Original Article

Nurses' Responses to Requests for Forgiveness at the End of Life

Betty Ferrell, RN, PhD, FAAN, FPCN,
Shirley Otis-Green, MSW, ACSW LCSW OSW-C, Reverend Pamela Baird, AA, and
Andrea Garcia, BA

Division of Nursing Research & Education (B.F., S.O.-G., A.G.), Department of Population Sciences, City of Hope, Duarte; and Seasons of Life (R.P.B.), Arcadia, California, USA

Abstract

Context. Patients or family members facing serious illness often express regrets over life events or the need for forgiveness. Professionals, including nurses as the prominent discipline at the bedside, witness these expressions of regret or needs for forgiveness but may not be adequately prepared to optimally address patient concerns regarding forgiveness.

Objectives. The objectives of this descriptive study were to 1) identify contexts in which nurses have witnessed expressions of regret or the need for forgiveness and 2) describe nurses' responses to these clinical experiences related to forgiveness.

Methods. Nurses attending palliative care educational programs shared narratives of their experiences in caring for patients who expressed regret or the need for forgiveness. Study narratives were analyzed qualitatively, using content analysis. Themes were identified.

Results. Narratives were provided by 339 nurses from courses throughout the U.S. and Belize, India, the Philippines, and Romania.

Conclusion. Nurses provide clinical care for patients with advanced illness who struggle with issues of forgiveness. Nurses would benefit from additional education regarding how best to address these concerns.   J Pain Symptom Manage 2014;47:631−641. © 2014 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words

Forgiveness, regret, communication, relationships at end of life, palliative nursing

Address correspondence to: Betty Ferrell, RN, FAAN, FPCN, Nursing Research and Education, Division of Population Sciences, City of Hope, 1500 E. Duarte Road, Duarte, CA 91010, USA. E-mail: bferrell@coh.org

Introduction

Background and Literature Review

Patients facing serious illness or the end of life may review their lives, reflecting on critical life events, relationships, missed opportunities, or actions now seen as regretful. The need for forgiveness may be expressed as self-forgiveness, the need to seek forgiveness

from others, or forgiveness from God or a higher power.[1–3] The concept of forgiveness as a task of end-of-life closure has been increasingly recognized in the palliative care literature.[4–8]

In palliative care, recognition of forgiveness is built on research and theory derived from the fields of psychology, psychiatry, and theology.[9] Forgiveness has been described as restoring justice or balance through making a prosocial response that recognizes the injustice yet provides a merciful internal response to the injustice. Exline et al.[10] state that "When people forgive, they reduce or let go of bitter, resentful feelings and desires for revenge." There are diverse definitions of forgiveness but some common elements. There is common recognition that forgiveness is a conscious decision by one who has felt harmed to release the offender from threat of retribution and to forgo bitterness and vengeance. The literature describes many harmful effects on individuals from holding on to the hurt and failing to forgive.[10] These harms include chronic anger, depression, distress at the end of life, and difficult bereavement for family caregivers. Conversely, benefits ascribed to forgiveness include improved emotional status, decreased depression, decreased anger, improved hope, and completion of life tasks.[11–16]

Scholars in the field of forgiveness[17,18] also have sought to clarify what forgiveness is not. Forgiveness is not simply forgetting, excusing, condoning, minimizing, denying, reconciling, or pardoning. Forgiveness is described as an internal process in which the harm or damage is fully acknowledged and the impact of the harm is described.[19] Forgiveness includes both the conscious internal decision to let go of the harm and to seek peace as well as the hard work of the emotional transformation from replacing negative unforgiving emotions with positive, other-oriented emotions such as empathy, sympathy, compassion, and love.[9]

In recent years, palliative care researchers have applied forgiveness theories in intervention studies focused on patients at end of life.[20] Intervention studies prompt patients to think within the logical flow of the interventionist, and thus, data on thought processes of patients who attend the intervention might not reflect what occurs in patients in naturally occurring settings. Nevertheless, an intervention that does not connect with a patient's felt experience is unlikely to be effective, so it is important to consider interventions. Kramer et al. studied family conflict at the end of life in a sample of 120 community-based frail elders and their family members who were in a managed care program. Addressing conflicts arising at the end of life includes attention to issues of forgiveness, complex relationships, and facilitating communication.[21,22] Another study by Kramer et al.[23] of predictors of family conflict at end of life involved 155 spouses or adult children of patients with lung cancer. This study reinforced opportunities for clinicians to assess for unresolved family conflict early in the course of care and, if possible, to facilitate communication and resolution of the conflict.[24] Such interventions can contribute to improved decision making in end-of-life care, improved communication, and enhanced quality of life (QOL) at end of life for patients and families.

Hansen et al.[25] conducted an intervention study in which they assessed the efficacy of a four-week forgiveness therapy protocol ($N = 20$) in terminally ill elderly cancer patients. The intervention was successful in all outcomes measured including forgiveness, hope, QOL, and anger. The authors concluded that, "As part of comprehensive intervention in palliative care, forgiveness therapy may help to improve QOL at the end of life."

Steinhauser et al.[14] conducted a randomized, pilot control test of an intervention based on life review and emotional disclosure. The intervention subjects participated in three sessions addressing life story, forgiveness, and heritage/legacy. The session on forgiveness used the questions by the facilitator of the intervention (Table 1). Steinhauser et al. concluded that this brief, standardized, and replicable intervention could improve QOL for patients with serious illness by instigating talk about regret and forgiveness and facilitating patients' dealing with difficult-to-address issues.

A nurse-scholar who has significantly contributed to understanding forgiveness in palliative care is Prince-Paul.[26–28] Her work has addressed relational communication, the interaction between spiritual well-being and forgiveness, and interventions that support

Table 1
Intervention Questions

- **Prompt:** "The concept of forgiveness is often discussed in palliative care as patients or family members may seek forgiveness during terminal illness. Describe any examples you have observed of those seeking forgiveness."
- **If you were to do things again, what might you do differently?**
- **Are there things or times you regret?**
- **Is there anyone to whom you would like to offer forgiveness?**
- **Is there anyone from whom you would like to ask forgiveness?**
- **Are you at peace?**

Reprinted with permission from Steinhauser et al. [14]

patients and caregivers in reconciliation and forgiveness. Her studies have explored aspects of well-being and communication at the end of life. A study in hospice care identified six themes that described the meaning of social well-being at the end of life. These themes include the meaning of relationships with family, friends, and coworkers; meaning of relationship with God or a higher power; loss and gains of role function; love; gratitude; and lessons on living.[28]

The substantial body of literature on forgiveness as well as recent intervention studies to promote forgiveness, therefore, have provided a solid foundation for understanding forgiveness in the context of serious illness. Models of care have involved highly skilled psychosocial professionals offering structured teaching and experimental processes. These have largely been provided within a research context as opposed to routine clinical practice and have focused on a wide range of perceived "transgressions."[29–31]

Present Study

In the present research, we sought to explore clinical nurses' recall of "everyday" instances of expressions of regret or forgiveness, either by or to the patient, that they had witnessed at the bedside. It is often within the intimacy of a home visit or the darkness of a hospital room on the night shift when a patient who is alone expresses regrets or need for forgiveness to the clinical nurse. Research and clinical experience would suggest that nurses in the position of witnessing the intense need for forgiveness from or to the patient may not be well prepared to adequately address the complex dynamics or processes of how to appropriately respond.[32–35]

Based on the literature, we expected to find that nurses would report bedside communications of forgiveness they had

witnessed that were structured along several processes:

1) Personal relationships and conflictual relationships and situational contexts should be primary foci in which specific transgressions and conflicts occurred.

2) Recounting of wrongs done to and by the patient should be expected, with the implication that an account is called for or might have been forthcoming. In addition, we expected an elaboration of the consequences of the wrongdoing.[36]

3) According to Byock,[37] four themes are anticipated in the accounts; apologies (e.g., I'm sorry); seeking forgiveness (i.e., Can you forgive me?); expressions of love; and expressions of gratitude. We expected the first two themes to predominate in nurse-recalled accounts.

4) According to communication theory,[36] we expected a communication that permits the interchange to end gracefully (i.e., "That's okay" or "I forgive you" or "Thank you").

Theory-driven quantitative research can test the presence or absence of statements in such categories. One of the benefits of qualitative methods, however, is that the participants speak for themselves and researchers can often discern departures from prevalent theories within the responses. In the present study, we analyzed the nurses' responses in light of communication theory.

Because nurses are the most prominent health care providers across settings, we were interested in understanding nurses' experiences in witnessing the expression of regret or need for forgiveness. By understanding the stories

and circumstances and also nurses' responses, we could develop more cogent research and education to better support nurses in these situations. Similar to enhancing communication skills in breaking bad news or facilitating treatment decision making, communication training based on a description of the needs regarding the expression of regret or need for forgiveness could potentially support nurses and other health care professionals in these communications.

Methods

The present study grew from participation by the primary author and principal investigator in an international project on "Love and Forgiveness," which was supported by the John E. Fetzer Institute.[38] Through this initiative, 12 professional "circles" were invited to participate. The circles included diverse professions such as experts in world religion, health, law, education, media, and others. Each professional circle invited 10–15 professionals to participate in the group over the two year project. These groups developed ideas for projects related to love or forgiveness, and the groups served as peer consultants and reviewers to select projects for foundation support.

The present project addressed nurses' experiences in witnessing issues of regret or forgiveness. In addition to the nurse P. I., we included two coinvestigators, who were a senior social worker in palliative care and a senior chaplain with extensive experience in hospice and palliative care, and two external consultants.

Procedures

This descriptive narrative study used qualitative analysis methods to understand nurses' experiences. Nurses attending a palliative care conference sponsored by the End of Life Nursing Education Consortium (ELNEC)[39] were invited to complete a written, open-ended survey. This use of ELNEC course participants was selected as a means of obtaining diversity in culture, nationality, and geography. The survey consisted of a few demographic variables and a single open-ended item that read: "The concept of forgiveness is often discussed in palliative care as patients or family members may

seek forgiveness during terminal illness. Describe any examples you have observed of those seeking forgiveness."

The surveys were distributed at course registration, and participants were encouraged to complete their survey before the training began to avoid biasing their responses. Nurses were asked to consent via a "checkbox" that they gave permission for their narrative to be used for presentations or publications.

Data Analysis

The narratives were transcribed verbatim into a database and the combined data were reviewed by the investigators. Narrative content analysis methods as described by Earthy and Cronin[40] were used. Each investigator independently assigned themes and subthemes. To maximize validity and interrater reliability, the investigators met to discuss similarities and discrepancies in coding and eventually reached consensus about the key items, with exemplars selected for each subtheme and theme. The coding was then reviewed by the two external consultants and final analysis incorporated their suggestions.

Key Findings

Surveys ($N = 389$) were obtained from 15 different ELNEC courses held in eight states (Georgia, Massachusetts, Illinois, Florida, California, Oregon, Missouri, and the District of Columbia) and five countries (Belize, India, Philippines, Romania, and the U.S.). Although 50 of the 389 (12.9%) respondents indicated that they had not yet had an experience with patients requesting forgiveness, many ($n = 14$) of these qualified their response with an indication that they were new to this field and anticipated it would be a concern in the future. Nurses ($n = 339$) reported detailed examples to the initial probe; seven gave multiple examples (resulting in 346 total stories). Respondents provided personal ($n = 69$) and professional ($n = 277$) narratives. Nurses reported both on how they managed questions of forgiveness in general and offered specific instances of detailed narratives of memorable forgiveness experiences.

Table 2 describes eight relationships identified by the nurses as involved in the narratives of transgression or conflict they witnessed. The most common was conflict between parent

Table 2
Relationship of the Patient With the Person With Whom the Conflict or Transgression Occurred, Identified by Nurse Respondents

Relationship in Which the Conflict or Transgression Occurred	N = 346
Parent/children	134
Unspecified	88
Family (as a group)	58
Spouse	51
Self/God	24
Extended (grandparent, aunt, uncle, niece, grandchild, friend, enemy)	24
Siblings	14
Staff	4

and child. Often this involved an adult patient recalling an event from early adulthood that had resulted in estrangement from a parent. Many times the relationship was not specified, and nurses wrote vaguely about patients who described having done things they regret without mention of the relationships involved. Several narratives involved the family as a group, conflicts and transgressions between spouses,[41] between self and God,[42] extended family or siblings.

Responses were grouped based on two key issues: whether the narrative described examples of the nurses' observations of forgiveness (Table 3) or focused primarily on the nurses' reaction to these observations (Table 4). For example, nurses indicated that they too sometimes became tearful when witnessing these events, and some reported concern about whether it was appropriate to show their emotions. Nurses' responses were described in either passive language from their role as an observer or witness ($n = 176$) or in active language detailing times when they were actively involved in orchestrating a desired outcome ($n = 94$). The nurses reported empathy for those struggling with issues of forgiveness and reported that "strong emotions" were common during these types of interactions (using words like "crying," "hugging," "kissing," and "anger" to describe what they had witnessed).

Perhaps not surprisingly, spiritual care providers were the most commonly noted discipline in the narratives, but their role was often limited to the performance of specific religious rituals. Chaplains and community pastors were reported more frequently than social workers or other health professionals

to address issues related to forgiveness. Many respondents' mentioned the important "role of God" for patients facing end of life, yet chaplains were not often identified as a resource.

Table 3 provides 12 thematic topic areas and exemplars from the nursing narratives that highlight the identified responses. We have organized these roughly according to communication theory as discussed by Schönbach.[36] Generally, our themes could be organized according to the four major processes suggested by Schönbach; however, there was some conceptual strain. Thus, four of the themes seemed to be concerned with the context of the transgression or conflict (culture; nurses' perceived transgressions; hardships; medically related issues). Reproaches were represented by two themes (anger, guilt, regret; missed opportunities). Accounts were represented by two themes (implied; proactive). Closure-related statements were represented by two themes (nurses' perception; spiritual).

Table 4 offers exemplars of the impact that forgiveness work has made on the nurses. Nurses reported strong feelings that resulted from witnessing forgiveness interactions resulting in attempts to "help" (offering quick fixes, reassurances, connections to other resources, arranging for rituals, and included some proselytizing attempts). Nurses expressed changed practice resulting from these experiences and, in some cases, a desire to address forgiveness issues in their own families.

Discussion

The narratives from this study highlight the importance of forgiveness in clinical care and provide evidence of the importance of preparing nurses to more confidently respond to this essential human concern. The National Consensus Project Guidelines for palliative care include attention to social, psychological, cultural, and spiritual care as essential to the provision of quality palliative care,[43] yet few professionals are adequately prepared to address common existential concerns such as forgiveness. Only a few nurses described experiences of witnessing skilled colleagues address forgiveness, and only a small percentage indicated that they collaborated with

Table 3
Thematic Topics with Narrative Exemplars[a]

Themes of Narratives ($N = 34$)	Examples
Contexts	**Relationships and situational aspects**
Culture ($n = 11$)	Most of the patients that I've observed that are in that state, they all just leave it up to God especially with us Filipinos. Some of us would say that if it's our time and it is really then our time. They wholeheartedly accept the sacrament without any feelings of bitterness in their heart but a joyful heart that soon will be with the creator, the Almighty God. Filipinos react that way I think. Filipinos are happy people that even up to their death they want it to be happy.
Nurses' perceived "transgressions" ($n = 81$) ("sins," alcohol, abuse, divorce, theft, drugs, abortion, sexual orientation, HIV/AIDS, confession, suicide, homicide, smoking)	I had a young man, married and father of 2 who attempted suicide and landed in the ICU on life support in septic shock. Despite 2 kids, a large house, and money, the typical American dream family was secretly falling apart for years. The wife was so angry and hurt it was hard to communicate. … Eventually she became more emotional and finally said "I forgive you, go ahead."… She crawled in bed with him for an hour or so and held him as he took his last breath. It was truly amazing to see this transition. She found a place of forgiveness, which made his last moments more peaceful.
	As a hospice nurse, I had a patient whose wife had drowned under suspicious circumstances years before. As he was dying he confessed to killing his wife to his son. He was asking for forgiveness for his wife's death. His son was tortured for years afterward with the knowledge of his father's crime.
	We took care of a COPDer who was near EOL. Her daughter had moved to Hawaii (we are in NY). I had several discussions on the phone to the daughter about mom's condition (She was the DPA.) I found out why the daughter moved to Hawaii was to be far away from her mother as possible. I didn't know her stepfather had sexually abused her. The daughter was feeling extremely guilty and didn't know what to do. I encouraged her to forgive her mother and to let go. I explained to her it would help her mother on her journey as well. Several days later, the daughter called her mother and forgave her. After struggling several weeks with the COPD the patient was at peace and left us comfortably and at ease.
Hardships ($n = 27$) (money, homelessness, military experiences)	Patients asking forgiveness to their sick child because of living poor that they could not afford them to provide all their wants during their days that their child still can be able to play, interact and appreciate.
	I had a veteran who was agitated at end of life. The family shared "he did what he had to, but people died and it's always worried him". He was lucid, but we talked to him about this and suggested he forgive "himself" and ask forgiveness, he gradually become more peaceful, less agitated. His family felt successful and the death was less traumatic for them.
Medically related issues ($n = 43$) (treatment, caregiving, illness)	I cared for a patient who was dying of the same syndrome his brother had. The brother was older and their single mother had the older brother get a stem cell transplant (only cure for their syndrome). The older brother died of complications from transplant. So she had decided not to do transplant for the younger brother. Then with the younger brother dying of sequelae of his syndrome, the mother felt incredible guilt that her decisions "led to both her sons dying". Her guilt and grief manifested as anger. So it took me a while to even process her real feelings. Once she admitted how she really felt, she could start working on ways to get her to forgive herself. I'm not sure that she ever really did.
	I took care of a dying ICU patient for 2 days. During this time her 3 children either called or came in. One daughter was local and in often. We spent our time talking about how she had to forgive her siblings for not helping her or their dying mom. I helped her realize, she gave her mom a gift, a very valuable gift of time, care and compassion. She was not responsible for forgiving her siblings in their choices. She learned it was her path and was able to let go of some anger towards family.
Team ($n = 42$) (palliative care team, social worker, chaplain)	I had a really hard time with a patient that confessed to me an "encounter" he had with his daughter when she was 3 years old—he needed to be forgiven "before he died". I'd met his daughter during her visits and noted strain in their relationship. I called the chaplain and tried to give the best care I could.
	I had a really tough case of patient who was in distress because instead of seeing angels or deceased family as the end drew near he was reliving his time in Vietnam. He talked of hell and expressed a wish to ask forgiveness of those he had hurt/killed. After listening for quite some time I sought help from the chaplain who did work with PTSD. Very sad and bothered the staff.
	In the early 90s, I was caring for a 32-year-old man dying of AIDS. He had not had any contact with his family for many years. With the help of a social worker, he called his

Table 3
Continued

Themes of Narratives (N = 34)	Examples
	family and let them know he was dying. My experience was when an elderly man and woman (the parents) and a younger man (brother) stepped off the elevator. The men were in overalls and explained that this was the first time they had ever been out of Kansas. I walked them to the room and the brother immediately climbed into bed and lovingly cradled his brother. It was a very tender moment.
Reproaches	**Actions done to and by patients and consequences**
Anger, guilt, regret (*n* = 58)	One of the most poignant requests for forgiveness was from our peds team. The young man was turning 20 when he died. He lived several years past what was projected. His mother was the main provider of care. When it came closer to his death he was asking for forgiveness for the "burden". His guilt of his despair and the hardships on is family was profound. Once he was finally released of his guilt he was so much more peaceful and received less meds.
Missed opportunities (*n* = 36) (unforgiven post death, unresponsive)	One incident that I cannot forget is when a patient died and he was not able to "reconcile" with his family. It was a sad moment since I observed it was a "conflicting time" for the family members. He was described to be an "irresponsible father" he was abusive both verbally and physically, it was like at that time "good riddance" for his family, but still the family suffered loss and I think went thru a difficult process of grief.
Accounts	**Responses to the reproaches that either indicate forgiveness or reconciliation or not**
Implied (*n* = 11) (assumed, body language, hugs, presence, etc.)	I remember a patient who was nearing [the end]. We were all surprised that she hadn't died yet. The family mentioned that she had a son that she hadn't spoken to in years, living in California. (We are in Wisconsin.) He was on his way to see her. We told her that he was coming even though she had become nonverbal. He arrived and sat at her bedside. She immediately calmed down and died 2 hours later. Although there was never an "I'm sorry" spoken, it was clear that the peace that was present between the two of them allowed her to finally relax and die. The son viewed this experience as very positive and was very happy that he had decided to come.
Proactive (*n* = 40) (advice, plan, initiating conversation on forgiveness, "proselytizing")	I didn't know her stepfather had sexually abused her. The daughter was feeling extremely guilty and didn't know what to do. I encouraged her to forgive her mother and to let go. I explained to her it would help her mother on her journey as well. Several days later, the daughter called her mother and forgave her. After struggling several weeks with the COPD the patient was at peace and left us comfortably and at ease.
	I ask families if they have any "fences to mend." Our pastoral care dept. assesses this daily as well. We all open dialogue …
	An 18-year-old patient was admitted with septic abortion a day after admission. [The] patient started having hyperpyrexia and trembling, there was hallucinations; the relatives became afraid that she was dying. She started asking God to forgive her in any way she has done wrong. I as the nurse asked her if she is ready to give her life to Christ. She says yes, she did. But after medication, spiritual, and psychological intervention, patient came back to life. She was happy she made peace with God although the cause of her critical period of illness and believe that as has made peace with Christ made her well again. (To her is miraculous) my happiness was that my patient came back to life and we were joyful together.
Closing communications	**Reassurance and statements that permit closure of the interaction**
Nurses' perception (*n* = 89) (role of forgiveness, theories)	It is interesting to see the family members that are comfortable letting them go and those that appear to still have issues—they are more likely to want to do "everything" including putting them through a PEG procedure at end of life.
Spiritual (*n* = 13) (heaven, karma, God, faith, sacrament, religion, Catholicism)	Another example that I witnessed is the returning to the original religion. This person transferred from Catholic to Protestant. He suffered a lot for a while, until somebody suggested that please ask for a priest for a confession and return to being a Catholic and after the confession, he peacefully joined the creator.
	Had hospice patient end of life, stated "I was in World War II, I looked in the faces of the men I killed—I don't think God will let me in heaven." MSW and chaplain with nursing assisted with this issue of patient assist. We ended up calling in his elder in his church, patient passed 2 days after—wife stated later "he was so at peace after his church elder came to visit and pray with him. His physical pain was gone—and then his mind was at ease."

ICU = intensive care unit; COPD = chronic obstructive pulmonary disease; EOL = end of life; PTSD = post-traumatic stress disorder; PEG = percutaneous endoscopic gastrostomy.
*a*Twelve thematic topics and exemplars from nursing narratives, categorized by Byock's four themes.

Table 4
Nurses' Reactions with Narrative Exemplars

Nurses' Reactions	Examples
Career/life lessons learned	The most common example I have observed is long lost family members who resurface at time of death. It is those who seeked peace with ones who said they have held grudges against, before a person is laid to rest. I have learned from those that life is too short to not speak to loved ones, even if you don't agree with them.
	I realized at that time that you have to show your love to your parents while they are alive, it's never too late to tell them how much you love them, to ask forgiveness and to forgive.
Emotional impact	I walked by the room and he was curled up on the window sill of the room, staring at his mother and sobbing about his lost opportunities with her. I was a newer nurse at the time but will never forget that.
	This story unfortunately has a sad ending ….I often wonder how he felt about everything he'd been through, the family discord, lack of family support, and ultimately the family not forgiving each other before his death. He was all alone, it breaks my heart that the family couldn't set aside their differences for their terminally ill loved one, very sad!
	The son then felt a bond with the dad he didn't know (>5 years apart) and the family began to talk to the vented patient, bond with one another. It was dysfunctionally inspiring and beautiful.
	The act that caused the original hurt or anger seems diminished or forgotten by one joy or reconciliation. I recall forgiveness experiences taking place in person at the deathbed and even by the telephone. Again, it's a privilege to witness this intimate loving event.

interdisciplinary colleagues regarding issues of forgiveness. The development of targeted professional education regarding culturally congruent communication skills is urgently needed in this area.[44,45]

Many nurses described occurrences of "peaceful deaths" following acts of forgiveness and reconciliations as "miraculous." They reported that there were potential lessons to be learned from both positive and negative outcomes, and nurses described experiences of memorable and life-altering events. For example, a nurse recalled a patient who "raised her hand and said: 'God, receive my soul.' I heard her last breath like air getting out from her abdomen up to her mouth. She died on my side and spent her last moments with me. That event in my life made several implications and changed the life I had." A particularly reflective nurse asked "Why do we wait until dying to resolve these issues?" and many articulated personal and professional strategies to encourage the resolution of forgiveness issues.

It was a common theme for nurses to assume that patients who seemed to be "lingering" were struggling with unresolved relational issues that could be resolved through acts of forgiveness and result in a "peaceful death." Numerous accounts offered examples of this belief, with detailed descriptions of estranged relationships being resolved followed by a peaceful death. This perception that a dying person can "wait" until "unfinished business"

is appropriately settled occurred from nurses across many settings and cultures and was tied to a belief that forgiveness "helps" all involved (patients, family, and staff). Those who were "unforgiven" were believed to struggle with more pain or anger and experience a delayed death. Despite this common assumption, it is important to note that the nurses may have a recall bias, and that people might have died peaceably even if not reconciled or that those not reconciled might have died with difficulty regardless of whether reconciliation failed.

Forgiveness of one's "self" was seen by many of the respondents as one of the most difficult things to do and the failure to forgive oneself was viewed as a source of significant suffering. Patients struggled with being a "burden" for their families and with areas of regret and remorse. Worthington[46] has identified six steps to forgiving oneself.[47] He argues that self-forgiveness (Step 4) is not simply letting oneself off the hook but rather self-forgiveness typically relies on addressing and attempting to correct the spiritual, social, and psychological harm one has done before experiencing self-forgiveness. Thus, on one's death bed, it is more difficult than at other times to have the energy or capability of repairing spiritual, social, and psychological damage of wrongdoing or failure to meet one's own expectations.

There was a wide range of "transgressions" that nurses noted as troubling for patients

and families. These included regret over affairs; histories of sexual, emotional, and physical abuse (including the murder of a parent); abortions; alcohol and drug addictions and lack of acceptance for a child's sexual orientation. One nurse witnessed a parent's remorse over a lack of full disclosure regarding the adolescent child's illness. Additionally, many patients were noted to have expressed suffering and remorse from actions that they had committed or witnessed while serving in the military.

Many of the nurse respondents described a richly nuanced understanding of the complexities involved in resolving forgiveness issues that had been crafted from a lifetime of careful reflection. Other respondents acknowledged that they lacked professional training and mentorship to guide their desire to assist patients and families in this regard, and they relied on their cultural and religious training to guide them. Although this worked for some, it also led to instances of proselytizing activities from well-meaning nurses who had developed prescriptive religious beliefs regarding how to resolve patient suffering. Several novice nurses noted that they learned what they knew about handling forgiveness from the media, citing examples of specific books, movies, and television shows where patients died peacefully following family reconciliations. Nuland[48] described such accounts as modern versions of the *ars moriendi* (i.e., an idealized way of dying), which are intended to help people hold onto faith and hope as they die. Yet, as Nuland notes, "The good death is increasingly becoming a myth. Actually, it has always been for the most part a myth, but never nearly as much as today" (48, p. xvi.).

One of the striking observations in review of the data was how frequently nurses seemed to offer a "quick fix," for example, a patient would share a very intense experience of having caused harm and the well-intentioned nurse would offer simple assurances of "It's ok," "I'm sure he forgives you." In many instances, the nurse would share having offered this absolution of "It's ok" and then share how the patient "died peacefully" shortly after. Although certainly some patients may be comforted by such offers of support by the nurse, the literature on forgiveness would suggest that more intense intervention is often needed.

Strengths and Limitations of Study

The findings from this qualitative study are limited in generalizability because of a number of factors. This sample came from palliative care conferences and was limited to nurses. The study involved no random assignment to conditions and was a retrospective study that relied on each nurses' memory, which is highly subject to distortion and bias. Interestingly, the nurse respondents were typically able to describe detailed accounts of specific patient scenarios, even when they had occurred years previously. Several started their narratives with words like 'I'll never forget" or "I still remember"—indicating the lasting impact of witnessing these potentially transformative events. But it should be noted that the nature of long-term memory is reconstructive and may not be highly accurate in the specific details. Despite these limitations, the relatively large, culturally and geographically diverse sample size and rich narrative detail provide a window into the experiences of nurses related to addressing forgiveness concerns of patients facing end of life. Future research exploring forgiveness with other members of the clinical care environment is needed.

Conclusion

The study of forgiveness is an important element of psychosocial, cultural, and spiritual care, which are essential aspects of palliative care.[49] A national consensus conference on improving the quality of spiritual care in palliative care defined spirituality as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."[43] Addressing relationships and supporting life review is a key component of quality spiritual care in palliative care,[15] which includes unresolved conflicts and relationships. The authors hope to be able to build on this study by developing an educational program for nurses and other professionals in communication regarding

forgiveness that could provide improved care for patients and families.

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