Consolation in Conjunction With Incurable Cancer

Ulrica Langegard, RN, MSc, and Karin Ahlberg, RN, PhD

Purpose/Objectives: To increase knowledge of what patients with incurable cancer have found consoling during the course of the disease.

Design: Descriptive, cross-sectional analysis.

Setting: Hospice in western Sweden.

Sample: 10 patients (8 women, 2 men) aged 30–90 years.

Methods: Data were collected through semistructured interviews and analyzed with the constant comparative method of analysis.

Findings: Four categories emerged from the interview data: connection, self-control, affirmation, and acceptance. The core variable of the study was developed and defined as "being seen." To be seen and, therefore, consoled results from experiencing a sense of connection, self-control, affirmation, and acceptance. To be consoled is a step toward increased well-being. When patients feel their suffering is seen and understood by another person, they are filled with relief.

Conclusions: Raising the issue of consolation and what consolation means to the patient is essential. Physical contact is not as important as mental presence. The act of listening is the most important factor when it comes to being seen, and what the nurse communicates is what defines the patient/nurse relationship. Nurses should be clear that they have the time and interest to deal with the patient. In addition, a nurse who is concerned with patients and has the courage to stay with them during difficult situations develops an attitude marked by presence, understanding, and commitment. Creativity, knowledge, and, most of all, courage are needed from the nurse as a caregiver to recognize the patient's need for consolation. Creativity and knowledge are needed to determine what point the patient has reached, and courage is needed to be present with the patient during difficult times. Results show that the caregiver, without having an established long-term relationship with the patient, can still bring consolation to the patient.

Implications for Nursing: Creativity, knowledge, and courage are needed to comprehend and accept a patient's need for consolation. By using simple interventions, the nurse can console the patient with little effort. Words become less important when consolation is done through body language.

Improvements in medical treatment and increased life expectancy mean more people are enduring incurable chronic diseases. About 20,000 people die each year in Sweden from a variety of cancers and, at some point during the course of their disease progression, most of the patients require palliative care (National Board of Health and Welfare, 2005). Palliative care is care given to patients with symptoms originating from incurable disease or with a progressive disease with short expected survival. Palliative care is an active, comprehensive care model built on a clearly defined philosophy with an aim to create the requirements for quality of life (QOL) when a cure is no longer possible (Beck-Friis & Strang, 2005). Patients suffering from a life-threatening disease are in need of assistance to alleviate their distress.

Being stricken with an incurable disease is a traumatizing experience, and nurses often are the healthcare providers who console suffering patients. Consolation is a natural act and has always been part of care situations. One task of a nurse is to relieve suffering to bring about enhanced well-being. In the relationship between patient and healthcare provider, consolation is sparingly used as an intervention, although, through other care interventions, comfort could presumably be found in the daily interaction between nurse and patient.

The palliative phase at the end of life is generally short, a few months at the most. Psychological well-being in connection with end-of-life care is significant, and a sense of meaning and spiritual well-being is essential (Benzein, Norberg, & Saveman, 2001; Cohen & Leis, 2002; Sahlberg Blom, Ternestedt, & Johansson, 2001). The suffering patient is in need of consolation. Suffering is alien to the patient and is seen as a threat to personal identity, integrity, and communion. Suffering disconnects patients from themselves, other people, the surrounding world, and spiritual meaning (Casell, 1991; Younger, 1995). Consolation is a vague concept within the nursing profession, possibly because consolation is such an everyday concept and such an obvious act that the literature scarcely addresses the topic. Several studies (e.g., Back-Petersson, 2006), however, have shown that nurses have little knowledge about consoling incurable patients. The current study increases the knowledge of what patients with incurable cancer have

Quick Facts: Sweden

Geography: Sweden is situated in northern Europe. Neighboring countries are Denmark, Norway, and Finland. The capital city is Stockholm.

Population: The total population was about 9 million as of 2007. As with populations in Western countries, the population in Sweden is becoming increasingly older. Advancements in medical treatments and expansions of treatment options have increased the demand for care. About 18% of the population is older than 65 years of age.

Healthcare system priorities and programs: Health policy is a national-level responsibility, but the healthcare system in Sweden is highly decentralized. Health services are overwhelmingly tax financed, and privately financed care is marginal. Swedes have good accessibility to care. The country has good medical outcomes and effects as evidenced by low infant mortality rate, high survival from cardiovascular diseases, and low mortality for cancer. About 50,000 Swedes are diagnosed with cancer every year. About half are cured. Prostate cancer is the most common cancer in men and breast cancer is the most common in women, representing about 30% of the cases in 2006.

Bibliography

National Board of Health and Welfare. (2008). Socialstyrelsen. Retrieved December 4, 2008, from http://www.sos.se

Statistics Sweden. (2008). Statistiska centralbyran. Retrieved December 4, 2008, from http://www.scb.se

found consoling, and the results may lead to an awareness of the importance of consolation and its use as a tool to reduce patient suffering and, therefore, enhance well-being.

Background

Suffering

Suffering is considered a primary motive for care; the alleviation of suffering is a caregiver's most essential task. In the current study, the idea of human suffering is based on Eriksson's (1994) theory of a solitary absolute experience of facing pain. Ohlen (2001) compared the alleviation of suffering to being in a sanctuary (having positive feelings despite the poor prognosis). The experience relies on time and of giving patients the space to be themselves, alone or with others. The experience is corporeal, mental, and spiritual. Ohlen noted that, for patients, equal importance is placed on corporeal, mental, and spiritual care, not as separate units but as a whole. Doubled suffering (Raholm & Lindholm, 1999) occurs when patients feel the need to protect others from their own suffering and, therefore, do not have an outlet to express their suffering. Arman and Rehnsfeldt (2006) concluded that being a witness to a patient's suffering may bring support to the patient. Witnessing may be seen by patients as a light in the darkness of suffering.

Well-Being

Several studies have shown that psychosocial interventions influence well-being in patients with cancer in a positive manner. In care situations, well-being involves a correspondence among individuals' opportunities, their actual existence, and their experienced sense of meaning. Well-being originates in receiving attention and a feeling of being well taken care of. Well-being arises when the patient senses that the nurse has the competence to recognize the patient's own resources, has the ability to clinically evaluate, is present in the interaction, and treats the patient respectfully (Meyer & Mark, 1995; Sheard & Maguire, 1999; Spiegel, Bloom, Kraemer, & Gottheil, 1989). The caring interaction with the nurse creates a feeling of solidarity, an increased sense of well-being, and a healing effect (Halldorsdottir, 1997). In consideration of this, it can be assumed that consolation leads to increased well-being.

Theoretical Studies on Consolation

Consolation in the nursing literature has often been addressed from an existential perspective. In the fearful moments of desolation, when no meaning seems possible, consolation can penetrate the patient's darkness and create a new meaning. This happens when nothing positive seems possible (Norberg, Bergsten, & Lundman, 2001). Siefert (2002) sought a more lucid definition and meaning of consolation, necessary when investigating the importance of consolation to patients. The close bond between suffering and consolation is highlighted in care theory by Morse, Botorff, and Hutchinson (1995), who also put emphasis on the calming, soothing, and strength-creating character of consolation. Raholm and Lindholm (1999) stressed that human suffering can, in the caring context, broaden a person's mind and can bring people closer together within their relationships. Mattson-Lidsle and Lindstrom (2001) argued that consolation is soothing, giving a sense of calm, joy, and relief. Consolation also entails faith, hopefulness, and trust and can give the patient strength. In addition, consolation involves help and a beneficial deed, leading to the creation of meaning and increasing the sense of well-being.

Empirical Studies on Consolation

Alfredsson, Wiren, and Lutzen's (1995) study on consolation reveals that a feeling of hope arises through protection, relief, and tranquility. This hope is directed toward what is significant for the individual, and consolation is created in the presence of someone else who can share suffering in a good living environment (Hermann, 2006). Arman, Rehnsfeldt, Lindholm, and Hamrin (2002) suggested that the experience of suffering casts a shadow over a patient's inner sphere. Sharing the suffering with someone is needed to overcome suffering;

this sharing also helps attach a meaning to the suffering. Several studies have demonstrated that patients feel consoled when they are recognized as human beings and when an opportunity exists for them to maintain self-control (Alfredsson et al.; Arman et al.; Raholm & Lindholm, 1999). Patients in a study by Williams and Irurita (2005) expressed that self-control of emotions was central to feeling consoled. In addition, the experience of receiving emotional consolation is described as a necessity for greater well-being. Williams and Irurita (2006) found that consolation is a connection between body and spirit, and that patients value holistic treatment that also involves emotional support. Consolation was, at one time, considered an alleviation of physical ailments; however, it now is more of an ongoing process in which support from caregivers can alleviate suffering from an overall perspective and, therefore, enhance well-being (Williams & Irurita, 2005).

Consoling can be difficult. Words may feel strained and disgenuine. The content may not be what the patient wants to hear, particularly when no possibility of a positive alteration can be recognized. Offering verbal consolation in this situation may not be possible, at least not in the sense of promising the patient future health improvement. The basis for many verbal consolations is that the patient will get better, but, when dealing with a patient with an incurable disease, nurses cannot follow that path. The only recourse is to be a witness (Beck-Friis & Strang, 2005).

Norberg et al. (2001) advised that a nurse offering consolation should spend time with the suffering patient and communicate that he or she is not alone. A nurse giving consolation must be ready to see and listen to a suffering patient and should, under no circumstances, have any preconceptions, either positive or negative. Feeling safe is a prerequisite in this relationship, for the nurse and the patient. Even in uncertain situations, the nurse should be at the side of the suffering patient. To be receptive and present takes trust. If trust is created, the patient can gather the courage to face the cause of the suffering. The nurse is present at the patient's side and shows that vulnerability, grief, and exposing pain are accepted. Both parties accept that the illness is undeniable, that it exists, and that nothing else can be done (Norberg et al.). A nurse must be open to the patient's suffering in this model; that openness takes courage from both parties.

Purpose

The goal of the current study was to gain new knowledge of what patients with incurable cancer have found consoling during the course of the disease. That knowledge may give professional care providers and family members the tools to meet the varying consolation needs of patients, alleviate suffering, and increase well-being.

Methods

The study was approved by the ethics council of Goteborg Univerity in Gothenburg, Sweden. The study is qualitative, with interviews serving as the method of inquiry. Patients with cancer nursed at a hospice were included in the study. Participants were identified and asked by the personnel at the hospice and the principal researcher if they were interested in being included in the study. The researcher was handed a written informed consent signed by the participants. Interview questions asked included

- What have you found consoling regarding psychological suffering?
- When you have felt consoled, has it increased your well-being?
- What have you found consoling at the hospital or hospice and in your home environment?
- Have you actively sought comfort at the hospital or hospice?

The questionnaire was modified during the course of the study. Initially, a description of what the participant had found comforting at home as opposed to the hospital was requested. After four interviews, the researcher found no differentiation and the questionnaire was modified to focus on consolation in a care setting.

Participants

Inclusion criteria included in-house patients with cancer who had given written consent to participate in the study. Exclusion criteria included being unable to understand and speak Swedish and suffering from dementia or a similar condition. Thirteen patients were invited to participate in the study. Three could not participate because their diseases worsened by the time of the interview.

Data Collection

Interviews were taped and transcribed verbatim. Demographic data were collected from the patients. Data collection and analysis were done concurrently.

Analysis

The material was analyzed with the constant comparative method (Glaser, 1978; Glaser & Strauss, 1967). Initially, the data from the interviews were coded line by line. The encapsulating concepts then were compared with each other and, gradually, the number of concepts were reduced although new ones also were generated. Naming or conceptualizing the most significant data patterns that occurred was the next step. One core variable became evident: being seen. Thereafter, the amount of data and, later, the collection of data were restricted to the areas of most importance for the detected core variable and its properties. This way of handling the data is referred to

as selective theoretical data evaluation (Hartman, 2001; Starrin, 1997). After 10 interviews, the material seemed saturated (i.e., the most important new occurrences could be explained by the core variable).

Results

The participants included eight women and two men ranging in age from 30–90 years (see Table 1). Four categories emerged from the data: connection, self-control, affirmation, and acceptance. The distribution of categories is displayed in Figure 1, and the carriers of meaning that the categories are based on are summarized in Table 2. Connection, self-control, affirmation, and acceptance form a basis in the progression toward enhanced well-being. Patients are filled with relief when their suffering is seen and understood by another person. Not accepting the situation can make consolation difficult.

Connection

The experience of being in connection with someone was divided into three subcategories: belonging, faith in God, and communion. One participant experienced belonging with other people as the least important factor but could, on the other hand, feel a need to belong with God. Most participants, however, considered belonging with family, friends, and caregivers to be of great importance. The participants described that the belonging could be with other people but it could also be a sense of security within oneself.

Faith in God was a common denominator for most of the participants. God was a support. Only one of the participants reported no belief in God.

Several of the participants considered communion with other patients, particularly with patients who had the same diagnosis or with in-house patients, to be particularly comforting. The relationship was less demanding when the other person also was afflicted. Some patients described that communion with family was of particular importance but that this communion also could be demanding when they found themselves in situations where they had to console others. This situation could be experienced as burdensome in the sense that they had to handle the other person's anxiety as well as their own. One participant avoided the situation because it was unbearable to deal with another person's anxiety.

Table 1. Study Participants

Gender	Age (Years)	Marital Status	Children	Diagnosis	Time Since Diagnosis
Female	78	Widow	–	Breast cancer	4.5 years
Female	72	Widow	2	Breast cancer	10 years
Female	90	Single	–	Colon cancer	5 years
Female	37	Single	4	Ovarian and breast cancer	1.5 years
Female	30	Single	1	Neuroendocrine cancer	2 years
Male	88	Married	4	Prostate cancer	4 years
Female	85	Single	–	Liver cancer	6 months
Male	86	Married	3	Ventricular cancer	2 months
Female	66	Married	2	Ovarian cancer	3 years
Female	70	Widow	3	Sarcoma	9 years

Self-Control

Experiencing a need for self-control was divided into two subcategories: to find consolation within yourself and to interact with professional caregivers. The need for self-control was common to all participants but expressed itself in different ways. Some of the participants described the feeling of self-control as strength within themselves. The subcategory also was shaped by participants who expressed a need to be alone with their thoughts and their body. One participant reported that, by being left alone, he had a feeling of consolation.

Interaction with professional caregivers is motivated by the professional caregiver paying attention to patients and guiding them toward increased self-control. The professional caregiver can offer genuine care and, with that care, bring strength to patients and give them the ability to use their own resources toward increased well-being. In this situation, listening and showing interest were the required nursing interventions, demonstrating the importance of the caregiver being a good listener.

Affirmation

Experiencing affirmation was divided into four subcategories: that someone listens to my story, that someone conveys calm and security, to meet with others in the same situation, and to feel special. Confirming patients' reality by listening to their story was an important step for caregivers. If the caregiver remembered what had been said, the patient felt hopeful and trust was created. By being able to talk

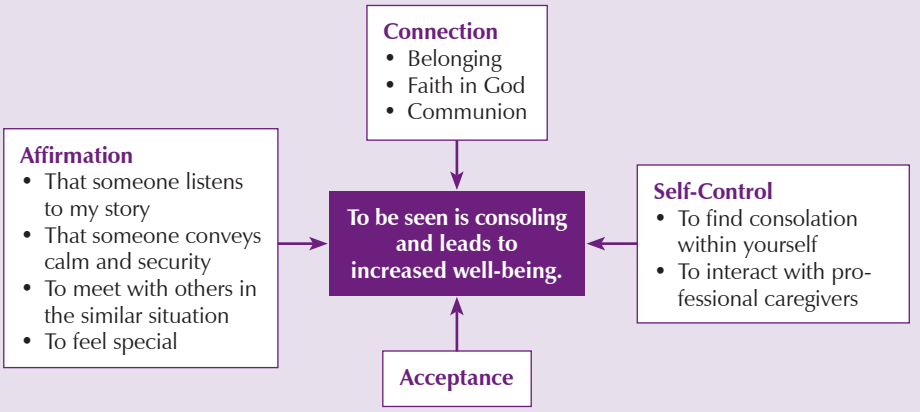

Figure 1. Categories of Consolation

to someone, an understanding of the situation arose that, in turn, opened up the possibility for consolation. One participant reported that, if she did not understand the significance of her disease, she could not possibly be consoled. Some of the participants considered consolation to be someone conveying calm and security, which was conveyed through affirmation. This happened in situations where the caregiver stood by what she or he had promised. Some of the participants found that to meet with others in the same situation was consoling and that staying at a hospice was a unique experience. Several participants noted a special sense of communion with everyone knowing why they were there. This implied a more relaxed relationship. Consolation could occur with another patient by talking about the deceased—a moment of communion because, at the same time, both patients know their likely outcomes. This highlights the benefits of talking about sad things as well.

Some of the participants felt that it was important and satisfying to be remembered. One participant reported that she found consolation after receiving a card from a nurse in the hospice ward. Another described how consoling it could be to be greeted by a smile.

Acceptance

Several participants discussed their feelings about accepting their situation. To do so, having space to tell their stories was necessary. One of the participants explained that the first step toward comfort was acceptance. The participant also described how this became a way of understanding and, therefore, being consoled becomes possible. Another participant had not accepted his situation, but not much time had passed since the diagnosis, which may explain his feelings.

Discussion

The goal of the study was to increase the knowledge base concerning what patients with incurable cancer find consoling during the course of the disease. Many participants believed that the study was important; however, some said the interview was complicated and that describing the relationship between consolation and well-being was difficult. In terms of actual consolation that the participants received, many agreed that the nurse, caregiver, or family member simply listening was the most important aspect. None of the participants was told by caregivers about specific consolation they would receive; however, many were simply consoled by their caregivers' acts.

Williams and Irurita (2005) described consolation as a link between body and spirit and that patients value the holistic treatment because it involves emotional support. This argument was confirmed by Ohlen and Holm (2006), who demonstrated that being consoled means being in connection with your body, your self, and others. Ohlen and Holm also discussed the importance of returning to a way of living that was normal before the disease onset. Their concepts of connection and affirmation also can be found within existential research, where the importance of the nurse acknowledging the patient's need regarding connection is noted (Hermann, 2006). Several studies have shown that nurses understand the importance of supporting their patients when it comes to these areas but that they find it problematic because of time constraints and lack of knowledge (Kuuppelomaki, 2003; Strang, Strang, & Ternstedt, 2001).

When suffering patients have someone at their side who can face the pain with them, patients can be set free from overwhelmingly dark thoughts and reevaluate the situation. Finding meaning in the suffering may help the patient. This process requires that the patient has had good experiences in life. If not, it may be difficult for the patient to find meaning (Norberg et al., 2001). A nurse can reduce psychological suffering by taking the time to listen to a patient. The need for affirmation is formed and a process of acceptance is initiated for the suffering patient (Norberg et al.). Eriksson and Lindstrom (2003) noted that an understanding of the patient's current situation is necessary if the nurse or caregiver is to actively perform in different care situations and care activities. According to Roxberg (2005), consoling a patient who seems like a stranger can be difficult. From the caregiver's perspective, a close relationship does not exist. Sundin, Axelsson, Jansson, and Norberg (2001) revealed that it takes communion. When individuals experience communion, they dare

Table 2. Categories of Consolation and Supporting Statements

Category	Patient Statements
Connection Belonging Faith in God Communion	Talking about my feelings is natural to me, although perhaps not to outsiders. For me, it is essential to know the person well. It is not necessary to know the person who listens well as long as he or she signals that there is time. I can be consoled by a stranger even if I believe that there's a different sort of consolation compared with being consoled by someone you know. The trust is there within me. The words, "It will be all right," can be of great importance in consolation, not that I will survive, but that things will be okay with my son. Those words are of great importance. I have all but tried to find consolation within myself in some strange, inexplicable way. I have tried to find the strength. I pray to our Lord to give me strength, give me the power I need. That is my pillar of strength. I'm a Christian and I'm convinced that I'm not the one worse off. I'm going to someplace better. It is those who are left behind that grieve. Attention from relatives and friends is consoling. And now, when I'm so ill, they understand that I don't have the energy for them. That's important.
Self-control Finding consolation within yourself To interact with professional caregivers	I think it's relieving to be alone as well, to be alone with my thoughts and my body. Perhaps I'm trying to find calm within myself by not thinking too much. . . . It hurts too much. For me, being left alone is most consoling. To be able to fall asleep and die. Nobody gains from me living on like this. I don't want to be a burden any longer. I have no need to be consoled by other people. I have consolation within myself. One of my caregivers is on a very professional level. . . . I receive a lot of consolation from her. . . . I think about how she consoles me. . . . When I leave her I feel stronger, mostly. She listens and tries to make me put my feeling into words. I don't know if the personnel console me, but they are very friendly and skilled and that makes me calm. Maybe that's consolation.
Affirmation That someone listens to my story That someone conveys calm and security To meet with others in similar situations To feel special	To talk about what feels worse . . . what feels most. . . . It is important being allowed to put my story and my thoughts into words and the communion it leads to with the person who listens. Consolation means that someone listens and that someone makes me put my situation into words. Even if I can't find the words and the consolation at the time, it comes back to me later. This leads to psychological relief and enhanced well-being. Someone who is close by and who listens and understands and who also remembers what has been said. You always feel better when you've gotten things off your chest. Perhaps not so much that someone pats you on your arm. Consolation to me is when I can trust people when someone says, "Good-bye then, I'll soon be back," . . . and then she really is coming back. If she isn't, I can't trust her. But if she is, it's a great solace. The one who consoles me tries to give me calm . . . tries to make the person in need of consolation to sort of feel more at ease, to feel, to convey that things will work out one way or another. It can be consoling to meet with others in the same situation. I had that possibility. It was my doctor that arranged that contact. Unfortunately, the patient in question died before we had time to benefit from each other. I've been feeling special in some way. I've had two postcards sent to me and the personnel from the hospital have visited me. That has been a consolation. Not having to feel alone here. There's always time for a pat on the shoulder or a kind word. It can be enough to get a smile from the person you meet in the corridor.
Acceptance	The first step towards consolation is acceptance of my situation. Talking about it is a way of getting the truth into my head. Through putting my situation into words, it becomes a way of understanding and then I have a possibility to be consoled. If I don't understand the consequences of my disease, I can't possibly be consoled. It's like going through mourning: You have to go through these steps otherwise you might become inconsolable. It's not about giving up, but it's about realizing that this is the way it is. It's over, it's incurable. I've come to a certain stage in which everything feels almost trivial to me. I don't know what to say about acceptance but if it's not comfortable or good to live, then it's all the same. That's how it is.

to share the suffering without trying to change the other person.

From this point of view, a close relationship and communion built on trust are necessary elements to receive and give consolation. The results of this study show that listening is the most important factor when it comes to the patient being seen and that what the nurse communicates defines the relationship. The nurse who shows concern for her patients and is willing to stay with them during difficult situations portrays a professional attitude marked by presence, understanding, and commitment, an attitude that meets the patients' needs. Conveying interest in listening to the patient inspires trust and brings consolation to the patient. Eight of the participants believed that they could be consoled by a stranger; however, opportunities are needed for patients to tell their stories repeatedly. The participants stated that they could realize the truth and accept their situation if they had an opportunity to describe their feelings. This confirms the significance of a nurse's job to be a good listener and to help the patient find meaning. Roxberg (2005) suggested that the ability of patients to share their feelings with a stranger (i.e., nurse or other healthcare provider) depends upon that stranger being secure with his or her own self and having the ability to invite the patients into a relationship where they can be themselves.

The current study demonstrates that patients experience consolation differently. To have somebody at their side may be consoling to some patients, and knowing that someone is willing to sit and listen can be consoling to others. Any consoling action taken by a caregiver demonstrates care and commitment. The patient, in turn, experiences a consoling act. Faith in God is a common denominator; closeness to God gives strength.

Care that creates an opportunity for consolation on the patient's own terms inspires increased well-being and alleviates suffering. The opportunity is created when the caregiver has knowledge of the importance of consolation. Ohlen (2001) suggested that listening to patients' stories is a possible way for caregivers to alleviate suffering. To achieve this, being present in the here and now and staying in the moment are necessary. The results of the current study conclude that consolation (i.e., something that is soothing and gives a sense of calm, joy, and relief) (Mattson-Lidsle & Lindstrom, 2001) can be expanded with the opportunity to be seen (when the nurse gives patients time to be heard). To be seen involves many definitions that are imperative for the nurse to know. Consolation in connection with cancer involves connection, affirmation, self-control, and acceptance. These are vital tools for the nurse. By being seen, the patient feels respected for being the person he or she is. The feelings that arise from personal interaction also can be a form of consolation. The caregiver's openness to a patient's particular needs and the ability to listen to the patient's story may be a first step toward reflecting on the situation. Being open to patients also involves respecting the needs of patients to be alone so they can find inner consolation. This attitude shows that the caregiver cares and is willing to open up to the person who suffers and find a particular way to comfort a particular person.

The Absence of Consolation

Several participants described situations in which they experienced great sadness. Some pointed out that they had trouble interacting with healthcare personnel who were cheerful. Others described how healthcare personnel did not seem to recognize that the patients were in a state of shock. One patient attempted to excuse this lack of professionalism by feeling responsible and reflecting back on her own situation.

> It can't be easy to deal with a patient in my situation. It can end up with me having to deal with both the [healthcare provider's] and my own fear and anxiety. In that case, I would rather be without consolation.

Implications for Nursing Practice

The current study enhances the nurse's capacity to address a patient's need for consolation. Creativity, knowledge, and, most of all, courage are needed to identify when a patient needs consolation. Creativity and knowledge determine what point the patient has reached; courage is needed to be present with the patient, even if interaction is difficult. Study results indicate that the caregiver, with understanding and knowledge about the importance of consolation, should focus professional and purposeful care through connection, self-control, affirmation, and acceptance. Results show that the caregiver, without having an established long-term relationship with the patient, can still bring consolation to the patient.

Nurses can console patients using little effort. When consolation is communicated through body language, words become less important. The nurse does not have to make things more difficult than they already are. The nurse often is result-oriented and wants to alleviate the patient's suffering at any cost but is perhaps too often guided by personal needs. The nurse may find it extremely distressing to watch the patient suffer, but, through acts of good care, much of the nurse's own fears and anxiety can be alleviated. Nurses are afraid that they will not suffice and can easily lose faith in their own ability. But, by expressing sincere interest, listening to the patients' stories, signaling that they have time for the patients, and having the courage to ask what consolation involves for the patient, nurses will understand the meaning of consolation in relation to the patient.

Conclusion

The study has helped in providing an increased understanding and knowledge of consolation in relation to patients with cancer and encourages the caregiver to be attentive to the unique needs of each patient. The results show the importance of all variations of consolation. Reasons exist for the nurse to raise the question of what consolation is for a particular patient, particularly when the focus is on mental presence rather than physical touch. In a care situation, care and commitment from a nurse or caregiver can have a significant influence on the patient feeling special and being seen as a person. To be seen and, thereby, consoled is a source of relief to the patient. The results also show that an established relationship is not necessary for consolation to be reached but that what the nurse conveys is what defines the relationship. The caregiver has to have an open mind and a clear vision toward patients who wish to be alone with their thoughts and bodies.

Ulrica Langegard, RN, MSc, is a clinical nurse specialist, and Karin Ahlberg, RN, PhD, is a clinical senior lecturer in oncology nursing, both in the Department of Oncology at Sahlgrenska University Hospital and the Institute of Health and Care Sciences at Sahlgrenska Academy at Goteborg University in Gothenburg, Sweden. No financial relationships to disclose. Langegard can be reached at ulrica.langegard@gu.se, with copy to editor at ONFEditor@ons.org. (Submitted December 2007. Accepted for publication April 2, 2008.)

Digital Object Identifier: 10.1188/09.ONF.E99-E106

References

Alfredsson, E., Wiren, B., & Lutzen, A. (1995). Comfort, a flow of best wishes and well-being. *Nordic Journal of Nursing Research and Clinical Studies, 15*(1), 34–39.

Arman, M., & Rehnsfeldt, A. (2006). How can we research human suffering? *Scandinavian Journal of Caring Sciences, 20*(3), 241–250.

Arman, M., Rehnsfeldt, A., Lindholm, L., & Hamrin, E. (2002). The face of suffering among women with breast cancer—Being in a field of forces. *Cancer Nursing, 25*(2), 96–103.

Back-Petersson, S. (2006). *Caring in research and practice—Some nursing aspects.* Sahlgrenska Akademien. Thesis. University of Gothenburg, Gothenburg, Sweden.

Beck-Friis, B., & Strang, P. (2005). *Palliative medicine*. Stockholm, Sweden: Liber.

Benzein, E., Norberg, A., & Saveman, B.I. (2001). The meaning of lived experience of hope in patients with cancer in palliative home care. *Palliative Medicine, 15*(2), 117–126.

Casell, E.J. (1991). Recognizing suffering. *Hastings Center Report, 21*(1), 24–31.

Cohen, S.R., & Leis, A. (2002). What determines the quality of life of terminally ill cancer patients from their own perspective? *Journal of Palliative Care, 18*(1), 48–58.

Eriksson, K. (1994). *The suffering human.* Stockholm, Sweden: Liber.

Eriksson, K., & Lindstrom, U. (2003). *Gryning II: Klirisk vardvetenskap.* Vasa, Sweden: Abo Akademi University.

Glaser, B. (1978). *Theoretical sensivity. Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A. (1967). *Discovery of grounded theory. Strategies for qualitative research.* New York: Aldin de Gruyter.

Halldorsdottir, S. (1997). Caring and uncaring encounters within nursing and health care from the cancer patient's perspective. *Cancer Nursing, 20*(2), 120–128.

Hartman, J. (2001). *Grounded theory*. Lund, Sweden: Studentlitteratur.

Hermann, C. (2006). Development and testing of the Spiritual Needs Inventory for patients near the end of life. *Oncology Nursing Forum, 33*(4), 737–744.

Kuuppelomaki, M. (2003). Emotional support for dying patients: The nurses' perspective. *European Journal of Oncology Nursing, 7*(2), 120–129.

Mattson-Lidsle, B., & Lindstrom, U. (2001). Comfort—A concept analysis. *Nordic Journal of Nursing Research and Clinical Studies, 3*(1), 47–50.

Meyer, T.J., & Mark, M.M. (1995). Effects of psychosocial interventions with adult cancer patients: A meta-analysis of randomized experiments. *Health Psychology, 14*(2), 101–108.

Morse, J.M., Botorff, J.L., & Hutchinson, S. (1995). The paradox of comfort. *Nursing Research, 44*(1), 14–19.

National Board of Health and Welfare. (2005). Homepage. Retrieved May 11, 2006, from http://www.sos.se

Norberg, A., Bergsten, M., & Lundman, B. (2001). A model of consolation. *Nursing Ethics, 8*(6), 544–553.

Ohlen, J. (2001). *Alleviated suffering. Being in a lived retreat—Narratives from palliative care*. Falun, Sweden: Nya Doxa.

Ohlen, J., & Holm, A.K. (2006). Transforming desolation into consolation: Being a mother with life-threatening breast cancer. *Health Care for Women International, 27*(1), 18–44.

Raholm, M.B., & Lindholm, L. (1999). Being in the world of the suffering: A challenge to nursing ethics. *Nursing Ethics, 6*(6), 528–539.

Roxberg, A. (2005). *Caring and noncaring comfort*. Vasa, Sweden: Abo Akademi University.

Sahlberg Blom, E., Ternestedt, B.M., & Johansson, J.E. (2001). Is good "quality of life" possible at the end of life? An explorative study of the experiences of a group of cancer patients in two different care cultures. *Journal of Clinical Nursing, 10*(4), 550–562.

Sheard, T., & Maguire, P. (1999). The effect of psychological interventions on anxiety and depression in cancer patients: Results of two meta-analyses. *British Journal of Cancer, 80*(11), 1770–1780.

Siefert, M.L. (2002). Concept analysis of comfort. *Nursing Forum, 37*(1), 16–23.

Spiegel, D., Bloom, J.R., Kraemer, H.C., & Gottheil, E. (1989). Effect of psychosocial treatment on survival of patients with metastatic breast cancer. *Lancet, 2*(8668), 888–891.

Starrin, B. (1997). *Along the path of discovery.* Lund, Sweden: Studentlitteratur.

Strang, S., Strang, P., & Ternstedt, B.M. (2001). Existential support in brain tumour patients and their spouses. *Supportive Care in Cancer, 9*(8), 625–633.

Sundin, K., Axelsson, K., Jansson, L., & Norberg, A. (2000). Suffering from care as expressed in the narratives of former patients in somatic wards. *Scandinavian Journal of Caring Sciences, 14*(1), 16–22.

Williams, A., & Irurita, V. (2005). Enhancing the therapeutic potential of hospital environments by increasing the personal control of hospitalized patients. *Applied Nursing Research, 18*(1), 22–28.

Williams, A., & Irurita, V. (2006). Emotional comfort: The patient's perspective of a therapeutic context. *International Journal of Nursing Studies, 43*(4), 405–415.

Younger, J.B. (1995). The alienation of the sufferer. *Advances in Nursing Science, 17*(1), 53–72.