- Sage Publications: 54 articles
- Wiley Online Library: 57 articles
- Cambridge University Press: 19 articles
- Oxford University Press: 10 articles
- *Search Parameters*:
- Publication Date: For empirical studies, the search was limited to articles published from January 2000 to December 2023 to capture the modern evolution of psycho-oncology. This restriction was waived for theoretical, foundational, and methodological papers to include seminal works critical to the framework's development.
- Search Terms: A combination of MeSH terms and keywords related to cancer, coping, quality of life, social support, financial toxicity, spirituality, dyadic coping, family dynamics, cultural competence, and illness perception was used within each publisher's database search function.

Eligibility and Exclusion Criteria

Studies were selected based on the following criteria:

Inclusion Criteria

- Peer-reviewed empirical studies (qualitative, quantitative, mixed-methods) and seminal theoretical papers.

- *Population:* Adult cancer patients (≥18 years) at any phase of the illness trajectory.
- *Geography:* Studies conducted in Western (US and Canada), European, Asian, or Australian contexts to ensure a diverse yet focused cultural perspective.
- *Subject Matter:* Research focusing on Coping Mechanisms and Strategies, Religion, Spirituality and Meaning-Based Coping, Psychological Distress and Mental Health, Social, Cultural and Familial Contexts, Financial Toxicity and Burden, and Illness Perception, Uncertainty and Clinical Communication. Theoretical and methodological papers were included without date or geographic restriction.
- *Language:* English

Exclusion Criteria

- Studies focusing exclusively on paediatric oncology.
- Purely methodological or statistical papers that offered no substantive inferences or findings on coping, mental health, family support, or illness perceptions.
- Studies of non-malignant conditions.
- Editorials, commentaries, and conference abstracts.

Study Selection Process

The study selection process involved a two-phase screening against the eligibility criteria as follows.

Title and Abstract Screening

All 140 retrieved citations were screened by two independent reviewers. This phase focused on identifying studies with relevant subject matter and excluding those based on the core exclusion criteria (for example, paediatric focus).

Full-Text Review

The full texts of the remaining articles were obtained and assessed in detail for final inclusion. This phase ensured the studies met all geographic, demographic, and substantive criteria.

Final Literature Selection and Characteristics

The rigorous selection process resulted in a final corpus of 108 articles for in-depth analysis and synthesis. The composition of the final literature set is characterised as follows:

- ***By Publication Period:***
- Pre-2000: 6 articles (**5.6%**)
- 2000-2010: 20 articles (**18.5%**)
- 2011-2020: 40 articles (**37.0%**)
- 2021-2023: 42 articles (**38.9%**)
- ***By Study Region:***
- Western (US and Canada): 34 articles (**31.5%**)
- European: 22 articles (**20.4%**)
- Asian: 19 articles (**17.6%**)
- Australian: 4 articles (**3.7%**)

Note: The sum of these regional classifications is 79 articles (73.1%). The remaining 29 articles (26.9%) are theoretical, methodological, or multi-regional studies not confined to a single geographic context.

- ***By Primary Subject Matter***
- Theoretical Foundations and Methodologies: 6 (**5.6%**)
- Coping Mechanisms and Strategies: **40** (**37.0%**)
- Religion, Spirituality and Meaning-Based Coping: 18 (**16.7%**)
- Psychological Distress and Mental Health: **19** (**17.6%**)
- Social, Cultural and Familial Contexts: 13 (**12.0%**)
- Financial Toxicity and Burden: 4 (**3.7%**)
- Illness Perception, Uncertainty and Clinical Communication: 8 (**7.4%**)

Data Extraction and Synthesis

Data from the 108 included studies were extracted into a standardised matrix. Thematic synthesis, as outlined by Thomas and Harden (2008), was employed. This involved line-by-line coding of findings, the development of descriptive themes, and the generation of analytical themes. This process allowed for the identification of interconnections between the existential, relational, and structural systems and the inductive development of the phase-based DSE model.

Ethical Considerations

As this study synthesised data from previously published, peer-reviewed research, no separate ethical approval was required.

Theoretical Framework

The Dynamic Socio-Existential (DSE) Model: A Theoretical Foundation

The profound and multifaceted challenge of adapting to cancer necessitates a theoretical lens that is equally comprehensive and nuanced. Moving beyond models that focus primarily on individual psychology or social context in isolation, this paper proposes the Dynamic Socio-Existential (DSE) Model of Cancer Adaptation. This integrative framework posits that psychological adjustment and the redefinition of quality of life are achieved through the continuous and dynamic interplay of three interconnected systems, that is, the *Existential*, the *Relational*, and the *Structural*. This chapter delineates the core tenets of this model, drawing upon established theories to explain how these systems function independently and synergistically across the illness trajectory.

The Existential System: Meaning, Mortality, and the Self

The existential system encompasses the individual's internal psychological processes triggered by the confrontation with a life-threatening illness. Grounded in Terror Management Theory (TMT) (Greenberg et al. 1986) and the Meaning-Making Model (Park and Folkman 1997), this system addresses the fundamental rupture in the individual's assumptive world, their core beliefs about fairness, predictability, and mortality. The cancer diagnosis induces a state of mortality salience, provoking an existential crisis that challenges one's sense of identity, purpose, and continuity.

The primary work of this system is meaning-making, the cognitive and emotional effort to reconcile the reality of the illness with one's global worldview and goals. This process, as defined by Park and Folkman (1997), drives the adoption of specific coping strategies. The effectiveness of these strategies is crucial for managing effective symptoms. Ultimately, the existential system is concerned with answering the question, "How do I make sense of this experience and who am I now?"

The Relational System: Dyads, Families, and Clinical Alliances

The relational system constitutes the immediate micro-social context in which the illness experience is embedded and negotiated. It focuses on the interpersonal transactions that either buffer or exacerbate distress. Central to this system is Dyadic Coping Theory (Bodenmann 2005), which views cancer as a "we-disease" and emphasises how patients and their close partners collaboratively appraise and manage stress.

This system extends beyond the dyad to include family functioning, where roles, responsibilities, and communication patterns must adapt to the demands of illness (Walsh 2016). It also encompasses the critical patient-clinician relationship, which can serve as a foundational source of trust, information, and security or, conversely, as a source of miscommunication and uncertainty (Fujimori and Uchitomi 2009). The relational system provides the scaffolding for support but can also be a source of "social constraints" when others inhibit the patient's natural emotional processing, thereby influencing coping efficacy and psychological adjustment (Lepore and Revenson 2007).

The Structural System: Culture, Inequity, and Access

The structural system represents the macro-social, cultural, and economic forces that form the overarching context for the entire adaptation process. An intersectional framework (Crenshaw 1989; Bowleg 2012) is essential here, as it acknowledges that an individual's social location, based on race, gender, socioeconomic status (SES), nationality, and other identities, creates unique experiences of privilege and disadvantage.

This system includes cultural and religious norms that provide the foundational schema for understanding illness causality, dictating acceptable coping expressions, and shaping help-seeking behaviours. Crucially, it encompasses the material reality of structural inequities, such as financial toxicity (Zafar and Abernethy 2013), the devastating financial burden of treatment, and disparities in access to healthcare and psychosocial re-

sources. These structural factors are not mere background variables, but they are active, powerful determinants that enable or constrain the functioning of both the relational and existential systems.

The Dynamic Interplay Across the Illness Trajectory

The DSE Model is fundamentally *dynamic* and *process-oriented*. The salience and influence of each system are not static, as they shift and evolve across the illness trajectory.

The core premise of the DSE model is that adaptation is a non-linear process of negotiation *between* these systems. A structural barrier like poverty (Structural System) can deplete cognitive resources, limiting capacity for meaning-making (Existential System) and straining family relationships (Relational System). Conversely, a strong cultural or religious framework (Structural System) can bolster existential coping and strengthen familial support. It is through this continuous interplay that the individual's "quality of life" is constantly redefined.

RESULTS

The following sections present the rich, empirical findings from the literature synthesis, breathing life into the three core systems of the DSE Model. The data reveals not just abstract concepts, but the lived, human experience of navigating cancer, now illuminated by both qualitative depth and quantitative evidence.

The Existential System: The Internal Battle for Meaning

This section details the profound internal psychological journey of cancer patients, a journey marked by a search for reason, an arsenal of coping mechanisms, and, for many, a turn toward the spiritual.

The Landscape of Perception and Causality: Making Sense of the Shattered Self

A cancer diagnosis is far more than a medical event, it is an ontological earthquake that shatters an individual's fundamental sense of reality and self. The Common-Sense Model (CSM) of self-regulation provides a lens for this chaos, suggesting individuals desperately try to rebuild order by forming "illness perceptions" that are cognitive frameworks that answer urgent questions about the disease's identity, cause, timeline, consequences, and controllability (Leventhal et al. 1980, as applied in cancer contexts by Hopman and Rijken 2015).

The initial perception is often one of indiscriminate, lethal invaders, accompanied by a visceral sense of shock, a primal fear of death, and a devastating loss of control (Lipton 2012). Quantitatively, this is reflected in sharp spikes in distress scores. For example, one study found that 48 percent of patients met the criteria for clinical anxiety immediately following diagnosis (Bronner et al. 2018). Yet, the human spirit is adaptive. These perceptions are not static. Over time, the acute threat can evolve into a chronic, manageable condition, or even a catalyst for profound positive change, a process known as post-traumatic growth (PTG). For some long-term survivors, the narrative transforms completely, as they come to view cancer not as a curse, but as a "teachable moment" that brutally yet effectively reshaped their life priorities and values (Bilodeau et al. 2022). Empirically, PTG is a measurable outcome, as a study of breast cancer survivors found a mean PTG inventory score of 65.2 (SD = 19.5), with the "Appreciation of Life" domain scoring the highest, quantitatively supporting this qualitative shift in perspective (Lelorain et al. 2011).

The Search for Causality: The Haunting Question of "Why Me?"

Confronted with this crisis, patients and their loved ones instinctively embark on a search for causality, a fundamental human attempt to construct a narrative around the illness and restore a sense of order, however painful. This search rarely confines itself to sterile biomedical explanations. Instead, it is deeply embedded in personal history, cultural background, and social context, manifesting in several overlapping themes as follows.

Lifestyle and Behavioural Factors

Many internalise public health messages, attributing their cancer to modifiable behaviours like smoking, diet, or alcohol, which can lead to agonising self-blame but also a motivating sense of

control (Yildirim et al. 2018; Hall et al. 2019). In a cross-country study, lifestyle factors were the most common attribution, cited by 60.3 percent of patients, with diet (33.7%) and smoking (27.1%) being the most frequent specific causes (Hall et al. 2019).

Environmental and External Exposures

Others attribute their illness to factors beyond their control, such as pollution, occupational hazards, or even medical treatments, externalising blame and potentially mitigating feelings of personal guilt (Hall et al. 2019; Kumar and Bharti 2021).

Genetic and Biological Predisposition

A family history often leads to a genetic explanatory model, which can create a sense of inevitability or fate (Postolica et al. 2017).

Spiritual, Religious, and Fatalistic Causes

Particularly in collectivistic and religious cultures, cancer may be perceived as "God's will", "fate" (karma), a divine test, or a predetermined destiny. This reframes a random tragedy into an event imbued with spiritual meaning and potential for growth (Banerjee et al. 2011; Kaliampos and Roussi 2017; Nikfarid et al. 2018; Almuhtaseb et al. 2020).

Psychological and Emotional Factors

A common, though scientifically contentious, perception is that personality traits, chronic stress, or emotional trauma can cause cancer (Yildirim et al. 2018).

The Multiplicity of Coping: Navigating from Avoidance to Meaning-Making

Faced with this existential threat, individuals deploy a vast array of coping strategies in a dynamic and imperative process of adaptation.

Problem Focused versus Emotion Focused Coping

This classic dichotomy (Folkman 1984) remains a foundational lens. Problem-focused coping involves active efforts to alter the stressful situation itself, researching treatments, adhering meticulously to regimens. Guan et al. (2020) demonstrated that such active strategies were a lifeline to mental well-being. Their path analysis showed that problem-focused coping had a significant positive effect on mental quality of life ($\beta = 0.24$, $p < .01$). Conversely, emotion-focused coping aims to regulate emotional distress. This can be adaptive (for example, positive reframing) or maladaptive. Guan et al. (2020) found that avoidant coping, including denial, behavioural disengagement, and substance use, was a heavy anchor, strongly pulling down mental well-being and acting as a key mediator between the terror of uncertainty and poor outcomes. In their model, avoidant coping on mental well-being ($\beta = -0.38$, $p < .001$).

Meaning Focused Coping

This represents a more advanced form of coping, where individuals draw on deeply held values, beliefs, and goals to not just endure, but to find significance in their suffering (Park and Folkman 1997). Krok et al. (2019) specifically identified meaning-focused coping as a critical mediator, a bridge that could lessen the impact of negative illness perceptions on affective symptoms. Their moderated mediation analysis confirmed that meaning-focused coping partially mediated the relationship between illness perception and depression (indirect effect = 0.08, SE = 0.03, 95% CI [0.03, 0.15]). Their crucial finding was that this bridge was stronger for some than others, and its effectiveness was moderated by the patient's pre-existing sense of meaning in life, highlighting that it is not a resource all can equally access.

Emotional Approach Coping (EAC)

Stanton et al. (2000) delineated EAC into two distinct processes of emotional processing (actively acknowledging and exploring one's emotions) and emotional expression (verbally or nonverbally communicating them). Darabos et al. (2021) revealed the nuanced nature of this mechanism. They found that the internal work of emotional processing (for example, journaling to understand one's fears) was linked to higher resilience and posttraumatic growth. Quantitatively, emotional processing was significantly associated with higher resilience ($r = 0.29$, $p < .01$) and greater PTG ($r = 0.25$, $p < .05$). In stark contrast, the external act of

emotional expression (for example, constantly venting fears without resolution) was associated with lower resilience and a greater, gnawing fear of recurrence, with correlations showing expression was linked to lower resilience ($r = -0.24$, $p < .05$) and higher FoR ($r = 0.30$, $p < .01$), suggesting that the social context and reception of this expression are crucial determinants of its benefit.

The Spiritual Shield: Religion and Spirituality as Existential Resources

For many, spirituality and religion emerge not as a simple comfort but as a pivotal and dynamic adaptive toolkit within the existential system.

The Functions of Spiritual and Religious Coping (SRC)

SRC serves multiple critical functions, as it helps in Finding Meaning and Purpose, reframing the experience within a larger cosmic narrative (Ahmadi and Ahmadi 2017; Krok et al. 2019; Nagy et al. 2024), Fostering Hope and Positive Reappraisal by seeing God as a benevolent partner or perceiving potential for growth, strategies linked to lower depression and better quality of life (Kaliampos and Roussi 2017; Bruce et al. 2020; Shannonhouse et al. 2023); For instance, in a study of Black and White men with prostate cancer, positive religious coping was significantly associated with better mental quality of life ($\beta = 0.18$, $p < .05$) (Bruce et al. 2020). Providing Emotional and Social Comfort through belief in a compassionate higher power and the tangible support of religious communities (Bowie et al. 2017; Ahmadi et al. 2019; Lundmark 2019; Lövgren et al. 2019), and Enhancing Perceived Control through paradoxical forms of surrender, such as collaborative coping (partnering with God) or deferring coping (surrendering control), both of which can relieve the unbearable burden of ultimate responsibility (Ahmadi and Ahmadi 2017; Almuhtaseb et al. 2020).

Cultural Manifestations

The expression of SRC is a tapestry woven with cultural threads. In highly secular societies like Sweden, patients often utilise a private, individualised spirituality focused on inner peace and meaning rather than formal doctrine (Ahmadi and Ahmadi 2017). In Muslim contexts (for example, Turkey, Iran), coping is characterised by concepts of *tawakkul* (trust in God's plan) and *sabr* (patience), with prayer and Quran recitation being central acts of devotion (Nikfarid et al. 2018; Ahmadi et al. 2019; Almuhtaseb et al. 2020). In Christian contexts, patients draw on a personal relationship with Christ, the power of prayer, and the support of church communities for hope and solace (Choumanova et al. 2006; Shannonhouse et al. 2023).

The Relational System: The Interpersonal Web of Support and Strain

The existential crisis of cancer is not faced alone. It is enacted within a network of relationships that forms a critical scaffolding for support, but can also be a source of significant stress and constraint.

The Relational Scaffold: Dyadic, Familial, and Social Support

Human beings are inherently social, and cancer forces a profound reliance on others. The support system constitutes a multi-layered scaffold.

Perceived Social Support

The simple, powerful perception that one is cared for and part of a supportive network is a consistent buffer against psychological distress. Ozdemir and Tas Arslan (2018) found a direct, positive correlation, that is, as patients felt more supported by their families, their use of effective coping strategies increased (p. 2214). Their analysis quantified this relationship, showing a strong positive correlation between family social support and effective coping ($r = 0.56$, $p < .001$).

Dyadic Coping

Cancer is truly a "we-disease", managed within the context of a primary relationship. Dyadic coping involves a couple's shared appraisal of the stress and their collaborative efforts to manage it (Bodenmann 2005). The study by Guan et al. (2020) emerged from a dyadic intervention trial, underscoring that effective coping is a tandem activity, interwoven with the partner's response. Rottmann et al. (2015) found that when couples cope togeth-

er as a united team, it leads to better intimate relationships and fosters post-traumatic growth in patients, a finding corroborated by Suo et al. (2021), who demonstrated that positive dyadic coping enhances post-traumatic growth both directly and through its positive effect on marital satisfaction. Their longitudinal study showed that positive dyadic coping was a significant predictor of PTG in patients over a 5-year period ($\beta = 0.16$, $p < .05$).

Social Constraints

Paradoxically, the very networks meant to support can also become sources of stress. Darabos et al. (2021) alluded to a "socially constraining environment" that might explain why emotional expression was not beneficial for young adults (p. 732). Adams et al. (2017) demonstrated this powerfully, showing that when patients feel unable to express their true thoughts and feelings to others, that is, a state of perceived social constraints, it can push them toward avoidant coping, which in turn mediates a higher symptom burden and poorer overall adjustment. Their mediation model was statistically significant, showing that avoidant coping mediated the relationship between social constraints and both depressive symptoms (indirect effect = 0.07, SE = 0.02, 95% CI [0.03, 0.12]) and physical symptoms (indirect effect = 0.05, SE = 0.02, 95% CI [0.02, 0.09]). This manifests when loved ones, often with good intentions, minimise fears ("Stay positive!"), avoid the patient, or offer unhelpful commentary, thereby inhibiting the patient's necessary emotional processing (Lepore and Revenson 2007).

Parenting in the Shadow of Illness: The Profound Disruption of Family

A cancer diagnosis sends seismic shockwaves through the entire family system, particularly for patients who are parents, creating a devastating dual burden.

The Dual Burden: Parental Guilt and Protective Buffering

The primary dynamic is a heart-wrenching conflict between personal survival needs and the desperate desire to protect one's children. This manifests as intense parental guilt for being less available, for the emotional distress caused, and for draining family resources (Kennedy and Lloyd-Williams 2009). A common, though often counterproductive, strategy to manage this is protective buffering, that is, concealing worries, symptoms, and negative emotions from family members (Hagedoorn et al. 2000). When children sense this concealment, it can heighten their anxiety, leaving them to imagine the worst without a framework for understanding (Turner et al. 2005).

Impact on Children and the Parent-Child Relationship

The impact is deeply influenced by the child's age. Young children may exhibit regressive behaviours, clinginess, or anger, often labouring under tragic misconceptions (for example, believing they caused the illness) due to cognitive egocentrism (Patterson 1995). Adolescents and young adults may be forced into premature adulthood, taking on caregiving and household responsibilities, a phenomenon known as parentification, which can disrupt their own developmental trajectory and social opportunities (Walczak et al. 2018).

The Role of the Co-Parent and Family Resilience

The patient's partner or co-parent plays a pivotal and often overwhelming role, becoming the primary emotional and logistical anchor for the children while managing their own distress (Northouse et al. 2012). The quality of the parental relationship is a critical mediator. Effective communication and shared coping strategies between parents are essential for presenting a united, secure front to the children, alleviating the patient's burden of guilt, and enabling a more cohesive approach (Kershaw et al. 2008). The key to family resilience is not avoiding change, but navigating it with flexibility, open communication, and a shared sense of purpose (Walsh 2016), a process that can be significantly aided by targeted family support programs (Bugge et al. 2009).

The Clinical Relationship: The Foundation of Trust and Information

The relationship between the patient and the healthcare provider is a foundational element of the relational support system, setting the stage for the entire treatment journey.

The First Encounter: Delivering the Diagnosis

The manner in which the diagnosis is delivered is imprinted on the patient's psyche forever. The initial reaction is often one of cognitive shock, as patients frequently report that after hearing the word "cancer", the rest of the consultation becomes a blur, a phenomenon linked to acute stress-induced impairment of working memory (Ercoli et al. 2015). Therefore, communication that is empathetic, clear, and allows space for questions can mitigate this trauma, while a cold, rushed, or ambiguous delivery can exponentially exacerbate feelings of terror and helplessness (Fujimori and Uchitomi 2009). This first encounter lays the cornerstone of trust, which is essential for subsequent adherence and coping (Zwingmann et al. 2006).

Ongoing Communication and Managing Uncertainty

The clinical relationship is the primary vehicle for managing the pervasive uncertainty that defines cancer. Guan et al. (2020) empirically demonstrated that this inability to determine the meaning of illness-related events directly and negatively impacts both physical and mental well-being. Clinicians mitigate this by providing clear, consistent communication and validating patient concerns. Furthermore, a disconnect between a patient's perceived cause of illness (for example, a spiritual cause) and the clinician's biomedical model can create a significant barrier to communication and erode trust in the treatment plan.

The Therapeutic Alliance as a Support Mechanism

Beyond providing medical treatment, the healthcare team itself is a fundamental support mechanism. Multidisciplinary teams that integrate psychologists, social workers, and nurse navigators provide structured coping strategies and emotional support. The efficacy of the patient-clinician relationship is a key factor, with clear, compassionate communication fostering trust and reducing illness-related uncertainty, ensuring no patient has to navigate the journey alone (Meggiolaro et al. 2016; Collet et al. 2022).

The Structural System: The Overarching Weight of Context

The existential and relational systems do not operate in a vacuum. They are profoundly shaped, empowered, or constrained by the overarching macro-social, cultural, and economic context, which forms the structural system.

The Cultural Scaffolding of Illness Meaning

Culture provides the invisible blueprint upon which the meanings of illness, treatment, and support are built.

Cultural and Religious Beliefs as a Foundational Schema

Cultural background provides the primary lens for understanding causality and meaning. For instance, South Asian immigrant parents in Canada sometimes attributed their child's cancer to spiritual causes or past actions (*karma*), which influenced a more fatalistic perception and specific help-seeking behaviours (Banerjee et al. 2011). Similarly, in Turkey and among Arab-Palestinian women, religiosity provided a framework for acceptance and hope, shaping the perception of cancer as a test from God or a predetermined fate (Ahmadi et al. 2019; Almuhtaseb et al. 2020). Even in highly secular contexts like Sweden, patients turned to God for strength and meaning, albeit in a more private, individualised manner (Ahmadi and Ahmadi 2017).

Cultural Norms Governing Expression and Support

Cultural norms dictate the very rules of engagement with the illness. The study in Turkey (Ozdemir and Tas Arslan 2018) exemplifies a collectivist context where the psycho-social experience is deeply embedded within the family unit. The high value placed on family support is a protective factor, but it also comes with expectations that can limit individual autonomy. This contrasts with more individualistic Western contexts, where the emphasis is often on self-efficacy and accessing professional support systems, which can sometimes create its own unique pressure, or the "tyranny of positivity".

Stigma and Disclosure

In many cultures, cancer remains a stigmatised, taboo subject, discussed in whispers (Marlow et al. 2015). This can prevent timely help-seeking and isolate patients from potential community support (Else-Quest and Jackson 2014). Cultural norms also dictate communication styles around prognosis, with some cultures valuing protection of the patient through non-disclosure, and others valuing full transparency (Blackhall et al. 1995).

The Crushing Weight of Context: Financial Toxicity and Structural Inequity

Beyond culture, the structural system includes the brutal material and economic realities that can enable or cripple adaptation.

Financial Toxicity

Socioeconomic status (SES) is a primary determinant of financial toxicity, the devastating combination of high treatment costs and lost income that constitutes a unique and severe psycho-social morbidity (Zafar and Abernethy 2013). The stress of medical bankruptcy, choosing between rent and prescriptions, and draining lifelong savings is a burden that transcends the physical disease (Carrera et al. 2018). A large study of working-age cancer survivors in the U.S. found that 33.6 percent had incurred medical debt, and 3.3 percent had declared bankruptcy as a result of their illness (Banegas et al. 2016). This toxicity is not evenly distributed, as it disproportionately ravages those with lower incomes, inadequate insurance, and less flexible employment (Yabroff et al. 2019). The constant, grinding worry about finances can directly inhibit recovery, increase non-adherence to life-saving medications, and exacerbate anxiety and depression (Banegas et al. 2016). In a Chinese nationwide study, higher financial toxicity was directly correlated with a greater need for specific coping actions, such as spending savings (OR=1.48, 95% CI [1.32, 1.66]) or borrowing money (OR=1.72, 95% CI [1.53, 1.93]), demonstrating how a structural stressor dictates behavioural coping responses (Liu et al. 2024).

Systemic Racism and Medical Mistrust

Race and ethnicity compound economic disparities through the lived experience of systemic racism. Historical and ongoing injustices have bred deep-seated medical mistrust among Black communities (Brandon et al. 2005), which can lead to later-stage diagnosis, refusal of care, and tragically poorer survival rates (Bediako et al. 2016). Furthermore, patients from marginalised communities may face unconscious bias within the healthcare system, creating significant barriers to collaborative coping and eroding the essential patient-clinician alliance.

The Intersectional Compounding of Vulnerabilities

An intersectional analysis (Bowleg 2012) reveals that these structural factors do not operate in isolation but synergistically to create compounded vulnerabilities. For example, a young, low-income, immigrant woman of colour with cervical cancer faces a unique, multifaceted burden. Her youth brings a devastating identity crisis and terror for her fertility. Her gender and cultural context may impose silence and stigma around gynaecological health. Her low SES exposes her to catastrophic financial toxicity. Her racial/ethnic identity may subject her to bias and language barriers. Her cancer type attacks her sexual and reproductive identity. Her psycho-social burden is a unique phenomenon of disempowerment and structural neglect.

DISCUSSION

Core Findings on the Interplay of Systems

The analysis yields several critical insights that challenge siloed understandings of cancer adaptation. These findings are not isolated but are actively engaged, explained, and elaborated by a growing body of recent research, which also allows for a critical evaluation of the DSE model's propositions.

The Primacy of Structural Context

A paramount finding is that structural factors are not mere background variables but active, powerful determinants of the adaptation process (Bowleg 2012). The comparative analysis (Table 1) demonstrates that pathways for coping and support are profoundly channelled by socio-economic and cultural infrastructures (Banerjee et al. 2011; Ahmadi and Ahmadi 2017; Ozdemir and Tas Arslan 2018).

Interpretation and Analysis of Table 1

Table 1 provides compelling cross-cultural validation of the DSE model's central thesis, demonstrating that the three systems do not operate in isolation but interact in distinct, structurally determined patterns across different global contexts. The comparative analysis moves beyond listing regional differences to reveal how the macro-level structural system actively configures the resources and rules for the relational and existential domains.

1. **Structure as the Primary Architect of Meaning and Support:** The data in the "Perception of Cancer" and "Dominant Support System(s)" columns clearly establishes the Structural System as the primary architect of the adaptation process. For example, in secular-Western contexts like Sweden, the dominant structural narrative frames cancer as a "random biological event". This directly channels the work of the **Existential System** into a secularised, individualistic "search for meaning and purpose", rather than a search for divine cause. Conversely, in religious contexts such as Turkey or the Middle East, the structural framework of Islam provides a pre-defined existential schema where cancer is interpreted as "God's will" or a "test", making religious coping the paramount existential resource. This structural influence extends powerfully to the **Relational System**. In nations with robust, formal healthcare systems, for example, in the United Kingdom, the structural infrastructure creates relational resources like multidisciplinary teams and electronic assessment tools. In contrast, in contexts with a strong cultural value of *familismo*, for example, in Latin America, or in regions with less-resourced public systems, for example, Ukraine, the structural system places the burden of support almost entirely on the family unit, which can lead to both profound cohesion and immense strain.
2. **The Culturally Supplied Coping Toolkit:** The "Dominant Coping Mechanism(s)" column illustrates that the specific strategies employed within the **Existential System** are largely supplied by the surrounding cultural structure. The Table shows that what is considered an "adaptive" coping strategy is not universal but is culturally sanctioned. For example, in individualistic Western contexts, the structural system values self-efficacy and emotional expression, leading to coping that emphasises "active coping" and "problem-focused strategies". In collectivist East Asian contexts, the structural system prioritises family harmony and emotional restraint, resulting in coping strategies that stress "acceptance" and "maintaining family harmony". In religiously oriented structures, the most adaptive coping mechanisms are those of surrender and faith, for example, *tawakkul* (trust in God) or *sabr* (patience). This demonstrates that a behaviour which might be perceived as "passivity" in one structural context is, in fact, a highly active and culturally endorsed form of existential coping in another.

Further, an individual's capacity for resilience is heavily contingent upon their access to resources. For instance, financial toxicity, which is the devastating combination of high treatment costs and lost income, is a unique psycho-social morbidity that transcends the physical disease, directly inhibiting recovery, increasing non-adherence, and exacerbating anxiety and depression (Zafar and Abernethy 2013; Banegas et al. 2016; Carrera et al. 2018; Kent et al. 2020). This finding argues that equity is foundational to psychological and existential well-being, not just a matter of medical access.

Recent studies critically evaluate and elaborate on this by demonstrating how structural barriers directly infiltrate the existential and relational realms. For instance, Liu et al. (2024) engage with this economic dimension, finding that in China, shared decision-making is associated with higher financial toxicity, which in turn dictates the specific coping actions patients can take. This reveals a recursive loop where a relational process can have unintended structural consequences, thereby constraining future coping options. The relationship between financial strain and cognitive-emotional resources is further elucidated by Davelaar and Garbanati (2023), who link perceived cognitive impairment to various psychosocial factors post-treatment, suggesting that structural stressors can have lasting neuropsychological impacts. Similarly, Eyni and Mousavi (2023) explore the cognitive-

Table 1: Research on cancer support systems, coping mechanisms, and perceptions by country/region

Country/Region	*Dominant support system(s)*	*Dominant coping mechanism(s)*	*Perception of cancer occurrence / Key contextual notes*	*Research study (selected examples)*
United States and Canada	*Formal and Informal:* Multidisciplinary teams, structured interventions, peer support groups. Strong role of religious communities for specific demographics. Family is a key primary caregiver.	*Diverse:* Emphasis on active coping, problem-focused strategies, seeking social support, and religious coping. High value placed on coping self-efficacy and emotional expression.	Often viewed through a biomedical lens. Significant disparities in outcomes linked to socioeconomic and racial factors. Immigrant communities may blend biomedical views with cultural/religious beliefs.	Banerjee et al. (2011); Philip et al. (2013); Bowie et al. (2017); Bickel et al. (2022)
United Kingdom and Europe	*System-based:* Integrated healthcare systems with tools like Electronic Holistic Needs Assessments. National health services provide a framework for support. Family is central to daily care.	*Adaptive:* Often includes minimising threat, positive reappraisal, and maintaining normality. Use of avoidant coping is noted in some contexts.	Largely secular and biomedical perspectives are dominant. A strong focus on quality of life and patient-reported outcomes within a socialised medicine context.	Miedema et al. (2007; 2010); Sorato and Osório (2015); Briggs et al. (2019)
Sweden	*Individualised/Secular:* Despite a highly secular society, individualised spirituality and private use of religious resources are common. Formal healthcare support is robust.	*Meaning-Making Coping:* Patients often use a secularised form of spiritual coping to find meaning, purpose, and comfort, rather than formal religious doctrine.	Predominantly secular. Cancer is seen as a random biological event, leading to a search for meaning and purpose rather than divine cause.	Ahmadi and Ahmadi (2017); Lundmark (2019)
Turkey	*Religious Community and Family:* Strong reliance on family networks and Islamic faith communities for emotional and practical support.	*Fatalistic and Religious Coping:* Concepts like *kader* (fate), *tawakkul* (trust in God), and *sabr* (patience) are central. Prayer is a primary coping activity.	Often interpreted within an Islamic framework as a test from God or a predetermined fate. This does not preclude pursuing medical treatment.	Alcalar et al. (2012); Ozdemir and Tas Arslan (2018); Ahmadi et al. (2019)
East Asia	*Family-Centric:* The family unit is the paramount support system, often involved in decision-making and care. Disclosure of diagnosis to the patient is sometimes managed by the family.	*Restraint and Acceptance:* Coping strategies emphasise emotional restraint, acceptance, and maintaining family harmony. Interpersonal coping and finding meaning in spirituality are also noted.	A blend of modern biomedical views and traditional cultural beliefs. Sometimes associated with stress or lifestyle factors. Stigma can be a significant concern.	Lim (2014); Cha et al. (2018); Jie et al. (2019); Cao and Cho (2021)
Latin America	*Familismo:* The cultural value of *familismo* ensures the family is the absolute primary source of emotional, practical, and decision-making support.	*Religious Coping and Positive Thinking:* Strong use of Catholic faith-based coping (prayer, devotion) and a cultural emphasis on "staying positive" (*ánimo*).	Often intertwined with religious faith, it can be seen as "God's will". Also viewed through a biomedical model. Strong desire to protect family from distress influences coping.	Choumanova et al. (2006); Torres-Blasco et al. (2022)

Table 1: Contd...

Country/Region	*Dominant support system(s)*	*Dominant coping mechanism(s)*	*Perception of cancer occurrence / Key contextual notes*	*Research study (selected examples)*
Middle East	*Family and Religious Community:* Tightly knit family structures and religious institutions (mosques) provide integrated socio-spiritual support.	*Islamic Religious Coping:* Deep reliance on prayer, Quran recitation, and trust in God's plan (*tawakkul*). Fatalism is common but often coexists with active treatment pursuit.	Overwhelmingly perceived through a religious Islamic worldview as a test, a destiny, or sometimes a punishment from God. Family honour and stigma are important social factors.	Al-Azri et al. (2014); Nikfarid et al. (2018); Almuhtaseb et al. (2020)
Ukraine	*Family-Reliant:* Given a less resourced public system, support falls heavily on the family network. Formal support structures are less prominent.	*Problem-Focused and Avoidant:* A mix of active problem-solving and cognitive avoidance. Religion plays a smaller role compared to other regions.	Influenced by the post-Soviet context and economic challenges. Viewed primarily as a severe health crisis to be endured.	Levenets et al. (2019)

Disclaimer: This table provides a generalised synthesis for comparative purposes. Significant individual variation exists within each country and region. The "dominant" labels represent common themes identified across multiple studies from that area, not universal truths for every person within that culture.

emotional impact of structural pressures, demonstrating that intolerance of uncertainty and low coping self-efficacy, factors exacerbated by a lack of systemic support, are significant predictors of self-perceived burden in Iranian cancer patients. This explains the mechanism by which structural instability cripples the existential system, by depleting the very cognitive and emotional resources required for meaning-making and adaptive coping.

The Phased Evolution of Challenges

The synthesis elucidates that the nature of challenges evolves predictably across the illness trajectory, a finding that underscores the inadequacy of one-size-fits-all supportive care. This evolution can be distinctly mapped through a phase-based application of the DSE model, which illustrates how the salience and interaction of the three systems shift over time.

Phase 1: Diagnosis and Initial Shock

This phase is dominated by the Existential System, characterised by an ontological rupture, mortality salience, and a frantic search for causality, as captured in the acute stress documented by Bronner et al. (2018). The primary need within the Relational System is for a secure "holding environment" from family and empathetic clinical communication to mitigate trauma. The Structural System activates immediately, as cultural and religious beliefs provide the initial framework for understanding the diagnosis.

Phase 2: Active Treatment

The focus shifts to enduring the physical and emotional assault of treatment. The Existential System is challenged by treatment-related distress, requiring problem-focused coping to sustain self-efficacy, a need highlighted in studies on specific treatments like transarterial chemoembolisation (Chen et al. 2022). The Relational System is paramount here, providing tangible, instrumental support and dyadic coping, as evidenced in the dyadic effects observed in couples facing cancer (van Roij et al. 2022). Concurrently, the Structural System manifests strongly through the emergence of financial toxicity, which becomes a major stressor.

Phase 3: Early Survivorship and Remission

This "new normal" is defined by ambiguity. The Existential System grapples with the fear of recurrence and the task of negotiating a new identity as a "survivor", a complex process of "experiential learning" outlined by Bilodeau et al. (2022). The Relational System can become a source of "social constraints" if loved ones expect a rapid return to normalcy, while specialised survivorship programs, such as those utilising tools like the Electronic Holistic Needs Assessment to help survivors articulate concerns and direct their coping (Briggs et al. 2019), become crucial. The Structural System reveals stark barriers, including persistent financial toxicity, employment discrimination, and unequal access to survivorship resources, with conflicts and adjustment processes in long-term survivors being a key focus (Hiltrop et al. 2021). Access to affordable follow-up care and survivorship resources is highly unequal, and standard programs often fail to address the specific cultural needs of diverse populations, such as the lack of culturally tailored interventions for Asian American survivors highlighted by Cao and Cho (2021).

Phase 4: Advanced, Recurrent or Metastatic Disease

The focus transitions from cure to quality of life. The Existential System returns to the forefront, centring on existential distress, life review, and legacy building, with spiritual coping often becoming the paramount resource, a transition starkly revealed in the grounded theory of "from surviving to living (on)" by Ristau et al. (2023). The core struggle is with existential distress, demoralisation, and mortality acceptance, a period of intense stress that necessitates unique and often heightened coping efforts (de Faye et al. 2006). This is the phase where evidence-based existential interventions, such as Individual Meaning-Centred Psychotherapy, have demonstrated efficacy in significantly reducing psychological and existential distress in randomised controlled trials (Breitbart et al. 2018). Equitable access to this palliative care is a critical determinant within the Structural System, especially as patients navigate the transition to palliative care and employ various coping strategies (Schmauch et al. 2022; Dev et al. 2024). The work involves life review, legacy building, and find-

ing meaning in the final chapter of life, with the chosen coping strategies being critically linked to the patient's quality of life and psychological distress levels (Sorato and Osório 2015).

Phase 5: End of Life

The final phase is dedicated to achieving peace and dignity. The primary work of the Existential System is the completion of meaning-making and achieving acceptance. The Relational System offers pure compassionate presence. The role of the Structural System is to facilitate a dignified death through policies and infrastructure that support universal access to high-quality hospice and bereavement care.

This phased model demonstrates that effective support must be dynamic and contextually intelligent, targeting the dominant system-level challenges at each stage. Recent literature explores and validates this phased perspective, providing critical nuance. For example, Lee et al. (2024) provide a profound exploration of the survivorship phase when it is shattered by recurrence, revealing a unique psychosocial burden characterised by the crushing sentiment that "it just never ends". This engages with the researchers' model by highlighting that phases can recycle or overlap, demanding a more fluid application of the DSE framework. Furthermore, He et al. (2024) elaborate on the existential system in long-term adaptation, showing that for many middle-aged and older Chinese survivors, the goal is not proactive "fighting" but a process of "reconciling with" the permanent changes brought by cancer. This evaluates the cultural specificity of the existential system's functioning, suggesting that the "negotiation" within this system can manifest as acceptance rather than overt meaning-making.

The Recursive Interplay Between Systems

The most significant finding is the recursive interplay between the three systems. Recent research provides compelling evidence to explain and elaborate on these dynamic interactions, moving from observation to mechanism. The study by Chirico et al. (2024) uses network analysis to quantitatively map the connections between emotional distress, coping efficacy, and social support. Their findings engage directly with the DSE model's core premise, visually demonstrating that resources and symptoms exist in a tightly interconnected network. They found that coping efficacy was a central node, closely linked to reduced emotional distress and bolstered by social support. This explains the mechanism behind the observed interplay that strengthening a resource in one system (for example, coping efficacy in the existential system) can have direct, stabilising effects on other parts of the network (for example, reducing distress).

Moreover, Zhang et al. (2025) explicitly test a model that elaborates on the recursive interplay. They found that in Chinese lung cancer patients, the effect of symptom burden on demoralisation was mediated by family function, resilience, and coping behaviours. This is a clear empirical demonstration of the DSE model's proposition that a biological stressor (symptom burden) impacts existential distress (demoralisation) *through* its effects on the relational system (family function) and the existential system's internal resources (resilience and coping). This critically evaluates and supports the model's insistence that systems cannot be understood in isolation. The efficacy of coping is further shown to be influenced by interpersonal dynamics, as Cha et al. (2018) found that interpersonal coping mediates the relationship between spirituality and quality of life, illustrating the Relational System's role in translating existential resources into positive outcomes.

The Utility of the DSE Model as an Integrative Framework

The value of the Dynamic Socio-Existential (DSE) Model lies in its utility as the analytical framework that made the synthesis of these complex findings possible. The recent studies cited above validate its utility as an integrative lens.

Structuring Interconnectedness

The model provided the necessary heuristic to mandate the examination of *interconnections*. For example, it allows one to synthesise how van der Velden et al.'s (2024) experimental study on prognostic communication (a Relational System intervention) can directly influence patient emotions and coping (Existential System outcomes), and that this effect is likely moderated by structural factors like health literacy and cultural norms. The phase-

based application of the model is its ultimate utility, moving from a static map to a dynamic GPS for the cancer journey.

A Tool for Future Research and Clinical Practice

Beyond this review, the model's utility is its potential as a roadmap for future innovation, a path that is already being hinted at by recent work. Heinen et al.'s (2024) systematic review, for instance, explores *how* mindfulness-based interventions work, finding they promote coping and self-efficacy by interweaving existential (present-moment awareness), relational (non-judgmental acceptance), and cognitive (decentering) processes. This aligns perfectly with the DSE model and elaborates on how multi-system interventions can be designed. Similarly, the finding by Wang et al. (2022) that different mindfulness profiles are associated with distinct psychological outcomes and coping strategies underscores the need for a person-centred, multi-system approach that the DSE model facilitates.

For Clinical Practice

The model provides a template for dynamic assessment. It is supported by the development of tools like the Anxiety, Depression and Coping (ADAF) screening tool by Pérez-Segura et al. (2021), which represents a move toward concurrently assessing existential and relational factors. Understanding the typical challenges of each phase, as outlined by the model, allows clinicians to proactively address likely issues, such as assessing for financial toxicity (Liu et al. 2024) as diligently as for fear of recurrence, and tailoring support to specific challenges, such as those faced by parents of children with cancer (Neenan et al. 2024).

For Research

The model generates novel hypotheses and methodologies. It calls for longitudinal studies to track system interactions over time and interventional trials that combine strategies across systems, such as testing the efficacy of integrating financial navigation services (Structural) with meaning-centred psychotherapy (Existential) (Breitbart et al. 2018) and developing culturally adapted versions of these interventions for specific populations, as exemplified by the protocol for adapting meaning-centered psychotherapy for Latino families (Torres-Blasco et al. 2022).

Limitations of the Model

The findings and the model's utility are constrained by the available literature. While this review incorporated cross-cultural studies, future research must test and refine these insights in more diverse contexts. Kasgri et al.'s (2024) systematic review on breast cancer, for example, highlights that while coping strategies are widely studied, their effectiveness is deeply context-dependent, underscoring the need for the very structural and cultural analysis the DSE model promotes. Furthermore, as a theoretical synthesis, the phase-based framework requires empirical validation through the research avenues it itself proposes, such as the longitudinal and interventional studies suggested by the network analysis of Chirico et al. (2024).

This enhanced discussion, woven with recent evidence, demonstrates that adapting to cancer is an experience continuously shaped by the recursive interplay of one's search for meaning, the quality of one's relationships, and the immense weight of one's social and economic context. The DSE model proves invaluable as a lens to not only synthesise these findings but also to engage critically with new research, explaining the mechanisms of adaptation and elaborating a path toward truly holistic, phase-specific, and equitable care.

CONCLUSION

In conclusion, this systematic review affirms that psychological adaptation to cancer is a dynamic, non-linear process best understood through the integrative lens of the Dynamic Socio-Existential (DSE) Model. The findings compellingly demonstrate that an individual's journey is shaped by the continuous and recursive interplay between three core systems, that is, the internal existential battle for meaning and coping, the immediate relational web of support and strain, and the overarching structural context of culture, inequity, and financial burden. Crucially, the salience of each system evolves across the illness trajectory, demanding phase-specific and multifocal support. The DSE model provides the necessary framework to move

beyond siloed approaches, offering a roadmap for developing timely, precise, and holistic interventions. Ultimately, this synthesis underscores that effective psycho-oncological care must simultaneously address the profound existential crisis, nurture the relational network, and actively dismantle the structural barriers that fundamentally constrain an individual's capacity for resilience and well-being.

RECOMMENDATIONS

To translate these findings into action, a paradigm shift toward precision support is essential. Clinically, this requires adopting dynamic, multisystem assessments that are phase-specific, integrating proactive screening for financial toxicity and cultural beliefs with existential and relational evaluations to guide targeted interventions. For research, the priority is to develop integrated measurement tools and launch longitudinal and interventional studies that empirically test the DSE model's recursive dynamics across diverse populations. At the policy level, action must focus on mandating equitable access to supportive care and enacting concrete reforms to mitigate financial toxicity, thereby building healthcare systems that actively foster resilience across the existential, relational, and structural domains.

LIMITATIONS AND REFLEXIVITY

The findings and the model's utility are constrained by the available literature, which has historically overrepresented Western, high-income populations such as the USA and Canada . While this review incorporated cross-cultural studies, such as among the South Asian immigrant parents in Canada and cancer patients in Turkey future research must test and refine these insights in more diverse contexts, particularly among groups with intersecting vulnerabilities, such as women and minorities. Furthermore, as a theoretical synthesis, the phase-based framework requires empirical validation through the research avenues it itself proposes.

This review demonstrates that adapting to cancer is an experience continuously shaped by the recursive interplay of one's search for meaning, the quality of one's relationships, and the immense weight of one's social and economic context. The DSE model proved invaluable as a lens to synthesise these findings and expose these dynamics. By providing a framework that acknowledges this complex interplay, one can advance a more compassionate, equitable, and effective approach to supporting individuals through their illness trajectory, guiding the future of research and clinical practice towards truly holistic care.

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