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Chapter

The Moment of Establishing Transpersonal Caring in a Grieving Adolescent Daughter beside Her Mother's Deathbed and Hansen's Disease Survivors Sharing Their Life Review

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Abstract

Evidence-based nursing (EBN) ensures the science of nursing practice, while the philosophical and ethical aspects of nursing practice are based on caring. Caring not only leads to the patient and their family's healing but also to the nurse's professional and personal growth since caring includes mutual approval and reciprocity. In the latter half of the chapter, we explain how to establish Dr. Jean Watson's transpersonal caring using the following two events: ① case study: An expert nurse unintentionally says, "Your mother continues to be near and protect you," to a crying daughter beside her mother's deathbed; and ② our project: sanatorium's nurses listen to Hansen's disease survivors' life review.

Keywords: caring, spirituality, Jean Watson, Hansen's disease, end-of-life care, nursing philosophy

1. Understanding clients and nursing practices

The concept of "caring" is significant in nursing practice and characterizes nursing practice philosophically and ethically. We make additions and corrections to the lecture at Okayama Prefectural Nursing Association in Japan: "Caring for nursing practice—Let's reflect our nursing practice philosophically." In this chapter, we first explain about understanding clients based on Holism and the significance of caring in nursing practice. Second, we study why and how to establish our two nursing practices as transpersonal caring using Jean Watson's caring theory, and we discuss the significance of caring. The two cases are (1) a crying adolescent daughter in her mother's deathbed and (2) Hansen's disease survivors sharing about their own life review. Finally, we discuss the significance of caring in medical ethics.

### 1.1 What is needed for high-quality nursing practice?

Nursing is, undoubtedly, a science of practice. In practical sciences, we not only analyze and critique the phenomenon, but we also use our body as a tool and intervene in the phenomenon to develop and improve. Therefore, the relationship between clients and nurses is important because nursing interventions involves the relationship between them.

When engaging in high-quality nursing practice, two things are important. First, we must understand the clients deeply in order to decide the direction of the approach. Second, we must identify what and how the practice is building.

1.2 Understanding clients based on holism

Holism is important in nursing. In natural sciences, the phenomenon is understood by breaking it into elements, based on element reductionism. On the other hand, in holism, we try to understand human beings as a whole, whose existence is greater than the sum of their parts. For example, in **Figure 1(a)** and **(b)**, the three-dimensional PET bottle is shown as two-dimensional when perceived from above or below. Many people may be unable to understand the PET bottle by seeing only (a) and (b). Understanding "as a whole" means understanding the PET bottle as three-dimensional without dividing it into two dimensions. However, because human beings live in more than four dimensions' world, understanding them "as a whole" is very difficult. Therefore, we attempt to draw a multidimensional image by combining several perspectives.

The first perspective understands human beings from four aspects: physical, physiological, social, and spiritual. The sufferings of cancer patients or patients in the terminal stage are known as total pain, which occurs through the interactions of
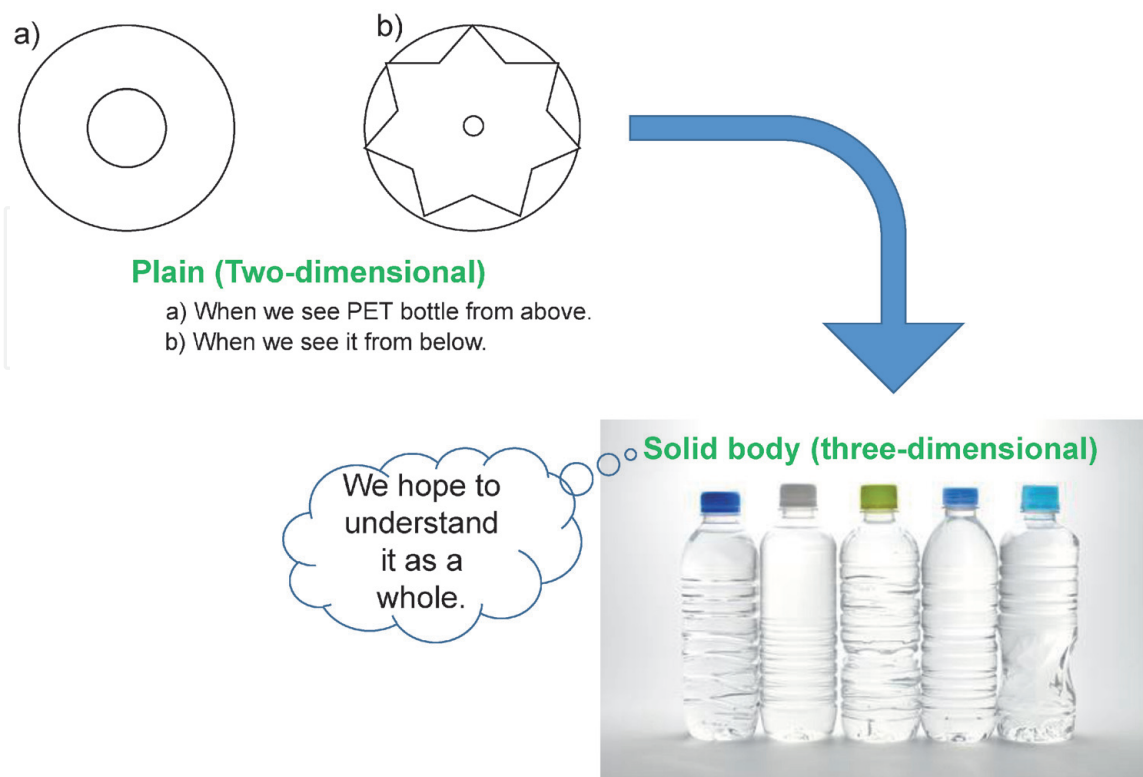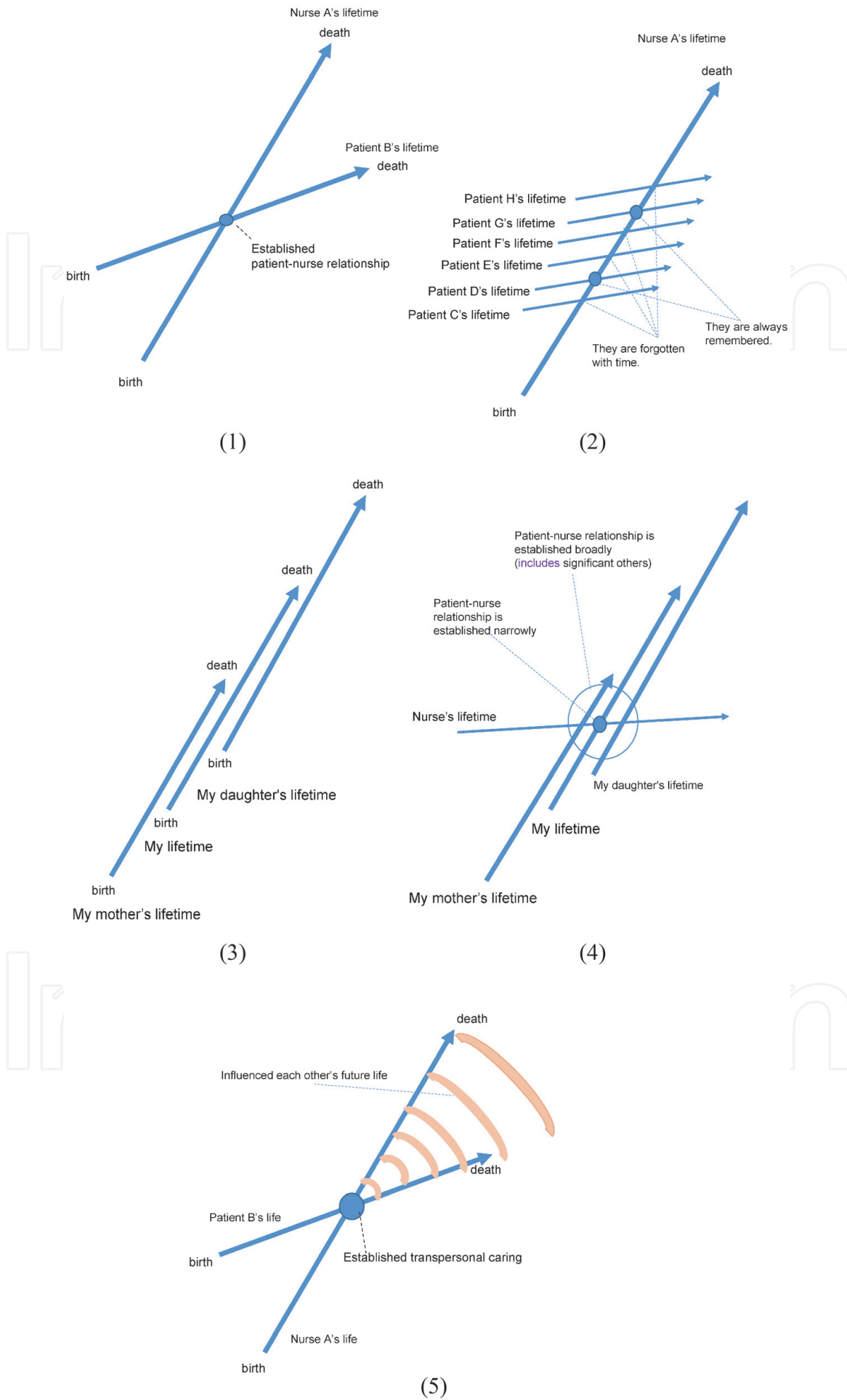

Figure 1.
Understanding as a whole.

physical, physiological, social, and spiritual pain. On the other hand, although the quality of life (QOL) emphasizes the client's subjectivity over objective indicators, it helps understand not one but multiple aspects. Haas' QOL model [1] states that the QOL includes physical, psychological, social, and spiritual well-being. In other words, experiencing pain in these four aspects (physical, psychological, social, and spiritual) is called total pain, while experiencing well-being in these four aspects is called high-level QOL. The relationship between total pain and the QOL is akin to the two sides of the same coin. Therefore, both total pain and QOL focus on understanding human beings from four aspects (physical, psychological, social, and spiritual). When the nurses decide the goals and direction for nursing intervention, they consider what high-level QOL is for the client and evaluate the effectiveness of nursing practice from the client's QOL. Understanding these four aspects is important because QOL is an important concept for nursing practice.

The second perspective is positioning on the life cycle. In **Figure 2(1)**, the arrow presents the patient's and nurse's lifetime from birth to death. The intersection of the two arrows shows the moment wherein the nurse's life and the patient's life cross, i.e., the moment when the patient–nurse relationship was established. The patient–nurse relationship is maintained for a short time in their lifespan. Therefore, if the nurse wants to understand the client deeply, she/he should endeavor to know how the client has lived until meeting her/him and how the client wants to live in the future. Sometimes, nurses are derided that "she knows only patients wearing pajamas", because her concerns are only about the present and she does not make efforts to understand the client's lifecycle. Especially, in end-of-life care, nurses must understand the client's life deeply and support that the client can live and die in his/her own way. Additionally, a nurse meets a great number of patients during her professional life. Although most patients are forgotten with time, some patients are always remembered (see **Figure 2(2)**). We will explain why the differences exist in the next term.

The third perspective includes the clients' significant others as subjects of nursing practice. The arrows in **Figure 2(3)** show my lifetime, my mother's lifetime, and my daughter's lifetime. I have lived with my mother since my birth; the relationship between my mother and me will continue until her death, although the physical and psychological distance increases with my growth. Similarly, the relationship between my child and me begins in the middle of my lifetime at my child's birth and would ordinarily end at my death. It is similar to a family's life cycle in the family development theory. As shown in **Figure 2(4)**, when a patient–nurse relationship is established, not only the patient but also his/her significant others (in this case, my mother and daughter) are comprised in circles, because they are living their life together and are connected through strong bonds.

The fourth perspective is "disease" and "illness" in medical anthropology. While "disease" shows objective events, "illness" shows subjective experience. For example, "blood vessels nourishing the heart are obstructed, the myocardium is necrosis, and pump function of the heart is decreased" is a "disease"; the communication between various medical staff can be established by using a common language, "myocardial infarction." In contrast, when the attack occurred, "I felt that I will die," "I thought about tomorrow's significant job," and "the face of a young child flashed" are "illness" expressing subjective experiences, and 100 people can have 100 types of experiences. Because the goal of nursing practice is the client's physical, psychological, social, and spiritual well-being, nurses must understand not only the pathophysiology (what occurs in the body) and the effect of the disease in their daily life but also the client's subjective experience. The ability to understand both disease and illness is a strength for nurses.
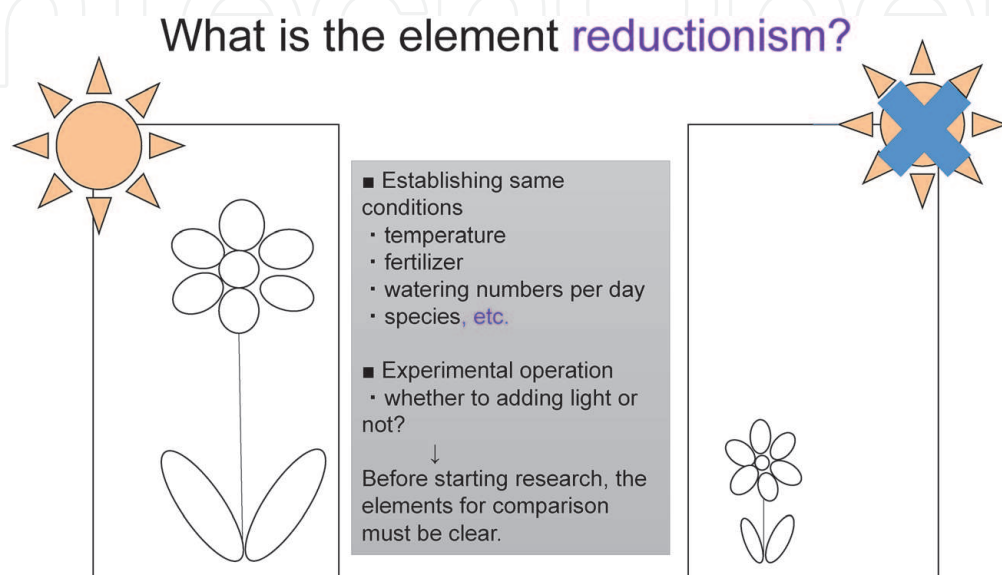
Figure 2.
(1) Intersection of nurse A's life and patient B's life established patient-nurse relationship). (2) A nurse meets many patients during their professional life. (3) My life, my mother's life, and my daughter's life. (4) Not only the patient but also his/her significant others are included in the patient-nurse relationship. (5) Transpersonal caring.

1.3 Affinity with the qualitative research approach

The qualitative research method is highly significant to understand "illness" (client's subjective experiences) (see **Figure 3**). Some readers might investigate whether light affects plant growth as elementary school summer vacation homework. In this case, we identify conditions affecting plant growth, light, temperature, fertilizer, amount of watering per day, species type, etc., and compare the experimental (with light) and control groups (without light) while keeping other conditions constant. This is an experimental research based on element reduction and basic research in natural sciences. On the other hand, the qualitative study analyzes the responses of research participants inductively and performs an abstraction, thereby clarifying the nature of the phenomenon. In other words, the researcher not only describes the subjective experiences but also utilizes a theory or middle-range theory to explain the construction and process of the phenomenon. For example, why does the phenomenon occur? What is the nature of the phenomenon? What is the outcome? If we can identify the construction and process of the phenomenon, we can consider where and how to approach to get good outcomes and can find a new direction for care [2].

Understanding the subjects in real clinical settings is very difficult. The first reason is the difficulty in understanding the nature of the phenomenon. **Figure 4** shows blind men evaluating an elephant. Blind man A touches the elephant's nose and feels that it is a tube. Blind man B touches the elephant's ear and feels that it is a big fan. Blind man C touches the elephant's leg and feels that it is a thick pillar. However, no blind man could find the essence (elephant) of the thing they touched. Likewise, we cannot directly touch the essence of the phenomenon and only have partial knowledge in a real clinical setting. Therefore, we must repeat the process of trial and error. The second reason is that we must decide the direction for approach and begin support before clarifying the essence of the phenomenon (we cannot wait until the overall picture and essence are clarified). If we explain using **Figure 1**, we believe the double circle (a) and star shape (b) as truth, and we cannot notice the PET bottle as truth, and then we employ a wrong intervention without knowing the truth. The third reason is that the situation and the phenomenon transform at every moment. In other words, if we can clarify the essence of the phenomenon, we must continue to consider the essence of the phenomenon because the situation would continue to change.

Figure 3.
Experimental research based on element reductionism. "Does plant growth need light?"

Qualitative study
What is the essence of the phenomenon?

Blind men and an elephant: Illustrator unknown - From Martha Adelaide Holton & Charles Madison Curry, *Holton-Curry readers*, Rand McNally & Co. (Chicago), p. 108.

Blind men evaluate an elephant

Because we live in real clinical settings, we have partial knowledge.
↓
But we do not know the overall picture and the essence of the phenomenon.
↓
Using qualitative study, we can describe, explain, and predict from chaotic phenomenon.
=draw out the essences

Figure 4.
What is a qualitative study?—Drawing out the essences of the phenomenon.

Mentioned above are difficulties in understanding human beings as a whole. Unlike the traditional experimental research based on element reductionism, the origin of qualitative research approach is humanics (philosophy, sociology, cultural anthropology), and researchers try to clarify the nature of the relevant phenomenon, i.e., they try to clarify that it is not a tube, a big fan, or a thick pillar, but an elephant. Therefore, the qualitative research approach and nursing practice have high affinity because nursing practice is based on holism. The qualitative approach has taken root not only in nursing but also in the academic area of human support (pedagogy, welfare studies, psychology, etc.). Recently, the business world and mass media use stories as a narrative approach. Specifically, the specialty of qualitative research in nursing is to help understand the patients' subjective experiences, i.e., the description of "illness." Accumulating data using qualitative study is like accumulating knowledge of the "illness" and developing area adhesion-type theory or a middle-range theory to explain and predict the relevant phenomenon. Therefore, it contributes to the development of the academic system of nursing by providing evidence and academic infrastructure.

1.4 Nursing as a science of practice

The second important thing to enable high-quality nursing practice is clarifying what constitutes the nursing practices. The goals of nursing practices are the client's physical, psychological, social, and spiritual well-being based on Hass' QOL model [1] and health and happiness as a whole person. Dr. Hinohara [3, 4] said, "Nursing is an Art, based on Science," based on Dr. William Osler's quote. Nursing as science means evidence-based nursing (EBN) as one area of natural sciences and emphasizes logical and critical thinking and purposeful actions. On the other hand, nursing

as art means understanding clients through humanics (humanities, social sciences, art, etc.) and emphasizes the narrative-based nursing and caring.

1.5 What is caring?

The origin of caring is similar to mothering and parenting, and these had been born into home spontaneously, such as caring for a sick family member by other family members, childbearing by women, etc. Therefore, caring is based on nursing, although only caring is not specific to nursing. Philosopher Milton Mayeroff [5] states that care is established through interactions between the care receiver and caregiver. The essence of care is that both the caregiver and care receiver grow, fulfill self-realization, and find meanings and worth. Caregivers assist the care receiver's self-realization and growth, and they achieve their self-realization through the supporting process. This caring relationship is not one-sided self-sacrifice but involves mutual approval and reciprocity (mutually beneficial). Elements of care include knowledge, changing rhythm, patience, honesty, trust, humility, hope, and courage. Therefore, we consider mutual approval and reciprocity as characteristics of caring and the achievement of self-realization by both the care receiver and caregiver as the process of caring.

The concept of caring involves deliberation about "being (how we exist?)" against "doing (what we do?)." It means that the nurse's existence itself soothes the patients. O'Brien and Davies [6] demonstrated caring in the end-of-life care by Petal illustration: the nurse respects and connects with the suffering patient, searches what is useful for the patient, empowers and helps unleash the potential of the lethargic patient, helps them search for meaning from their sufferings, and then helps the patient maintain their wholeness. The poet, Tomihiro Hoshino [7], had a cervical spine injury and quadriplegia by falling from a horizontal bar in his first year as a teacher and experienced deep existential suffering. He, then, became a Christian, got married, and drew flowers and wrote poems by having a paintbrush in his mouth. His poems expressed the essence of caring from a care receiver's perspective: "I can be standing, because you are supporting me. I can lean off the cliff, because you are supporting me. I can dream invisible tomorrow, because you are supporting me. Although my lifetime is like walking tightrope, I can alive by supporting from you."

One expertise of nurses caring for dying and death is "enduring to stay with a patient suffering severe physical pain" [8]. As death approaches, our "doing (problem-solving method)" becomes less and less effective. When the nurse stays with the dying patient suffering bitter pain without an effective support method, the nurse feels their helplessness and pain. Therefore, it is one of the causes of burnout among nurses. Furthermore, when the nurse remains by the patient's side, the nurse's presence brings peace to the patient. The essence of caring in end-of-life care is "being (how the nurse exists)," as opposed to "doing (do something useful)."

2. The moment of established transpersonal caring by Dr. Jean Watson's theory

Nursing theorist Dr. Jean Watson strengthened the philosophical and ethical foundations of nursing practice. She considered caring in nursing and theorized transpersonal caring, which involves resonating with each other at a spiritual level. In this section, after overviewing Dr. Watson's theory, we describe two nursing practices in which transpersonal caring was established.
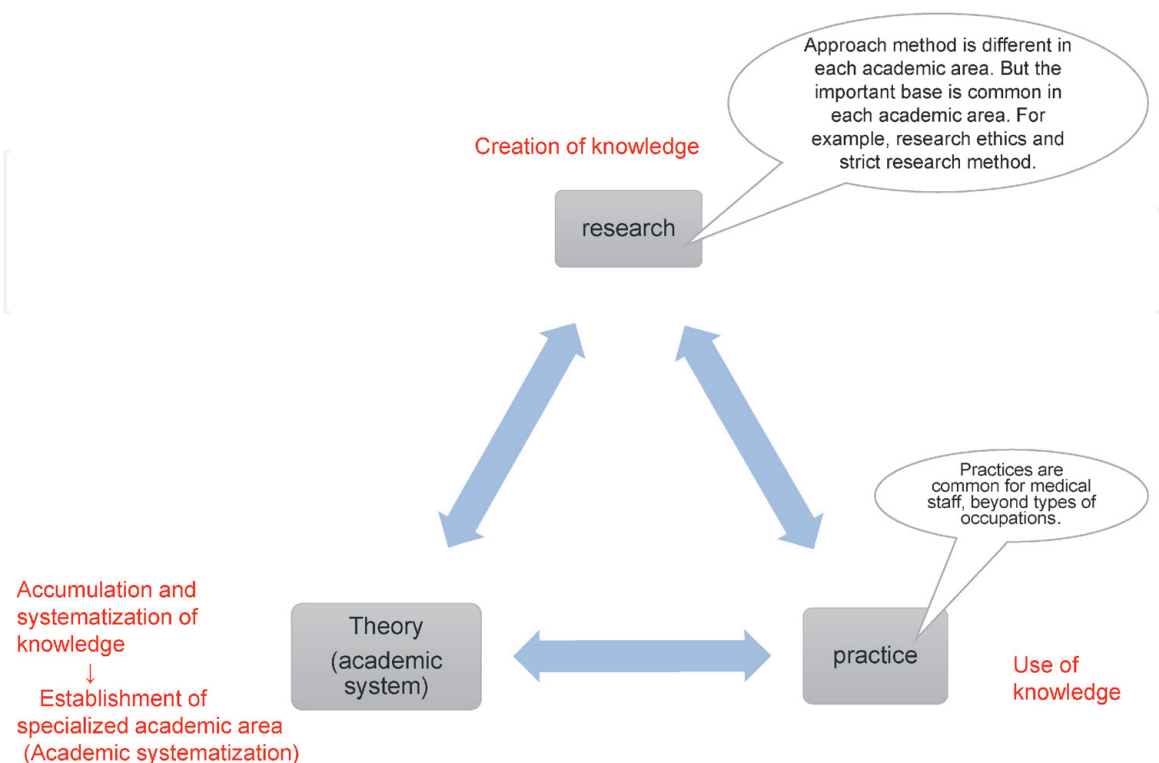
2.1 Why is a theory needed?

A theory is the systematic knowledge that explains each phenomenon and fact and has predictive power and a deductive system created by combining hypotheses and laws, which are formulated concepts having clear definitions [9]. **Figure 5** shows the relationship between practice, theory, and research. In nursing, practice is usually the most important. The practice involves using knowledge through which nursing becomes a practical science, enhancing the existence value in society. However, the knowledge supporting practice is not always scientific knowledge; unclear evidence and habits exist, such as "we have been doing it for a long time" or "the matter is common sense in this place."

Research is the creation of knowledge, i.e., a process of elucidating various problems arising in nursing practice by using logical thinking and scientific methods and creating evidence for sustaining nursing practices. Therefore, there are research buds (issues to be investigated) in nursing practices.

A theory is systematized knowledge created by research and has established nursing as an academic area. Because nursing had emerged spontaneously like mothering and parenting is based on medical knowledge to perform a medical doctor's supplementary work, has theories and systematized evidence to sustain nursing practice, and has academically systematized theories, nursing becomes nursing science. A theory involves accumulating and systematizing knowledge; it is a sustained practice by giving theoretical and academic foundations.

2.2 Deduction and induction

When we use a theory for nursing practice or create a theory from nursing practice, understanding deduction and induction becomes important. Deduction and induction are the ladder to move between abstract and concrete and enables logical explanation about this movement. Therefore, these inference methods are

Creation of knowledge

Approach method is different in each academic area. But the important base is common in each academic area. For example, research ethics and strict research method.

research

Practices are common for medical staff, beyond types of occupations.

Accumulation and systematization of knowledge
↓
Establishment of specialized academic area
(Academic systematization)

Theory (academic system)

practice

Use of knowledge

Figure 5.
Relevance of practice, research, and theory.

indispensable for logical thinking. Induction proceeds from the concrete to abstract, and deduction proceeds from abstract to concrete. Examples of deduction include case study (using existing theory, analyzing the difficult case, and identifying a solution) and quantitative study (making a theoretical framework and evaluating its validity by using statistics). Examples of induction include qualitative study (creating abstract concepts from concrete phenomenon) (see **Figure 6**). There are many miscellaneous things: ballpoint pen, frying pan, stethoscope, etc. When we gather them by similarity, the ballpoint pen, pencil case, and eraser are comprised under "things to use when writing"; the frying pan, pot, and spoon are comprised under "things to use when cooking'"; ship, airplane, and electric train are comprised under "things to use when traveling"; and weight scale, stethoscope, and thermometer are comprised under "things to use when diagnosing." These are named "stationery," "cooking utensils," "vehicle," and "medical equipment," respectively. Then, these are gathered and defined as "things people use to do something" and named "tool," which is a more abstract concept. In summary, the goal of the inductive method was to create a highly abstract and explainable concept of "tool." Regarding the concepts' usefulness, if we enumerate "stationery" concretely, we can create a thick catalog containing thousands of concrete examples; however, if we use the concept and definition, we can express thousands of concrete examples in one word "stationery." Therefore, a concept's usefulness is highly explainable and convenient.

On the other hand, if we use theory to understand the difficult case (e.g., case study), a deduction is used. Its purpose is to select a suitable theory for the relevant phenomenon. For this, the researchers must study the characteristics of various theories and increase their knowledge, like a sommelier. Additionally, there is one caution; we use theory to analyze the relevant phenomenon. When we use one theory, we naturally understand the phenomenon according to the selected theory, and we cannot understand other perspectives. As a result, we may overlook important things and the essence of the phenomenon.
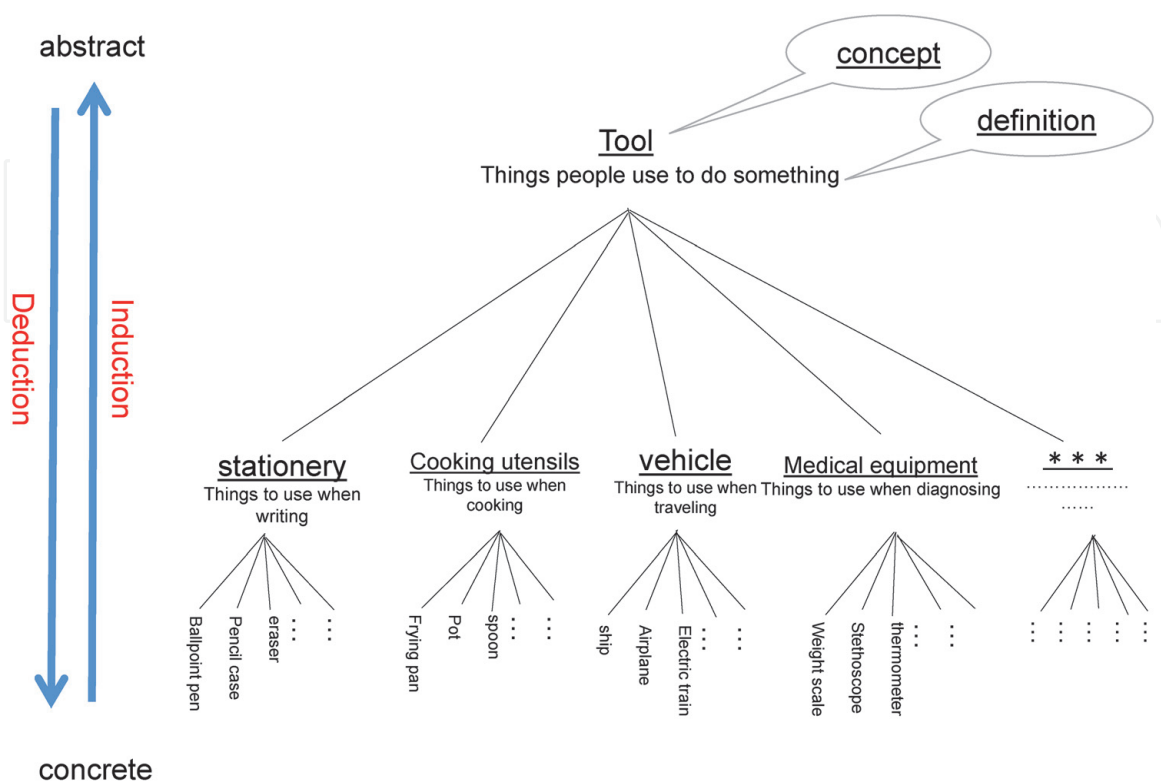
Figure 6.
Deduction and induction.

2.3 Case analysis method by Dr. Jean Watson's human caring theory

Dr. Margaret Jean Harman Watson [10–13] considered "what is nursing?" and the essence and universality of nursing and developed the human caring theory, which is philosophical and ethical. On one hand, she is a practitioner and proponent of caring. On the other hand, she emphasizes the worth of healing as an experienced person, because she lost an eye and her husband. She believes that true healing and change cannot occur in the real world by seeking utilitarian success but by spiritual healing. She also emphasizes the essence of nursing in caring, which is healing a human's wholeness and establishing nursing philosophy.

Our understanding of Watson's theory in this section was based on her books (Japanese Version) [10–13], an overview of her theory by Emoto [14, 15], and books about nursing theories and their theorists (Japanese Version) [16, 17]. Therefore, there may be some differences between Watson's original expressions because of back-translation. Additionally, although Dr. Rina Emoto described the case analysis sheet (we describe the following), we modified it to clarify the interaction between nurse and subject.

Important concepts to understand Watson's human caring theory include "human care," "transpersonal," "caritas literacy," and "caritas process/carative factor."
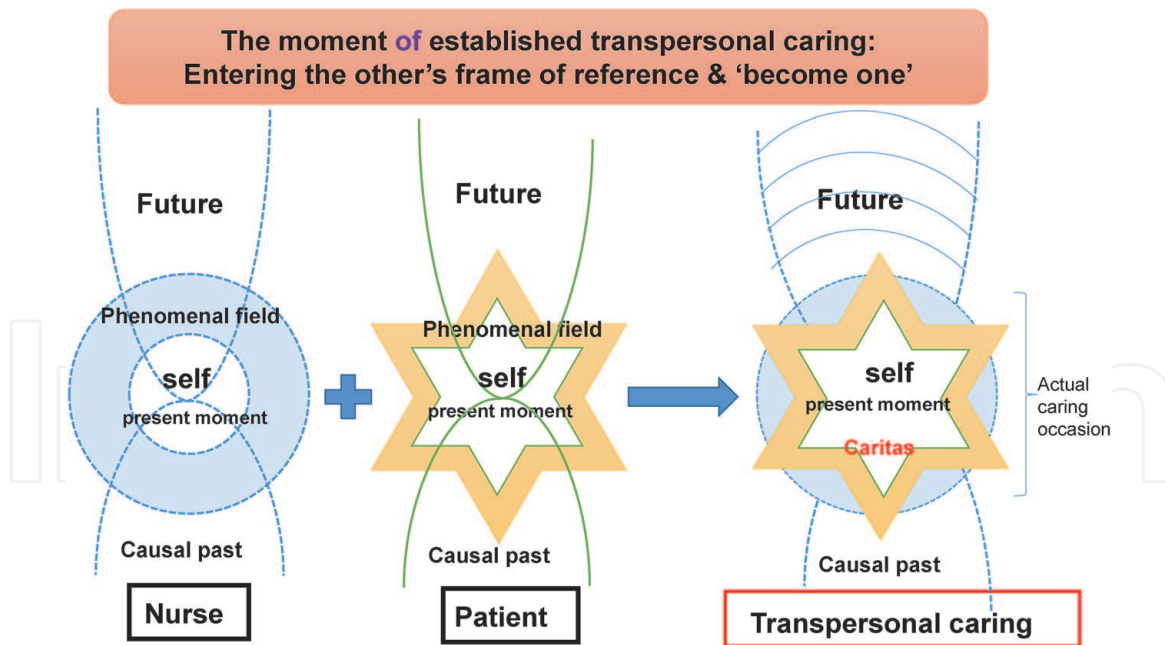
2.3.1 Transpersonal

Transpersonal is a human-to-human connection beyond the person-body-ego at the moment of care, wherein both persons influence each other and share the same time. If transpersonal caring is established, both persons have deeply connected feelings at the spiritual level. **Figure 8** shows the establishment of transpersonal caring. In the time axis containing past-present-future, nurse's present (left-most in **Figure** 7) and patient's present (middle in **Figure** 7) overlap and share the same time, resonate at a spiritual level, and influence each other's future (right-most in **Figure** 7). **Figures 2–(5)** presents transpersonal caring through the arrows showing the nurse's and patient's life, as explained above. We will explain the following case analysis about what happens at the moment wherein transpersonal caring is established.

When using the arrows showing the nurse's and the patient's life in the above section (in understanding clients based on holism, **Figure 2**), transpersonal caring is shown in **Figures 2–(5)**.

2.3.2 Caritas processes/carative factors and modified case analysis sheet

The caritas processes/carative factors make the core of human caring. She initially expressed "carative factors" and later changed it to "caritas process." The first three carative factors/caritas processes form the philosophical basis, the next six (4th to 9th) are expressed as a practice of care, and the tenth expresses existential understanding. **Figure 8** shows the construction of caritas processes, and ①–⑩ in **Figure 8** are the number of carative factors (corresponding to the number of caritas processes).

Figure 8 shows the following: ① putting value in humanistic altruism and practicing affection, kindness, and calmness with self and others; ② being with whole body and whole spirit, respecting and sustaining own and other's subjective worlds and beliefs, and instilling hope and trust; and ③ fostering sensitivity to self and others formed the "foundation sustaining caring" and establishes the "interaction" between "patient" and "nurse." The "nurse" ⑥ solves problems creatively and

Figure 7.
Dynamics of the human caring process. References (created by this paper's author based on the references [14, 15, 24, 25]).
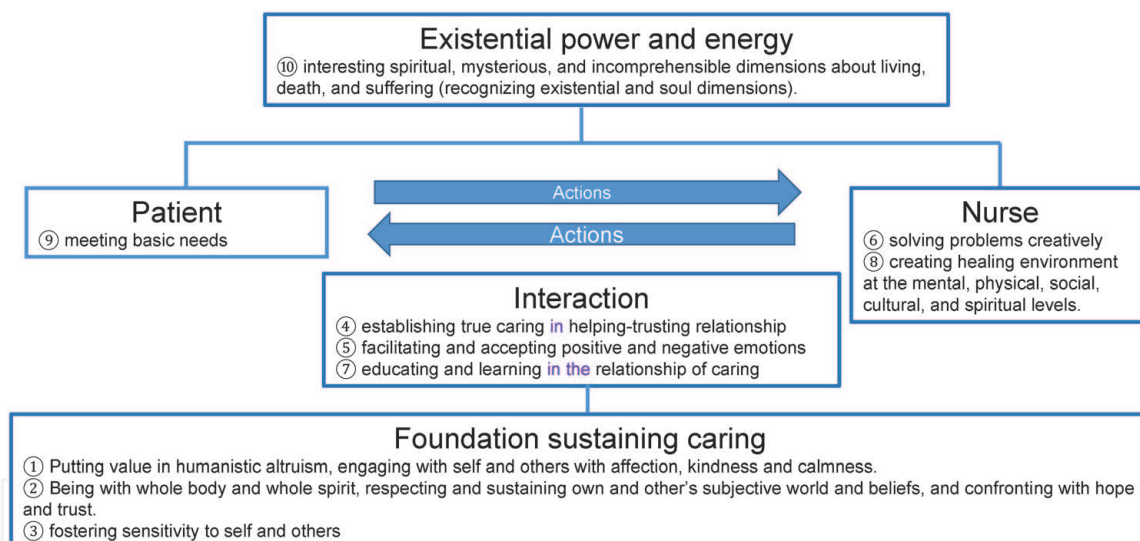
Figure 8.
Case analysis sheet based on transpersonal caring by Jean Watson (partially modified) [10–17].
Footnotes: Main framework is made from above references, and we modify about following. ①～⑩ are expressed caritas process or carative factor. Modifying from 'bilateral relationship' to "interaction", adding two "actions" arrows, and adding box in order to write contents of interaction. Changing the line connecting boxes. "Foundation sustaining caring" sustain "interaction", and "patient" and "nurse" connect "existential power and energy". Modifying from "existential and phenomenological power" to "existential power". Actor of ⑨ is not nurse but patient. Therefore, modifying from "supporting" to "meeting", because of selecting the verb for which the patient is the subject.

⑧ creates a healing environment at mental, physical, social, cultural, and spiritual levels, while the "patient" acts to ⑨ meet basic needs. "Interaction" between the nurse and patient involves ④ establishing true caring into a helping-trusting relationship, ⑤ facilitating and accepting positive and negative emotions, and ⑦ promoting education and learning in the relationship of caring. From the "interaction," "existential power and energy" is born, which contains ⑩ interesting spiritual, mysterious, and incomprehensible dimensions about life, death, and suffering (recognizing existential and soul dimensions).

We modified following five points in order to analyze case: (1) ①–⑩ described the caritas processes or carative factors. (2) We modified "bilateral relationship" to "interaction," and added two "action" arrows and a box to write contents of inter-action. (3) We changed the line connecting boxes. "Foundation sustaining caring" sustains "interaction," and "patient" and "nurse" connect "existential power and energy." (4) We modified "existential and phenomenological power" to "existential power." (5) The actor of ⑨ is not the nurse but the patient. Therefore, we modified 'supporting' to 'meeting' to convey the patient as the subject. In the next section, we explain the results using this case analysis sheet.

2.3.3 Caritas literacy

Caritas means compassion, gratitude, taking special interest and expressing philanthropy, mercy, compassion, and soul generosity. In human caring, the onto-logical attitude "being here" is considered caritas literacy, which contains 15 actions, such as guessing other's feelings accurately, listening to other's subjective story and its meanings, listening to the truth behind the words, etc.

2.3.4 Human caring

Human caring, known as care from the moral viewpoint, comprises protecting, maintaining, and enhancing human dignity. If the nurse and patient maintain a relationship with transpersonal caring, two people make one story, and caring and healing occur simultaneously. Transpersonal caring-healing has spatial and tempo-ral spread and is connected with a higher and deeper cosmic energy. Therefore, the ontological attitude "being here" influences the healing process. These interactions are human caring.

2.4 The moment of established transpersonal caring-healing (case 1): interaction between a crying adolescent daughter beside her mother's deathbed and an expert nurse

In this section, we introduce an expert nurse's experience of the moment of established transpersonal caring. An expert nurse shared this story when we conducted grounded theory about the grieving process of nurses who continued to care for the dying patients [8] and introduced care for withdrawing and enhancing the bereaved family's "grieving ability" in the beginner's book about terminal care [18]. An illustrated explanation from the viewpoint of the bereaved daughter's grieving ability is presented in **Figure 9**, and the analysis of human caring by Dr. Jean Watson is presented in **Figure 10**.

2.4.1 Case overview

Nurse B (late 40s, female) was in charge of patient C (late 40s, female) on the deathbed. Coincidentally, nurse B was not a primary nurse but a shift nurse. Patient C and nurse B first met when patient C was on her deathbed. When nurse B saw the adolescent daughter A crying heavily beside the mother's (patient C) death bed, nurse B empathized with daughter A's deep sadness and involuntarily said, "your mother is near and protect you." Following is the verbatim account of nurse B.

When a senior high school girl lost her mother to lung cancer, she told me how hard it was for her and started to cry. At that time, I truly understood how she was feeling, and we cried together. I did not just feel sorry for her, but I understood her deepest darkest feelings and how she had so much to contemplate. Just thinking about it makes me cry. At that time,

Sharing mother's deathbed

Daughter A (17 years old)

Mother C dying at deathbed.

Nurse B (late 40s)

Adolescent needs mother

Daughter A: Crying violently 'I am sad!!'

Nurse B: She truly understood how the daughter was feeling, and she cried naturally. She could feel the daughter's deep thoughts.

● Nurse B experienced loss of a significant family member
↓
She knows the experience of bereavement in her body.

She encountered bereavement of mother, and is mourning and sorrowful.(Grief)

Grieving ability

Her grief work progressed.

She felt her mother as being near and watching over her. She could continue her life after the loss of mother.

She naturally said to the daughter, 'your mother is near and watching over, if she dies.' (She spoke the feelings of the dying mother.)

● Nurse B belongs to the same generation as mother C, and nurse B has a daughter of the same age as daughter A.
↓
・She can understand mother C's sadness and abandonment of leaving her child, as if it was her own.
・she can understand daughter C's feelings like her own daughter.

' I think so.'

' Your mother is always near, isn't it?'
・She began to believe the soul stayed behind and protected the significant person left behind.
・She discussed about death with the patient
(Her ability as a nurse caring for dying patients led to growth and increased spirituality.

Footnotes:
daughter A is shown in blue letters,
nurse B is shown in red letters.

Figure 9.
Introduction case 1 [18].

Analysis of transpersonal caring by Dr. Watson (1)
the case of the adolescent daughter crying mother's death bed

Existential power
① Daughter A: She overcomes her mother's death and starts her own life after losing her mother. She gets a sense of security and comfort that her mother is near and protecting her.
② Nurse B: She believes in the existence of the soul, eternal life, and something greater than self. Her spirituality increases, and she can talk with patients about death as much as they want. She experienced real pleasure in giving end-of-life care. She has a high ability to care for dying patients (See Fig. 12)
③ Mother C: She may probably feel relieved that her daughter could overcome the bereavement and have the ability of opening up new paths in life even without her mother. By getting relieved about her daughter, she may rest in peace.

Crying loudly

Speaking for dying mother 'your mother is near and protecting you'

Mother C in deathbed
・Instead of herself, mother C may have summoned nurse B who can emphasize and accept daughter C's suffering and grief, and can be near and protect her daughter.
・Mother C may have expressed her thoughts to her daughter left behind though the mouth of nurse B.

Interactions
・At the moment of death, the spirituality of mother C, daughter A and nurse B overlapped and resonated at the transpersonal level, and the inner world of the three were crossed.
・Nurse B can hear and empathize with the daughter's sufferings that could not be described in words, and the mother's voice without voice, and the dying mother's thoughts for her daughter are conveyed though the nurse's mouth, and the dying mother and her daughter interact at the level of the soul.

Nurse B
・Nurse B can empathize the spiritual pain of the daughter losing her mother
・Nurse B can empathize with the dying mother's deep regret of leaving behind her daughter and worrying about her.
↓
She is running side-by-side, helping the daughter's grief work
↓
She confirms the progress in the daughter's grief work.

Adolescent daughter A
・Her spiritual pain due to her mother's death before nesting have accepted.
↓
・Her grief work progressed due to nurse B's nearness and protection.
↓
She can realize that her mother is near and protecting her.

'I think my mother is near and still protects me .'

'Is that so….' (the nurse confirms that the daughter's grief work has reached the stage where she can rest.)

Interactions
・Although grief work requires tremendous psychological energy, the daughter works on it and the nurse is running side-by side, and then they finally achieve it.

The philosophical foundation sustaining caring
・Nursing philosophy: philanthropy, altruism
・Philosophy of end-of-life care: supporting the living and dying with respect for their value and way of life.
(holistic understanding of people, including emphasizing the existential and spiritual, and believing in something greater than self)
・Grief care: deeply understanding the sufferings of bereavement and sufferings brought about by grief work
・Ownership as mother (in private): having deep affection for nurturing children (mothering)
・Ownership as experienced person of bereavement (in private): As an experienced person, deeply understanding patient's experience as 'illness', understanding dying person's feeling and thought, and understanding suffering of the bereaved family

Figure 10.
Analysis of case 1.

I was able to tell her, 'Look, your mother is up there,' unintentionally. I'd never been able to breathe empty words like that before. I'm not a mystic or someone who believes in spirits. But now I'm confident, because I think that, when a person died, the soul deep within that person shares the same space. Later, when she seemed to have calmed down quite well, she

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told me, 'My mum always follows me.' 'Oh, is that so?' I replied. When She said that, I felt so glad that I'd been involved in that way. (Quoted from Makiko Kondo, Grieving Process of Nurses Continuing to Care for Dying Patients, Horizon Research Publishing, USA, 2017).

2.4.2 The moment of established transpersonal caring

Although daughter A and her mother C (patient) have lived with each other, bereavement was coming without waiting for the daughter A's nesting. Daughter A, mother C, and nurse B shared the same time due to chance. The life of daughter A and mother C who had walked together in life continuing the "past-present-future" and the life of the nurse B who had lived completely separate from them overlapped and made "present." It is the moment of crossing each other's life (**Figures 2–(5)** and **7**).

Development tasks of the daughter A at high school include spontaneity, diligence, and working on identity. Because the mother's death is too early before nesting, the bereaved daughter's suffering was like tearing a raw tree and spiritual pain. Likewise, because one of the sufferings of the middle-aged dying mother with cancer (regret that death will separate her from her children) was spiritual pain without a relieving strategy [19], she might also die with existential sufferings.

On the other hand, nurse B coincidentally met mother C on the deathbed. However, she experienced bereavement of the significant family and understood the physical difficulties. She also understood (deeply empathized) and resonated with the daughter's sadness. Additionally, nurse B belonged to the same generation as mother C and had a daughter of the same age as daughter A. Therefore, she could understand mother C's sadness and abandonment of leaving her child as if it was her own. She could empathize with daughter C like her own daughter.

Daughter A, nurse B, and mother C were connected at the spiritual level and shared spiritual pain. Nurse B could deeply empathize with daughter A's spiritual pain and could feel mother C's regrettable sadness of dying and leaving the child as if her own. Spiritual pain is the sufferings in a relationship with something greater than self. Dr. Watson mentioned about the connection with the universe [10] that people resonate at the spiritual level beyond space and time. "Look, your mother is up there" and "your mum always follows you after her death" were the worried words from nurse B to the bereaved daughter. Nurse B's words "unintentionally" and "I'd never been able to breathe empty words like that before" showed that her actions were not deliberate and artificial. Therefore, the thoughts mother C was unable to express might have been conveyed to daughter A through nurse B because the trio was connected at a transpersonal level. It is precisely the moment of established transpersonal caring.

The encounter between nurse B and the mother and daughter was coincidental. Although we mentioned above that regret that death will separate her from her children was spiritual pain without a relieving strategy for the dying mother, the mother's love for her child is deep, and therefore, her concern is strong, like the folktales about "mothering ghost" (after mother's death, a baby is born at the tomb, and the mother's ghost comes to buy candy for her baby) that are prevalent at various places in Japan. By the power of something greater than self, mother C's love for her daughter A might attract nurse B in the form of coincidence, who has the ability to deeply empathize with the mother's and daughter's spiritual pain and support daughter A after her mother's death. The words of nurse B, "I'm not a mystic (spirit medium) or someone who believes in spirits," show that she had awareness of living in the world of positivism that emphasized evidence. Still, nurse B was convinced that the soul remains and protects the significant person after death. It shows that the medical field provides opportunities to encounter

life-and-death events, in which we must recognize the existence of "something greater than self" and "eternal life."

2.4.3 After establishing transpersonal caring

According to Dr. Watson's theory, if one person's present and other person's present overlap and resonate at the spiritual level, it influences each other's subsequent life. In **Figures 2–(5)** and **7**, the arcs show the influence on each other's subsequent life.

Daughter A processed her grief while being watched over by nurse B and overcame the crisis of her mother's death by using her grieving ability. Although the mother's body was lost, she believed that her mother was near and protecting her and that she could continue her life after her mother's death.

Nurse B was convinced that her actions were right when she noticed that daughter A processed her grief and overcame her mother's death. Nurse B also heard daughter A saying, "My mum always follows me." Because nurse B was convinced about the existence of a soul, eternal life, and something greater than self, her spirituality manifested, and she could reach the stage of being able to talk and listen to any patient as much as they liked. Although the expert nurse's ability to care for dying patients was shown as a four-layer structure (foundations for continuing to face issues of life and death and skills and tools for facing issues of life and death, overcoming distress, and actively and willingly continuing to face issues of life and death; see **Figure 11**) [8], these abilities of nurse B were enhanced by experiencing transpersonal caring in this case. Although many patients are forgotten over time, this case remained in nurse B's memory because it evoked the pleasure of being involved in the care of dying and of growth as a nurse and human being (**Figure 2(2)**).
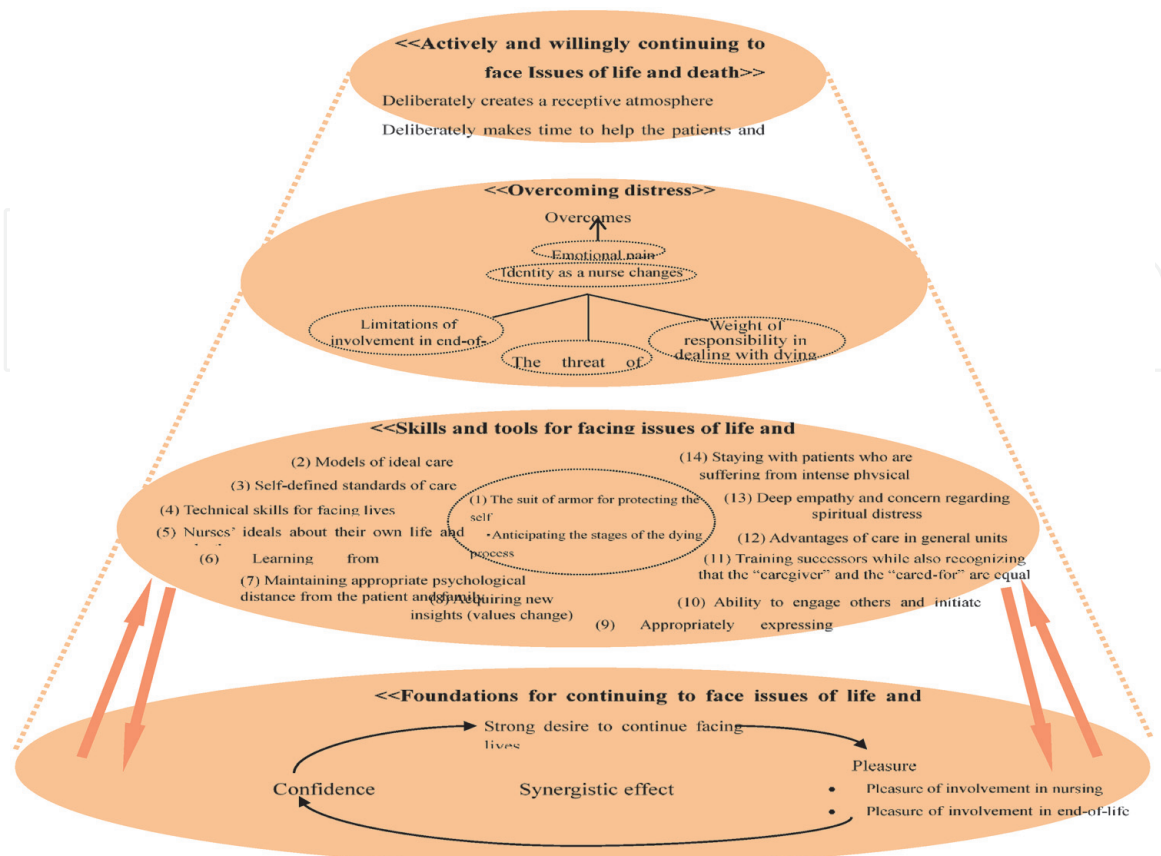
Figure 11.
Capacity to continue facing issues of life and death head-on. Transcription [8].

We cannot escape speculation about mother C. That daughter A could overcome her mother's death and continue her life brought relief to mother C because mother C had a good relationship with her daughter and worried about leaving her daughter behind and hoped for her daughter's happiness. Folktale "mothering ghost" states that a mother dying with strong concerns in this world becomes a ghost and fosters the child. We think that the daughter believed that overcoming bereavement is the reason for memorial services and brings peace.

2.5 The moment of established transpersonal caring (case 2): listening to Hansen's disease survivors' life review by nurses at leprosarium

2.5.1 Hansen's disease and life review

Hansen's disease is caused by *Mycobacterium leprae*, which invades the skin and peripheral nerves (sensory, motor, and autonomic nerves) and can change the patients' appearance. Known as "divine punishment disease," it has been stigmatized since ancient times. Therefore, patients continue to suffer from discrimination and rejection. Some Hansen's disease patients ousted from their hometowns became "wandering lepers" who begged at the gates of temples and shrines and departed on wandering journeys. Silver bullet "promin," discovered in 1943, made it possible to cure Hansen's disease completely.

In Japan, Hansen's disease was regarded as a "national disgrace" around World War II, because "wandering lepers" were a symbol of late civilization in a country. The police authorities forcibly placed them in leprosarium under the Leprosy Prevention Law (1907) passed by the government, and they suffered from lifelong isolation. Hansen's disease patients received inhumane treatment in leprosarium at that time, for example, vasectomy, disciplinary confinement where in the sanatorium direction dicided the punisment; exchanging the sanatorium currency for
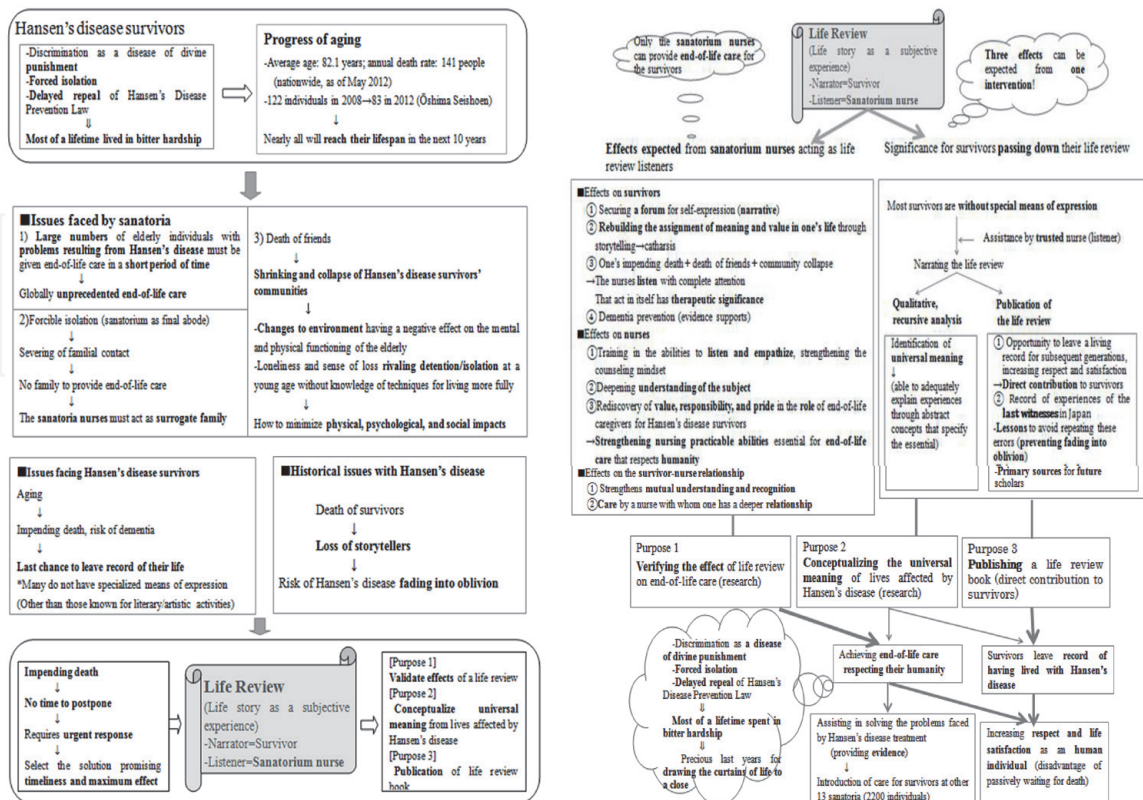
Figure 12.
The significance of listening to Hansen's disease survivors' life review by leprosarium's nurses.
Transcription: [21].
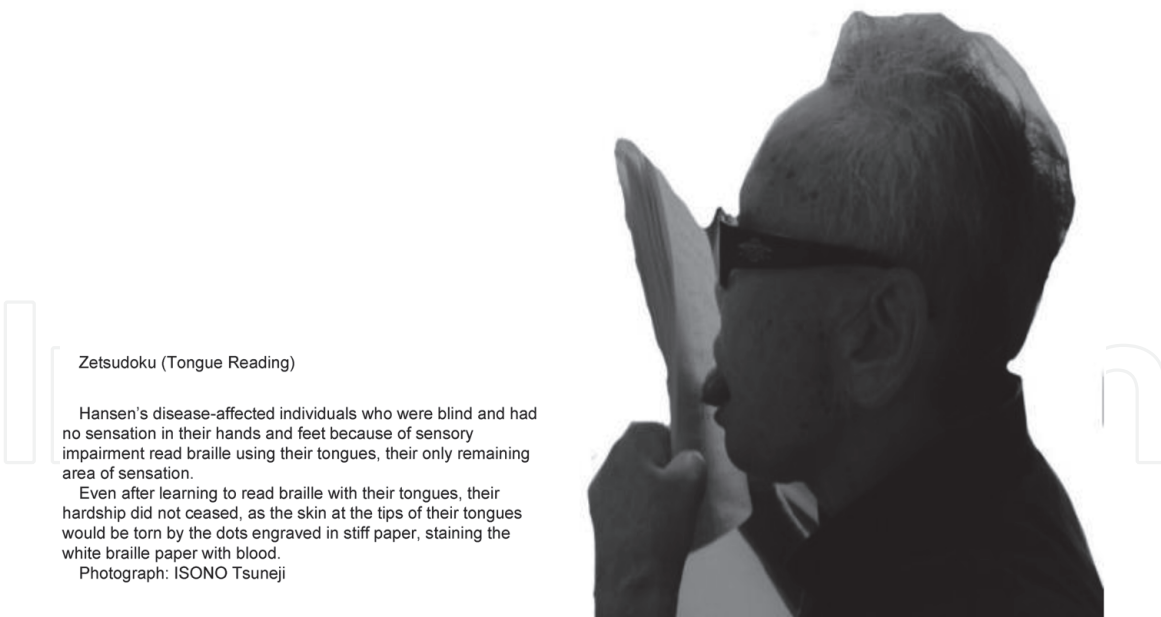
Zetsudoku (Tongue Reading)

Hansen's disease-affected individuals who were blind and had no sensation in their hands and feet because of sensory impairment read braille using their tongues, their only remaining area of sensation.
Even after learning to read braille with their tongues, their hardship did not ceased, as the skin at the tips of their tongues would be torn by the dots engraved in stiff paper, staining the white braille paper with blood.
Photograph: ISONO Tsuneji

Figure 13.
Zetsudoku by Hansen's disease patient [21].

Ossuary (above picture)
(A majority of the residents lived their remaining days on the island and were cremated here. Those whose remains were not returned to their hometowns are kept in this ossuary on the island.)

First Ossuary (left picture)
The 674 people who passed away between 1901 and 1936 are buried here. The oldest remains are dated June 12, 1901 (Ōshima Sanatorium opened on April 1, 1901).

Figure 14.
Ossuary in leprosarium.

preventing runaways; changing patient's name to internal alias; forced labor for maintaining the sanatorium despite doctors, nurses, and other staff; establishment of diseased/non-diseased boundary and autopsy; etc.

By efforts of the National Hansen's Disease Sanatorium Residents' Council, the Leprosy Prevention Law was abolished in 1996, and at the National Redress in 2001, the government was convicted over their error of the isolation policy and formally apologized. In 2009, the Law on Promoting a Resolution to the Hansen's Disease Problem was established, and the treatment for Hansen's disease survivors improved drastically. However, many of Hansen's disease survivors residing at the sanatorium have missed the opportunity to return to society because the Leprosy

Prevention Law was abolished belatedly. Their average age was over 85 years; they did not have families because of the sterilization surgeries (Vasectomies) and had either cut off their families willingly or were cut off from them to prevent their families from being discriminated against and rejected by the society. Currently, an important issue in the sanatorium is how to sustain the purpose of life during their life's last phase and care for peaceful dying and death, i.e., how to practice a high level of end-of-life care (see **Figures 12–14**).

In our project, to resolve this issue, the sanatorium nurses listened to life reviews of Hansen's disease survivors at the National Sanatorium Oshima Seisho-en (located in Oshima at Seto Inland Sea, Japan). Because Hansen's disease survivors and sanatorium nurse relationships are difficult to find in general hospitals [20], we could not establish a deep relationship for respecting the survivor's life worth and purpose of life for high-level end-of-life care. We published a book containing 19 Hansen's disease survivors' life reviews [21] (see **Figure 15**), which is also a record of our nursing practice.
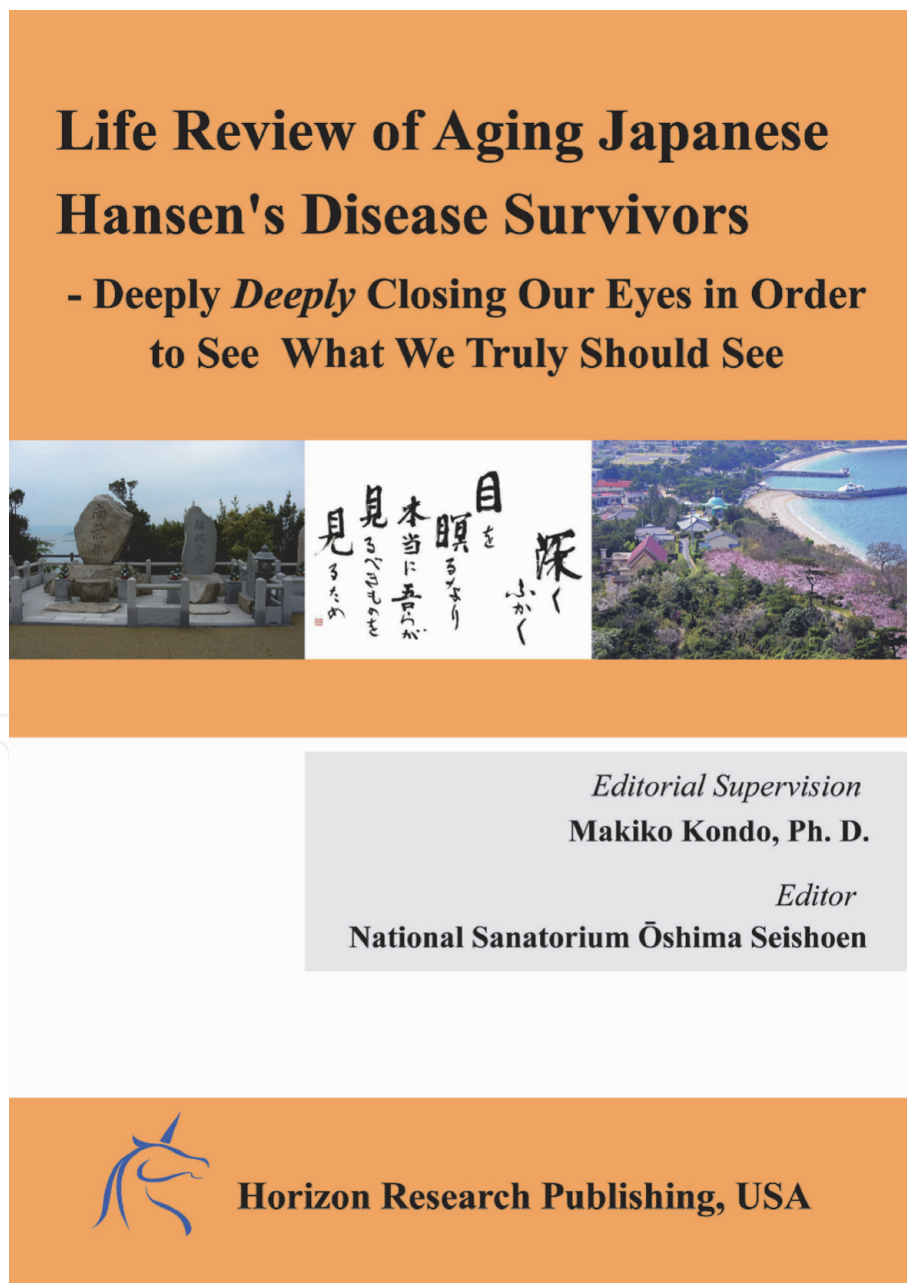
Figure 15.
Our book on life reviews [21].

2.5.2 Transpersonal caring in listening to Hansen's disease survivors' life review

Figure 16 shows the analysis of listening to Hansen's disease survivors' life review by sanatorium nurses by Dr. Watson's transpersonal caring model. First, for the nurses in the leprosarium, "listening to their life review" raised the nurses' ability to empathize and listen, enhanced their counseling mind, deepened their understanding about Hansen's disease survivors' sufferings, and improved their ability of nursing practice concerning their form of existence and life worth for providing indispensable and high-quality end-of-life care.

Second, for Hansen's disease survivors, the opportunity to share their life review promoted attainment of meaning and worth from the tribulation and sufferings because of the disease and had a cathartic effect by purifying bitter experiences. Because they are 85 years old on average, they confront their imminent death, loss of friends who shared a hard time together, and the collapse of the National Hansen's Disease Sanatorium Residents' Council due to decreasing survivors who have been fighting against the nation and promoting autonomous by survivors. Therefore, they experience sufferings and loneliness. However, when they connect with the nurse, grief work (contained anticipatory grief) is processed. Additionally, we know that sharing their life review is effective in preventing dementia.

Interaction by the sharing and listening of the life review enhanced mutual understanding and mutual approval and deepened their relationship. A nurse can play the role of pseudo-family and can care for dying and death warmly and peacefully like their real family, which could not be created due to sterilization surgery.

The philosophical foundations sustaining these interactions include (1) philosophy of nursing (holism, intention for caring, philanthropy), (2) philosophy of end-of-life care (sustaining and respecting the subject's form of existence and life worth, peaceful death, and care for dying warmly and kindly like family),
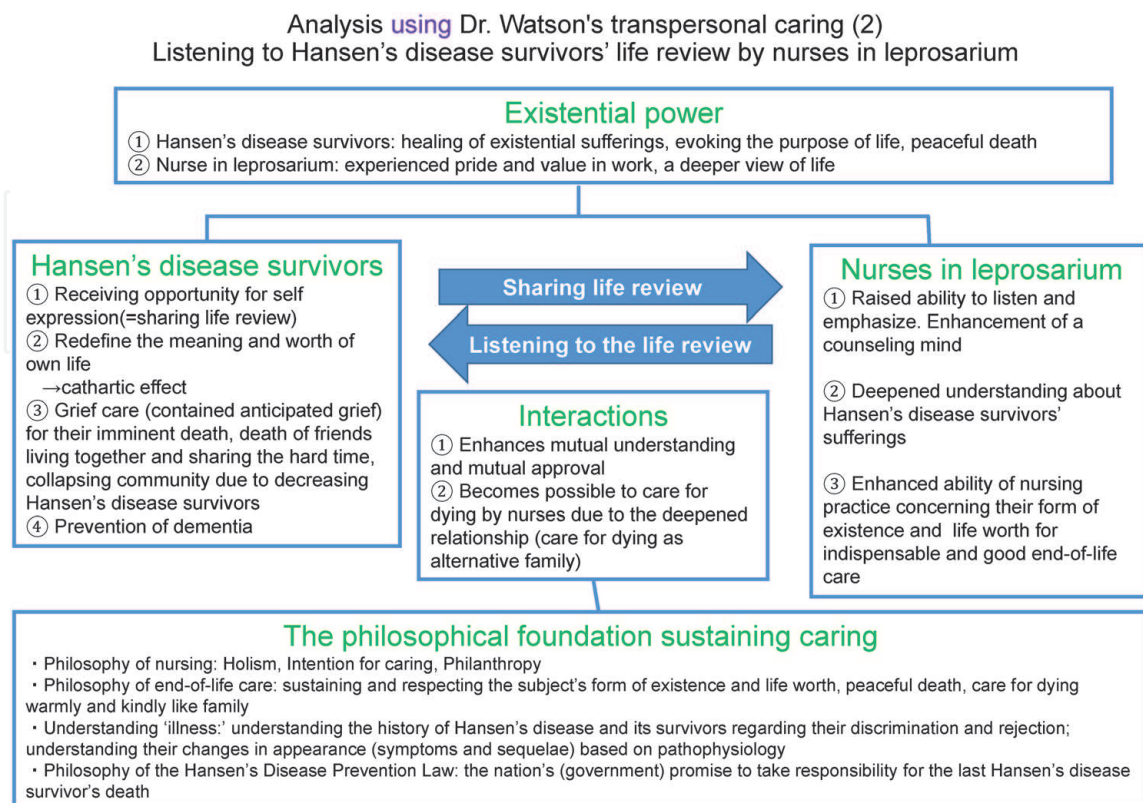
Figure 16.
Analysis of case 2.

(3) understanding "illness" (understanding the history of Hansen's disease and its survivors regarding their discrimination and rejection, understanding their changes in appearance (symptoms and sequelae) based on pathophysiology), and (4) philosophy of the Hansen's Disease Prevention Law (the government's promise to take responsibility for the last Hansen's disease survivor's death).

Existential power of the interaction include (1) Hansen's disease survivors healed from their existential sufferings, evoking the purpose of life and peaceful death, and (2) nurse in leprosarium experienced pride and value in work and a deeper view of life.

3. Significance of caring in medical ethics

When we talk about caring, the significance is ethics finally. The Oath of Hippocrates is the foundation of western medical ethics, and some of them are still widely used. After World War II, the Nuremberg Code was established based on the reflections on the Nazi human experiments. The Nuremberg code contained the subject's rights in a medical experiment. Thereafter, the Nuremberg code became the Helsinki Declaration after the Geneva Declaration.

In nursing, the first ethical guideline is the principle of medical ethics (respect for autonomy, non-maleficence, beneficence, and justice). Therefore, when nurses engage in nursing practice, they decide their actions according to the principle; if they have an ethical conflict, they consider what principle among the four ethical principles is threatened or which principles conflict with which principles and then resolve the ethical conflict. The second ethical guideline for nurses' actions is the ICN Code of Ethics for Nurses [22] and the Code of Ethics for Nurses by the Japanese Nursing Association [23]. The third guideline for medical ethics is caring.

Caring is an interaction based on mutual approval and reciprocity. In the old sanatorium, the treatment of Hansen's disease patients was inhumane. Some medical staff showed philanthropy and mercy and made efforts to help and rescue Hansen's disease patients. However, the government committed mistakes in judgment at that time, which led to the violation of Hansen's disease patients' human rights by many medical staff members. If we, the medical staff, respect the patient as a person with dignity and establish a human-to-human relationship, we will experience resistance and disgust against participating in inhumane treatments. However, if we regard them as materials and not humans, we can engage in inhumane treatment without any sense of resistance. Do not let others do what we cannot do to our family and loved ones. If a caring mind is cultivated, ethical sensitivity is enhanced, and actions based on the medical ethics principle is born spontaneously, the principle of non-maleficence (do not hurt) would be needless. Therefore, caring functions as a stopper and prevents ethically deviant behavior.

Additionally, one of the issues in the current medical field is how to protect human rights and dignity of vulnerable patients, such as those who cannot express their will or have the power to make decisions. When patients have to rely on other people for daily life activities and cannot express their opinion and wills, the caregivers' state directly influences the patient's quality of life. If the caregiver respects the patient's dignity as an irreplaceable person, the quality of care provided is high. Nevertheless, there are news reports about painful incidents, for example, abuse in care homes. Caring includes strategies for protecting the dignity of weak people in a relationship where power balance exists and avoiding ethical issues.

It is difficult to experience transpersonal caring (resonating with each other at the existential level) frequently in daily life. But there is caring in daily commonplace nursing, for example, nurses' smile, calm and warm talking, listening and

empathizing, comfortable bed baths, etc, and these charitas literacy encourages the patient's natural healing power. In Japanese, there are many ancient unique words for respecting and taking care of someone, for example, "arigato (thank you)," "omotenashi (hospitality)," "ogenkide (take care, see you again)," and "odaijini (I hope you get well)." The medical staff uses "odaijini" for patients in the daily medical field, and "odaijini" shows the way of existence ("being" against "doing," as mentioned above). When nurses sincerely confront and dedicate themselves to the patients and their families, they grow by caring, which is characterized by mutual approval and reciprocity. A nurse, who knows real pleasure increases self-affirmation, finds value and pride in her/his work, becomes more independent, and searches for patients' happiness and health. Therefore, caring is sustaining a philosophical and ethical foundation for nursing practice and protecting patients' dignity in the daily clinical field.

4. Conclusion

We explain how to establish Dr. Jean Watson's transpersonal caring using two events: ① case study: An expert nurse unintentionally says, "Your mother continues to be near and protect you," to a crying daughter beside her mother's deathbed; and ② our project: sanatorium's nurses listen to Hansen's disease survivors' life review. When the participants (① dying mother, bereaved daughter, and expert nurse; and ② Hansen's disease survivors and sanatorium nurses) shared the same time and place and made one story together (① mother's deathbed and ② life review), they spiritually empathized with each other (① mother and daughter's spiritual pain due to separation by death; and ② difficult life and existential distress due to Hansen's disease) and formed a deeper relationship, thereby influencing each other future lives (① daughter: overcoming mother's death and moving on with life, and nurse: realizing soul's existence and increasing competence in end-of-life care; and ② Hansen's disease survivors: cathartic effect by sharing their bitter past experiences, peaceful death by nurses' care like real family despite inability to have their own children, and nurse: discovering the significance and worth of sustaining Hansen's disease survivor's life, caring for the peaceful death of those who have experienced a harsh life).

Acknowledgements

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