Academic Journal of Medicine & Health Sciences

ISSN 2616-5791 Vol. 6, Issue 6: 32-40, DOI: 10.25236/AJMHS.2025.060605

Beyond Physical Suffering: A Qualitative Meta-Synthesis of the Multidimensional Illness Experience in Cancer Pain Patients

Zhimiao Wang, Miao Cheng, Aichun Zhou

Department of Oncology, The Third People's Hospital of Hangzhou City, Hangzhou, Zhejiang Province, China, 310000

Abstract: *To systematically evaluate the real experience of cancer patients with pain, and to provide a reference for medical personnel to formulate comprehensive and targeted cancer pain management plans, this systematic review retrieved qualitative studies on the illness experience of cancer pain patients from PubMed, Web of Science, Embase, The Cochrane Library, PsycINFO, ScienceDirect, CINAHL, CNKI, Wanfang, CQVIP, and the China Biomedical Literature Database, covering literature up to January 2025. The included studies were evaluated using the Joanna Briggs Institute (JBI) Evidence-based Health Care Centre qualitative research quality assessment criteria and synthesized using meta-aggregation. A total of 18 articles were included, yielding 71 themes categorized into 9 categories and consolidated into 4 integrated findings: the multi-dimensional dilemma of psychological pain and physical discomfort, multiple challenges of cancer pain management, social and cultural constraints and support network fracture, and cancer pain cognition and response. These findings underscore the importance for medical staff to prioritize the patient experience of cancer pain. To enhance patient coping efficacy, it is crucial to establish a comprehensive person-centered, full-process, and culturally-sensitive care model, implementing stratified psychological interventions, culturally-sensitive communication, and precise pain education.*

Keywords: *Cancer Pain; Qualitative Research; Meta-Synthesis*

Cancer pain refers to pain caused by tumor invasion of bone, viscera, or nerves, or tissue/nerve damage resulting from cancer treatments (surgery, chemotherapy, radiotherapy) [1]. Studies indicate that approximately 45% of cancer patients experience cancer-related pain, with 31% suffering moderate-to-severe pain [2]. This pain is frequently accompanied by cognitive changes and complex negative emotions—including fear and despair—that intensify the suffering experience [3].Traditional biomedical approaches predominantly focus on pharmacological interventions, overlooking the holistic needs of patients as whole persons. While quantitative studies provide standardized measures of pain intensity or quality of life, they fail to capture the richness and dynamic nature of subjective experiences, potentially missing critical intervention targets. Furthermore, existing evidence lacks systematic integration of illness experiences across diverse geographic and disease-stage contexts.Consequently, interventions developed without this understanding may inadequately address patients' actual needs, compromising pain management efficacy and quality of life. This meta-synthesis of qualitative studies aims to explore the subjective illness experience of cancer pain patients, providing evidence for developing comprehensive and individualized pain management protocols.

1. Materials and Methods

1.1 Inclusion and Exclusion Criteria for Literature

Inclusion Criteria: This study sets the inclusion criteria for literature based on the PICoS model. 1) Research subjects (population, P): Cancer pain patients; 2) Interesting phenomena (interest of phenomena, I): The experiences and feelings of cancer pain patients; 3) Research context (context, Co): The context is a medical setting, community, nursing home, or patient's home; 4) Research design (study design, S): Qualitative research including phenomenological research, grounded theory research, ethnographic research, and ethnographic research; 5) The quality evaluation of included literature is A or B level. Exclusion Criteria: 1) Non-Chinese or non-English literature; 2) Unable to obtain the full text; 3) Literature that does not match the research topic; 4) Duplicate published literature; 5)

Conference papers and review articles.

1.2 Literature Search Strategy

Search the databases of PubMed, Web of Science, Embase, Cochrane Library, PsycINFO, ScienceDirect, CINAHL, China National Knowledge Infrastructure (CNKI), Wanfang, VIP, and China Biomedical Literature Database. The search period is from the establishment of the databases to January 2025. The Chinese search terms include "cancer pain/cancer-related pain/tumor pain/cancer pain/cancer-related pain", "qualitative research/qualitative study/phenomenological research/rooted theory/focus group method/interview/feeling/experience". The English search terms include: "neoplasm pain/cancer pain/cancerous pain/carcinomatous pain/oncology pain", "qualitative research/qualitative study/grounded theory/focus group method/feeling/interview/patient perspective". All English database searches adopt a combination strategy of MeSH terms and free terms.

1.3 Literature Screening and Data Extraction

The retrieved literature was imported into the Zotero software to remove duplicate entries. The first and second authors independently screened the literature strictly according to the inclusion and exclusion criteria of the literature, and cross-checked each other. In case of any disagreement, they consulted the third researcher for resolution. Relevant data were extracted from the included literature, including the authors, publication time, country, research subjects, research methods, interesting phenomena, and research results.

1.4 Evaluation of Literature Methodological Quality

The quality of the literature was evaluated according to the qualitative research quality evaluation standards of the JBI Evidence-Based Health Care Center in Australia [4]. The evaluation content consisted of 10 items. Those that fully met the evaluation standards were rated as grade A, those that partially met the standards were rated as grade B, and those that did not meet the standards at all were rated as grade C. The first and second researchers independently evaluated the quality of the included literature. If there was a disagreement, the third researcher would negotiate and resolve it. Finally, the literature with a grade of A or B was included in this study.

1.5 Data Analysis Method

The JBI evidence-based health care center's comprehensive method for pooling data was adopted [4]. Through repeated reading, analysis, and interpretation of the included literature, similar results were summarized and new categories were formed. Finally, different new categories were integrated into a generalized consolidated result.

2. Results

2.1 Literature Search Results

A total of 4,640 relevant documents were initially retrieved. After duplicate removal, initial screening, re-screening, and quality evaluation, 18 documents were finally included. The document screening process is shown in Figure 1.

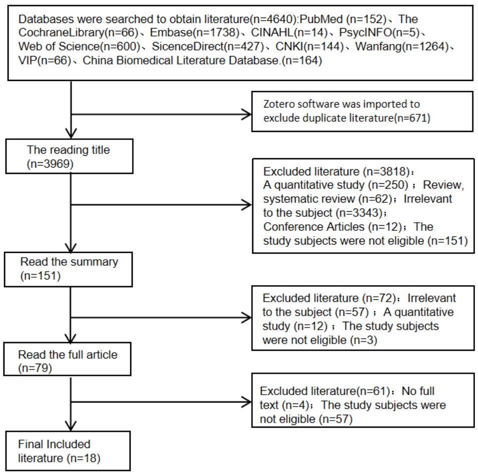

Figure 1 Literature screening process

2.2 Basic characteristics of the included literature

Seven Chinese literatures [5-11] and 11 English literatures [12-22] were included. The basic characteristics of the included literatures are shown in Table 1

Table 1 Basic characteristics of the included literature (n=18)

Included literature	Year of publication	The state	Subjects	Research Methods	Phenomenon of interest	Main Outcome measures
Hong Chen et al [5]	2015	China	20 patients with cancer pain	A phenomenological study	The demand of cancer pain patients for nursing services	1) More supportive psychological intervention is needed;2) Higher demand for drug use knowledge;3) Higher demand for ward treatment environment;4) More humanized nursing intervention is needed
Xueyun Chu et al [6]	2020	China	21 patients with cancer burst pain	A phenomenological study	To investigate the quality of life and nursing needs of patients with cancer outbreak pain	1) Poor quality of life;2) Insufficient knowledge of outbreak pain;3) High expectations for pain management4) Insufficient humanistic nursing;5) High requirements for ward environment
Zebin Luo et al [7]	2021	China	23 patients with cancer	A phenomenological study	Patients' real experience of cancer pain self-management	1) Medication management; 2) cancer pain cognition and coping management;3) Psychological management;4) Life management;5) Interpersonal communication management
Ying Song et al [8]	2023	China	20 cases of advanced cancer patients	A phenomenological study	To explore the special experience and inner feelings of advanced cancer patients with cancer burst pain	1) Breakout pain related knowledge level;2) Inner experience when breakout pain occurred; 3) Cognition of analgesic drugs ;4) Coping attitude when breakout pain occurred
Chang Tian et al [9]	2023	China	14 cases of refractory cancer pain patients	A phenomenological study	Breakout pain experience in patients with advanced cancer	1) Physical distress; 2) Mental/psychological distress; 3) Family/social distress; 4) Self-management disorder
Yan Zhang et al [10]	2018	China	23 cases of small cell lung cancer patients	A phenomenological study	To explore the cognition and coping of pain in patients with small cell lung cancer	1) Strong negative emotions; 2) Nnot correctly reflecting the real pain situation; 3) Lack of pain coping measures
Songxian Zhao et al [11]	2017	China	12 cases of advanced cancer patients who experienced breakthrough pain	A phenomenological study	Breakout pain experience in patients with advanced cancer	1) Overall perception of breakout pain; 2) Experience of breakout pain;3) Personal growth related to breakout pain
Alsaraireh et al [12]	2022	Jordan	21 patients with advanced cancer	To describe the qualitative study	Pain experience of patients participating in multidisciplinary pain management and still receiving treatment and cancer pain management	1) Relationship between patients and healthcare professionals; 2) Satisfaction with services
Bender et al[13]	2008	Canada	18 Cases of Breast Cancer The patient	To describe the qualitative study	Experience and management of cancer-related pain in women with breast cancer	1) Understanding cancer pain;2) What happens to pain related things ;3) The choice of pain control; 4) Coping with cancer pain;5) Communicating with patients with cancer pain; 6) Seeking help for cancer pain;7) Having difficulty adequately describing their pain

Dunham et al[14]	2017	Britain	9 elderly cancer patients receiving palliative care	A phenomenological study	Pain experience of elderly cancer patients	1) It is better to be old than to die of cancer; 2) Maintain control and independence;3) Losing oneself in adaptation and grief; 4) Don't like pain relief ;5) Pain denial
Im et al[15]	2008	The United States	11 African American patients with cancer	Ethnographic studies	The pain experience of African American cancer patients	1) Viewing cancer as a life challenge;2) Cancer pain is different from ordinary pain;3) African Americans, especially women, inhibited expressing pain and seeking help with pain management; 4) Patients' views on the disease process changed
Im et al[16]	2006	The United State	29 white patients with cancer	To describe the qualitative study	Gender and racial differences in the experience of pain among white cancer patients	1) Pain accompanied by cancer; 2) ndividual culture-specific characteristics and perceptions of pain and cancer may contribute to the differential experience of cancer pain among white cancer patients; 3) Medical providers did not take female patients' pain seriously; 4) Highly personalized pain experience with emotional distress; 5) Desire to be in control of their pain management process
Maly et al[17]	2018	The United State	18 African American patients with cancer	To describe the qualitative study	African American understanding of cancer pain and perceived control of pain	1) The struggle of chronic pain experience; 2) Perceived benefits of pain control
Reticenae et al[18]	2015	Brazil	12 elderly patients with cancer	A phenomenological study	The treatment experience of cancer pain in the elderly	1) Cancer pain leads to the imprisonment and oppression experienced by the elderly;2) Cancer pain brings life pain
Smith et al[19]	2023	Australia	14 breast cancer patients with pain for more than three months	To describe the qualitative study	Experiences of women with persistent pain after breast cancer treatment	1) Characteristics of pain; 2) Interaction with healthcare providers; 3) Pain management
Xia et al[20]	2024	China	17 patients with advanced cancer pain	A phenomenological study	The experience of coping with chronic pain in patients with advanced cancer	1) Pain catastrophizing; 2) Rumination;3) Avoidance coping; 4) Constructive action
Xu et al[21]	2019	China	12 patients with cancer pain	To describe the qualitative study	Pain acceptance in patients with chronic cancer pain	1) Adaptation; 2) Emotional response to pain; 3) Functional limitation; 4) Coping strategies
Zhang et al[22]	2023	China	11Cases of breast cancer The patient	A phenomenological study	Causes of pain in breast cancer patients during postoperative chemotherapy	1) Physical memory of pain; 2) The special significance of time; 3) Treatment and prognosis; 4) Interpersonal communication and coping; 5) Personal behavior and growth

2.3 Quality evaluation results of included literature

The quality evaluation of 18 articles was grade B, as shown in Table 2.

Table 2 Results of methodological quality assessment of the included literatures (n=18)

Included literature	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)	Quality grade evaluation
Hong Chen et al [5]	C	Y	Y	Y	Y	N	N	Y	C	Y	B
Xueyun Chu et al [6]	Y	Y	Y	Y	Y	N	Y	Y	C	Y	B
Zebin Luo et al [7]	Y	Y	Y	Y	Y	N	Y	Y	C	Y	B
Ying Song et al [8]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B
Chang Tian et al [9]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B
Yan Zhang et al [10]	Y	Y	Y	Y	Y	N	N	Y	C	Y	B
Songxian Zhao et al [11]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Alsaraireh et al [12]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Bender et al[13]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Dunham et al[14]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Im et al[15]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Im et al[16]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Maly et al[17]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Reticenae et al[18]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Smith et al[19]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Xia et al[20]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	B
Xu et al[21]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B
Zhang et al[22]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B

Note: 1) Whether the philosophical basis is consistent with the methodology; 2) Whether the methodology is consistent with the research question or research objective; 3) Whether the methodology and data collection methods are consistent; 4) Consistency of methodology, data analysis and expression; 5) Whether the methodology is consistent with the interpretation of results; 6) Whether to explain the status of the researcher from the perspective of cultural background and values; 7) Whether it describes the impact of researchers on the study or the impact of research on the researchers; 8) Whether it fully represents the meaning stated by the participant; 9) Whether the study was approved by the ethics committee; 10) Whether the conclusion is derived from the analysis and interpretation of the data. Legend: Y = Yes; C = Can't Tell; N = No.

2.4 Meta-Synthesis Findings

Through iterative reading, coding, and hermeneutic analysis of the 18 included studies, we identified 71 descriptive themes. These were subsequently grouped into 9 analytical categories and finally synthesized into 4 integrated findings.

2.4.1 Integrated Finding 1: Multidimensional Distress in Psychological and Physical Domains

Category 1: Diverse Manifestations of Emotional Distress,Acute Phase: Stress-induced emotional dysregulation was observed (e.g., "I throw objects when in agony" [5]), irritability ("Pain makes me more irritable" [21]), and despair ("Unbearable pain feels like bones cracking" [21]). Chronic Phase: Existential crises emerged, characterized by meaninglessness ("What's the point of living?" [21]), fatalism ("Blame my ill-fated destiny" [8]), and perseverative cognition ("Why must I suffer so?" [20]), with suicidal ideation ("Consider euthanasia or jumping" [20]).

Category 2: Physical Distress and Environmental ,Triggers ,Cancer pain induced progressive functional decline: Somatic compromise: Ageusia ("Cannot smell food" [18]), anorexia ("Unable to eat" [18]), cachexia ("80kgdropped to 55kg" [18]), and sleep fragmentation ("Waking hourly due to pain" [6]). -Environmental exacerbation: Ward noise disrupted rest ("Other patients disturb my quiet time" [5]) and directly amplified pain perception ("Hospital clamor intensifies pain" [6]).

2.4.2 Integrated Finding 2: Multifaceted Challenges in Cancer Pain Management

Category 3: Medication Cognition Barriers,Patients demonstrated therapeutic ambivalence due to:Opioid stigma: Self-tapering from misconceptions ("Stopped regular dosing after hearing 'mo rphine is a drug'" [7]),Nocebo effects: Anticipatory fear of side effects ("Worried about hepatotoxicity" [21]).Physiological intolerance: Treatment discontinuation from adverse events ("Nausea after taking pills" [8]), leading to non-adherence ("Reduced to one pill/day" [21]).

Category 4: Clinician-Patient Trust Erosion,Nursing deficits: Delayed assessment ("No timely pain evaluation" [5]),Mechanical practices ("Only asked pain level with ruler" [6]),Empathy gap ("Craved comforting words" [11]). Medical invalidation: Physician dismissal of subjective experience ("You shouldn't feel pain' - doctors denied my report" [19]) without explanation, disregarding patient agency [17]).

Category 5: Structural Healthcare Barriers,Resource fragmentation: Regional disparities concentrated pain specialists in tertiary hospitals ("Must go to top-tier hospitals" [9]), causing: Care delays ("Traveled miles, waited days for beds" [20]),Premature transfers ("Forced to secondary hospitals post-treatment" [9]),Systemic failures: Inadequate downstream capacity ("Secondary hospitals couldn't manage my agony" [9]) and severed continuity of care ("No post-discharge support" [10]).

2.4.3 Integrated Finding 3: Sociocultural Constraints and Support Network Breakdown

Category 6: Cultural Suppression of Pain Expression.Community cultural norms restricting emotional expression hinder individuals' ability to seek appropriate avenues for processing inner distress, potentially impacting overall community mental health levels ("I grew up in the Black community; we don't express pain openly" [15]). Furthermore, societal gender stereotypes influence healthcare perceptions. The implicit belief that men contribute more economically to families and society leads to their health concerns being prioritized ("Men are often the traditional breadwinners; their cancer is taken more seriously by family, friends, and doctors" [16]). Physicians also demonstrate a tendency to place greater credence in male patients' symptom reports ("Doctors are more inclined to believe male patients' complaints about pain" [16]). These gendered role expectations result in men receiving more support and attention for pain, while women often internalize their suffering ("I don't speak up when I'm in pain" [16]).

Category 7: Breakdown of Familial Support. The prolonged need for analgesic treatment ("Sold the house to pay for treatment the first two years; now the pain patches cost a fortune, really can't afford it" [9]) and the high cost of effective pain medication ("Effective analgesics are relatively expensive" [6]) impose significant economic burdens on patients' families. Consequently, patients simplify pain management decisions into cost-benefit calculations, actively enduring pain to reduce family expenses ("Endure what I can to cut costs" [6]). This situation, compounded by lost work capacity, traps them in a "treatment-poverty cycle" ("I'm just a rural resident; I don't earn much in a year" [6]). Single-parent patients experience intense intergenerational guilt due to their caregiving responsibilities ("The pain is unbearable; as a single mother, I feel like I'm just burdening my child" [7]).

2.4.4 Integrated Finding 4: Cancer Pain Cognition and Coping

Category 8: Cognitive Biases Regarding the Nature of Cancer Pain.Patients engage in psychological defense mechanisms, such as lexical substitution (e.g., using terms like "a lot of trouble" or "feeling awful" instead of explicitly naming pain [7]), reflecting a subconscious denial of the uncontrollable nature of cancer pain. Some patients lose the ability to describe their pain accurately due to its complexity, manifesting as vague spatial localization ("General discomfort, couldn't pinpoint exactly where" [10]), impaired quantification ("The worst kind of pain" [10]), and suppressed emotional expression ("When in pain, I wouldn't tell anyone" [22]). Concurrently, patients employ trial-and-error analgesic approaches, including thermotherapy ("When the pain starts, I apply heat for a while" [11]) and distraction techniques ("Reading newspapers or listening to comedy to distract myself" [11]). However, a lack of understanding of pain mechanisms leads to fragmented and ultimately unsustainable strategies ("Tried many things at home like acupuncture and massage; they helped at first but then stopped working" [9]). When analgesic measures fail, patients descend into existential helplessness ("I've given up" [19]).

Category 9: Dynamic Adaptation in Cancer Pain Coping.Coping with cancer pain encompasses four evolving dimensions:1) Medication-Centric Survival Strategies: Prioritizing pharmacological interventions for rapid pain relief ("Injections work very well for stopping the pain quickly" [8]).2) Behaviorally Empowered Daily Living: Mitigating pain through progressive physical activity ("Exercising slowly within my physical limits" [11]), functional eating ("Eating foods I used to dislike, treating them like medicine" [11]), and family-assisted massage ("Massages from my family ease the pain a little" [7]).3) Socio-Spiritual Integration and Support: Reducing cancer-related fear through knowledge sharing ("Consulted my nursing student friend; she taught me coping strategies" [7]), spiritual practices like scripture recitation ("My daughter got me protective charms and Buddhist scriptures from the temple; they help when I get restless from the pain" [21]), and prayer ("Thanking God for guiding me through this cancer journey lessens my fear" [15]).4) Reconstruction of Life Meaning: Deepening intimate relationships ("I'm more willing to share my thoughts with family now than before" [20]), transforming physical improvements into social capital ("Before I couldn't bend to pick things up, now I can; this lets me move around and do things I couldn't before" [17]), and rebuilding future aspirations ("Once the pain subsides, I still want to travel, make videos, and pursue my passions" [20]).

3. Discussion

3.1 Emphasizing the Mind-Body State of Cancer Pain Patients and Influencing Factors on Pain Expression, Facilitating Patient Communication

The findings of this study reveal that the psychological distress experienced by cancer pain patients is not a singular emotional response, but rather a dynamic process resulting from the interplay of physiological, psychological, and socio-cultural factors. Patients' feelings of despair, stigma, and suicidal ideation are closely linked to the uncontrollable nature of their pain (e.g., unpredictable breakthrough pain) and the loss of social roles (e.g., deprivation of family function). This finding aligns with the "Total Pain" theory proposed by Cicely Saunders [23], which conceptualizes the pain experience as an integration of physical, emotional, social, and spiritual suffering.Inadequately managed pain severely compromises patients' daily functioning and quality of life, leading to reduced survival duration and diminished quality of life [24]. This pervasive decline in physiological function underscores the clinical need to establish dynamic assessment systems, expanding the goals of pain management beyond mere analgesia to encompass functional rehabilitation.Within this study, a crisis of trust between patients, healthcare providers, and caregivers emerged as a critical barrier to effective pain expression. Pain serves as a vital bodily signal; it is imperative that healthcare professionals listen to it attentively, respect it, and respond to it scientifically. Viewing patients' narratives as essential diagnostic clues is fundamental to achieving patient-centered care. This approach enhances patients' belief in their ability to cope actively with pain and facilitates a crucial shift in the care paradigm – from a focus on "curing disease" to improving "quality of life and survival.

3.2 Strengthening Professional Guidance for Cancer Pain Self-Management and Enhancing Patient Understanding

This study reveals that patients with cancer pain often lack essential knowledge for self-managing their pain, primarily manifested through misconceptions about cancer pain itself and analgesic medications. This knowledge gap significantly hinders the effective implementation of subsequent pain treatment interventions.Studies indicate [25] that implementing empowerment education for cancer pain patients improves medication adherence, reduces the incidence of breakthrough cancer pain, alleviates barriers to pain control, and fosters the adoption of positive coping strategies, thereby enhancing overall pain management.

Consequently, comprehensive patient education on cancer pain is paramount to ensuring the success of pain treatment protocols. This necessitates a multi-faceted approach:1) Enhancing Nursing Expertise: Strengthen specialized training for nursing staff covering the clinical manifestations and symptoms of cancer pain, assessment methods, adverse impacts, pain relief modalities, and nursing interventions. This elevates their competence in cancer pain care [26].2) Delivering Tailored Patient Education:Utilizing diverse channels such as hospital bulletin boards, official social media accounts, and short videos, trained nurses should conduct health education. Education content must be personalized based on the patient's pain duration and hospitalization length to establish accurate understanding of cancer pain and analgesics [27].3) Ensuring Efficacy and Collaboration: Post-training evaluations are crucial to inform future training initiatives. Following patient comprehension, healthcare providers must collaborate with patients to establish a consensus on the pain management plan, actively engaging them in the process. Regular follow-up evaluations are essential to assess the plan's effectiveness and facilitate timely adjustments.

3.3 Strengthening Support Systems from Multiple Angles to Optimize Cancer Pain Coping Pathways

This study highlights the current status and challenges in coping strategies among cancer pain patients. Key findings include a widespread lack of effective coping mechanisms, leading to suboptimal pain control. While patients actively seek support from multiple sources—including healthcare providers, family, and friends—inconsistent information from these sources can cause confusion and uncertainty [6].To address these challenges, a multi-level approach is essential:1) Individualized Support & Leveraging Significant Others: Healthcare providers should first assess each patient's unique coping capacity and personal characteristics. Activating their social support networks is crucial to meet their emotional needs related to pain. Significant others [28], as vital components of patients' social networks, should be integrated into pain self-management plans to assist patients collaboratively.2) Hospital-Level System Improvements: Addressing common patient grievances in the Chinese context—particularly high medical costs and long wait times for hospital beds [29]—requires hospitals to increase staffing support, streamline oncology patient pathways, implement dynamic bed allocation systems, and establish noise-reduced wards.3) Government-Level Policy & Resource Optimization: Optimizing healthcare resource allocation and enhancing standardized cancer pain diagnosis and treatment protocols at primary care levels are essential government responsibilities to meet patient needs [30].4) Integrating Digital Health Solutions: Leveraging rapid internet development, dual "online-offline" service channels should be implemented. Ensuring responsive online consultations addresses cancer pain concerns promptly and supports effective pain management for home-based patients [31].Ultimately, building a comprehensive "Hospital-Community-Family" social support system is paramount. This integrated model should provide patients with holistic support, including pain education, medication self-management guidance, and psychological counseling. Such a system strengthens patients' motivation to cope with pain, optimizes their coping pathways, and positively impacts their overall health and well-being [32].

4. Conclusions

This meta-synthesis study provides an in-depth exploration of the illness experiences of cancer pain patients and delineates the current state of pain self-management and coping strategies. The findings underscore the urgent need for clinical practice to adopt a Comprehensive Person-Process-Culture Care Model. Implementing this model requires: Stratified psychological interventions to address patients' negative emotions. Enhanced patient education focusing on the disease and relevant knowledge. Increased support to improve patients' coping efficacy regarding cancer pain. However, this study has limitations. All included research employed phenomenological methodologies, indicating a lack of methodological diversity. Furthermore, several studies failed to address the researchers' potential influence on the findings. Future research should incorporate methodological enhancements to address these gaps.

References

[1] Bennett M I, Kaasas B, Barkea A, et al. The IASP classification of chronic pain for ICD-11: chronic cancer-related pain[J]. Pain, 2019, 160(1): 38-44.
[2] Snijdersra H, Brom L, Theunissen M, et al. Update on prevalence of pain in patients with cancer 2022: a systematic literature review and Meta-analysis[J]. Cancers, 2023, 15(3): 591.
[3] Sjattar E L, Arafat R, Ling L W. Cancer pain self-management interventions in adults: scoping review[J]. BMJ Support Palliat Care, 2024, (14): 1-5.
[4] Hu Y, Hao Y. Evidence-Based Nursing (2nd ed.)[M]. People's Medical Publishing House, 2018: 157-174.
[5] Chen H, Yao Z, Cai M, et al. A qualitative study on the nursing needs of cancer pain patients[J]. Journal of Bengbu Medical College, 2015, (12): 1762-1764.
[6] Chu X, Li N, Huang Z. A qualitative study on the quality of life and nursing needs of patients with cancer breakthrough pain[J]. Qilu Journal of Nursing, 2020, (11): 102-105.
[7] Luo Z, Luo B, Chen Q, et al. The self-management experience of cancer pain in cancer patients: A qualitative study[J]. Journal of Nursing Science, 2021, (11): 21-24.
[8] Song Y, Tian C, Li J. A qualitative study on the experience of breakthrough pain in patients with advanced tumors[J]. Chinese General Practice Nursing, 2023, (20): 2848-2851.
[9] Tian C, Song Y, Li J. A qualitative study on the pain experience of patients with refractory cancer pain[J]. Journal of Nurses Training, 2023, (4): 380-383.
[10] Zhang Y, Sun J, Cao Y, et al. A qualitative study on pain cognition and coping styles in 23 patients with small cell lung cancer[J]. Shanghai Journal of Preventive Medicine, 2018, (3): 233-235.
[11] Zhao S, Qiang W, Shen A, et al. A qualitative study on the breakthrough pain experience of advanced cancer patients[J]. Chinese Journal of Practical Nursing, 2017, (22): 1694-1697.
[12] Alsaraireh M, Albashtawy M, Abdalrahim A, et al. Cancer Pain Management Program: Patients' experiences-A qualitative study[J]. Nurs Forum, 2022, 57(5): 773-784.
[13] Bender J L, Hohenadel J, Wong J, et al. What Patients with Cancer Want to Know About Pain: A Qualitative Study[J]. Journal of Pain and Symptom Management, 2008, 35(2): 177-187.
[14] Dunham M, Allmark P, Collins K. Older People's Experiences of Cancer Pain: A Qualitative Study[J]. Nursing older people, 2017, 29(6): 28-32.
[15] Im E O, Lim H J, Clark M, et al. African American Cancer Patients' Pain Experience[J]. Cancer Nurs, 2008, 31(1): 38-48.
[16] Im E O. White Cancer Patients' Perception of Gender and Ethnic Differences in Pain Experience[J]. Cancer Nurs, 2006, 29(6): 441-450.
[17] Maly A, Singh N, Vallerand A H. Experiences of Urban African Americans with Cancer Pain[J]. Pain Management Nursing, 2018, 19(1): 72-78.
[18] Reticena K, Beuter M, Sales C A. Life experiences of elderly with cancer pain: the existential comprehensive approach[J]. Rev Esc Enferm USP, 2015, 49(3): 419-425.
[19] Smith M D, Manning J, Nielsen M, et al. Exploring Women's Experiences with Persistent Pain and Pain Management Following Breast Cancer Treatment: A Qualitative Study[J]. Front Pain Res (Lausanne), 2023, 4: 1095377.
[20] Xia W, Ou M, Chen Y, et al. Experiences of Patients with Advanced Cancer Coping with Chronic Pain: A Qualitative Analysis[J]. BMC Palliat Care, 2024, 23(1): 94.
[21] Xu X, Cheng Q, Ou M, et al. Pain Acceptance in Cancer Patients with Chronic Pain in Hunan, China: A Qualitative Study[J]. Int J Nurs Sci, 2019, 6(4): 385-391.
[22] Zhang Y, Long W, Wang H, et al. Pain Catastrophising in Chinese Patients with Breast Cancer during Postoperative Chemotherapy: A Qualitative Study[J]. BMJ Open, 2023, 13(9): e076362.
[23] Saunders C M. The management of terminal illness[M]. London: Hospital Medicine Publications, 1967.
[24] Hang J F, Chan D N S, Liu X L, et al. Effects of self-management interventions for cancer patients with pain: A systematic review of randomised controlled trials[J]. J Clin Nurs, 2023, 32(17-18): 5652-5667.
[25] Zhang R. Effect of empowerment education combined with cancer pain nursing intervention on medication adherence, cancer pain, and quality of life in tumor patients[J]. Heilongjiang Medicine, 2022, (5): 1237-1240.
[26] Niu M, Zhang X. Development and validation of a questionnaire on health education needs of cancer pain patients[J]. Chinese Journal of Modern Nursing, 2023, (3): 293-299.
[27] Niu M, Tie W, Zhang X, et al. Analysis of the level and influencing factors of knowledge, attitude, and practice regarding pain in cancer pain patients[J]. Chinese Journal of Practical Nursing, 2022, (35): 2749-2755.

[28] Huang X, Gao J, Zheng X, et al. Research progress on pain responses of significant others in chronic pain patients[J]. Military Nursing, 2023, (3): 87-90.
[29] Hao J, Fan Z, Zhang Y, et al. Analysis of satisfaction with healthcare experience among inpatients in 136 tertiary public hospitals in China[J]. Chinese Journal of Hospital Administration, 2021, (6): 465-469.
[30] Wu K, Yang S, Li W, et al. Construction and exploration of a one-stop remote collaboration service platform under the Specialist Medical Consortium model[J]. Journal of Medical Informatics, 2023, (1): 65-69.
[31] Zhang Z, Xiong J. Analysis of patient preference for healthcare choices on an online medical platform from 2016 to 2020[J]. Chinese Journal of Hospital Administration, 2022, 38(2): 129-133.
[32] Kim M D, Jung Y E. Factors associated with health-related quality of life among older people exposed to the jeju 4·3 incident[J]. Psychiatry Investig, 2021, 18(9): 809-817.