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Forgiveness and Reconciliation Processes in Dying Patients With Cancer

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Abstract

This article studies forgiveness and reconciliation (F/R) in patients with cancer. It focuses on the end of life, when family conflicts resurface and unfinished business challenges patients and causes spiritual distress. Forgiveness and reconciliation may intensify patient–family relationships and facilitate peace of mind and peaceful death. Existing forgiveness models and interventions focus on coping in life, yet no study has examined F/R processes until death. Our mixed-method exploratory study hypothesized that F/R processes occur in phases, repeatedly, and are spurred by approaching death. Three interdisciplinary units at a major Swiss hospital observed 50 dying patients with cancer experiencing severe conflicts with relatives, themselves, and/or with fate/God. Participant observation was combined with interpretative phenomenological analysis and descriptive statistical analysis. A semi-structured observation protocol was developed based on a 5-phase model. The protocol included space for notes (emotions, interventions, effects on dying processes). It was assessed by 20 professionals for 1 year. Analysis was supported by international interdisciplinary experts. We found that conflicts were complex and involved relational, biographical, and spiritual layers. In 62% of patients, F/R processes occurred repeatedly. Many patients died after finding F/R (22 within 48 hours). Patients indicated that imminent death, a mediating third party, acceptance, and experiences of hope motivated them to seek F/R. Although deep relationships may support F/R processes, our limited data on near-death experience/spiritual experiences restrict interpretation. Forgiveness and reconciliation processes oscillate between 5 phases: denial, crisis, experience of hope, decision, and finding F/R. Understanding F/R processes, empathy, hope, and a neutral third party may support patients in seeking forgiveness.

Keywords

forgiveness, reconciliation, hope, family conflicts, spirituality, spiritual care, end-of-life care, life review

Forgiveness and reconciliation (F/R) is a clinically important task of life completion,[1-5] when family conflicts often resurface[2,6,7] and when outside support is needed.[7-11] The interpersonal, intrapersonal, and spiritual dimensions of forgiveness have recently attracted increasing attention.[8,9,12-14] Unresolved forgiveness issues and guilt may cause spiritual distress.[15,16] Forgiveness and reconciliation may strengthen relationships,[17,18] enhance peace of mind,[2,6] and help ensure a more peaceful death.[3,8,19] Forgiveness has been defined as "prosocial change" toward a perceived offender and often leads to cooperation. Reconciliation involves the "restoration of a broken relationship."[20]

Forgiveness therapy is an often successful psychosocial intervention.[15,21,22,23] Step-by-step models by Enright and Worthington focus on life crises and define "decision" as pivotal.[24,25] Various researches have emerged from clinical practice: surveys of nurses and social workers,[8,9] interviews with family members,[2,18] intervention studies,[1,23,26] a study on religion/spirituality and well-being,[27] and another on forgiveness therapy in elderly patients with terminally ill cancer.[23] This work highlights the importance of F/R for life review[1,26] and for psychological and existential well-being. One study analyzed open-ended interviews with 25 patients with cancer (20 in terminal care) using grounded theory and proposed a 4-phase model: enduring the incident, escalating tension, gaining perspective, and letting go of negative emotions.[10] However, to our knowledge, no study has examined F/R processes in dying patients until death.

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Aim

We explored the dynamics, trajectories, and phases of F/R processes in patients approaching death. What was the role of decision before death? What motivated patients (eg, spiritual experience, love)? What were supportive interventions/experiences? Did awareness of the end of life intensify the desire to forgive and to find reconciliation? Did F/R affect the dying process?

Method

In our mixed-method exploratory observational study,[28] patients with cancer with terminal prognosis were observed by nurses, physicians, therapists, and spiritual caregivers at 3 units of a major Swiss hospital (palliative medicine, inpatient and outpatient oncology). These patients expressed or confirmed serious interpersonal, personal (biographical), and spiritual conflicts.

The research team developed a semi-structured protocol for participant observation based on previous studies[28,29] and on the main author's long-standing experience as a therapist, spiritual caregiver, and researcher (M.R.).[28-31] She analyzed a 100 forgiveness trajectories in former therapy protocols and drafted an observation protocol (O-protocol). The latter was used as a pilot by 20 caregivers for 1 year. Caregivers were introduced to the research topic and methodology by the main author and the leading physician (D.B.). Most attended a 2-day voluntary workshop on changing consciousness in dying processes. Other topics included patients' verbal, symbolic, and nonverbal communication; F/R trajectories; and their possible effects on dying processes. Next, the study team consensually adapted the O-protocol. This addressed the 5 phases of F/R processes: (1) denial, (2) crisis, (3) experience of hope, (4) decision to forgive and to engage in reconciliation, and (5) forgiveness/reconciliation. The first 2 phases correspond to Kübler-Ross model.[32] Phases 3 to 5 were defined by subcategories (Figures 2–4). In phase 5, the subcategories were subsumed into 4 mutually exclusive groups: release/scapegoating (5a), "live and let live" (5b), intrapsychic forgiveness (expressed or confirmed) (5c), and reconciliation (5d). Release/scapegoating was included because analysis and discussion confirmed that family tension can be temporarily released, for example, by blame-shifting[33] or by scapegoating the physician. Our study design was approved by the state ethics commission.

Data Collection and Analysis

We included patients who were aware of their approaching death and when F/R emerged as a topic during conversations with nurses, physicians, therapists, or spiritual caregivers. We also noted patients' way of coping with illness, as well as their spiritual attitude and any previous spiritual and/or near-death experiences (NDEs). Then, an O-protocol was completed whenever F/R was mentioned. Patients either expressed their feelings or confirmed (eg, by nodding) the research team's observation of body language and behavior. Caregivers also noted effective interventions and patients' verbal and nonverbal communication. We included the analgesic and psychotropic drugs listed on the medical chart to observe whether F/R before death might be drug induced. Whenever possible, we noted the effects of F/R on dying processes (eg, subsequent peaceful somnolence) and when patients died. The coded data of deceased patients were entered into the database set up by the hospital's Clinical Trial Unit. We collected data until 50 patients had died (July 2016 to January 2019). This number was based on previous studies.[28,29] We excluded patients with diagnosed psychosis, dementia, with a poor command of German or English, or if only 1 profession (nurses, physician, therapists/spiritual caregivers) was involved in observation.

The data and notes were analyzed using descriptive statistics and interpretative phenomenological analysis.[28] In case of doubt, the main author and the study nurse consulted a previously assigned third person (physician). Notes on the effects of F/R on dying processes were only analyzed after the last incidence of phase 5. In patients who did not die before the end of data collection, but who expressed no concern about F/R for 6 months, we analyzed the occurrence of phase 5. An international panel (co-authors and experts in philosophy, theology, NDE) discussed the analysis plan, preliminary results, and open questions. Subsequently, the study team concluded its analysis.

We visualized trajectories and sequences of phases in longitudinal graphs: (1) interpersonal F/R (eg, with spouse/children), (2) F/R with oneself and the illness, (3) F/R with fate/God and (4) the real-time process. Case vignettes served to clarify individual processes. We then checked the occurrence of conflicts, phases, subcategories, and correlations. Based on the observational notes, we explored what motivated patients to engage in F/R.

Results

Sample, Data, and Graphs

Of the 50 participants, 31 were men and 19 women (average age 64.4 years). Forty-two were Christians. During the routine medical or therapeutic/spiritual conversation, 19 called themselves religious/spiritual, while 15 indicated merely a general interest in religion/spirituality (Table 1). Our study yielded 660 O-protocols (49 completed by physicians, 204 by nurses, 407 by therapists/spiritual caregivers) and 42 notes on the effects of F/R on dying processes. For the purpose of comparison, we also studied 95 O-protocols from 10 patients who did not die. The graphs and case vignettes revealed layers of conflicts (relational/biographical/spiritual), trajectories, and repeatedly attempted processes (Figure 1: No.5;13;60; Case Vignette: Patient 13=Figure 1B).

Conflicts

Thirty-eight (76%) patients had complex conflicts (relational/biographical/spiritual). Forty-four (88%) patients mentioned

Table 1. Characteristics of Sample.

	Deceased Patients, N = 50		Nondeceased Patients, N = 10	
Male	31	62%	3	30%
Female	19	38%	7	70%
Age, years				
38-50	5	10%	1	10%
51-70	30	60%	4	40%
71-87	15	30%	5	50%
Religious affiliation				
Protestant	18	36%	3	30%
Catholics	21	42%	4	40%
Free protestant churches	2	4%	1	10%
Other Christian denominations	1	2%	1	10%
No religious tradition	8	16%	1	10%
Religious/spiritual attitude				
I am religious/I like to pray	7	14%	2	20%
I am spiritual/I like to meditate	3	6%	2	20%
I am religious and spiritual	9	18%	1	10%
I am only generally interested in religious/spiritual	15	30%	3	30%
I am neither religious nor spiritual	16	32%	2	20%
Experiences and coping strategies				
I had a near-death/deep spiritual experience	7	14%	3	30%
Repression helps me	27	54%	3	30%
Deep relationships help me	28	56%	9	90%

conflicts with at least 1 family member (36 with spouse/children, 15 with parents/brothers/sisters). Twenty-six mentioned that relationships had broken off for 2 to 20 years, while 10 stayed in contact despite severe conflicts. Relatives identified 5 patients as physically or sexually violent (eg, when drunk, 4 of them confessed this). Sixteen patients also expressed conflicts with professionals, 44 with biography/illness, and 42 with God/fate. Thirty-one patients repeatedly experienced F/R and restarted the process in the phases denial or crisis (Figure 1: No.5;13;60, Table 2).

Phases of and Finding F/R

Forty-nine (98%) patients achieved F/R at least once: 4 experienced release/scapegoating (5a), 4 "live and let live" (5b), 13 intrapsychic forgiveness (5c), and 28 reconciliation (5d). Forty-five patients died during or after F/R (according to the last O-Protocol), 19 during or after reconciliation. Of the remaining 5 (N = 50), 4 died during or after denial, 1 during or after an experience of hope (Tables 2 and 3).

Forty-two patients said that imminent death motivated them to tackle conflict. At the end of life, the F/R process intensified in 26 (56%) patients (Figure 1: No.5;60). However, relationships and hence reconciliation became less important at the very end of life and near somnolence: Only 16 patients of the 28 who found reconciliation (5d) also died during or after reconciliation; 11 died during or after intrapsychic forgiveness (5c; Figure 1: No.5); 1 during or after "live and let live" (5b).

Many of the 45 patients who found F/R according to the last O-protocol relaxed shortly afterward: 22 died within 2 days, while 6 became peacefully somnolent hours later. We found no link between medication and F/R processes when approaching death: Of the 45 patients who died during or after F/R, 7 had reduced medication after the last instance of F/R, while medication remained stable in 22 patients.

Twenty-three (46%) patients underwent all 5 phases, 19 underwent 4 phases. *Denial*: 40 patients underwent denial (107/16.2% of 660 O-Protocols). *Crisis*: 48 patients experienced a crisis; 20 started the process directly in crisis. Of total, 159 (24.1%) O-protocols described a crisis. *Experiences of hope* occurred in 46 patients (173/26.2% O-protocols). Twenty-seven patients experienced hope before their first decision (only 31 patients made a decision). Another 24 experienced hope before the first instance of F/R. Sequences and dynamics often changed before death: Such experiences were skipped or no longer communicated in 10 patients with previous hope experiences. The most frequent subcategory of hope experiences (37 patients) was being understood/loved by a neutral person (eg, therapist, Figure 2). *Decision*: 31 patients made a decision, as reported on 69 (10.5%) O-protocols. Although decision was infrequent, it had a motivating effect: In 26 of 28 patients who found reconciliation, this was preceded by decision (Table 2, Figure 5). Yet before death, decisions were skipped or no longer communicated in 16 patients who had previously taken a decision (Figure 1: No.13). Of all decisional subcategories, only 5 patients met their conflicting party without a neutral person (Figure 3). *Forgiveness/reconciliation* was experienced by 49 (98%) deceased patients (152/23% O-protocols) compared to 6 (60%) nondeceased patients.

Supportive Factors/Interventions

Patients who expressed regret and guilt (27), patients with empathy (16), and patients who showed acceptance (saying "Yes") often experienced 5c or 5d (Figure 5). Among supportive factors, patients mentioned a loving and/or confrontational neutral person (third party [43], Figure 5), deep relationships (28, Figure 6), music-assisted imagination (23, Figure 2), and previous NDE/deep spiritual experiences (eg, "I see that the gate to heaven is open") (7, Figure 6). Repression did not seem helpful (27, Figure 6). Spirituality, regardless of religious affiliation, seems to correlate slightly with F/R (Figure 7). Of the 16 patients who were neither religious nor spiritual, 10 found reconciliation. Six of these patients indicated that deep relationships were paramount (Figure 6).

Discussion

Engaging in and finding F/R is an important clinical topic in dying processes. Nevertheless, it seems underresearched to date. Forgiveness and reconciliation may be triggered by imminent death (Figure 1: No.5;60; Figure 5), as other studies confirm: Caregivers have reported that 88% of conversations with

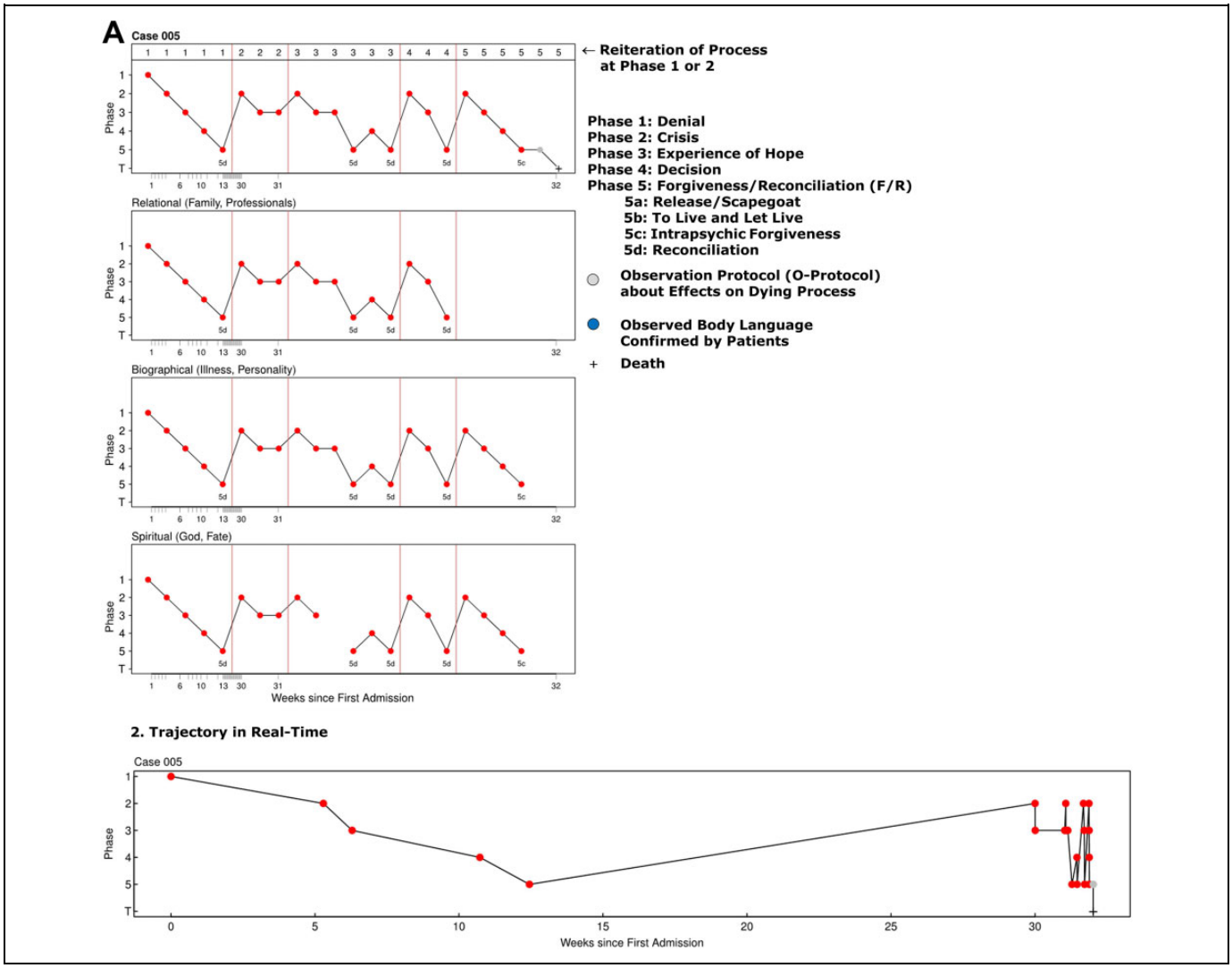


Figure 1. (A) Patient 5: Trajectory and conflicts. (B) Patient 13: Trajectory and conflicts. (C) Patient 60: Trajectory and conflicts. Case Vignette: Patient No. 13 (see Figure 1: Patient 13)

seriously ill patients,[8] or up to 50% of conversation time,[9] concerned forgiveness.

Most patients had conflicts on all 3 levels: relational, biographical, and spiritual. These levels have recently attracted attention in end-of-life care.[8,9,12-14] Forgiveness processes resemble ones leading to reconciliation, as reported also by Walker and Gorsuch.[34] We found the 5-phase model (1: denial, 2: crisis, 3: experience of hope, 4: decision, 5: reconciliation/R) helpful for understanding the "ups and downs" of many processes, also when patients fell back into denial or crisis after experiencing F/R (Figure 1: No.5;13;60). Oscillation between phases has also been noted by Mickley and Cowles.[10] While other models[24,25] emphasize the importance of decision, in our study this became less frequent near death. This is probably due to the cognitive behavioral focus[24,25] of forgiveness models, which in turn facilitate life review approaches.[1,23,26] Our model includes dying patients having unresolved conflicts until death, as well as ones who are no longer cognitively aware or willing to undergo a life review.

An impressive 49 (98%) deceased patients experienced F/R at least once compared to 60% of nondeceased patients. Other studies have found that 84% of patients with terminal cancer undergoing successful palliative treatment denied a need for F/R,[35] as did about two-thirds of hospice patients.[1] Studies on personal confrontations with death after life-threatening situations,[36] on post-traumatic growth,[37] and on NDE[38] have shown that those concerned reappreciate life and care more about others. They did not, however, focus on forgiveness in particular, perhaps because death was not imminent enough. Our study finds that many processes intensify at the very end (Figure 1: No.5;13;60, case vignette Figure 1B). A sense of limited time seems a catalyst for forgiveness processes.[39] And yet, the different forms of F/R must be taken into account: Whereas most patients experienced reconciliation or intrapsychic

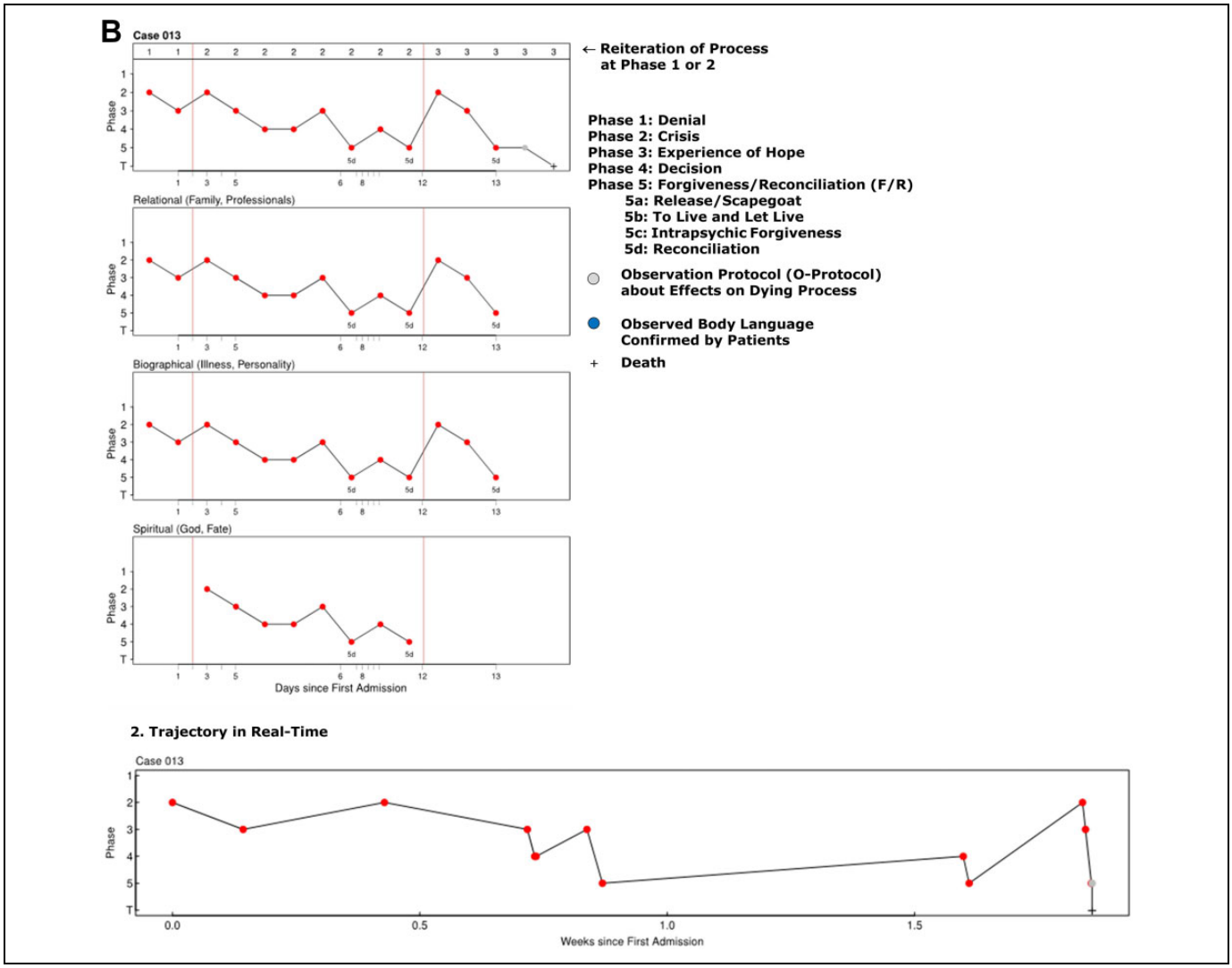


Figure 1. (B) I saw Nils* (50, a sarcoma sufferer) in the middle of a crisis, phase 2 (ph.2). The next day, after music-assisted imagination, he told me about a spiritual experience. The blue light he had seen after his operation a year ago had given him insights into his guilt and deep love for his family (ph.3). In the following days, his symptoms escalated and family conflicts burdened him. His wife remained withdrawn and had given him up (ph.2). Why did he never ring the children? He took her point, said that he sometimes needed a kick up the backside, and assured her that he loved her. He cried bitterly. This softened his wife. I suggested that he (with my help) send both adolescent children a text message (ph.3). — The physician entered the room and observed empathy and decision (ph.4). Shortly afterward, Nils wrote, "Dear Lara, I am fond of you. I understand that you are angry with me, but believe me, I love you. Kiss. Papa." "Dear Joel. . . . " He writhed in pain and cried so that the mobile phone stopped working. Finally, he sent the messages, solemnly, and prayed silently (ph.4). Joel reacted sweetly, Lara curtly replied: "Ciao." Nils sent other messages (ph.3). His wife visited and brought along photographs of their wedding day (20 years ago). They embraced (ph.5). Nils became somnolent. A few days later, his wife wanted the children to visit their father, but they refused. I offered help and talked to both children about their feelings and freedom of choice. Joel came with me to see his father, who was gentle and wanted reconciliation (ph.4). Father and son cried and prayed. Nils said that although she was not present, Lara was among them in spirit. The physician was impressed by the peaceful atmosphere (ph.5). However, Nils did not die, but was restless (ph.2). Was he waiting for Lara? No answer. Was he waiting until Lara had sorted herself out and could be with the rest of the family under happier omens when he died? "Yes!" (ph.3). Finally, Lara left moving words of farewell on her father's mobile phone. He heard them amid his escalating symptoms (ph.5), grew calm (effect on dying process) and died 15 minutes later. *Name changed.

forgiveness (eg, "I don't have to tell him, I'm in peace."), few described their relationship as "live and let live," similar to a political truce, or merely as emotional/energetic release/scapegoating (5a). They temporarily deflected family conflicts, for example, by blame-shifting/scapegoating the physician. Their calmness was not long lasting: We found 19 instances of release/scapegoating, followed by denial (5), crisis (6), experience of hope (2), release/scapegoating (1), and live and let live (2). Release/scapegoating was a final observation only in 3 patients (ie, followed neither by intrapsychic forgiveness nor by reconciliation). Most scapegoating patients needed another chance (including denial/crisis) before finding intrapsychic

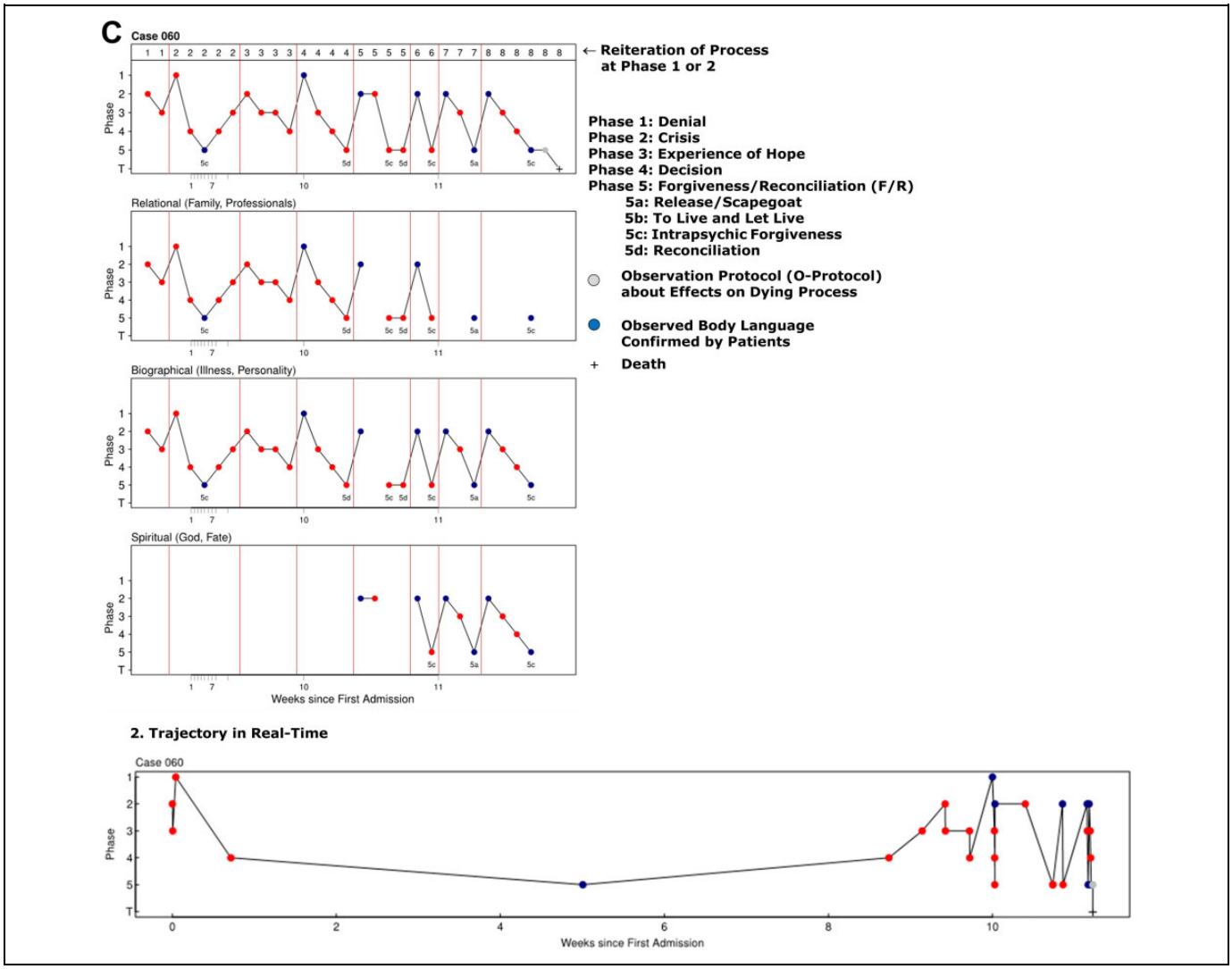


Figure 1. (C) (continued).

forgiveness or reconciliation (Figure 1: No.60). Scapegoating is a common pattern, at least in Judeo-Christian and Muslim cultures.[40] During Enright's work phase, scapegoated suffering must become consciously processed (absorbed).[15] However, release/scapegoating or blame-shifting[33] is still underresearched in dying processes.

Forgiveness and reconciliation processes are an important clinical phenomenon. They intensify at the end of life. Yet at the very end, and near somnolence, more seems to happen inwardly, that is, less on the level of relationship and reconciliation. This corresponds to our earlier findings[28,29] that family processes—although intense at first—become less important with changing consciousness near death. The exception are patients with acute family problems! Our present study focused on these patients: Many died within 2 days of finding F/R or became peacefully somnolent shortly afterward. Other studies have also suggested a link between forgiveness and a peaceful death.[3,8,19]

Interestingly, in our study, F/R did not seem drug induced nor did it reduce the need for medication. Symptoms and their medical control seemed mostly independent. In contrast to our previous study, in which drugs could be reduced when patients experienced changing consciousness and entered the peaceful post-transitional states before death,[28] our present study found no correlation with F/R processes. This suggests that F/R happened mostly when patients were still present in the here and now, perhaps "waiting" and "resisting somnolence." Changing consciousness and post-transitional states (eg, peaceful somnolence) either occurred subsequently or patients died immediately after experiencing F/R.

Particular Phases and Their Importance

Crisis seemed to accelerate processes: Only 2 patients exhibited no (observed) crisis. 40% began their F/R process directly in crisis, as might be expected due to acute hospitalization.

Table 2. Patients: Conflicts and Phases.

	Deceased Patients, N = 50		Nondeceased Patients, N = 10	
Conflicts				
Relational and biographical and spiritual	38	76%	6	60%
With at least 1 family member	44	88%	10	100%
Relationship interrupted for 2 to 20 years	26	52%	5	50%
Maintain relationship in spite of difficulties	10	20%	2	20%
Transgressors (identified by themselves and/or relatives)	5	10%	-	-
With professionals	16	32%	3	30%
With biography/illness	44	88%	7	70%
With God/fate	42	84%	7	70%
Phases				
Combination of all 5 phases	23	46%	4	40%
Combination of 4 phases	19	38%	3	30%
Reaching phase 5, but reiteration at phase 1 or 2	31	62%	3	30%
Imminence of death as factor	42	84%	5	50%
Intensified F/R process before death	26	52%	-	-
Occurrence of phases (at least once)				
Phase 1: Denial	40	80%	9	90%
Phase 2: Crisis	48	96%	10	100%
Phase 3: Experience of hope	46	92%	10	100%
Phase 4: Decision	31	62%	6	60%
Phase 5: F/R (at least once)	49	98%	6	60%
(5a): Emotional release/scapegoating	4	8%	-	-
(5b): Live and let live	4	8%	-	-
(5c): Intrapsychic forgiveness	13	26%	5	50%
(5d): Reconciliation	28	56%	1	10%
Died in/after emotional release/scapegoating (N = 28)	-	-	-	-
Died in/after live and let live (N = 28)	1	4%	-	-
Died in/after intrapsychic forgiveness (N = 28)	11	39%	-	-
Died in/after reconciliation (N = 28)	16	57%	-	-
Particular sequences of phases				
Denial at start (phase 1)	30	60%	6	60%
Crisis at start (phase 2)	20	40%	4	40%
What preceded particular phases?				
Crisis (phase 2) before first experience of hope (phase 3)	35	70%	8	80%
Experience of hope (phase 3) before first decision (phase 4)	27	54%	6	60%
Experience of hope (phase 3) before first F/R (phase 5)	24	48%	2	20%
Decision (phase 4) before first F/R (phase 5)	19	38%	4	40%
Phases skipped before death				
Skipped experience of hope (phase 3) before death	10	20%	-	-
Skipped decision (phase 4) before death	16	32%	-	-

Abbreviation: F/R, forgiveness and reconciliation.

Other studies have mentioned that while unresolved forgiveness issues may increase suffering,[8,22] they also encourage forgiveness processes.[4,10] *Experiences of hope* were a turning point, as many patients emphasized (only 4 had none). Such experiences motivated patients to take decisions or to proceed directly to F/R. Further, they might be internalized at some stage of the process and are then no longer communicated at the end. Hope has been reported as an outcome of forgiveness therapy[23,41] and as dignity-conserving.[42] It does, however, need to be further explored as the motivational moment of forgiveness. Wade et al have highlighted that forgiveness may be important for overcoming traumatic experiences and finding meaning. However, what comes first—finding meaning or forgiveness—needs further research.[43] *Decisions:* Surprisingly, only 62% of patients in our study decided to forgive. This contrasts with the central role of decision according to Enright,[24] and yet it does not: *Decision* also proved qualitatively important and facilitated a high level of F/R, especially of reconciliation (Figure 5). Based on our results, we suggest that in facing death many decisions might be internalized and unconsciously present. Thus, F/R often just "occurred."

Supportive Factors/Interventions

Mediating third factors. Within the observed experiences of hope, the subcategory of being understood/loved by a neutral third party (eg, therapist) was frequent. However, within the decisional subcategories, only 5 patients met their conflicting party

without a neutral third party. Most patients mentioned that such a party or factor was important (Figure 5). The importance of such parties is well documented (see peace negotiations, the development of judicial institutions and of therapy). In palliative care, patients often need outside support to resolve family problems.[6,10,44]

Table 3. Forgiveness/Reconciliation Before Death.

	n	%
Last observation protocol and F/R		
F/R (phase 5)[a]	45	100
Emotional release/scapegoating (5a)	3	7
Live and let live (5b)	4	9
Intrapsychic forgiveness (5c)	20	44
Reconciliation (5d)	19	42
Effects of F/R on dying process		
Died within ≤48 hours after F/R (phase 5)	22	49
Died within 3 to 7 days	10	22
Died >7 days	13	29
Medication and F/R (before somnolence/death)		
Medication reduced	7	16
Medication (stable dose)	22	49
At high level	9	20
At low level	13	29
Medication increased	15	33
Missing data	1	2

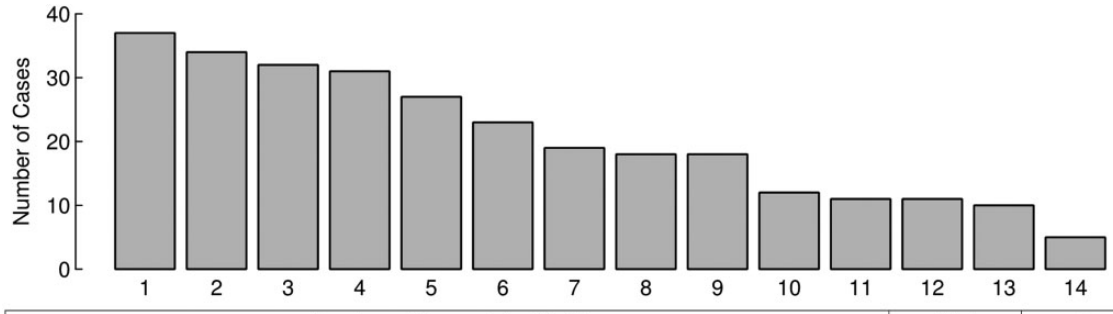
Abbreviation: F/R, forgiveness and reconciliation.
[a] Four patients died in/after denial; 1 patient died in/after an experience of hope.

Patients who were able to feel guilt (27, Figure 5), including 4 of 5 transgressors who actively regretted their misdemeanors, exhibited a high level of F/R. This insight is comparable to the awareness gained by Anonymous Alcoholics.[45] As reported, the attitude of patients with cancer toward guilt seems dependent on disease stage.[46] Existential guilt and the need for self-forgiveness seem important clinical issues[4] and may merit further research.

Empathy with adversaries or offenders and acceptance are well-known supportive factors.[24,25,31,34] Empathy and forgiveness are even linked neurologically.[47] In our study, 15 patients mentioned explicitly that saying "Yes" was decisive. As in previous studies,[28,29,31] experience-based spirituality (NDE/spiritual experiences) helped, as did deep relationships in contrast to repression,[28] moreover irrespective of spiritual/religious attitude. Other studies have also noted a significant sense of relatedness in dying patients.[3,12,18] Both deep relationships and experience-based spirituality enable us to feel dependent and touched. It may, therefore, be paramount that patients accept powerlessness and risk devotion.

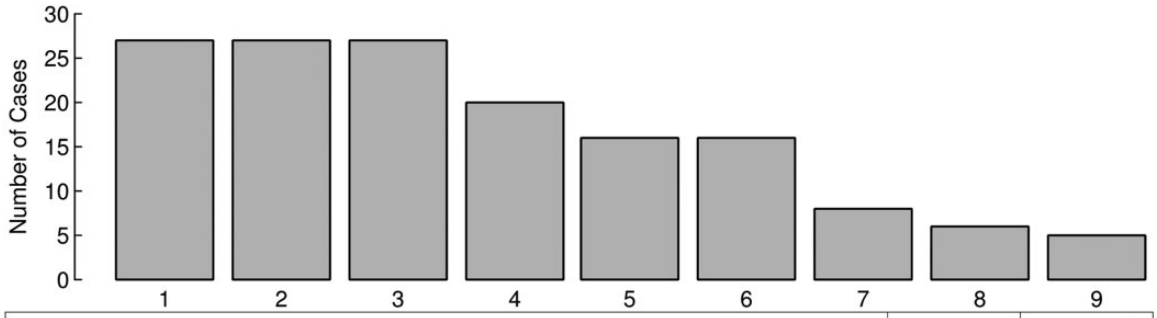
Limitations

- We only studied patients with cancer with a (secularized) Christian background.
- The O-protocol was developed specifically based on discussions with professionals at our hospital and hence tailored to our patients' needs. However, 20 professionals from different backgrounds (nurses, physicians,



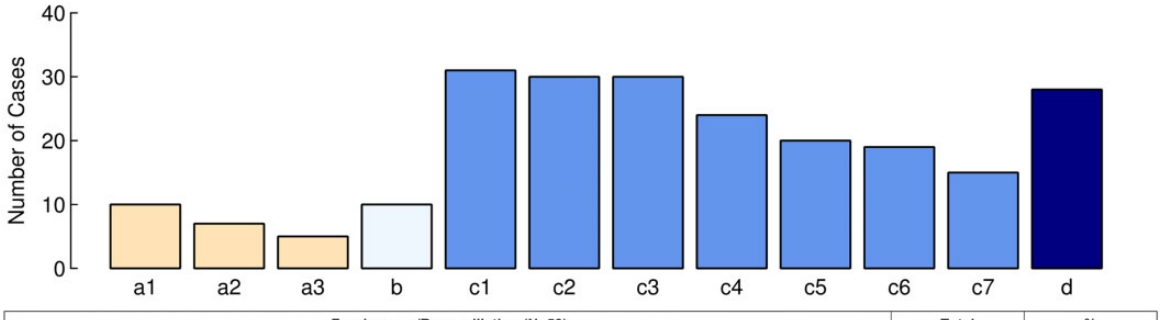
Experience of Hope per Patient (N=50)	Total	%
1. Being understood, loved by third persons/God	37	74%
2. Verbally expressing hurt/guilt	34	68%
3. Longing for peace in facing death	32	64%
4 .Getting into contact with feelings, getting into the "flow"	31	62%
5. Change in the family structure, new boss, mediator	27	54%
6. Music-assisted imagination, relaxation, ritual, prayer	23	46%
7. Satisfaction, dialogue with the other side took place	19	38%
8. Control of pain and symptoms	18	36%
9. Surprise by the other party, gift, gesture	18	36%
10. I do it for the sake of my children, somebody else, commitment	12	24%
11. Seeing suffering in others decreases one's own suffering	11	22%
12. Synchronicity: case discussion, prayer by others, "something" happened	11	22%
13. Dream, spiritual experience	10	20%
14. Experience: I have been for given, God is full of grace	5	10%

Figure 2. Subcategories of phase 3 (experiences of hope).



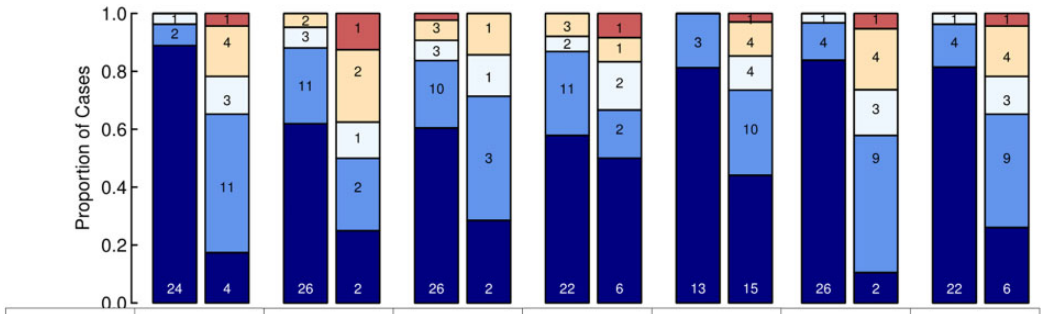
Decisions per Patient (N=50)	Total	%
1. Time to act: now or never. Accepts therapeutic support	27	54%
2. Empathy, willing to forgive (oneself and others)	27	54%
3. Acceptance. Decision to say "yes"	27	54%
4. Dialogue with the other side in the*presence* of a neutral third person	20	40%
5. Gesture of forgiveness, settlement	16	32%
6. Enduring symptom distress, pain, breathing exercises	16	32%
7. Prayer for the other person/persons or for one's own openness	8	16%
8. To enter into dialogue with God, wrestling with God	6	12%
9. Dialogue with the other side*without* neutral third person	5	10%

Figure 3. Subcategories of phase 4 (decisions).



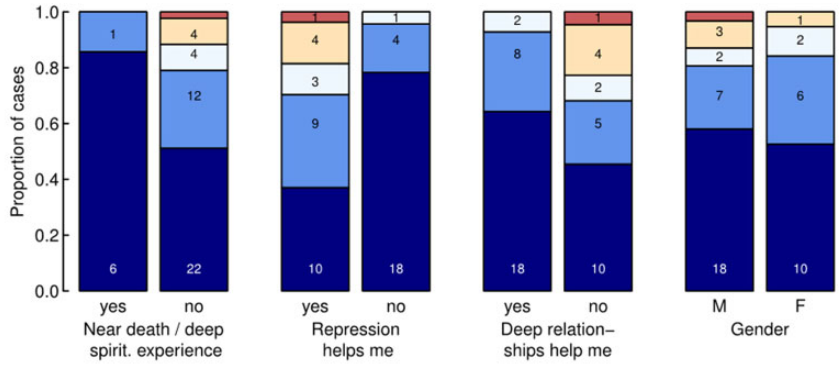
Forgiveness/Reconciliation (N=50)	Total	%
a1. Release happened, but patient is not calm	10	20
a2. Patient is calm due to repression of problem	7	14
a3. Patient is calm because ofscapegoating	5	10
b. Live and let live	10	20
c1. Inner forgiveness, trustful, loving	31	62
c2. New attitude to oneself and others	30	60
c3. Less symptoms because of forgiveness	30	60
c4. Expressed being in peace, new spirituality	24	48
c5. Regrets and feelings of guilt are allowed	20	40
c6. Wordless, moved, touched	19	38
c7. Wordless, well-being, peaceful	15	30
d. Reconciliation	28	56

Figure 4. Subcategories of phase 5 (forgiveness/reconciliation).



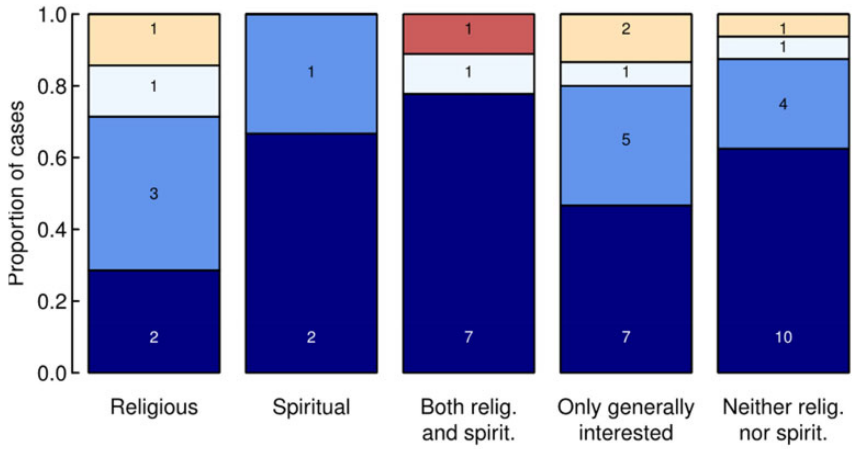
	Guilt, Regret		Imminence of Death		Third Persons Third Factors		Spiritual Dimension helps		Trait Empathy		Decision		Acceptance	
	yes (N=27)	no (N=23)	yes (N=42)	no (N=8)	yes (N=43)	no (N=7)	yes (N=38)	no (N=12)	yes (N=16)	no (N=34)	yes (N=31)	no (N=19)	yes (N=27)	no (N=23)
No Forgiveness	--	1 (4%	--	1 (13%)	1 (2%)	--	--	1 (8%)	--	1 (3%)	--	1 (5%)	--	1 (4%)
Release/ Scapegoating	--	4 (17%)	2 (5%)	2 (25%)	3 (7%)	1 (14%)	3 (8%)	1 (8%)	--	4 (12%)	--	4 (21%)	--	4 (18%)
To Live & Let Live	1 (4%)	3 (13%)	3 (7%)	1 (13%)	3 (7%)	1 (14%)	2 (5%)	2 (17%)	--	4 (12%)	1 (3%)	3 (16%)	1 (4%)	3 (13%)
Intrapsychic Forgiveness	2 (7%)	11 (48%)	11 (26%)	2 (25%)	10 (23%)	3 (43%)	11 (29%)	2 (17%)	3 (19%)	10 (29%)	4 (13%)	9 (47%)	4 (15%)	9 (39%)
Reconciliation	24 (89%)	4 (17%)	26 (62%)	2 (25%)	26 (61%)	2 (29%)	22 (58%)	6 (50%)	13 (81%)	15 (44%)	26 (84%)	2 (11%)	22 (81%)	6 (26%)

Figure 5. Situational factors: Guilt/shame, imminence of death, third parties, spiritual dimension, trait empathy, decision, acceptance.



	Near-death/Deep Spiritual Experience		Repression Helps Me		Deep Relationship Help Me		Gender	
	yes (N=7)	no (N=43)	yes (N=27)	no (N=23)	yes (N=28)	no (N=22)	Male (N=31)	Female (N=19)
No Forgiveness	--	1 (2%)	1 (4%)	--	--	1 (5%)	1 (3%)	--
Release/ Scapegoating	--	4 (9%)	4 (15%)	--	--	4 (18%)	3 (10%)	1 (5%)
To Live & Let Live	--	4 (9%)	3 (11%)	1 (4%)	2 (7%)	2 (9%)	2 (6%)	2 (11%)
Intrapsychic Forgiveness	1 (14%)	12 (28%)	9 (33%)	4 (17%)	8 (29%)	5 (23%)	7 (23%)	6 (32%)
Reconciliation	6 (86%)	22 (51%)	10 (37%)	18 (78%)	18 (64%)	10 (45%)	18 (58%)	10 (53%)

Figure 6. Dispositional factors: NDE/deep spiritual experience, repression, deep relationships, and gender. NDE indicates near-death experience.



	Religious (N=7)	Spiritual (N=3)	Both Religious and Spiritual (N=9)	Only Generally Interested (N=15)	Neither Religious Nor Spiritual (N=16)
No Forgiveness	--	--	1 (11)	--	--
Release/ Scapegoating	1 (14%)	--	--	2 (13%)	1 (6%)
To Live & Let Live	1 (14%)	--	1 (11%)	1 (7%)	1 (6%)
Intrapsychic Forgiveness	3 (43%)	2 (33%)	--	5 (33%)	4 (25%)
Reconciliation	2 (29%)	3 (67%)	7 (78%)	7 (47%)	10 (63%)

Figure 7. Dispositional factors: religion/spirituality.

therapists, spiritual caregivers) were involved. Moreover, we ran a 1-year pilot.

- Between observations lay unrecorded periods. Particular phases, especially decisions, may have been present but were not communicated. Nevertheless, the amount of data is large (660 O-protocols) and allows interpretation.
- Observations might be biased by the observers' personal attitudes and different professional backgrounds. However, 2 factors helped reduce individual bias: Our study involved 3 hospital units and only included patients who were observed by at least 2 professions.
- The scarcity of comparable studies makes it difficult to conclude which factors may explain different findings.
- The limited data on NDE/spiritual experience barely allow drawing conclusions. It remains open whether gender, age, and religiosity significantly affect forgiveness.[48]

Conclusion and Clinical Relevance

- Approaching death, patients seek F/R.
- F/R processes accelerate in the final days/hours of life.
- After achieving F/R, many patients die or fall into somnolence.
- Forgiveness processes oscillate between 5 phases: denial, crisis, experience of hope, decision, and forgiveness/reconciliation.
- Especially a mediating (ie, neutral) party or experiences of hope may support patients in finding F/R. As caregivers, we need to consider: Which therapy, which intervention, which encouraging words would increase this particular patient's hope?

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