Palliative and Supportive Care (2006), **4**, 189–196. Printed in the USA.

DOI: 10.1017/S1478951506060251

Caring for the spiritual pain of patients with advanced cancer: A phenomenological approach to the lived experience

KEIKO TAMURA, R.N., M.S., C.N.S., PH.D.(C),[1] KAZUKO KIKUI, R.N., B.S.,[2]
AND MICHIYO WATANABE, R.N., M.A.[3]
[1]Department of Medical Ethics, Osaka University Graduate School of Medicine, Osaka, Japan
[2]School of Nursing, Kansai University of Social Welfare, Osaka, Japan
[3]College of Nursing, Aichi Medical University, Aichi, Japan

(RECEIVED December 1, 2005; ACCEPTED December 16, 2005)

ABSTRACT

Objective: The aim of this research was to reveal, from the perspective of the "lived experience" shared by cancer patients and their nurses, how patients facing death create lived experience in the context of palliative care. This research also aims to elucidate the meaning nurses find in patients' experiences while caring for their patients.

Methods: The participants in this study were cancer patients who were given opportunities to discuss events and concerns in their daily lives, with the interactions guided by the researchers. Transcriptions of conversations with the patients were analyzed using the method for empirical data classification set forth by Giorgi (1985) with appropriate modification.

Results: This study found that when the nurse correctly interprets the meaning of the concerns (Heidegger, 1962) of the patient facing death and shares that meaning with the patient, fundamental questions naturally arise for the patient. Answering these questions becomes possible only through interactions that require the reexamination of the values of the patient and the nurse.

Significance of research: This research elucidates the spiritual pain experienced by cancer patients and discusses opportunities for nurses to address the spiritual care of these patients.

KEYWORDS: Advanced cancer patient, Caring, Spiritual pain, Phenomenological approach, Lived experience

INTRODUCTION

The objective of this research is to elucidate, from the perspective of "lived experience" between patients and nurses, first, how patients facing death as a result of a terminal cancer diagnosis create a lived experience for their situation and, second, how nurses find meaning in their relationships with their patients and then care for them.

Holistic assessment of patients as part of their pain relief is a well-known aspect of palliative care (World Health Organization, 1990, 2002). The significance of consideration of spiritual aspects has been also acknowledged. In the United States, the National Hospice Organization (1988) and the Joint Commission on Accreditation of Healthcare Organizations (1996) proposed, respectively, the

---

Corresponding author: Keiko Tamura, Department of Medical Ethics, Osaka University Graduate School of Medicine, 2-2 Yamadaoka, Suita, Osaka, 565-0871, Japan. E-mail: a287027@ych.or.jp

importance of and guidelines for the spiritual care of patients who were dying or were living with a chronic disease. In Britain, The National Health Service Confederation (1996) has drawn up guidelines for spiritual care. In Japan, the word "spiritual" is distinguished from its religious context, although the difficulty of determining what exactly the word represents is directly reflected in the difficulty of providing this type of care.

More recently, the structure of spiritual pain has been examined (Murata, 2003; Morita et al., 2004*b*; Kawa, 2005). Murata elucidated the spiritual pain of people facing death as pain experienced as (1) a being founded on temporality, (2) a being in relationship, and (3) a being with autonomy. He found spiritual pain expressed as (1) meaninglessness and worthlessness of living; (2) emptiness, loneliness, or anxiety; and (3) worthlessness, dependence, or burden, respectively.

The structure of spiritual pain is yet to be scientifically established. However, research on the care of spiritual pain has been based on the structure proposed by Murata (Morita et al., 2004*a*; Murata & Ozawa, 2004). In these studies of spiritual care, it was expected that Japanese cancer patients would express their spiritual distress. It was found, however, that many patients did not do so. On the contrary, it was found that medical staff are usually not trained in the provision of spiritual care and were unable to respond to patient questions such as "Why me? I haven't done anything wrong" or "What's going to happen after death?" The caregivers of the cancer patients reported feelings of confusion and helplessness.

A review of European and American reports of spiritual care for patients with advanced cancer found this care broadly consisted of basic care and care of specific types of pain (Morita et al., 2001). Seven types of basic care have been reported, concerning such matters as the establishment of relationships with patients, acceptance of reality and emotions, and reinforcement of social support, and areas that overlap traditional nursing practices (Tamura, 2002). Studies of spiritual care illustrate that patients are increasingly viewed as holistic beings, and palliative care is not the only context in which care is implemented using a holistic approach (Bishop & Scudder, 1997).

The key to the spiritual care of patients with advanced cancer is considered to be the care provided by the nurse who cares for the patient as a holistic being. For that reason, a quantitative approach is needed to illuminate spiritual pain and help determine its care, based on the interactions between patients and nurses who implement a holistic approach.

METHODS

Research Participants

The research participants were 2 adult patients admitted to a general hospital for cancer treatment who were capable of communication and able to take part in a number of interviews in the form of an ongoing conversation with a nurse-researcher. The participants were under treatment at the department of internal medicine and the trauma department, respectively, when the interviews began. These continued as the participants moved to the palliative care unit.

Data Collection

The participants were provided with a quiet environment in which they could privately discuss with a nurse-researcher their concerns and problems of daily life and events that had taken place since the previous interview. The nurse-researcher interacted with the participants, listened to them, inquired as to their condition, and provided advice as part of the caregiving team.

The nurse-researcher is a cancer care specialist with more than 20 years of clinical experience. The nurse-researcher indicated that she had always had an interest in the spiritual care of terminal cancer patients, and she provides her nursing care with a phenomenological view of human beings based on the philosophies of Heidegger and Merleau-Ponty (Tamura, 2005).

Interviews with the nurse-researcher were held for 30 to 90 min (average 60 min) at times requested by the participants (e.g., during outpatient visits). The interviews were held between February 2004 and February 2005, with consideration for the participants' physical condition. The interviews were recorded with the consent of the participants and verbatim transcriptions prepared.

Data Analysis

The transcripts were analyzed by two researchers and the nurse-researcher using the method for empirical data classification established by Giorgi (1985) with appropriate modification. An expert in phenomenology supervised the analysis.

1. The transcripts were carefully reviewed by the two researchers and the nurse-researcher to understand the whole of the meaning of the interactions between each participant and the nurse-researcher.

2. On the transcripts, the two researchers and the nurse-researcher marked noteworthy words and indicated which part of the conversation was spoken by the participant and by the nurse-researcher. The transcripts were also read in an attempt to comprehend the meaning of particular words and phrases. To eliminate bias, each of the researchers and the nurse-researcher analyzed the transcripts in the same way.

3. The researchers worked together with the nurse-researcher to mark noteworthy words and phrases, annotate the words and phrases with the reason they caught the researchers' attention, and interpreted them as a team.

4. The researchers noted how they interpreted each noteworthy word or phrase and commented on the similarity of the meaning of the word or phrase as the researcher understood it to the meaning given the word or phrase by the participant.

5. The meanings were categorized and the categories graphed by plotting them against time, and a narrative describing the world lived by the participant and the nurse was constructed.

Ethical Considerations

This research was approved by an ethical committee at the research facility. The research outline, voluntary nature of the participation, handling of the data, protection of privacy of the participants, information collection from the case record, and other research protocols were explained to the participants both orally and in writing before the interviews were undertaken, and written consent was obtained from the participants. When family members joined the interviews, the same explanations were given and the same consent obtained.

RESULTS

The 2 participants were informed of their cancer upon its diagnosis and subsequently informed of its stage and treatment. The participants chose their treatments by themselves with reference to the advice of the medical staff. Although the disease took a different course in each case, each participant attempted to live the rest of his or her life by restructuring his or her story of that life.

In the following reports from the transcripts, the nurse is identified as "I."

Story of Mrs. M and Her Nurse

Mrs. M was a 33-year-old homemaker. Her mother was diagnosed with lung cancer when Mrs. M was 26 years old and died after a 1-year battle with the disease. Mrs. M got married at age 28 and went to live with her husband and his parents in a newly purchased house. She had a child the following year, who developed asthma. Mrs. M had had a persistent cough since the previous summer, so she visited a physician. A chest X-ray showed an abnormality, so it was recommended that Mrs. M visit Y General Hospital for further examination, which she did.

A closer examination diagnosed primary lung cancer. Although chemotherapy was recommended, Mrs. M voluntarily left the hospital to receive alternative treatment in F Prefecture. About 2 months later, she was hospitalized in F Prefecture for aggravated dyspnea and transferred to Y General Hospital at her request. I visited Mrs. M as she "wanted to know more about hospice for future reference." Mrs. M, at our first meeting, seemed to be worried about the future. However, after being provided with information on hospice care, she smiled and said "I feel better now. I will need your help when the time comes."

In January 'XX, the chief of staff informed me that Mrs. M had been admitted to receive anticancer drug treatment as a last resort, her psychiatric condition was unstable, and hospital staff were having trouble handling the situation. I immediately visited Mrs. M, who cried out, "Help me! What is going to happen to me? I am going to die. . . . Why just me?" I listened to Mrs. M until she calmed down. I visited her almost every day for the next week before her discharge from hospital. After calming down somewhat, she was able to be discharged. The interviews resumed 1 week after her discharge at her request. A total of 16 interviews were held with her.

Fighting over a Stray Cat: The Importance of "Life" and a Useless, Bothersome Cat

Mrs. M looked happier at the first interview after her discharge from the hospital. She talked without stopping about how she came to realize that she needed to change herself, because the anti-cancer drug treatment was stabilizing her condition and she now believed that a miracle could happen. Behind this change was her relationship with her mother-in-law, which had not been good ever since her marriage. The reason for this difficult relationship was a stray cat that Mrs. M took in when she was pregnant and kept in the home despite her mother-in-law's disapproval. The asthma her child developed worsened the relationship with her mother-in-law.

First interview: February 4, 'XX. At the interview, Mrs. M described the cause of the cancer as the awkwardness between her mother-in-law and herself, stating that every difference in their values as shown by the cat incident had led to the disease. She was also convinced that this awkwardness was ultimately attributable to her selfishness. As Mrs. M talked, I noticed that she attempted to take on the unfair experience of the disease by blaming herself, which reminded me of her crying before her discharge. I wondered how great her emotional pain was and how excruciating it could become.

Trying to ease her immeasurable pain even a little, I asked, "Isn't it tough to think like that?" This unexpected question seemed to surprise her, bringing a sparkle to her eyes for a moment. This question gave Mrs. M a chance to look at herself objectively and seemed to have made her realize that the cause of her cancer was not her personality. However, the cat problem was not solved, and she described her sense of distress by saying "I want a place to escape to, but what should I do?" I did not know how to answer. However, I let her know that we would be working on the solution together, hoping to ease even a little the emotional pain brought on by her taking the blame for getting sick.

Interviews were held almost every week. Mrs. M had to keep taking the anticancer drug in spite of the physical discomfort it induced. In an attempt to share her understanding of how difficult her physical condition was, I provided Mrs. M with information on the drug's adverse effects and advice on ways she could care for herself. Mrs. M used my advice in her daily life. However, she also stated many times how she was merely a burden to her family, in a continuous dilemma between the realities of relying on an anticancer drug for a miracle without knowing how many more years she had and putting an ever greater financial burden to her family by continuing to use the drug. She also stated repeatedly that she did not appreciate the way her husband and father treated the cat and how frustrating it was not to be able to make them understand her feelings.

I was puzzled as to why she kept insisting on caring for the cat in spite of her family's strong opposition. Still, her body language indicated she was desperately asking for understanding and kept me listening to her.

Fifth interview: March 25, 'XX. At each interview, the story of the cat was a major element. However, no realistic solution was found and we kept talking in circles. Feeling impatient to do something about the situation, I came out and told her, "You are reflecting your own life in the fact that the cat's alive, right?" This is how I personally felt about her story about the cat so far.

At this interview, I was able to confirm that the cat was for Mrs. M, who was facing death even while hanging onto the hope of the anticancer drug, a family member, something to support her, and most importantly inseparable from her own life. Everything suddenly started to make sense. As a result of talking and interacting with me, Mrs. M was also able to realize what the existence of the cat meant for her. I was impressed by the way she persistently protected the cat without yielding to her family. This issue of the cat so affected me emotionally that I wanted to help her with this problem. I even said to her, "You can let me have a word with your husband" in order to have him understand.

Seventh interview: April 12, 'XX. When we had a talk with her husband some 2 weeks later, Mrs. M asked him to understand her distress. She described that she was "still upset" with her mother-in-law, who was very harsh on her when she brought the cat in. The husband, while wanting to value his wife's feelings, was not able to take either side because his parents were assisting them with medical costs and child care. Understanding his difficult situation very much, I, in turn, tried to encourage Mrs. M to ease her lonely battle with the disease by saying, "You are not the only one fighting the disease."

During the talk, Mrs. M expressed her anguish at using the anticancer drug and said, "I have to keep using it because I am only surviving" and "It feels like I ended up just living." This description of the life of Mrs. M moved me because it made me realize the difficulty of trying to understand a reality that is beyond imagination. Mrs. M maintained her desire to continue living and that inspired me. At this point, I decided to keep interacting with Mrs. M until the last moment of her life.

After this interview, Mrs. M and her husband had talks about the cat with her parents-in-law, though no conclusion was reached for a while. On the other hand, the cat did not come up very often in her later interviews with me. Instead, Mrs. M came to wish for a better relationship with her mother-in-law.

Interpretation. The issue of the cat originated from Mrs. M's desire for assurance of survival, which the use of the anticancer drug treatment did not by itself guarantee. The conflict over the cat with her mother-in-law needed to be solved for a miracle to happen. In addition, disrespecting the cat's life went against Mrs. M's value of life. For Mrs. M to live her unique "life," maintaining the cat's life was essential, no matter what her family and friends said.

When people sense death approaching, they are said to desire what is true and valuable to them (Saunders, 1988). For Mrs. M, the "cat's life" was considered truly valuable. Furthermore, "cat's life" refers not only to its literal existence. Instead, the meaning was restructured by the interaction of Mrs. M and the nurse, who was interested in and coexisted around the issue of the cat. The nurse also noticed that Mrs. M had such a compassion for life as she faced her own death. Her attitude toward life was inspiring. Throughout the experience, the nurse decided to continue to support Mrs. M's efforts to pursue her way of living until the end.

Liberation By Finding God: Release from the Sense of Guilt, Reconciliation with Mother-in-Law and Sense of Appreciation

During an interview held in mid-October, I explained to Mrs. M and her husband that the physician in charge and I had come to the conclusion on her growing pain that the anticancer drug could not be expected to provide any further benefit. The drug was discontinued and palliative care begun. The pain, however, became unmanageable through outpatient visits, and Mrs. M was admitted to hospice in late October.

Fifteenth interview: October 27, 'XX. During the third interview held after her admission to hospice, Mrs. M looked nervous and showed her confusion by saying, "I am not sure if I know what I feel." I was interested in what was confusing her and listened to her talk. Mrs. M was forced to confront the reality of losing her physical abilities. She was also feeling her physical strength slowly fading and that her time was limited. Mrs. M was feeling remorse for having continued to take the anticancer drug. Knowing her history, I was able to understand her regret well. Still, agreeing with her felt like denying her "life." I replied only by saying, "I think the timing of the end of the drug treatment was just right, though." Although Mrs. M responded "You're right," she was hesitant to acknowledge her reality and said "There's no other treatment, is there?" She also stated "When I look into the future, I sometimes seal it up." And when Christianity was mentioned, she said "Rather than thinking by Buddhist principles, it is easier to simply ask for help and protection from God," as she tried to relax herself as she thought about death.

I noticed that, as her death became more and more imminent, Mrs. M became extremely upset thinking about a future that included death. I thought, however, that this sort of distress could not be resolved by someone other than the patient herself, and I hoped to support Mrs. M by talking and interacting with her so that she could find meaning in her own unique "life."

Sixteenth interview: November 8, 'XX. Mrs. M's faith in Christianity deepened after meeting S, who was also a Christian, at the hospice. Christianity taught Mrs. M that the cause of her distress was accusation by others. She hoped to become free from the accusations and gain true consolation, and believed that the key to achieving these goals was faith in Christianity. A nurse who supported her was also a Christian, and that also helped her feel good about Christianity. She recovered peace of spirit by mercy of God. I was happy to see Mrs. M's change, while being a little surprised to see the quick transformation of her mind. Mrs. M stated that she thought of having herself baptized, along with her husband and child, and even having a Christian ceremony at her funeral, if possible. She stated that, for her, the Christian God was a comforting and encompassing being.

Mrs. M also developed a realistic view of her prognosis. Looking back on her experience with the disease, she calmly said, "After taking time to think about living and, of course, dying, too, I can finally say this is probably enough." She then announced that she wanted to live with a sense of appreciation for the people supporting her until the end. When I brought up her mother-in-law, she talked frankly about her gratitude for her mother-in-law and said, "I have to thank my mother," and "I hope to have a good relationship with her at the very end and say, 'See you, mother.'" I felt that Mrs. M was living with a clear vision of death. I promised myself I would continue to support her until the end, in order for her to have a life that she could sincerely appreciate.

After her discharge, I searched for a church that could fulfill Mrs. M's requests, although she did not get to be baptized. I continued my support for her by listening to her thoughts and advising her on changes in her physical condition, way of living, and other matters by sending her text messages on her cell phone and speaking with her at her outpatient visits. As she wished, she was able to "spend time at home" up to 5 days before her passing.

Interpretation. In being admitted to hospice, Mrs. M realized that death was rapidly approaching and was forced to again face her disease. What lay deep in her heart was her strong sense of guilt for having developed the disease and her impression that the disease meant a burden on others (Bahnson, 1980, 1981). Discovery of Christian teachings, which are based on a different value system from those of Buddhism, must have made her feel that faith in these teachings would free everything and God's great love would embrace her. The nurse was surprised at this transformation of Mrs. M's mind, but at the same time felt relieved by her finding tranquility never seen in the course of their talks and interactions thus far. This stability of mind and contentment of the nurse was sensed by Mrs. M, and she developed her faith in a Christian God further, determined to live without looking away from death. The presence of the nurse, who was always with Mrs. M to support her, encouraged her to change her view and ultimately liberated her from the sense of guilt, reconciled her with her mother-in-law, and made her realize how important it was to appreciate others.

Story of Mr. H and His Nurse

Mr. H was a 42-year-old male who grew up in a family consisting of his parents and a younger brother. After finishing a graduate degree, he took a job at a biotechnology company, where he conducted research in such areas as the genetics of cancer. At age 35, he was diagnosed with appendix cancer and underwent surgery. He was given adjuvant chemotherapy for 3 years after the operation. After 1 year, a local recurrence was discovered and chemotherapy was resumed. However, the tumor continued to grow, and a complete cure was considered doubtful. Mr. H called this resumed chemotherapy his "endless chemo" and he intended to continue living, even with cancer.

A year after the recommencement of his chemotherapy, his physician recommended his moving on to palliative care. Mr. H did "not want to give up yet" and requested the chemotherapy be continued. In the spring of 'XX, a life partner appeared in his "life only to have got cancer," who was willing to stay with him. Mr. H's desire to live even one more day became stronger. Nevertheless, that summer he began to feel increased fatigue as an adverse effect of chemotherapy and abdominal pain caused by the growth of the tumor.

I met Mr. H at a support group meeting for cancer patients held the year following his surgery. I continued to support his living with cancer after that. The interviews were initiated in late July 'XX, when his symptoms started to get worse, and 12 interviews were held in total.

Living with Disease: Wish To Survive with "Endless Chemo"

Fifth interview: September 22, 'XX. In mid-September, Mr. H suddenly developed diarrhea and melena accompanied by abdominal pain. The chemotherapy was discontinued immediately. I was aware that Mr. H intended to fight his cancer with the "endless chemo," namely, continuing life. I also knew, however, that this most recent incident suggested it was almost time for the chemotherapy to be terminated. At the interview, Mr. H looked pale but seemed to be animated again by recovering from his symptoms. Mr. H did not agree with the discontinuation of the therapy, although he admitted that the anticancer drug was poisonous. Even with my understanding of the invasiveness of the chemotherapy, I could not continue to recommend the discontinuation of chemotherapy. It was as if I was carried away by the strong desire of Mr. H to continue the therapy. I felt down after finishing this interview.

As his fatigue continued to increase, it was obvious that Mr. H was becoming systemically weaker. We talked about the ongoing chemotherapy at every interview, though his mind was made up to "continue" it and did not change. Although I was never sure whether "it was really all right," I was becoming overwhelmed by his way of living full of spirit and wishing to live for his partner at any cost. I was also feeling anxious about what was going to happen in the future. The reason for this anxiety was my own experience of regret, that is, I felt "his ending would be more peaceful if only the transfer to palliative care were half a month earlier." I imagined that the timing for the transfer to palliative care was not right for Mr. H, whom I had supported for almost 6 years. I could not help but felt frustrated, thinking "What if his ending is painful?" At the same time, I was afraid of possibly feeling sorry for myself. However, Mr. H was very self-assured. I even felt that he became more convinced each time I talked about it. I was feeling both resigned and angry, thinking "There is nothing more I can do." However, talking with Mr. H about his prayer-like hope "to live" made me change and think "I can only move forward now."

In mid-December, Mr. H's abdominal pain once again intensified, and living at home became difficult. Upon consulting with his physician, I explained to Mr. H that it was better for him to be under palliative care. This time Mr. H seemed to realize the limits of the therapy and was admitted to hospice right away.

From Limited Life to Eternal Life

Eleventh interview: December 29, 'XX. After coming to the hospice, Mr. H was updated on his condition by his physician. Subsequently he asked "How long do I have?" and the answer was "1 month, at the earliest." Mr. H kept silent for a while and then quietly said "I understand."

On the afternoon of that day, I talked with Mr. H as usual. He had relaxed after receiving an indication that there was at least "1 month" more for him to live. A while ago, I had told Mr. H "I will let you know if I see you going in the wrong direction." Talking with him made me realize that what I really meant had been delivered to his heart. My tension was suddenly gone, and I felt very relieved. However, I was also very moved by how passionately Mr. H longed to live, even while perfectly understanding his entire situation. I could not help but ask myself to what extent I had comprehended this emotion of his. I told Mr. H that I would "take responsibility," because what I could do then was, I thought, to continue my support for him until the end. Talking with each other was helping Mr. H realize the possibility of living his future in a different way from "endless chemo."

Later, thanks to successful symptom management, Mr. H enjoyed playing his favorite piano and violin and learning French. When "1 month" had almost passed, Mr. H eagerly wished to make the "proof of his life" into a book. The production of a book of his reminiscences began immediately with the help of his partner and parents. Mr. H passed away after seeing the draft volume completed.

Interpretation. After his recurrence, Mr. H called the chemotherapy "endless chemo" and continued to live without losing hope. On the other hand, he was immersed in an unshakable loneliness as shown by his description of his life as "only to have got cancer." The sincere wish of Mr. H, who had just found a life partner, to survive at any cost was more than clear to the nurse. Nonetheless, by that time Mr. H's physical condition had deteriorated significantly. The nurse was faced with the dilemma of hoping for him to stay on "endless chemo" and feeling anxious that continued chemotherapy might shorten his life instead. Mr. H was naturally aware of this nurse's dilemma. While appreciating the nurse's concerns, Mr. H still eagerly wished for "endless chemo." The nurse had to question once again how "I" should be as an individual, not as a member of the nursing staff (Mitsui, 2004). During the investigation of how "I" should be, which used to be obvious to her, the nurse was determined to believe in Mr. H's will to live and to support him in his ideal way of life. Throughout the interview process, the nurse's determination touched Mr. H's heart. Mr. H was able to feel relaxed in the warm spiritual embrace of the nurse and to continue living while comfortably being himself. The nurse's support helped transform the viewpoint of Mr. H from that of limited time to that of eternity, in the context of the confirmation of his approaching death.

DISCUSSION

Mrs. M, who began anticancer treatment without no guarantee of survival, was concerned with a cat's life and then became interested in Christianity when she sensed her own death approaching. Mr. H, who found a life partner during his long coexistence with cancer, focused on "endless chemo" and restructured his life accordingly. The two patients showed that in a given situation they were able to develop and maintain concerns as something to remind them of the future, even while being aware of their own limitations.

The nurse, on the other hand, continued to listen to her patients, always paying attention to what the patients were holding close to their hearts. In listening to the patients many times, these concerns became clear to the nurse. However, comprehension of what the patients' words truly meant was not easy. The nurse would always listen with an image of the whole patient in mind, attempting to determine the meaning manifested within everything the patient said. Also, the nurse lived in the patients' world as a result of considering various issues together with the patients, trying to develop a sense of their inner selves, what the patients had freed themselves from, and how they wanted to live. This intention was clear to the patients and allowed the patients to explore themselves and talk further. It is fair to say that the nurse's concern for her patients meant a great deal to the patients. Nevertheless, the concerns of the patients, who were preoccupied by death, were in many cases about their unique "life," which made the nurse question the way of the patient's being "the self." To understand a patient's concerns in this context, a nurse needs to put his or her own ideas and values aside, face the patient and try to accept the way the patient is. It is also important to reflect on what lies behind the patient's concerns.

Behind the concerns of Mrs. M was her questioning why she became sick, with her aim of finding the meaning of her illness. Mrs. M told herself that she was "to blame." However, this reasoning was not convincing, and thus she was persistent in protecting the cat's life. Furthermore, recognizing her inevitable death, Mrs. M looked to Christianity to break the spell of her guilt. During his long battle with his disease, Mr. H continued to question the meaning of life, asking "What meaning does life have, only to have developed cancer?" For that reason, he found more value in his life partner than anything else, which helped ease Mr. H's near-extreme solitude.

A concern provides a reason to keep going and collectively represents the whole concept of a human being (Benner & Wrubel, 1989). When a nurse correctly interprets the meaning of the concerns of a patient who faces his or her own death and that meaning is shared, the patient is able to raise fundamental questions about the meaning of his or her life. In other words, spiritual pain can be expressed through the questions and distress that unavoidably appear when a patient struggles to carry on valuing his or her sense of self.

To respond to such questions, as previously discussed, it is not enough for a nurse to simply eliminate his or her bias and consciously reconsider the situation the patient is in. It is also necessary to examine the values set aside by the patient and the nurse and restructure them. This is because the existence of the nurse is shaken, the nurse's view of life and values are questioned, and ultimately the nurse will gain a new point of view. The nurse uses the restructured values to answer the questions and lessen the distress of the patient while providing opportunities for the patient to transform his or her viewpoint for carrying on. This transformation eventually allows another story to be written. The patient and the nurse are able to confront their own deaths only through interactions that compel them to reexamine their values. This is what makes spiritual pain care possible for cancer patients, whose interests and entire life context have changed drastically.

The results of this research should be referred to by caregivers and other medical staff working with cancer patients in disease stages ranging from relapse to terminal to provide spiritual care to patients through the process of referring, amending, and sharing the results.

ACKNOWLEDGMENTS

We sincerely thank the patients and their family members, who willingly participated in this research. We also acknowledge Prof. Kiyokazu Washida, Vice President of Osaka University, and Dr. Motomu Shimoda, Associate Professor of Medical Ethics at Osaka University Graduate School of Medicine, who kindly guided the research. This research was subsidized by the Japan Hospice Palliative Care Foundation and The Sagawa Foundation for Promotion of Cancer Research.

REFERENCES

Bahnson, C.B. (1980). Stress and cancer: The state of the art, Part 1. *Psychomatics*, *21*, 975.

Bahnson, C.B. (1981). Stress and cancer: The state of the art, Part 2. *Psychomatics*, *22*, 207.

Benner, P. & Wrubel, J. (1989). *The Primacy of Caring: Stress and Coping in Health and Illness*. pp. 47–49. Menlo Park: Addison-Wesley Publishing Company.

Bishop, A.H. & Scudder, J.R. (1997). A phenomenological interpretation of holistic nursing. *Journal of Holistic Nursing*, *15*, 103–111.

Giorgi, A. (1985). *Phenomenology and Psychological Research*. Pittsburgh: Duquesne University Press.

Heidegger, M. (1962). *Being and Time*. Macquarrie, J. & Robinson, E. (trans.). New York: Harper and Row.

Joint Commission on Accreditation of Healthcare Organizations. (1996). JCAHO and spiritual care. Chicago: Joint Commission on Accreditation of Healthcare Organizations.

Kawa, M. (2005). The spiritual pain of patients suffering from terminal cancer and being cared for at Japanese palliative care units. *Journal of Death and Life Studies*, *5*, 48–82 (in Japanese).

Mitsui, S. (2004). *From Cure to Care*. pp. 124–129. Tokyo: Keiso Shobo (in Japanese).

Morita, M., Ihara, C., Kurihara, Y., et al. (2004*a*). Palliative care: Spiritual care for terminally ill cancer patients. *The Japanese Journal of Psychiatry*, *19*, 267–274 (in Japanese).

Morita, T., Kawa, M., Honke, Y., et al. (2004*b*). Existential concern of terminally ill cancer patients receiving specialized palliative care in Japan. *Supportive Care in Cancer*, *12*, 137–140.

Morita, T., Tei, Y., Inoue, S., et al. (2001). Care for spiritual and existential suffering of terminally ill cancer patients: Integration by systematic review. *Japanese Journal of Palliative Medicine*, *3*, 444–456 (in Japanese).

Murata, H. (2003). Spiritual pain and its care in patients with terminal cancer: Construction and conceptual framework by philosophical approach. *Palliative and Supportive Care*, *1*, 15–21.

Murata, H. & Ozawa, T. (2004). Spiritual care in patients with terminal cancer. *The Japanese Journal of Clinical Nursing*, *30*, 1450–1464 (in Japanese).

The National Health Services Confederation. (1996). *Spiritual care in NHS: A Guide for Purchases and Providers*. London: Nahat.

National Hospice Organization. (1988). *Standards for a Hospice Program.*

Saunders, C. (1988). Spiritual pain. *Journal of Palliative Care*, *4*, 29–32.

Tamura, K. (2002). Care for the spiritual pain of patients suffering from terminal cancer. *The Japanese Journal of Hospice and Palliative Care*, *12*, 82–92 (in Japanese).

Tamura, K. (2005). Spiritual care for patients with terminal cancer. *The Japanese Journal of Hospice and Palliative Care*, *15*, 396–401 (in Japanese).

World Health Organization. (1990). *Cancer pain relief and palliative care*. WHO technical report series No. 840. Geneva: World Health Organization.

World Health Organization. (2002). *National cancer control programmes: Policies and managerial guidelines*. 2nd ed. Geneva: World Health Organization.