Palliative and Supportive Care (2006), **4**, 179–188. Printed in the USA.

DOI: 10.1017/S147895150606024X

ORIGINAL ARTICLES

Development of a spiritual pain assessment sheet for terminal cancer patients: Targeting terminal cancer patients admitted to palliative care units in Japan

KEIKO TAMURA, R.N., M.S., C.N.S., PH.D. candidate,[1] KAORI ICHIHARA, R.N.,[2]
EIKO MAETAKI, R.N.,[2] KEIKO TAKAYAMA, R.N.,[2] KUMI TANISAWA, R.N.,[2]
AND MASAYUKI IKENAGA, M.D.[2]

[1]Department of Medical Ethics, Osaka University Graduate School of Medicine, Osaka, Japan
[2]Yodogawa Christian Hospital Hospice, Osaka, Japan

(RECEIVED November 2, 2005; ACCEPTED November 10, 2005)

ABSTRACT

Objective: This research explores the potential benefit of a spiritual pain assessment sheet to clinical practice. With spiritual pain defined as "pain caused by extinction of the being and meaning of the self," the spiritual pain assessment sheet was developed by Hisayuki Murata from his conceptual framework reflecting the three dimensions of a human being as a being founded on temporality, a being in relationship, and a being with autonomy. The assessment sheet was developed from reviews of the literature and examinations from a philosophical perspective on the structure of spiritual pain.

Methods: Patients admitted to palliative care units in Japan were interviewed using the assessment sheet. The responses were analyzed qualitatively. The usefulness of the assessment sheet and the burden placed on the patients by its use were also investigated.

Results: The spiritual pain elucidated by the assessment sheet was the same as that revealed in the earlier research of Morita. The patients reported that they did not find the use of the assessment sheet a burden, and more than half reported that it was useful. The burden of the assessment sheet on the subjects was thus determined to be low. Positive feedback on the assessment sheet was also received from the nurses who conducted the patient interviews, who said the assessment sheet made it easier to talk with the patients about their spiritual pain.

Significance of research: The research results indicate that the spiritual pain assessment sheet provided an appropriate assessment of spiritual pain among terminal cancer patients, showing that such a sheet could be used as an assessment tool in the future.

KEYWORDS: Terminal cancer patients, Spiritual pain, Assessment tool, Palliative care

INTRODUCTION

The expansion of hospice and palliative care as part of terminal care in Japan is raising discussion on spiritual pain and its care. "Spiritual pain," however, is an elusive concept, and no Japanese equivalent for the term exists. Spiritual pain and its care originate in the Christian view of life and death

---

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

(Kondo et al., 2002). The World Health Organization (WHO) definition describes a relationship with a superhuman entity. In Japan, many people report having no specific religion, which makes it difficult for these individuals to understand the WHO definition. Spiritual pain is thus more or less understood in Japan as being "connected to interests in and concerns of the meaning and objectives of living" (Chiba, 2004).

Although some confusion results from the lack of a common concept, most hospice and palliative care practitioners in Japan use the definition provided above (Sayama, 2002; Saigo, 2003). Spiritual pain is most commonly demonstrated in the words of patients interacting with medical staff. Therefore, the level of interest and understanding of spiritual matters among staff members can influence the way patient pain is recognized and patient care is provided (Morita et al., 2001). For medical staff to provide effective spiritual care, actions need to be taken with problem solving in mind. Comprehension of that which is observed and scrutiny of hypothesis are more important than the needs derived from the three types of pain making up holistic pain (Fish & Sherry, 1988; Tamura, 2002).

In other words, it is crucial for medical staff to have a common understanding of the spiritual pain experienced by terminal cancer patients and to assess their suffering appropriately. For this purpose, a concept of a spirituality that produces spiritual pain must be established through efforts in medicine, religion, ethics, psychology, and other fields (Imamura et al., 2002; Yuasa, 2003; Kubodera, 2004). The next step is to clarify the type, degree, and other characteristics of spiritual pain to provide effective spiritual care. Outside of Japan, the necessity of spiritual pain assessment has been acknowledged, and tools have been developed to assess spiritual needs in the medical care context (Highfield, 1992; Fitchett & Handzo, 1998; World Health Organization, 2002; McClain et al., 2003).

As described above, academic discussion of spiritual pain and spiritual care has just begun in Japan. In consideration of the current situation, Murata (2003) acknowledges the importance of clarifying the structure of spiritual pain for the sake of discussing the spiritual care of terminal cancer patients. He defined spiritual pain as "pain caused by extinction of the being and meaning of the self" and elucidated the establishment and structure of spiritual pain experienced by terminal cancer patients, based on a philosophical investigation. According to Murata, the "spiritual pain of terminal cancer patients arises from the fear of extinction of existence and meaningfulness of the self imposed by the approach of death" (Murata, 2003, pp. 17–18). He also argues that spiritual pain "can be elucidated as the future of a being founded on temporality, a being in relationship and a being with autonomy, the other people, the meaninglessness of the life caused by loss of the self, loss of identity, worthlessness, etc." The spiritual pain experienced by the patients in the earlier studies of Murata was assessed in each of the three dimensions of temporality, relationship, and autonomy; and from this research an approach to care was developed (Hara, 2004; Murata, 2004; Satake & Takahashi, 2004).

For the current study, a spiritual pain assessment sheet was developed using the conceptual framework of Murata and the words of patients interviewed by Murata to express their spiritual pain in the three dimensions of temporality, relationship, and autonomy. This assessment sheet was then used in patient interviews by medical staff to help clarify the characteristics of patient spiritual pain, which is rarely known unless expressed by the patients themselves, and to provide vital information for their care.

The objective of this research was to explore the potential benefit of a spiritual pain assessment sheet to clinical practice. The use of an assessment sheet based on the framework of Murata was expected to reveal the manner in which terminal cancer patients experience spiritual pain.

METHODS

Research Subjects

The subjects were Japanese cancer patients over 20 years old who were admitted to a palliative care unit in a general hospital authorized by the prefecture, were capable of holding a conversation for about 30 min, and consented to participate in this research. Three exclusion criteria were used: (1) disturbance of consciousness, dementia, or symptomatic brain metastasis; (2) incapacity for verbal communication; (3) diagnosis of cancer not revealed to the patient.

Data Collection

The research used the spiritual pain assessment sheet of Murata to collect data. It was developed from his framework reflecting the three dimensions of a human being as a being founded on temporality, a being in relationship, and a being with autonomy.

Spiritual Pain Assessment Sheet

Using a three-dimensional framework of spiritual pain, Murata (2004) analyzed the words of terminal

Table 1. *Spiritual pain assessment sheet*

Q1. “Things like this (treatment, etc.) would not help.”
Q2. “It is boring to stay in a hospital.”
Q3. “I have nothing to do.”
Q4. “I do not know what to do.”
Q5. “There is no point.”
Q6. “I wish to be relieved as soon as possible.”
Q7. “I wish I could meet the Maker soon.”
Q8. “There will not be anything left after death.”
Q9. “I feel lonely, feeling like I am left behind all alone.”
Q10. “Having my family with me does not help my loneliness.”
Q11. “I lose a true sense of living when staring at the ceiling alone.”
Q12. “No one understands this.”
Q13. “What will happen to me after death? Where will I go?”
Q14. “This is happening as a divine punishment.”
Q15. “My sins will never be cleared.”
Q16. “Why is this happening?”
Q17. “What does my life mean after all?”
Q18. “I feel sorry that I am under someone else’s care and causing trouble.”
Q19. “One is no longer a human being when he/she cannot take care of himself/herself.”
Q20. “I am no use and life’s not worth living.”

cancer patients he interviewed. From this analysis he developed a spiritual pain assessment sheet for the purpose of identifying and characterizing spiritual pain. As shown in Table 1, the assessment sheet consisted of 20 assessment items, with 7 items concerning a being founded on temporality, 8 concerning a being in relationship, and 5 concerning a being with autonomy, followed by the concluding question “What concerns you the most right now?” The responses of the patients are reproduced verbatim (in translation) below.

Interview Method

For the interviewers to develop a common understanding of the assessment sheet, the structure of spiritual pain was discussed with Murata before the interviews were conducted. The interviews were held from January to October, 2003. The interviewers were nurses who each have more than 10 years’ experience as a nurse and 7 years’ experience working in a palliative care unit without responsibility for the subject. The interviewers read the assessment items aloud as shown on the assessment sheet, and the subjects responded in their own words. At the end of each interview, each patient was asked, “What concerns you the most right now?” The interviews were tape-recorded with the consent of the patients and were then transcribed.

The assessment sheet was also evaluated for its usefulness in clinical practice. At the end of each interview and 1 week after the interview, each patient was surveyed on the psychological burden of being surveyed using the assessment sheet and how it helped the patient better understand his or her own psychological state. The feelings of the nurse regarding conduct of the interview were also surveyed.

Collection of Background Information

Personal information on the subjects was collected from medical records. Information on physical condition was collected from primary doctors.

Analysis Method

Each of the researchers analyzed the transcriptions of patient responses to the assessment items. Researchers carefully reviewed the responses in relation to the context in which the responses were provided and held a number of discussions to achieve consensus on their understanding. A cancer care specialist supervised the analysis. Patient responses to how they felt about being assessed with the assessment sheet are a straightforward tally.

Ethical Considerations

This research was approved by an ethical committee at the research site. Before each interview, verbal and written consent was obtained from each patient in writing after explaining the purpose of the research, the voluntary nature of the participation, handling of the data, protection of patient privacy, information collection from medical records, and other research protocols.

RESULTS

Subject Characteristics

The subjects comprised 10 terminal cancer patients including 5 males and 5 females. The mean age was 64.9 years, with a range from 50 to 80. The diagnoses were stomach cancer in 3 subjects, lung cancer in 2 subjects, rectal cancer in 2 subjects, and other cancers in 4 subjects. By religion, 8 subjects were Buddhists and 2 were Christians. By marital status, 7 were married, 1 was separated, and 2 were surviving spouses. Performance status at the time of the interview was grade 2 in 3 subjects and grade

3 in 7 subjects (Table 2). The interview was conducted in one session and lasted 30 to 40 min, although one subject interview took 150 min.

Spiritual Pain Elucidated by Each Item of the Assessment Sheet

Spiritual pain experienced by each subject was elucidated from the subject response to each item on the assessment sheet. The responses transcribed below include not only expressions of pain but also narration related to the facts leading to the pain and suggesting patient values and views of life and death. Supplemental contextual information is provided in parentheses.

Q1. In response to "Things like this (treatment, etc.) would not help," Patient G said "I somewhat agree," interpreting "things like this" as pain relief. Patient I, on the other hand, said "I do not receive treatment here," interpreting "things like this" as chemotherapy. Eight subjects stated "I do not agree."

> G: I somewhat agree. Frankly, the results are hard to see. I think things like this need a long time to get results.

Q2. In response to "It's boring to stay in a hospital," Patients B, G, and F said, "It's boring." Patient F, however, modified her response, saying that the meaning of the current situation could be changed while taking the interview, and it was not boring.

> G: Life in a hospital is the most boring. It really is (boring). Some people might like it, but I think there could be a little bit more happening. I sleep because there's nothing else to do. At home, I feel like doing something like gardening, my hobby. That kind of fun is difficult to find at a hospital.

> F: I drop by people who are bedridden and talk with them. They are really pleased. So I guess I would be lying if I said it was boring. I thought even I might be of some use for something.

Q3. In response to "I have nothing to do," Patient D described the current situation saying, "I am losing my motivation." Patient G responded following Q2, "It is boring to stay in a hospital." Responses from 7 other subjects included "I do not agree. I have many things to do," "I find things to do," and so on. These comments suggest that the subjects were motivated to do whatever was possible under the circumstances.

> D: I am losing my motivation. I don't feel strong at all. I have this (a calligraphy set) because I thought that writing might be a good distraction, but I can't write at all when I actually try.

> G: If I were at home, I could lie in a reclining chair and watch TV or doze off, whatever I want. At the hospital, I only watch TV because that's all I can do.

Q4. In response to "I do not know what to do," Patient G said "I agree," and Patient I said "I agree sometimes." Patient D, who in response to Q3 talked about having lost motivation, described her reality saying "I have things I want to do but I actually can't." Patient F described the misery of having to face "myself who cannot do."

> D: I have things I want to do. First, I want to read books. I opened a book when I felt like it, but I couldn't read.

> F: "I do not know what to do" is about my own pain, right? I guess I would try and find it. My

Table 2. *Subject backgrounds*

ID	Gender	Age	Cancer diagnosis	Performance status	Marital status	Occupation	Religion
A	Female	52	Sigmoid colon	2	Separated	Unemployed	Buddhism
B	Male	60	Stomach	3	Married	Suspended	Buddhism
C	Female	50	Uterus	2	Bereaved	Unemployed	Buddhism
D	Female	74	Stomach	3	Married	Unemployed	Buddhism
E	Male	57	Stomach	3	Married	Employed	Buddhism
F	Female	80	Lung	2	Bereaved	Unemployed	Christianity
G	Male	77	Lung	3	Married	Unemployed	Buddhism
H	Male	65	Rectal	3	Married	Unemployed	Buddhism
I	Female	67	Colorectal	3	Married	Unemployed	Christianity
J	Male	67	Prostate	3	Married	Unemployed	Buddhism

> feeling may be more like that I do not know if I can do it.

Q5. In response to “There is no point,” Patient B said “It is difficult to say.” Patient F stated “I feel like this when my condition is bad.” Patient J provided his opinion on the word “point.”

> B: Difficult to say. Sometimes that’s how I feel, but I also think it can’t be helped. . . . It sure is difficult to say.

> F: I feel like this when my condition is bad. But then, I thought it was wrong to think that way. I wouldn’t think there is no point, as long as I’m alive. It is a bit too sad to think like that.

> J: People can have different ideas. If you believe that this whole world is made up of lies, there is no point. There is no point unless you are connected to God.

Q6. In response to “I wish to be relieved as soon as possible,” all subjects questioned the meaning of the word “relieved.” The interviewers, in response, asked “What do you think it means?” After exchanging ideas with the interviewer, patients D and I said that they want their painful condition relieved. Patient J gave his opinion in the same manner as Q5.

> D: That is my biggest wish.

> I: You can say that, yes. I think so. I wish I could be relieved . . . I guess everyone does.

> J: When I have pain, I wish it was gone. But when I look back, it has its own meaning. God is giving such hardships for something. God satisfies my basic needs. So that question is irrelevant.

Q7. In response to “I wish I could meet the Maker soon,” only Patient D agreed. Patients B and J expanded on their response after stating that they did not agree.

> D: I agree. The sooner I could see Him the better. Being bedridden is very hard.

> B: First things first. My wishing such things doesn’t matter. I can only wait, you know. Just thinking about things like that is absurd.

> J: Humans are not limitless. The more restricted they are, the more happily death will be welcomed. I hope to be in such a state of mind that I can gladly meet the Maker, when the opportunity arrives.

Q8. In response to “There will not be anything left after death,” half of the subjects agreed. Patients C, E, and F did not agree and stressed that they would continue to have a connection with their family.

> B: I guess there wouldn’t be. I kind of believe (that humans are) coming from and returning to the soil. So nothing will be left. That burial in the ground, that’s been done because we’d for sure become nothing.

> D: After death, it’s like nothing. I don’t think there will be anything.

> G: I can see the point. But I think it’s fine if nothing will be left. It’s no use anyway. I don’t wish to be left hanging around forever.

> C: I don’t feel that way. I have a child, so I think I will be present in the heart of my child. I, myself, will disappear though. Even without a body, I shall remain. That’s why children are important.

> F: I saw my husband and mother pass on, but I feel they both left me something. The ones who were left may or may not notice, but that’s the only difference. I still feel like everyone is leaving something behind.

Q9. In response to “I feel lonely, feeling like I am left behind all alone,” Patients E, F, and I said that they felt lonely. Patient C, on the other hand, spoke of the importance of relationships.

> E: Lonely, that’s for sure. Whatever they say, this is a battle with myself. There must be no replacement.

> F: Left . . . left all alone. I don’t think that difficult, though I somehow felt a little bit lonely.

> C: Not so much, you know. Since I got sick, I feel grateful to other people.

Q10. In response to “Having my family with me does not help my loneliness,” Patients E and J talked passionately about how each person is, by nature, by oneself.

> E: I appreciate my family, of course. It had to be them, you know. I know they notice or do things,

> just because they are my family. It makes me happy (that my family is with me). It's nothing to do with that, though. I think humans are by nature alone.

> J: I think people are alone, ultimately. You have only yourself, in the end. As long as you have the goal in your thoughts to pass away on your own, you won't feel lonely.

Q11. In response to "I lose a true sense of living when staring at the ceiling alone," the comments were either "I do not agree" or "I do not stare the ceiling."

Q12. In response to "No one understands this," Patients C and F said "I somewhat agree." Patients E and J, who in response to Q10 said that humans were alone, described how natural it was if no one did.

> E: It's not that they don't understand. It would be wrong if they did without experiencing this. There's no way they understand. They don't know what they're talking about. Of course they don't.

> J: I'd say it's selfish to expect them to understand. The others have different ideas than mine, naturally.

Q13. In response to "What will happen to me after death? Where will I go?" Patient A replied that he wondered about that sometimes, emphasizing the fear of what happens after death. Replies received included that the subject would "return to the earth" and "become nothing" in relation to Q8, as well as "it is up to God," based on religious teachings. Patient J talked about his own view of "afterlife," which he developed from his experience hovering between life and death while ill with cardiac disease.

> A: I have thought about that, of course. I just wonder if there's a spiritual world or something like that. They talk about crossing death's river and stuff, right? There's a tingling sound, and so on. I am terribly scared. I try not to think about it much because it's scary, though.

> J: [When my heart almost stopped during cardiac surgery,] I felt like I had a glimpse of the world I was going to be in. They don't have any language. They never criticize each other, and they are training themselves in their own way. When I see the possibility of being allowed to live in that place, I feel like having a home to go back to.

Q14. In response to "This is happening as a divine punishment," half of the subjects said that they had thought that way. Patients D and G also said that they deserved it.

> D: I deserve it. I wish I had paid a bit more attention to my health.

> G: I know. I feel I must have done something bad somewhere. . . . I wonder when, to whom, and what I have done. My heart healed nicely, but I have other parts that are not cured. . . . We all might wonder if we have done something evil, really.

Q15. In response to "My sins will never be cleared," half of the subjects disagreed and said "I have not done anything that I think is a sin." Patient G, on the other hand, expressed his view that sin meant death.

> G: Isn't it the same as death? It could only mean that. Even if I manage to live for 10 years (more), there must be some bad things happening anyway.

Q16. In response to "Why is this happening?" half of the subjects said that they had thought about that and expressed a sense of regret. Patients B, H, and J, on the other hand, felt that it could not be helped.

> C: It has crossed my mind, yes. I was not getting check-ups, so I felt like I deserved it.

> D: That would still be my own mismanagement of health. I regret it.

> G: I know. Why is this happening? I will always wonder about this. We tend to think that we have been doing things, but maybe we haven't. Maybe I should have done more.

Q17: Half of the subjects said that they had asked the question, "What does my life mean after all?" to themselves. Each subject described emptiness, shortness, and bitterness of life, or similar feelings. One subjects replied "I hope that it was not 'nothing'" and another said he thought "God considers the meaning of life."

> C: I have thought about it. Half of my life was spent on my kids. Isn't it something everyone thinks about?

> D: Seems like my life has passed by meaninglessly. I don't have a hobby or anything, either. I was just living.

> E: I can't complain. It actually is very short. I need a little longer. If possible at all, a little bit longer. (This kind of thinking is) only negative, really. You can't live thinking this way. I want time. Well, I can only do my best each day, everyday.

> H: I have done my part all right. So I don't have regrets. To be honest, it wasn't quite enough. I couldn't really get there because I got sick. I feel a little sorry about that.

Q18: In response to "I feel sorry that I am under someone else's care and causing trouble," 7 subjects agreed, based on their own experiences in the past. Only Patient C, however, said "it is okay to cause trouble."

> D: I feel like this so very much.

> F: I came to think that I don't have to feel sorry. People all get their turns according to the age. Everyone is supposed to be seen off by the next generation. But still, when I get sick, I know that I'm feeling sorry for them.

> I: Yes, I feel like that. Well, I think I do. When my farther died, he was confined to bed and couldn't go to the bathroom by himself for almost 10 years. He was taken care of for everything, and I don't think I want to be like that.

Q19: In response to "One is no longer a human being when he/she cannot take care of himself/herself," only Patient D expressed a sense of misery, by using the word "pathetic." Patients B, E, and F did not agree, because that was not their intention. Patient H said that he had never thought about Q18 or Q19, because he won't live any longer.

> D: I can't take care of myself. That is the most pathetic.

Q20. In response to "I am no use and life's not worth living," only Patient D said that her life was not worth living with current conditions. However, 4 subjects said that there must be some value or meaning.

> D: Well, I agree for now. People's lives are worth living when they are healthy and able to take care of themselves and others as well. When they are under someone else's care and can't take care of themselves, I think they are worthless.

Analysis of the responses shows that the most common spiritual pain manifested by the subjects was "I feel sorry that I am under someone else's care and causing trouble," followed by "Why is this happening?" and then "What does my life mean after all?" All three questions suggest pain related to autonomy. All subjects felt pain in the dimensions of relationship and autonomy. Of the 10 subjects, 5 experienced pain in the dimension of temporality.

Impressions of the Subjects on Being Assessed

When questioned immediately after and 1 week after their interviews, 9 of the subjects (1 was unable to answer due to weakness) reported that they did not feel a psychological burden upon being assessed with the assessment sheet.

Immediately after the interview, 6 subjects said that the assessment sheet was useful, 1 said it was neither useful or useless, and 2 said that it was not really useful. Reasons why it was not so useful were "Those are the things I usually think about. The questions are too simple. You ask if I want to be relieved, but it really depends. It depends, for example, on how much pain I have. Some want to feel better because they are suffering. It's very different from wanting to feel better when nothing actually hurts." "Totally different from what I think about." One week after the interview, 6 said that it was useful, and 3 said it was neither useful nor useless.

Impressions of the Interviewers

The interviewers reported that expressions such as "things like this (treatment)" in Q1 were rephrased simply as "treatment" by all of the subjects. The interviewers also observed that the subjects had difficulty distinguishing between Q3 "I do not have anything to do" and Q4 "I do not know what to do," and between Q9 "I feel lonely, feeling like I am left behind all alone" and Q10 "Having my family with me does not help my loneliness." Consequently, the responses to these items were similar. Item Q6 "I wish to be relieved as soon as possible" triggered the question, "what does it mean to be relieved?" All of the interviewers experienced difficulty in explaining the meaning.

The interviewers felt very uncomfortable using such direct expressions as "There is no point," "I wish to be relieved as soon as possible," "I wish I could meet the Maker soon," "My sins will never be cleared," "There will not be anything left after death" and "One is no longer a human being when he/she cannot take care of himself/herself." For that reason, some interviewers said that they explained more than was necessary.

Opinions on interviewing patients with the assessment sheet included comments that it was easier to look directly into the spiritual aspects of patients' lives, which they did not normally talk about unless the subjects raised the issue themselves, and that it provided a chance to learn more about the patients' values and philosophies of life.

DISCUSSION

Characteristics of Spiritual Pain Elucidated by the Assessment Sheet

Analysis of the spiritual pain elucidated by the assessment sheet found spiritual pain manifested in all three dimensions of temporality, relationship, and autonomy. These results agree with those of Morita et al. (2004), that is, the existential pain of cancer patients investigated at four palliative care units in Japan was categorized as pain derived from relationship, pain derived from autonomy, pain derived from relationship and autonomy, and pain derived from temporality. As a result, the study of Morita found an assessment sheet to be useful for elucidating the spiritual pain of terminal cancer patients.

In this study, the spiritual pain most commonly manifested was "I feel sorry that I am under someone else's care and causing trouble." Patients developed a perception of themselves as "incapable" as they lost their physical function. This perception was also expanded to include others in that loss of function resulted in their reliance on others. This spiritual pain can be interpreted as the pain of a being in relationship, which was generated in a relationship with others.

The second most common spiritual pain was "Why is this happening?" and "What does my life mean after all?" Some subjects responded "I deserve it" and "Seems like my life has passed by meaninglessly," respectively. These responses indicate that they interpreted these items as asking them to reflect on their inner selves, for example, expressing self-criticism or regret or looking back on their lives. For them to find the solutions for these questions, the indispensable existence is the self-being that improves the self-esteem and accepts and approves of the self. In this sense, this spiritual pain can be classified as the pain of a being in relationship, which emerges between self and inner self.

In response to "one is no longer a human being when he/she cannot take care of himself/herself" and "I am no use and life is not worth living," only 1 subject clearly agreed. This result indicates that the subjects felt more than a little uncomfortable with such assertive expressions as "no longer a human being" and "not worth living." As Morioka (2001) pointed out, the fundamental reason for this discomfort is that the patients all shared the view promoted during Japan's era of strong economic growth that "only those who are productive have lives worth living." The subjects' reactions suggest that their once clear worldview has been shaken to its foundation by their disease.

This study also found that all subjects felt the pain of a being in relationship. The subjects appreciate their family's presence. However, they also seemed to experience an extreme sense of "loneliness" when their admission to a hospice did not allow them to look away from death. In response to "This is happening as a divine punishment," half of the subjects agreed, reasoning that they deserved it, although a relationship with a superhuman entity was not clearly stated. A belief that God or Buddha would punish people's wrongdoing underlies these answers.

Spiritual pain as a being with autonomy and a being in relationship was manifested by every subject. Conversely, spiritual pain as a being founded on temporality was acknowledged by only 5 of the 10 subjects. For the subjects, being admitted to a hospice signifies that they are one step closer to death. They were all aware of the implication of their admission to hospice. Still, that does not mean that they could easily renounce life. According to the framework of Murata, spiritual pain as a being founded on temporality and derived from meaninglessness, purposelessness, and the absurdity of living was expressed by terminal cancer patients who were aware of the approach of death and had lost hope for the future. Most of the assessment items in fact asked about the "meaninglessness of living." Some of the subjects' disagreement with the question is believed to represent their inner conflict over renouncing life by acknowledging the overwhelming fact of approaching death.

Research by Kawa et al. (2003; Kawa, 2005), on the structure of spiritual pain experienced by terminal cancer patients admitted to palliative care units, found three kinds of "pain caused by having to accept the reality" and "pain caused by the approach of death." Subcategories of "pain caused by the approach of death" were reported to be "desire to live," "fear of death," and "hopelessness." The category of "pain caused by the approach of death" was considered to incorporate the concept of temporality by its context and to correspond in this study to the pain associated with a being founded on temporality. Conversely, Morita et al. (2004) showed that 25% of patients, the highest number ($n = 22$), expressed “pain directly related to death” by such statements as “I am scared of death” and “I do not want to die.” Comparing the results of Morita with our results of the spiritual pain of a being founded on temporality, we conclude it is important to ask questions that allow subjects to communicate their desire to live and their anxiety and fear associated with death.

Use of the Spiritual Pain Assessment Sheet

When questioned about the use of the assessment sheet, none of the subjects said that it caused a psychological burden, and 6 subjects, in fact, stated that it was useful. This indicates that the assessment sheet helped them clarify their thoughts or provided an opportunity to reflect on what concerned them. Conversely, 2 subjects who said that it was not really useful commented that “Those are the things I usually think about” and “Totally different from what I think about.” These subjects had previously experienced diseases that had made them aware of their own mortality. These experiences had already established their own views of life and death as well as their worldview. For this reason, the subjects had already contemplated these concepts and believed the assessment sheet offered nothing remarkable.

The impressions of the nurses who conducted the interviews illustrate that, although the validity of the assessment items and appropriateness of their wording need to be further considered, they considered the use of the assessment sheet positively. Although the nurses are specialists in hospice care, they also feel psychological agitation and burden. This suggests the need for opportunities for care providers to learn about and reflect on life and death as well as the importance of developing their own views of life and death and values through learning.

Application of the Spiritual Pain Assessment Sheet to Clinical Practice

To provide spiritual care to cancer patients who live with the knowledge of their approaching death it is necessary to assess appropriately the spiritual pain these patients experience. Based on the discussion above, the assessment sheet used in this study was considered a potentially useful tool for assessing the spiritual pain of terminal cancer patients.

Because none of the subjects agreed with the item “I lose a true sense of living when staring at the ceiling alone,” the appropriateness of this item needs to be reconsidered. Also, the responses to several items were very similar, such as “I have nothing to do” and “I do not know what to do,” as well as “I feel lonely, feeling like I am left behind all alone” and “Having my family with me does not help my loneliness.” These related assessment items need to be reviewed in terms of their intention. The spiritual pain of a being founded on temporality and a being with autonomy were found not to be independent of each other but closely related, as represented by the expression “I feel sorry that I am under someone else’s care and causing trouble.” Furthermore, as pointed out in the discussion, assessment items need to be developed that help elucidate the subjects’ desire to live and communicate their anxiety and fear of death. The task lying ahead, in view of these findings, is to elaborate on the items set out on the assessment sheet.

LIMITATIONS AND FUTURE RESEARCH

The subjects for this research were cancer patients who were aware of their impending death from their disease and chose to be admitted to a palliative care unit. The interviews were conducted when their conditions were relatively stable. In view of these factors, the results of this research should be applied to some patients in a palliative care unit. Hereafter, elucidation of spiritual pain should be encouraged through the use of the assessment sheet. It is also considered important to monitor closely the pain of each subject who faces death and to continue exploring appropriate care, with the help of the assessment sheet.

CONCLUSION

Use of an assessment sheet helped to elucidate the spiritual pain experienced by terminal cancer patients admitted to a palliative care unit. The application of the assessment sheet in clinical practice was as follows:

1. Interviews conducted using the spiritual pain assessment sheet encouraged elucidation of the spiritual pain of terminal cancer patients who were aware of their approaching death.
2. All subjects experienced the pain of a being in relationship and the pain of a being with autonomy, and 5 of the 10 subjects experienced pain in the dimension of temporality.

3. In helping to elucidate patients' spiritual pain, the assessment sheet was a useful tool that placed little burden on patients.

REFERENCES

Chiba, T. (2004). On understanding spiritual pain in modern Japan. *Social philosophical research toward integrative comprehension of vital challenges in 21st century Japan*. Research report for funding for scientific research (Foundation (B) (1)) in fiscal, 133–142 (in Japanese).

Fish, S. & Sherry, J. (1988). *Spiritual Care*. Downers Grove, IL: InterVarsity Press.

Fitchett, G. & Handzo, G. (1998). Spiritual assessment, screening, and intervention. In *Psycho-Oncology*, Holland, J.C. (ed.), pp. 790–808. New York: Oxford University Press.

Hara, T. (2004). Reality of spiritual care and its process. *The Japanese Journal of Clinical Research on Death and Dying*, *27*, 49–50 (in Japanese).

Highfield, M.F. (1992). Spiritual health of oncology patients. Nurse and patient perspective. *Cancer Nurse*, *15*, 1–8.

Imamura, Y., Kawa, M., Kayama, M., et al. (2002). Conceptual structure on spirituality in end-of-life patients with cancer. *The Japanese Journal of Hospice and Palliative Care*, *5*, 425–434 (in Japanese).

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).

Kawa, M., Kayama, M., Maeyama, E., et al. (2003). Distress of inpatients with terminal cancer in Japanese palliative care units: From the viewpoint of spirituality. *Supportive Care in Cancer*, *11*, 481–490.

Kondo, H., Nakazato, T., & Morinaga, S., et al. (eds.). (2002). *Dictionary of Bioethics*. Tokyo: Taiyoushuppan Co. (in Japanese).

Kubodera, T. (2004). *Spiritual Care*. Tokyo: Miwa-Shoten Ltd. (in Japanese).

McClain, C.S., Rosenfeld, B., & Breitbart, W. (2003). Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients. *Lancet*, *361*, 1603–1607.

Morioka, M. (2001). *What Can Life Studies Do: Brain Death, Feminism and Ideas of Dominance*. pp. 288–302. Tokyo: Keisoshobo (in Japanese).

Morita, T., Kawa, M., Honke, Y., et al. (2004). 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. (2004). Reality of spiritual assessment and care. *The Japanese Journal of Clinical Research on Death and Dying*, *27*, 10–13 (in Japanese).

Saigo, J. (2003). Spiritual care for terminally ill patients. *Journal of Japanese Society of Cancer Nursing*, *17*, 167 (in Japanese).

Satake, M. & Takahashi, E. (2004). Analysis of spiritual pain of terminal cancer patients at home: A sample case of finding hope in completing a picture book as a bequest to children. *Journal of Japanese Society of Cancer Nursing*, *18*, 111 (in Japanese).

Sayama, T. (2002). To support patients who hope the unattainable. *The Japanese Journal of Clinical Research on Death and Dying*, *25*, 36–37 (in Japanese).

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).

Yuasa, Y. (ed.) (2003). *Current State of Spirituality: From Religious, Ethical and Psychological Viewpoints*. Tokyo: Jimbunshoin (in Japanese).

World Health Organization (2002). Department of Mental Health & Substance Dependence, *whoqol-SRPB: Field-Test Instrument-WHOQOL Spirituality, Religiousness and Personal Beliefs (SRPB) Field-Test Instrument: The WHOQOL-100 Questions plus 32 SRPB Questions*. Geneva, Switzerland, World Health Organization.